Psychology Postdoctoral Resident Manual

Training Year 2022-2023

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Program Aim, Competencies, and Elements

Aim Statement

The aim of the postdoctoral residency program at Community Health Center, Inc., is to produce professional psychologists equipped to serve individuals, families, and groups in a patient-centered medical home model, utilizing essential skills requisite of an advanced behavioral health clinical practitioner in an integrated primary care setting. The intention of the postdoctoral residency program is to develop professional, clinical, ethical, quality improvement, supervision, leadership and cultural skills under supervision and to provide a means for cultivating a resident's professional identity as a clinical psychologist, a functioning member of a clinical team, and a community member. Upon graduation from the residency, individuals will be able to confidently, ethically, and with cultural competency, provide psychotherapy to diverse underserved clients with various backgrounds across the lifespan. Residents will enhance their capacity to provide care through a wide range of services and methods to improve the physical and emotional health of the individuals and communities in which we serve.

Competencies

1. Integration of Science and Practice
1A: Displays clinical skills with a wide variety of clients and presenting concerns, including but not limited to: clients across the lifespan, varying diagnoses, and populations.
1B: Utilizes empirically supported treatments to inform therapeutic interventions.
1C: Demonstrates the flexibility to adapt interventions where appropriate for both in person and treatment over telehealth, specific to case and context.
1D: Provides diagnoses to clients that are clear, relevant and accurate, as well as provides comprehensive justifications for those diagnoses.
1E: Evaluates treatment progress and modifies treatment planning as indicated.

2. Individual and Cultural Diversity
2A: Independently monitors cultural awareness of self (including an understanding of how their own personal/cultural history, attitudes, and biases may affect how they understand and interact with

people different from themselves) and seeks appropriate consultation if there is a gap in this awareness.
2B: Considers aspects of the client's identities (including but not limited to ethnicity, race, gender, age, developmental stage, religion, disability, socioeconomic and sexual identity) and how they intersect in conceptualizing, diagnosing, and treating clients.
2C: Demonstrates ability to address differences in colleagues' intersecting identities, including the ability to integrate awareness and knowledge of individual and cultural differences in the conduct of professional roles (e.g., research, services, and other professional activities). Applies a framework for working effectively with areas of individual and cultural diversity not previously encountered over the course of their careers.
2D: Demonstrates knowledge of the current theoretical and empirical knowledge base as it relates to addressing diversity in all professional activities, including research, training, supervision, consultation, and service and can independently apply knowledge and demonstrate effectiveness in working with the range of diverse individuals and groups encountered during residency.

3. Ethical and Legal Standards
3A: Independently utilizes ethical decision-making in all professional activities, acting in accordance with the APA Ethical Principles of Psychologists and Code of Conduct.
3B: Understands the ethical and legal considerations related to a client's needs and can apply ethical decision- making processes in treating the client, including addressing exceptions that arise related to confidentiality.
3C: Proactively assesses and documents safety risk and interventions, including but not limited to: concerns of suicidality, homicidality, and suspicion of abuse, and seeks consultation in such situations.
3D: Documentation reflects expectations based on agency, professional, state, federal, and insurance laws, regulations, rules, policies, standards, and guidelines, including but not limited to: objectives being specific and measurable in the care plan, care plan including all diagnoses, goals in the care plan being in the patient's own words, care plan reviewed consistently in the expected interval (30, 60, then 90 days thereafter), and following guidelines related to appropriate use of telehealth.

4. Primary Care and Integrated Service Delivery
4A: Gathers relevant information during Warm Handoff visits in order to respond to the requesting provider in a succinct and timely manner.
4B: Actively engages in virtual and in person team meetings and communicates effectively with behavioral health, medical, leadership and other staff using synchronous and a-synchronous forms of communication to enhance collaboration and treatment outcomes.
4C: Applies behavioral health knowledge when identifying, screening, assessing, and diagnosing behavioral health needs as part of a primary care team, including but not limited to anxiety, trauma related disorders, mood disorders, insomnia, psychosis, substance use, violence, and attention concerns.
4D: Exhibits an understanding of the external factors that contribute to health related behaviors and addresses a client's psychosocial factors, including but not limited to: food insecurity, housing insecurity, community supports, employment, and any other related environmental stressors, when treating the client.
4E: Demonstrates the ability to provide behavioral health related feedback to common medical concerns in the primary care setting, including but not limited to: type II diabetes, chronic pain conditions, obesity, multiple sclerosis, HIV, and hepatitis-C.

5. Building and Running Groups
5A: Demonstrates the ability to build a group and select or develop an appropriate group curriculum.
5B: Conducts pre-group evaluations over the phone or telehealth video to establish rapport with patient and evaluate appropriateness for group and distinguishes between clients who are appropriate and inappropriate for the group modality of treatment.
5C: Appropriately refers clients to colleagues' groups, and follows up with their referrals regularly, as well as advertises, explains, and elicits referrals from other staff members and clients, including but not limited to other behavioral health clinicians, medical providers, and patient service associates.
5D: Shows ability to conduct group sessions independently.
5E: As a group facilitator, works to be inclusive of all members in the group process and comfortably addresses group dynamics as they arise.

6. Interpersonal Skills and Professional Development
6A: Verbal, nonverbal, and written communications are professional, informative, articulate, succinct, and completed in a timely manner, in accordance with agency policy and culture.
6B: Proactively addresses colleague conflicts in the workplace and seeks consultation when appropriate.
6C: Proactively addresses client ruptures, understands their role and the client's in the situation, and seeks consultation when appropriate.
6D: Conducts self in a professional manner across settings and situations.
6E: Demonstrates receptivity to corrective and constructive feedback from supervisors and staff as demonstrated by their verbal and non-verbal responses, and taking accountability is observed through their actions to resolve the matter.
6F: Provides feedback to supervisors and staff using effective and constructive feedback approaches.
6G: Exhibits the ability to reflect on one's reactions and behaviors in different interpersonal interactions.
6H: Provides presentations on clinical topics in team meetings and didactics in an organized, well-informed, professional and proficient way.

7. Supervision Development
7A: Articulates awareness of identity and value differences among trainee, self and clients, and articulates how these differences may affect dynamics between these groups.
7B: Fosters the trainee's consciousness of the identity and value differences among the resident, the trainee and the clients, and address these differences in therapy.
7C: Develops a supervisory alliance despite potential differences between supervisor and trainee.
7D: Shows awareness of supervisory developmental models and provides support to the trainee in a way that meets their current developmental need.
7E: Demonstrates the ability to provide both formative and summative feedback to trainee**.**
7F: Actively applies ethical, legal, and administrative considerations related to supervision of a trainee.

8. Quality Improvement
8A: Demonstrates knowledge of quality improvement processes and relevant healthcare innovations within an integrated healthcare service system.
8B: Systematically analyzes and utilizes appropriate tools to measure quality and impact of changes within an integrated healthcare service system.
8C: Contributes to performance improvement by identifying areas for change (e.g., issues related to clinical workflow) and uses appropriate quality improvement procedures to facilitate the change process.

9. Utilization of Telehealth
9A: Presents professionally while delivering telehealth services, including but not limited to the use of appropriate lighting, camera angle, professional attire and appearance, professional virtual setting, clear audio and picture quality, displaying professional credentials, setting up professional voicemail, and communicating absences.
9B: Conducts and adapts evidence-based treatments via telehealth by explaining and delivering exercises using virtual mediums, or uses technology to provide psychoeducation and explain key concepts to clients, such as those provided by Zoom, including but not limited to sharing their screen and utilizing the white board function, to augment their treatment when appropriate.
9C: Proactively addresses professional boundaries and challenges due to limited control over the client's environment, including but not limited to discussing appropriate client attire, the client being in an appropriate setting (i.e. not driving, in a quiet environment), clarifying expectations regarding others in the room and their expected participation during the session, and setting boundaries around online communication**.**
9D: Provides technical support to clients by assisting them in navigating minor technical challenges, assists clients with video capability to use video consistently, and effectively transitions to telephonic appointments when technical difficulties cannot be resolved or when a client does not have video capability.

10. Treatment of Opioid Use Disorders/Substance Use Disorders (OUD/SUD)
10A: Routinely assesses and diagnoses all clients and diagnoses all relevant OUD/SUDs, including but not limited to appropriately assessing tolerance and withdrawal, and identifying appropriate level of severity.
10B: Understands the disease model of addiction and can articulate the theory, framing the treatment of addiction within a biopsychosocial model and acknowledging the interaction between multiple psychosocial domains when planning the appropriate level of treatment.
10C: Exhibits awareness of how social justice elements intersect with personal biases and transference/countertransference towards individuals with substance use disorders, and proactively addresses concerns as they arise in supervision.
10D: Manages transitions between levels of care by connecting clients with appropriate resources and utilizing internal recovery care coordinators.
10E: Demonstrates understanding of the trans-theoretical model of change and correctly identifies client stage of change.
10F: Uses specific MI interventions in line with the stage of change of the client, including understanding the role of ambivalence in treating SUDs.
10G: Uses harm reduction as a primary lens for treating clients and determining whether to engage or discharge clients in care at CHC, and when discharges are appropriate, can articulate the reasons for discharge within a harm reduction framework.
10H: Can explain and utilize the CHC SUH program model and how it is implemented including interdisciplinary care and care coordination and seeks consultation when appropriate.
10I: Relapse prevention plans created with clients are specific, multi-step and strengths based.

Elements

Program Contact & Staff Information and Sites

Psychology Training Program Contacts

Post-Doctoral Residency Program & GPE Student Training Program	Title	Contact Information
Tim Kearney	Chief Behavioral Health Officer	KearneTR@chc1.com
Chelsea McIntosh	Training Director – Post-Doctoral Residency Program & GPE Grant	Mcintoc@chc1.com
Monique St. Paul	Program Specialist - GPE Grant & Post-Doctoral Residency Program	Stpaulm@chc1.com
Human Resources		
Victoria Malvey	Inter-professional Student Coordinator	malveyv@chc1.com
Psychology Internship Program		
Jessica Welt-Betensky	CGC CEO/Clinical Director	weltj@chc1.com
Julie Ringelheim	Psychology Internship Program Director	ringelj@chc1.com

Program Supervisors	Site
Alexandra Munro	Hartford
Brenda Beauchamp	Meriden
Catherine Savvides	Stratford (SBHC)
*Chelsea McIntosh	Norwalk
*Dariush Fathi	Danbury
Elliott Lacki	Middletown (SBHC)
*Eunice Rivera-Miranda	Waterbury/Bristol
Iván López	Meriden
Jennifer Bumpus	Meriden
Jessica Welt-Betensky	Stamford Broad St.
Julie Ringelheim	Stamford Broad St.

*Kate Patterson	Middletown/Clinton
Michael Cubria	Norwalk/Stamford
Sita Nadathur	Middletown
Theresa Wiblishauser	Waterbury
*Tim Kearney	Middletown
* Victoria Ramos	Meriden

**Postdoctoral Residency Leadership Team*

Behavioral Health Practicum Students	**Site**	**Supervisor**	**Email**
Alexander "Alex" Lerner	Middletown	Sita Nadathur	Alerner@springfieldcollege.edu
Alexandra "Alex" Strong	Hartford	Alexandra Munro	astrong@hartford.edu
Allison Villeda	Stamford -5th St	Michael Cubria	allison.villeda@uconn.edu
Grayson Stevens	Meriden	Brenda Beauchamp	gstevens@springfieldcollege.edu
Jennifer Cunningham	Waterbury	Theresa Wiblishauser	jennifer.cunningham@uconn.edu
Jessica "Jessie" Plouffe	Middletown	Jennifer Bumpus	JPLOUFFE@hartford.edu
Krista Sansone	Meriden	Iván López	kristasansonee@gmail.com
Nikita "Nikki" Bansal	Middletown	Kate Patterson	NBANSAL@hartford.edu
Rhea Bhatia	Norwalk	Chelsea McIntosh	rbhatia@springfieldcollege.edu

Psychology Post-Doctoral Residents

Resident	Site:	Supervisors 1	Supervisor 2
Areti Zikopoulos	Middletown/Clinton	Kate Patterson	Elliott Lacki
Emily Gray	Hartford/Enfield	Tim Kearney	Chelsea McIntosh
Megan Culp	Norwalk/Danbury	Dariush Fathi	Tim Kearney
Rosarimar Rodriguez	Waterbury/Bristol	Eunice Rivera-Miranda	Sita Nadathur

CHC Staff: Alum of the Postdoctoral Training Program

Name	Training Year	Site
Courtney Clark	2021-2022	Middletown
Alyson Faires	2021-2022	New London/Groton
Norah Rodriguez Bonilla	2020-2021	Meriden/New Britain
Joshua Cruz	2020-2021	Waterbury
Abisai Garcia	2020-2021	Norwalk/Danbury
Katiria Alfaro	2019-2020	Stamford
Sita Nadathur	2019-2020	Middletown
Rachel Tirnady	2019-2020	Enfield
Alexandra Munro	2017-2018	Hartford
Catherine Savvides	2016 -2017	School Based
Elliott Lacki	2016 -2017	School Based
Dariush Fathi	2015-2016	Danbury
Eunice Rivera-Miranda	2015-2016	Waterbury/Bristol
Chelsea McIntosh	2014-2015	Norwalk
Brenda Beauchamp	2014-2015	Meriden

Site List

Bristol 395 North Main Street Bristol, CT 06010 (860-585-5000) On Site BH Director = Eunice Rivera Miranda Ops Manager = Andrea Dobrozensky On Site Medical Director = Veena Channamsetty Nurse Manager = Maria Minei	**Middletown** 675 Main Street Middletown, CT 06457 (860-347-6971) On Site BH Director = Kate Patterson Ops Manager = Shannon Hanson On Site Medical Director = Carl Lecce Nurse Manager = Carla Ocampo
Clinton 114 East Main Street Clinton, CT 06413 (860-664-0787) On Site BH Director = Andrea Dobrozensky Ops Manager = Shannon Hanson On Site Medical Director = Elizabeth Dmowski Nurse Manager = Carla Ocampo	**New Britain** 85 Lafayette Street New Britain, CT 06051 (860-224-3642) On Site BH Director = Kevin Joe Chiang Ops Manager = (Pam Allen, & Jen Stewart Barrett, and Mette Smith) On Site Medical Director = Anthony Yoder Nurse Manager = Andrea McGraw
Danbury 8 Delay Street Danbury, CT 06810 (203-797-8330) On Site BH Director = Dariush Fathi Ops Manager = Carissa Catalano On Site Medical Director = Larissa Camano Selca Nurse Manager = Lucy Golding	**New London** 1 Shaws Cove New London, CT 06320 (860-447-8304) On Site BH Director = Sarah Hunt Ops Manager = Pam Allen On Site Medical Director = Mariana Salas Nurse Manager = Patrick Murphy
Enfield 5 North Main Street Enfield, CT 06082 (860-253-9024) On Site BH Director = Kevin Joe Chiang Ops Manager = Sarah Lappostato (Pam Allen covering) On Site Medical Director = Marat Gitman Nurse Manager = Andrea McGraw	**Norwalk** 49 Day Street Norwalk, CT 06854 (203-854-9292) On Site BH Director = Michael Cubria Ops Manager = Jassenia Palma On Site Medical Director = Nicole Seagriff Nurse Manager = Lucy Golding

Groton 481 Gold Star Hwy, Suite #100 Groton, CT 06340 (860-446-8858) On Site BH Director = Sarah Hunt Ops Manager = Pan Allen On Site Medical Director = Mariana Salas Nurse Manager = Patrick Murphy	**Old Saybrook** 263 Main Street, #202 Old Saybrook, CT 06475 (860-388-4433 On Site BH Director = Andrea Dobrozensky Ops Manager = Shannon Hanson
Hartford 76 New Britain Avenue Hartford, CT 06106 (860-547-0970) On Site BH Director = Alexandra Munro Ops Manager = Sarah Lappostato (Pam Allen covering) On Site Medical Director = Ho Chang Nurse Manager = Susan Bissonnette BH PSA: Cynthia Valle	**Stamford** 22 5th Street Stamford, CT 06905 (203-323-8160) 141 Franklin Street Stamford, CT 06901 (203-969-0802) On Site BH Director = Michael Cubria Ops Manager = Jassenia Palma On Site Medical Director = Nicole Seagriff Nurse Manager = Joanne Ford
Meriden 134 State Street Meriden, CT 06450 (203-237-2229) 165 Miller Street Meriden, CT 06450 (203-639-3500) On Site BH Director = Maria Victoria Ramos Ops Manager = (Pam Allen & Jen Stewart Barrett & Mette Smith covering) On Site Medical Director = Dipak Patel Nurse Manager = Deandra Whalen	**Stamford** **Child Guidance Center** 103 W Broad St Stamford, (203-324-6127) CEO = Jessica Welt-Betensky Internship Director = Julie Ringelheim On Site BH Director = Emily Bessette
Waterbury 51 North Elm Street Waterbury, CT 06702 (203-574-4000) On Site BH Director = Eunice Rivera Miranda Ops Manager = Carissa Catalano On Site Medical Director = Melissa Amicone Nurse Manager = Maria Minei	

Website Links and Resources

- CHC Sharepoint Home Page: https://chcsppr.chcntct.local/
- Workday: https://wd5.myworkday.com/wday/authgwy/osv_chc/login.htmld
- Behavioral Health webpage (forms, BH procedures, documents can be found) https://chcsppr.chcntct.local/BH/SitePages/Telehealth%20BH%20information%20page.aspx
- New Innovations: https://www.new-innov.com/Login/Login.aspx
- CHC Webpage: https://www.chc1.com/
- Information Technology: Please email ITSupport@chc1.com to report any issues with your computer, email, eCW, printers or other hardware/software or call (860) 347-6971 x3624

Evaluating Your Residency Experience with New Innovations

Consistent evaluation and monitoring is an essential component to maintaining and improving the quality and rigor of the program. Aside from valuing a conversational culture of openness to ongoing feedback and programmatic improvement, CHCI Residency Training Programs utilize a software platform called New Innovations for our evaluation activities. New Innovations is a user-friendly, intuitive, Residency Management Suite that the postdoctoral residency program uses for evaluations, weekly journals, and supervision forms.

Getting Started with New Innovations

1. Go to https://www.new-innov.com/Login/Login.aspx
2. Institution: chci
3. Username: First letter of your first name + last name; Password: Same as your username. You will be prompted to change your password.

Evaluation Requirements:

Reflective Journals	**Weekly – Due on Thursday**
Didactic Seminar Evaluations	**Weekly – Due on Thursday**
Competency Benchmark	**Due at 4, 8 and 12 months**
Resident Evaluation of Supervisor	**Due at 4, 8 and 12 months**
Self-Evaluation	**Due at 2, 8 and 12 months**
Supervision Form	**Due After Every Supervision Session**

Reflective Journal Instructions:

1) Journals are due every Thursday unless otherwise noted.
2) Maintain confidentiality and anonymity of patients and colleagues at all times.
3) To avoid losing work, we recommend you type your journal and paste into New Innovations.
4) Possible topic suggestions: a difficult patient encounter, a professional challenge you experienced, observations and experiences with the health care system, your experience with the residency, etc.

5) A topic can be provided by the training director or member of the leadership team as requested.
6) We encourage you to share your thoughts on all aspects of the residency experience, however, please don't feel it necessary to wait to share logistical concerns in your journals -- these can also be shared with supervisors at your site or program staff to ensure a more timely response.
7) Journals are reviewed by members of the leadership team who may reach out to you with a response if they have one.

Didactic Seminar Evaluations Submit an evaluation after the didactic ends to provide feedback on content and deliver. Your feedback is a critical component of continuous programmatic monitoring and improvement.

Evaluation Schedule

You will be evaluating yourself based on the competencies of the program three times a year (October, April and August). Your supervisor will be evaluating you on these same competencies in December, April and August. At the same time, you will review your evaluation of your supervisor and compare their evaluation of you to your self-assessment and individualized training plan (ITP). We encourage you to have an open discussion of each evaluation with your supervisor. If there are any barriers to providing your supervisor feedback about supervision, please reach out to the training director or member of the leadership team for support. Feedback to your supervisor and from your supervisor should be ongoing throughout the year outside of the formal evaluation period.

Competency Benchmark – This self-assessment provides an opportunity for you to assess your current level of skill in key competency areas that are deemed essential to master as a well-developed and competent psychologist in this setting. The self-assessment evaluates your perceived competency over time.

Evaluation of Supervisor – Quality clinical supervision is founded on positive supervisor–supervisee relationships that promote client welfare and the professional development of the supervisee. This evaluation provides an opportunity for residents to give feedback about their experience with their clinical supervisors.

Schedules and Weekly Calendars

Sample Schedule

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:30 am	EST 30	EST 30	Team Meeting		EST 30
9:00 am	Intake	ECHO			EST 30
9:30 am			Supervision		EST 30
10:00 am	EST 30			Group	EST 30
10:30 am	EST 45		EST 45	Supervision	EST 30
11:00 am		Intake		Lunch	Supervision
11: 30 am				Break	
12:00 pm	Lunch	Lunch	Lunch	QI	Lunch
12:30 pm	Break	Break	Break		Break
1:00 pm	EST 30	EST 45	WHO		EST 45
1:30 pm	EST 30		WHO		
2:00 pm	WHO		Intake	Didactic (2-4)	
2:30 pm	WHO	EST 30			Intake
3:00 pm	Case Review	EST 30	Case Review		
3:30 pm		EST 30			EST 45
4:00 pm	EST 30	EST 30	EST 30		

EST= Established Visit

WHO= Warm Hand Off Visit

Each resident is expected to work 40 hours a week, with at least one evening per week and one Saturday a month to meet the needs of our clients. Residents, based on space availability and for a hybrid training experience, are placed to be in person one day at each site and remote the other day(s). Residents who would like to be in person for more days can speak directly to their onsite behavioral health directors for site availability. Sites are typically open from 8:30 a.m. to 7:00 p.m. with some variations between sites during the week. Saturday hours are typically 8:30-12:30. On Site BH Directors create the Saturday schedules. **Residents should be only assigned to a Saturday rotation at one site only.**

Each site has a number of team meetings throughout the week. You will see these indicated in your templates in Centricity and on the schedule provided to you.

You will receive two hours of face-to-face individual supervision per week. You will have two supervisors, and your client caseload will be split between them. In some cases, supervision may have to be completed via video conference, although preference is for in person. You will also have one hour of group supervision Thursday from 10:00 -11:00 am, alternating between the Chief Behavioral Health Officer and the Postdoctoral Training Director. Didactic seminars occur Thursdays from 2:00 pm-4:00 pm. Quality Improvement Seminar (QI) is biweekly Thursdays from 12:00-1:30pm. Additional meetings including community resource, professional development and multicultural case conference will also be scheduled.

If you will be calling out sick or will be late to work, you must follow CHC's procedure by calling a CHC number and then extension 7425 (SICK). Also, let the Training Director, and your Onsite BH Director if it is a clinical day, know through email or text that you will be out. If you will be missing supervision, please proactively work with your supervisor to find an alternate time to meet. If you are going to miss a part of the didactic portion of the program, please let the Training Director and Program Specialist know. Residents will be unable to take time off in August (the last month of the training year) if they are not staying at the agency, or are switching site placements. For residents who do not stay on for employment at CHC, **PTO time and CME funds must be used prior to leaving the agency.**

Content discussed in supervision can be requested to remain confidential. Supervisors of residents meet monthly to discuss dynamics in supervision, focusing on improving approaches to supervising the residents and dynamics that arise. There may be times where information discussed and requested as confidential is deemed by the supervisor to be important and needed to be processed with the training director or in the supervisors' meeting. In this case, supervisors are expected to explain the rationale as to why the relevant information cannot be kept confidential, the extent of the information needed to be shared, and with whom the information will be shared.

Agency Cultures

Each resident will be working at different sites. Throughout the year, residents will experience similarities and differences in the culture and operations at each site and between departments. Residents are welcome to bring up concerns related to site operations in supervision, but residents are also encouraged to discuss site-specific operational issues directly with their On Site Behavioral Health Director, including and not limited to: schedule changes, site expectations, workflows around referrals, and coordinating with psychiatry and other departments.

Participation Expectations

- **Supervisor Contract and Individualized Training Plan**

  These documents will be drafted and signed within the first few meetings with your supervisors. The documents define expectations, goals, and processes as discussed and mutually agreed upon between supervisor and supervisee.

- **Project ECHO™ (Extension for Community Healthcare Outcomes)**

  ECHO provides specialty support for primary care and behavioral health providers seeking to gain expertise in the management of certain complex illnesses and conditions. Read the descriptions of ECHO topics, here.

  1) Residents will choose one ECHO to attend at the beginning of the year. They have the option to switch to a different ECHO six months into the program.
  2) Residents will be required to give one case presentation in ECHO during the training year.

Echo Offerings:

Improving the Safety and Quality of Chronic Pain Management

Weitzman ECHO Pain

1st and 3rd Thursdays; 11:30AM-1PM ET

Integrating Buprenorphine Maintenance Therapy in Primary Care Weitzman ECHO MAT

4th Tuesday; 12:30-2PM ET

Mentorship for Effective Management of Hepatitis C and HIV and Treating Key Populations in Primary Care Weitzman ECHO Key Populations

Every Friday; 1-2PM ET

Launching late October 2022: Childhood Trauma in COVID-19 ECHO

Tentatively 1st and 3rd Fridays; 12-1pm ET

Complex Integrated Pediatrics ECHO

2nd and 4th Wednesdays; 12-1pm ET

On hiatus in September and returns in October

Specialty Modules on Complex Issues Facing Primary Care

Advanced Primary Care ECHO

1st and 3rd Thursdays; 3-4pm ET

On hiatus in October and returns in November

- **Quality Improvement Seminar**

  In this bi-weekly seminar, residents will learn about how to implement quality improvement initiatives in a healthcare setting and work with the Behavioral Health Quality Improvement team to select a project currently being conducted at the agency with which to participate. There may be the potential to present this project in a poster session or prepare it for a paper. QI is a competency area and feedback on participation, collaboration, and presentation will

be conducted. Residents will be provided a biweekly scheduled time for working on their project.

❖ Supervision Training

Residents will additionally participate in an eight-week didactic seminar regarding various aspects about becoming a supervisor for one hour weekly. Residents will rotate co-facilitating group supervision for the doctoral student program or for the psychiatric nurse practitioner residents. Residents will also be paired with a psychology doctoral student in the second half of the year to be able to discuss cases and practice supervisory skills for one hour weekly.

❖ Resident Presentations

All residents will present a 90 min didactic on a clinical topic of their choosing to present to their fellow residents as well as the postdoctoral training director, chief behavioral health officer, and supervisors. Content must include clinical applications, and address aspects of diversity, and limitations (including if it is appropriate for underserved communities). These presentations will be scheduled monthly starting in January and residents will receive feedback.

Presentation Guidelines

Basics

- 8:30-10 am on the first Thursday of the month.
    - 10 minute break at 9:15
    - Allow time for questions
    - Prepare to present to a hybrid audience as there will likely be remote participants
- Include presentation objectives, highlighting diversity considerations
- Activities (case studies, simulations, short assessments, etc.) are encouraged
- Apply material to working clinically with CHC's treatment population
- Recommendations should note applicable/inapplicable clinical populations or scenarios, and aspects of diversity that may impact treatment
    - Apply the topic to both telehealth and in-person care practices
- Join a few minutes early to ensure mic, share screen, share audio (for videos) is working
- Cite written and visual references
- Sessions are recorded and posted with any material on an internal site for education purposes

Resources

- Versatile powerpoint templates - Canva.
- Images(most are free): Unsplash, pixabay, pexels, Gender Spectrum, Disabled and Here Collection
- Race/diversity collections: nappy; tonl; createherstock and blackillustrations

Deadlines

- Monday before your session: Send the program specialist your slides, poll questions, supplemental material or questions for the trainees.

Contact

Monique St. Paul, Program Specialist at stpaulm@chc1.com

Tips on Delivering a Dynamic Presentation

Build rapport

- Introduce yourself
- Share why you're speaking on the topic
- Allow trainees to introduce themselves

Structure

- Include some didactic, discussion, and practice
- Engage audience with questions, ask for opinions or shared experience
- Allow time for questions and reflection

Visuals

- Powerpoint – not required. If created, use it as a tool that complements the conversation
- Choose appropriate style, colors(see coolors.co, and fonts
- Use high resolution, professional, images, videos, charts, graphs, etc.
    - Resources
        - Images(most are free): Unsplash, pixabay, pexels, Gender Spectrum, Disabled and Here Collection
        - Race/diversity collections: nappy; tonl; createherstock and blackillustrations
- Refrain from using clip art
- Reduce the number of words on a slide

Video conference resources

- Collaborate with the whiteboard

- Encourage participation with polls, chat, links to relevant material

❖ **Development of Group Curriculum and Implementation:**

By October 1, residents will be expected to shadow a group that is already running if residents are not running or co-facilitating their own group. By January 1, through consultation with their supervisor, residents are expected to have chosen and begun implementing a group curriculum. During the fall, residents are expected to think about a particular population at their site or across the agency that they think is in need of a group program. There might be a particular diagnostic category, or presenting concern that is seen as best served by implementing a group curriculum. Residents are encouraged to talk to their supervisors about the ideas they have and any research they have found. Progress will be checked on in this area and support offered in group supervision. Residents will initially be blocked for 60 minutes for a group and once they have four or more clients attending regularly (at least 4 weeks) their schedule can be blocked for 90 minutes to give time for note writing and group case management.

❖ **Multicultural Case Conference**

Residents will be attending a monthly 90 minute case conference with practicum students as well as interns. Two trainees each month will be selected to present a case including a component for feedback related to aspect(s) of the client's and trainee's identity. This case conference will be co-facilitated by the Diversity, Equity, and Inclusion (DEI) officer as well as a clinical member of the training team.

❖ **Observation:**

Trainees are required to have their clinical work observed at least once per evaluation period. These can be live observations, or clients who are seen in person can have their sessions recorded. It is recommended that when trainees meet the client for the first time, they explain the role of observation and review consent to record form with a client at that time. In this manner, when the time comes to have observations completed, a list of consenting clients can be accessed to expedite the process.

❖ **Socialization as a Cohort:**

When the residency is partially conducted over telehealth, socialization needs to be a more intentional process without the ability to see others directly in a formal or informal way. We will discuss ways to develop and maintain cohesion as a cohort and are open to feedback as to how to best facilitate that experience for your cohort.

Residents are also welcome to participate in the following:

- Process Improvement (PI)
- Institutional Review Board (IRB)
- Research
- Psychological Testing
- School-based Rotation

- **Child Concentration:**

  Child concentration residents are evaluated by the same competencies and attend all resident activities as general postdoctoral residents. In addition to the activities above, child concentration residents will engage in the following:

  CGC Postdoctoral Residents will engage in a weekly Mobile Crisis shift.

  Middletown and Hartford Residents will engage in a six-month placement and then switch, conducting Multidisciplinary Evaluations (MDEs) for DCF or participating in the Multidisciplinary Team Meetings (MDTs).

  All Child Concentration Residents will engage in a monthly case conference to discuss child specific cases and concerns. They will be expected to select a child focused ECHO.

- **Mentorship:**

  Residents will be asked at the beginning of the year in what areas they would like to receive professional mentorship, including and not limited to aspects of identity and professional goals. A mentor will be assigned to each resident based on these areas of interest. A mentor is an informal relationship with a colleague who holds no evaluative capacity over the resident and can provide support and guidance with goals and other areas within and out of the context of the CHCI environment. If a resident's first language is Spanish and the resident was not assigned a Spanish speaking supervisor and would like to consult with a Spanish speaking supervisor to discuss a case, they are encouraged to contact the training director to facilitate this connection.

Post-Doctoral Policies and Processes

Grievance Policy

Purpose: The purpose of this policy is to establish the key guidelines for addressing postdoctoral psychology resident grievances.

Scope: This policy is applicable to all CHC postdoctoral psychology residents.

Open Door Problem Solving at Community Health Center Inc, strives to ensure fair and honest treatment of all employees and trainees. Supervisors, managers, employees and trainees are expected to treat one other with mutual respect. CHCI's postdoctoral residency program encourages an open atmosphere in which residents' problems, complaints, suggestions, or questions receive a timely response from their supervisors. The Postdoctoral Residency Program follows CHC's open door policy, which is a problem-solving process that encourages employees and trainees to openly discuss work-related problems and to attempt to solve problems constructively.

If a postdoctoral psychology resident disagrees with established rules of conduct, policies, or practices, they can express concern through the open door problem-solving procedure. No resident will be penalized, formally or informally, for voicing a complaint with CHC in a reasonable, business-like manner, or for using the open door problem-solving procedure.

The program's open door problem-solving process incorporates several principles:

- Confidentiality: If a resident requests the opportunity to discuss a matter confidentially, CHC will endeavor to keep the matter private. However, the law and other circumstances may require CHC to take specific actions when certain issues are raised, so confidentiality cannot be guaranteed in every instance. If confidentiality needs to be breached, the resident will be informed as to the reason and with whom information will be communicated.
- Freedom from retaliation: A resident will not be punished, whether formally or informally, for appropriate use of CHC's open door problem-solving procedure.
- Timeliness: A resident will receive a timely response from each person contacted in the process of using CHC's problem-solving procedure.

If a situation occurs when a resident believes that a condition of employment or a decision affecting them is unjust or inequitable, they are encouraged to make use of the following steps. The resident may discontinue the procedure at any step.

1. Residents who have concerns about their training experience(s), supervision, or other training related matters are encouraged to discuss those concerns with the individual that is directly involved. If the resident does not feel comfortable doing so, they may seek guidance or raise the matter with their supervisor. The resident should describe the problem in a timely, complete and accurate manner.

2. If they are not satisfied with the response of their supervisor, or if the problem is inappropriate for discussion with their supervisor, they should discuss the problem with the training director. The training director will work with the resident to try to resolve the problem.

3. If the resident is still not satisfied after working with the training director, they should discuss the problem with the Chief Behavioral Health Officer.

4. A resident may discontinue the procedure at any step. At any point during the open door problem-solving process, they are free to talk with any member of management or Postdoctoral Leadership team about the problem. Additionally, there may be points in the process where consultation with specific departments may be advised (e.g. Human Resources, Justice Equity Diversity Inclusion (JEDI) office, Legal). Whenever possible, however, a resident is encouraged to follow the steps listed.

Not every problem can be resolved to everyone's total satisfaction, but only through understanding and discussion of mutual problems can a resident and leadership develop confidence in each other. This confidence is important to the operation of an efficient and harmonious work environment.

Postdoctoral Psychology Due Process

Purpose: The purpose of this policy is to establish the key postdoctoral psychology resident performance improvement guidelines for addressing postdoctoral psychology resident performance

gaps.

Scope: This policy is applicable to all CHC postdoctoral psychology residents. Please note that individual contracts supersede certain procedures outlined in this policy.

Policy: Postdoctoral psychology residents are expected to fulfill core job/trainee requirements and accept personal responsibility for adhering to performance standards and personal conduct that are consistent with CHC's standards and values. CHC believes postdoctoral psychology residents want to meet and exceed performance exceptions and be successful in the performance of their job duties. To help postdoctoral psychology residents to achieve the expected performance standards, CHC generally attempts to address performance failures and misconduct through coaching and corrective action. Degrees of coaching and corrective action are generally progressive and are used to ensure that the postdoctoral psychology resident has the opportunity to correct his or her performance. The corrective action process is designed to keep safety, high reliability, and accountability a top priority and to help postdoctoral psychology residents maximize their performance and promote a healthy work environment for all.

Disciplinary Action Documents

Copies of any documented disciplinary action will be provided to postdoctoral psychology residents within one (1) business day of the disciplinary action. In the case of employment termination, documentation will be provided immediately.

Postdoctoral Psychology Resident Written Statement

Any postdoctoral psychology resident who disagrees with any or all of the contents of any CHC disciplinary document may submit a written statement explaining their position. A copy of the postdoctoral psychology resident's written statement will be placed in the postdoctoral psychology resident's personnel file. It will be reviewed by members of the leadership team.

Procedure for Coaching and Corrective action

If a postdoctoral psychology resident's performance, including attendance, falls below the expectations of his or her position and corrective action is appropriate, the postdoctoral psychology resident will be informed of the problem, encouraged to take ownership for his or her actions, and encouraged to correct the issue. CHC often uses a progressive approach to corrective action, beginning with coaching and counseling and continuing with a performance improvement plan. Depending on the nature of the offense, however, CHC reserves the right to commence the

corrective action at any level it deems appropriate under the circumstances. When determining corrective action, multiple factors are taken into consideration including, but not limited to:

- The nature of the offense
- The postdoctoral psychology resident's employment history
- The seriousness of the offense
- The impact, if any, on patient or co-worker safety
- Whether the act was deliberate
- Whether the act was malicious or determined to be willful misconduct
- The impact on any stakeholders and/or CHC
- Any mitigating or aggravating circumstances
- The length of time since the postdoctoral psychology resident's last corrective action
  At the discretion of the postdoctoral training director and/or Chief Behavioral Health officer, Human Resources can be consulted at any stage of the process.

When a postdoctoral psychology resident engages in behaviors which requires correction and follow up monitoring, the following procedure will be followed.

1. A remediation plan is developed by the resident and his/her supervisor(s). This plan includes, at a minimum, concrete steps to be taken with target dates for completion, review criteria and review dates identifying who will be reviewing the resident's response to the plan, and next steps in the case of successful compliance, partial compliance, and noncompliance. The review date will be no later than 8 weeks from the initial feedback session.
2. Following the meeting, the plan is reviewed by the Training Director and/or other members of the postdoctoral leadership team. Upon approval, a copy is sent to the resident.
3. The resident confirms that this is an accurate summary of the agreed upon plan in writing.
4. The resident, his/her supervisor(s) and, as requested by the resident or supervisors, the Training Director or another member of the leadership team, meet at the time agreed upon in the plan and discuss the resident's progress in meeting the goals.
5. A written summary of the discussion is sent to the resident, supervisors, and Training Director by the supervisor running the meeting. If all goals are met, no further meetings are scheduled other than the regularly planned evaluations. If goals are unmet or partially met,

then a new plan is made which may include further goals for the resident and/or the residency program.

Investigative Suspension

In cases where alleged serious misconduct occurs, the postdoctoral psychology resident may be placed on investigative suspension when it is necessary to make a full investigation to determine the facts of the case. In certain instances, the postdoctoral psychology resident may be suspended without pay while an investigation is conducted. Every effort will be made to complete the investigation expeditiously and within ten (10) days, when possible.

Unacceptable Behaviors

While it is not possible to list all forms of behavior that are considered unacceptable in the workplace, following are examples of inappropriate or unacceptable behavior that may result in formal corrective action, up to and including termination of employment.

The following list of examples of unacceptable behavior is for illustration purposes only and is not inclusive of every unacceptable behavior.

- Theft or inappropriate removal or possession of property
- Working or being on CHC property under the influence of alcohol or illegal drugs
- Possession, distribution, sale, transfer, or use of alcohol or illegal drugs in the workplace, while on duty, or while operating employer-owned vehicles or equipment
- Fighting, horseplay or threatening violence or bodily harm in the workplace
- Boisterous or disruptive activity in the workplace
- Negligence or improper conduct leading to damage of employer-owned or patient/client-owned property
- Insubordination or other disrespectful conduct
- Violation of safety or health rules
- Smoking in prohibited areas
- Sexual or other unlawful or unwelcome harassment
- Possession of dangerous or unauthorized materials, such as explosives, firearms, or other weapons, in the workplace

- Absence without proper notice that could be reasonably be provided or absence without good cause
- Unauthorized absence from work station during the workday
- Unauthorized use of telephones, mail system, or other employer-owned equipment
- Unauthorized disclosure of confidential information of a medical or non-medical nature
- Violation of personnel policies
- Unsatisfactory performance or conduct
- Failure to follow specific instructions from a supervisor
- Sleeping on the job
- Falsifying employment application, resume, time keeping records, or pay records.
- Making or circulating statements that are damaging to CHC
- Destruction, theft or unauthorized use of CHC property or property of other postdoctoral psychology residents.
- Engaging in conduct that violates state or federal anti-discrimination laws.
- Disclosing confidential information, duplicating or releasing any written information about the CHC or its postdoctoral psychology residents without written authorization from the President/CEO or Vice President/Clinical Director
- Failure to immediately report an injury, no matter how minor
- Failure to diligently work during scheduled work time
- Failure to obtain advance approval for working overtime hours
- Bullying or insulting behavior
- Discourtesy or rudeness to patients
- Failure to inform management in a timely manner of possible clinical, operational or financial problems
- Failure to safeguard any personal information or dispose of the information properly
- Failure to report a real or potential safety problem, or discouraging others from reporting it

Please be advised that respectful behavior and integrity are central to CHC's values, and that these are values which cannot be compromised. Disrespectful behavior, lack of honesty, lack of full disclosure or misleading behavior, are impermissible at CHC or in the performance of work.

Additional Policies

Termination of Employment

Termination of employment may occur when one or more levels of corrective action have failed to bring a significant and sustained improvement in the postdoctoral psychology resident's behavior, job performance including attendance, or in instances where a single offense is so severe, in the judgment of management, that the application of other forms of corrective behavior is inappropriate. This above list is for illustration purposes only and does not include every unacceptable behavior that may result in immediate termination of employment.

At-will-employment

CHC may revise, supplement, or rescind this (and any other) policy at any time as it deems appropriate in its sole and absolute discretion, without prior notice to postdoctoral psychology residents. This postdoctoral psychology policy (and any CHC policy) does not constitute a contract of employment and does not in any way limit or modify postdoctoral psychology residents' at-will employment status.

Evaluation Policy

In order to ensure that residents meet the minimum level of achievement, residents are assessed on a tri-annual basis. In order to meet the minimum level of achievement, residents must score an average of a four across domains and supervisors. The program determined a score of a four as a target because it is above the minimum level of operating at an advanced level.

The first resident evaluation is conducted at the end of December. If a resident does not score an average of four across domains and supervisors, a remediation meeting will be scheduled. Residents will meet with both supervisors to create a remediation plan to focus on how to improve the areas where they scored less than a four prior to the next evaluation period. If the average is still less than a four by the second evaluation period, which is conducted at the end of April, residents will again meet with their supervisors. In addition, residents will also meet with the training director and chief behavioral health officer to create a revised plan for improvement in the specific domains. From the

second evaluation forward, the resident will meet every 30 days with their supervisors to review the plan and address ways to improve their score in the specific domains and revise the plan as needed. If by the third evaluation period, conducted at the end of August, their average score remains below a four, they will not be able to successfully complete and graduate the postdoctoral program.

For those residents whose average score across domains and supervisors are above a four, but there are specific areas that are lower than a four, residents will meet with both supervisors at each evaluation period to discuss ways they can improve in these identified areas.

Commitment to Diversity and Multiculturalism

Our residents, supervisors and clients represent many different identities (including the areas of age, disability, religion, ethnicity, social class, sexual orientation, indigenous background, national origin, and gender). In discussing cases and in interacting with colleagues and peers, we encourage residents to keep this in mind and use supervision and consultation to discuss how aspects of one's identities may be interacting with others' identities in interactions. Everyone holds blind spots and growth areas in this respect, we recognize that exploration of these areas can be vulnerable, and it is the program's responsibility to create an atmosphere of safety in order to process these areas. If a resident experiences concerns with how an aspect of their identity or others are being addressed, they are encouraged to discuss this with their supervisor, the training director, or the diversity, equity, and inclusion (DEI) officer.

We value creating an environment of growth where we encourage each resident to share their opinions and contribute to the learning process, as well as support a learning environment that creates a space where people feel open to share in a respectful manner.

Obtaining a Reasonable Accommodation/Need to Take a Leave

To make a request for a reasonable accommodation or facilitate in the event that a resident needs to take a leave from the program, residents can contact the Training Director and the Human Resources Business Partner assigned to the resident's region.

According to the Americans with Disabilities Act of 1990 (ADA), the term **disability** means, with respect to an individual, a physical or mental impairment that substantially limits one or more major

life activities of such individual. This includes individuals who have a record of such an impairment, or are regarded as having a disability.

A **reasonable accommodation** is a modification or adjustment to a job, the work environment, or the way things usually are done that enables a qualified individual with a disability to enjoy an equal employment opportunity. An equal employment opportunity means an opportunity to attain the same level of performance or to enjoy equal benefits and privileges of employment as are available to an average similarly-situated employee without a disability. The ADA requires reasonable accommodation in three aspects of employment:

1) To ensure equal opportunity in the application process,

2) To enable a qualified individual with a disability to perform the essential functions of a job, and

3) To enable an employee with a disability to enjoy equal benefits and privileges of employment.

Visit the Job Accommodation Network at askjan.org/soar.cfm to learn more about specific accommodations.

Clinical Expectations

Therapy Supervision Expectations

The state of CT requires that residents successfully complete at least one year of supervised work experience pre- or post-doc to sit for the licensing exam. Pre-doctoral internships do NOT meet this requirement. This requirement includes 35 to 40 hours of work per week for at least 46 weeks in one year, or no less than 1800 hours in two years.

Face-to-face supervision with a CT licensed doctoral level psychologist is required. Residents need at least 3 hours of supervision per 40-hour workweek, of which at least one hour is individual. At CHC, residents will be receiving two hours of individual supervision, of which at least one is in person (other may be via telesupervision) and one hour of group supervision per week in order to meet this requirement. Residents are expected to attend all three hours of supervision each week**. If supervision needs to be cancelled, both supervisor and supervisee need to make best efforts to make up the time missed.**

Residents are expected to maintain an ongoing list of all of their clients. The list must include basic demographic information, the date treatment plan was created, the date care plan review is due and any other relevant information. For example, child providers in Middletown, where our Child Guidance Clinic is located, often include the date DCF-specific forms are completed and due.

Each supervision session residents are **required** to complete a supervision form in New Innovations, including the initials of clients discussed and any action items. These forms need to be signed by both the resident and the supervisor and submitted consistently after the supervision session.

Residents and their supervisors will determine the best and most productive use of supervision time. A contract will be created with resident and supervisor with goals for supervision for the training year. Supervision is a time for residents to review ongoing cases, intakes, and particular challenges or areas of growth. Residents are encouraged to use their supervisor's knowledge of particular areas to learn and to use this time for professional development.

Residents are required have their work observed throughout the year as a way to augment supervision. The expectation is at minimum one observation per evaluation period (December, April, August), per supervisor, for a total of six observations for the training year. Connecticut Law

as of the update of this manual does not permit recording sessions over telehealth; sessions can only be observed live until further notice.

Requirements for CT Licensure

Please check the website at http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389550 for up-to-date information about what residents need to do for CT licensure.

Resources for Treatment

How to Introduce Self to Patients

Postdoctoral Resident, working under the supervision of Dr. _____.

At CHC, we tend to use first names when addressing each other, with a few exceptions. How to introduce yourself to patients is a personal choice, though most of us tend to first introduce with "Dr. First Name, Last Name," which gives the patient a bit of a choice in how to address us.

Recording Client In Person Sessions

It is highly recommended that trainees during the initial visit with a client request consent from clients to have their sessions recorded for purposes of receiving feedback from their supervisor or in-group supervision. If a client consents to record sessions, trainees will need to have the client complete the consent for recording form and retain that form in the client's documents. Trainees should retain a list of clients who have consented to record their in person sessions. It is strongly encouraged that trainees use recording of sessions as an opportunity to deepen their training by receiving feedback from their peers and supervisors. Instructions on how to record sessions are found at the end of this manual.

Crisis Management

As stated in the Connecticut statutes, licensed psychologists are able to complete an emergency evaluation certificate for a person who appears to be of danger to himself or herself or

others, or is gravely disabled. This certificate authorizes the transport of this person to the hospital for a medical examination which will be conducted within 24 hours. The person cannot be held at the hospital for more than 72 hours unless they are then committed by the examining physician.

What this means for you as a resident is that you may encounter a client who you believe to be psychiatrically impaired and in need of an emergency evaluation. Should that occur, you are expected to immediately contact your supervisor to assist you in making the determination and to identify the most appropriate person to assist in completing the documentation. If your supervisor is unavailable that day, please reach out to your onsite behavioral health director, if not available then your other supervisor, the training director, or the chief behavioral health officer, and they will assist you in either finding someone to help you out or help you handle the situation remotely.

APPENDIX A: Therapy Protocol

Paperwork

The basic paperwork that is required for all intakes includes:

- Rights and Responsibilities- includes HIPPA acknowledgement
- Care Plan signature page
- Releases of Information (schools, prior treaters, medical providers, etc)
- Recovery in Action (RIA) form
- Psychiatric Advanced Directive Information
- All forms are found here: https://chcsppr.chcntct.local/BH/Forms/Forms/AllItems.aspx

In terms of required paperwork for intakes with children and adolescents, additional forms are required. The Middlesex County sites are part of the Child Guidance Clinic, and thus have additional forms that are required per our DCF funding.

- Ohio Scales (worker, parent, and youth if over 12)
- PSDCRS intake and information data

All telephone contact (including outreach for scheduling when client does not attend their appointment) outside of visits will be documented in telephone encounters (TEs). In healthcare the rule applies: **If it is not documented, then it did not happen.** Careful documentation enhances patient care, team collaboration, and protects you.

Procedures

As therapists, we are responsible for our clients' therapy as well as most case management details. We do things like connect them with Access to Care if they need help with insurance issues or obtaining insurance, or provide phone numbers for transportation assistance, how to get an emergency cell phone, etc. We also make referrals to higher levels of care (PHP, inpatient, dual

diagnosis programs, etc.). Your supervisor will be able to help you learn these systems of care and how to directly contact them.

Clients will bring us disability forms or other types of paperwork to complete, and this can be handled in a few ways. Many therapists are moving toward completing this paperwork during a session. Please reach out to your supervisor any time you have questions about paperwork, forms, case management, etc., as this is often a new learning experience for most residents. Also, all paperwork completed for patients must be cosigned by a supervisor.

The clinical day is typically comprised of 1 intake, two 45 min sessions, 1 group, approximately 2 Warm Hand Off (WHO) blocks, and the rest are 30 min sessions. WHOs consist of same day consults for medical or dental providers when they have a patient in need of urgent care, a patient who needs to make a connection with BH services, or if the patient is identified on our dashboard as having a greater potential for needing mental health treatment. Instead of taking a reactionary approach and introducing BH services only when a patient is in crisis, we are proactively introducing ourselves to a greater number of patients as part of the care team. Depending on the site, clinicians have either several 30 minute WHO slots or 4 hours of WHO blocks, at which time they are the assigned clinician to introduce BH services to our patients identified by using the dashboard data or responding to a provider's request for a WHO. Once the WHO is completed, the clinician provides feedback to the provider requesting the WHO, either verbally or by sending at TE. You should always be prepared to offer a psychological perspective on a client issue when approached by a medical or dental provider to help!

Children are generally not seen without parent's permission. Please reference the CHC minor policy for additional information. At the clinic based programs, since children are brought in by parents this is seldom an issue. At school based programs, children who self-refer or are in crisis may be seen briefly to assess safety or to describe the program and how to enroll. Parents will then need to sign up for the program if they wish to have services and sign the Rights and Responsibilities and care plan forms. If you are covering for a leave at a school based clinic, these forms must be signed again by the family prior to starting treatment. At times, parents will drop children off at the clinic sites for their sessions or encourage children to attend sessions alone. The state licensing requirements state that children are not to be dropped off for treatment, and that a

responsible adult must remain on site in case of emergency. If this becomes an issue, you should discuss it with your clinical supervisor.

Notes and other correspondence (TEs, emails) are to be completed ideally within 48 hours and notes sent to your supervisors for review. Care plans need to be reviewed in a timely manner (in 30, 60 and 90 day intervals).

APPENDIX B: Documentation Considerations

Case formulation samples:

Client is a x year old (client noted identifiers) who attended their BH intake. Then provide a summary of symptoms and why you are diagnosing what you are diagnosing. Then provide brief highlights of significant information from the intake (eg substance/legal history, history of bh treatment, history of suicidal/homicidal ideation). Then, document what your plan is for treatment, or if the intake was not completed, the reason it was not completed and that you will gather remaining information in a follow up visit.

Optional formatting that some staff use:

Pt is a 25 year old Jamaican American male, who was seen for a behavioral health intake for self-reported symptoms of depression. During the intake assessment, pt was appropriately groomed and alert. He was cooperative, engaged, and appeared adequately forthcoming. He exhibited wavering eye contact, but there was no disturbance in his speech or thought content. He presented with euthymic mood and congruent affect. The Behavioral Health policies and procedures were explained, and pt indicated his understanding and provided written consent for treatment at CHC.

Care plan reviews:

Initial: Client is appropriate for this level of care.

60/90: Discuss consistency in attendance, progress in treatment, what you have been working on, and goals during this next treatment period. Then add this blurb: If the client complies with treatment recommendations they will be expected to improve in 12 months. The next review will be within 60/90 days, was reviewed by the care team, and in the next review will be reviewed by the care team.

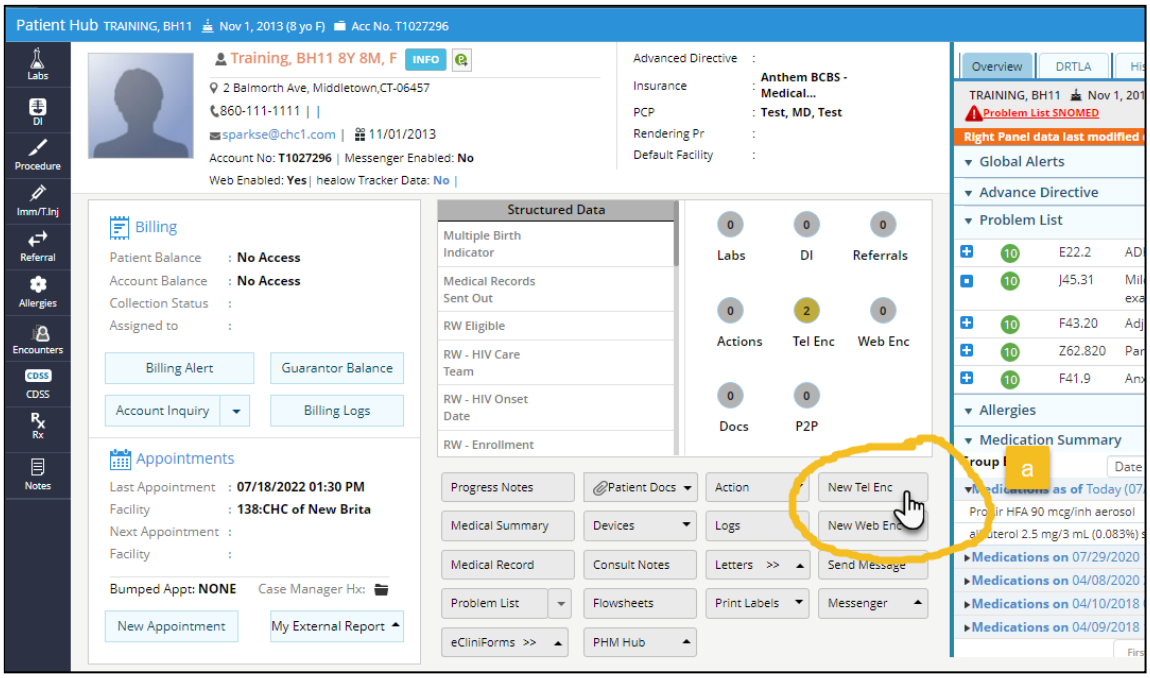
APPENDIX C: Discharges and Supervisor Note Review

Discharges

1) Set alert that they now need an intake
2) Close out care plan
3) Complete discharge process below:

A Visual Guide to Discharges

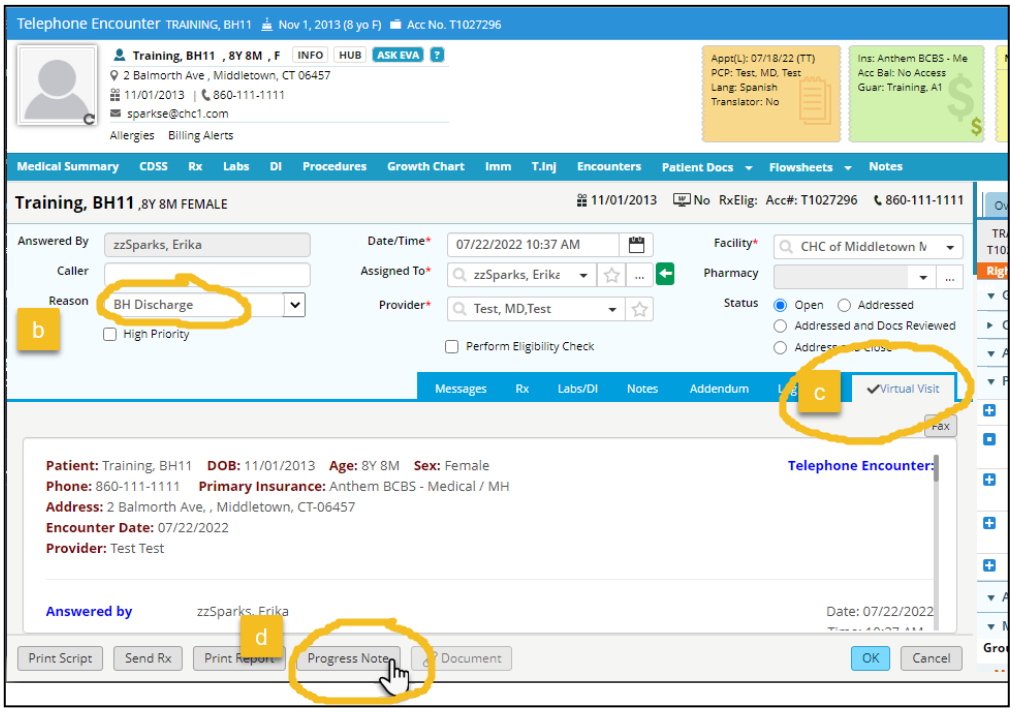
a. Open up the patient Hub and click New Telephone Encounter.



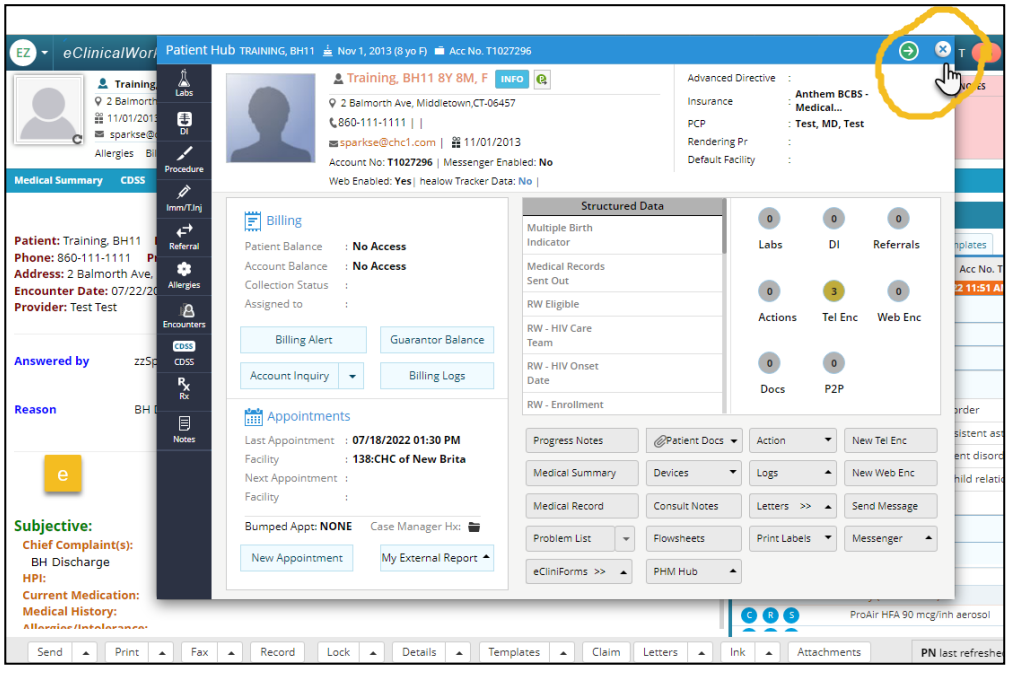
b. Select "**BH Discharge**" from the Reason field.

c. Next, click the **Virtual Visit** tab.

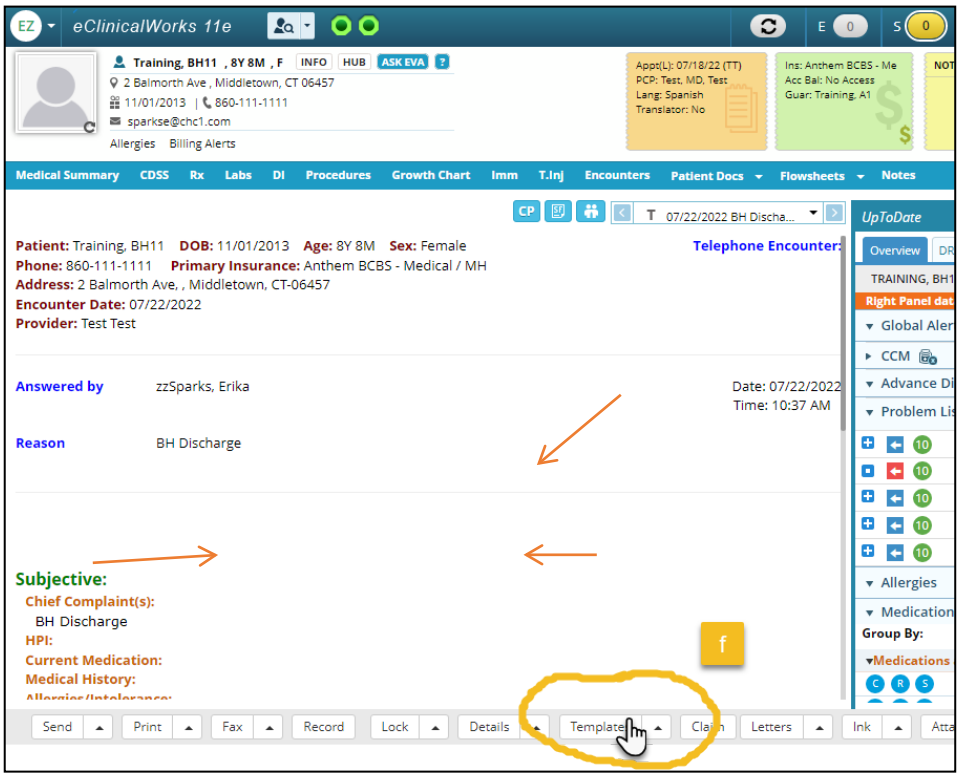
d. Once in the **Virtual Visit** tab, click the **Progress Notes** button at the bottom of the screen.



e. The **Progress Note** window will appear behind the **Patient Hub**, which was opened before accessing the **Telephone Encounter** window. Close the **Patient Hub** to utilize the **Progress Note** window.



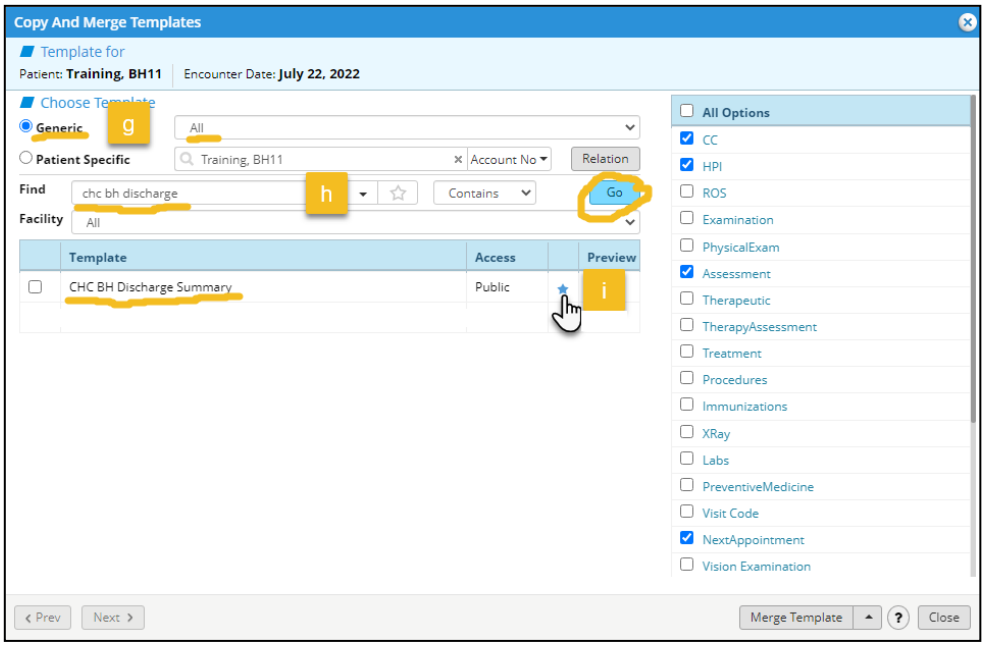
f. Click the **Templates** button to merge the **CHC Discharge** template.



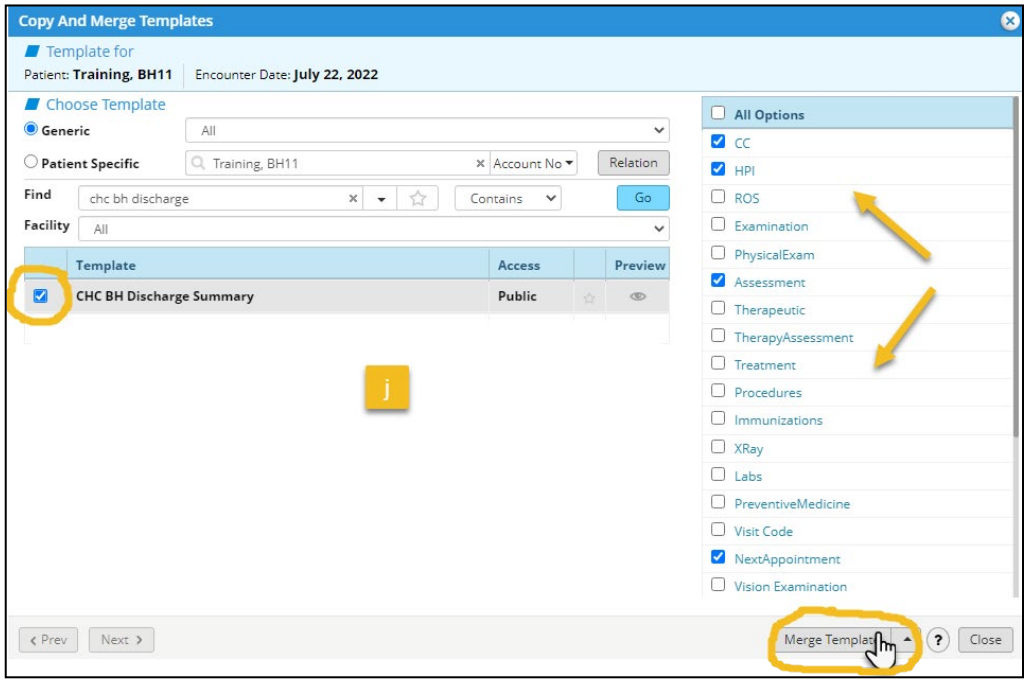
g. In the **Choose Template** pane, select **Generic**, then **All** for the **Category** field.

h. Type **CHC BH Discharge** in the **Find** field and click the **Go** button.

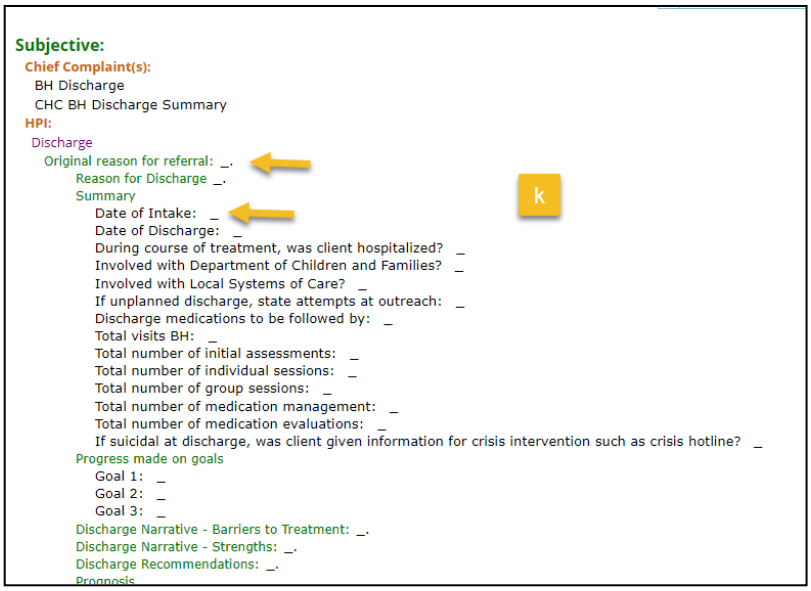
i. Select the **CHC BH Discharge Summary** template and click the **Star** icon to make it a favorite template.



j. To use, check the box next to the template, ensure that correct **Template Options** are checked, and then click the **Merge Template** button.



k. Use the **Orange, Purple, Green** or **Black** hyperlinks to complete the template questions.

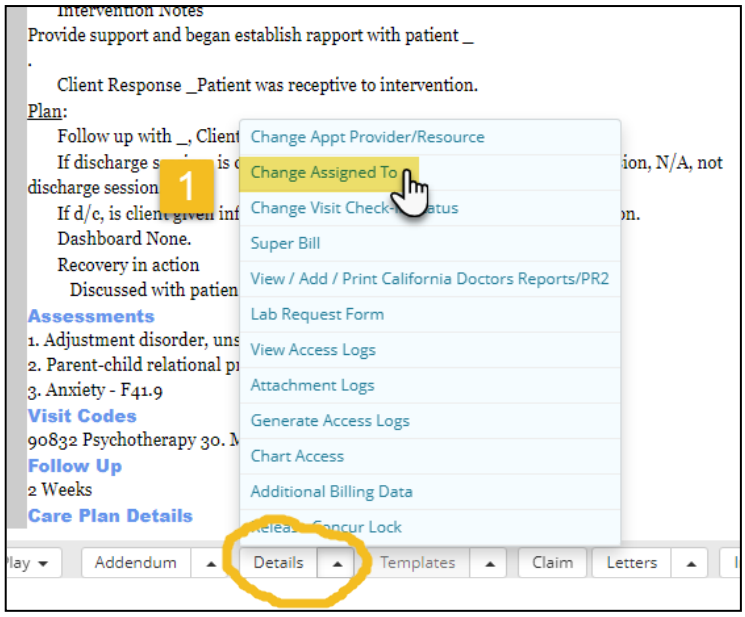


When finished, lock the note to address the Telephone Encounter.

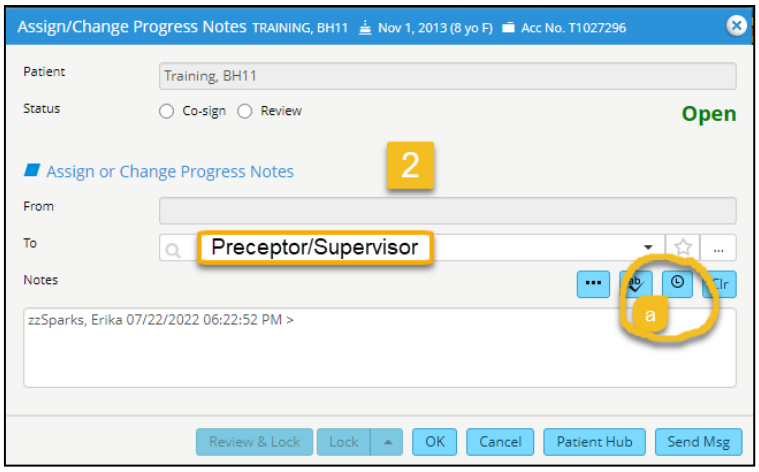
How Trainees Can Assign their Completed Note to Their Supervisor:

When the BH progress note is completed and locked, the trainee can assign their note to their supervisor.

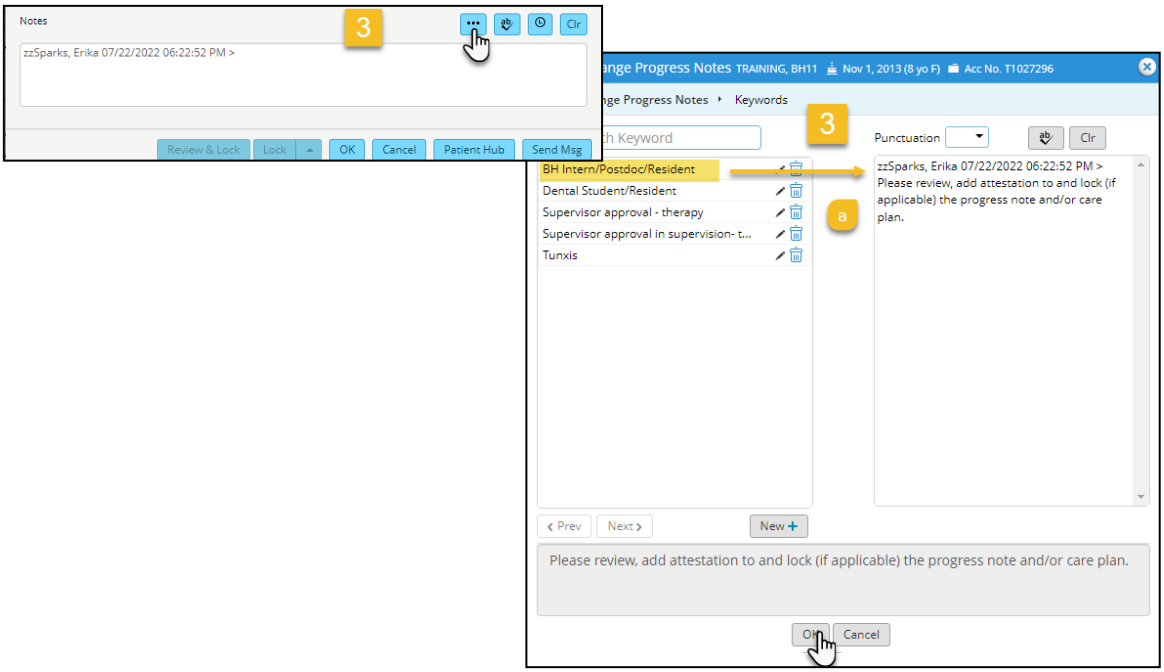
1. To assign the note, click the **Details** drop-down arrow, then select the **Change Assigned To** option to open the window:



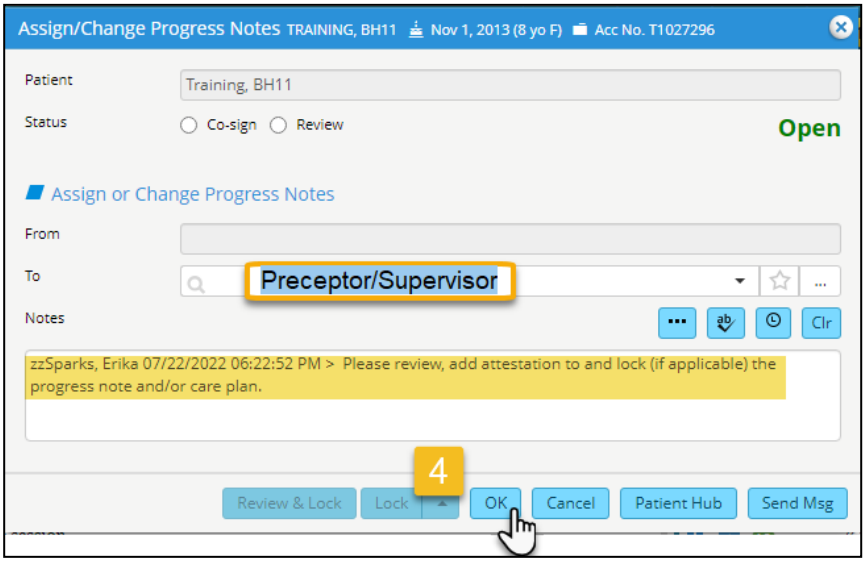
2. In the **Assign/Change Progress Notes** window, use the **To** drop-down arrow to select your supervisor.
    a. Next click the **Time Stamp** icon.



3. Next, click the **Browse** button to open the **Keywords** window.
    a. Select **BH Intern/Postdoc/Resident** to add the statement "**Please review, add attestation to and lock (if applicable) to the progress note and/or care plan.**" Then click the **OK** button.



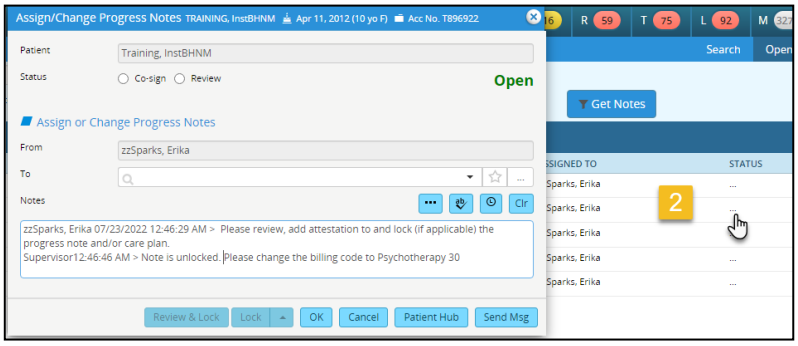
4. Returning to the **Assign/Change Progress Notes** window, click the **OK** button to close. This will transfer the note to the Supervisor.



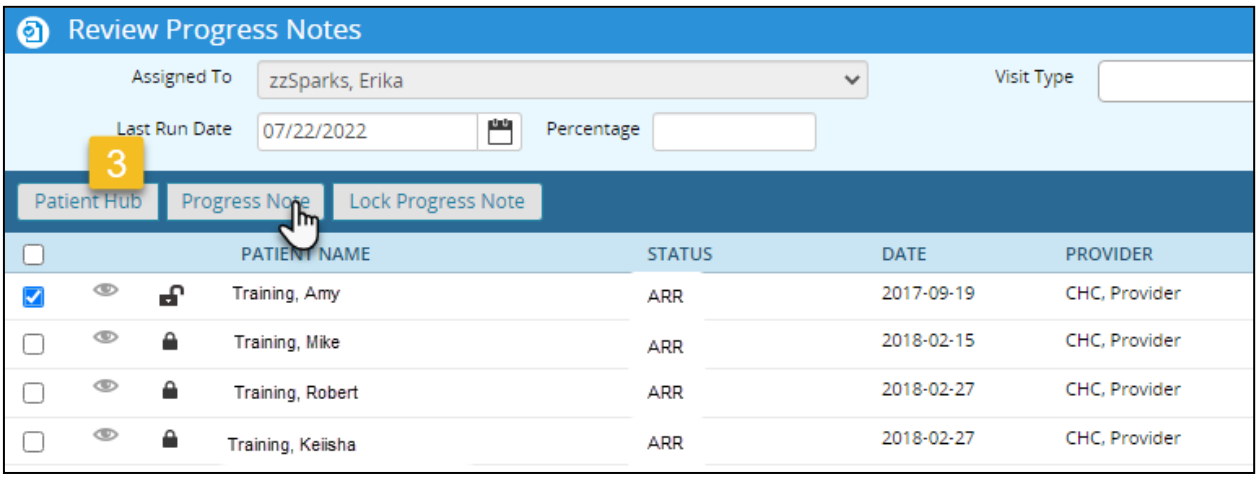
For Trainee: If Changes Needed – How to Access a Re-Assigned Note:

1. To access the assigned note, click directly on the letter **S** of the jelly bean, then select **Review Progress Notes** – (see the **Supervisor** section, pages 7 and 8, to access the assigned note).

2. In the **Status** column, click the ellipses (**...**) to access the **Assign/Change Progress Note** window. Read the Supervisor's revision notes, then click the **OK** button.



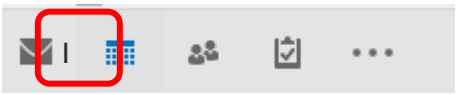
3. If changes required, access the **Progress Note** from the **Review Assigned Notes** window, ensure that the note is still selected, then click the **Progress Note** button to open the note.



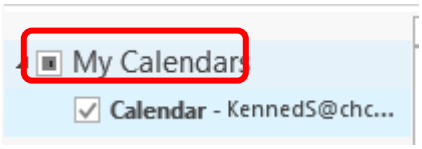
APPENDIX D: BH Trainee guide to Recording sessions

FIRST TIME SETUP

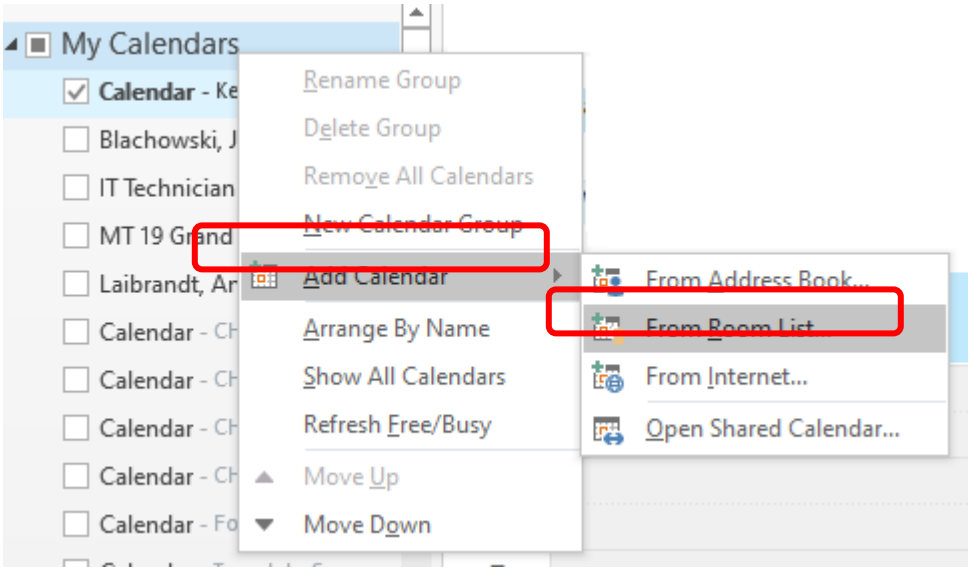
- Open Outlook
- Left Click on the Calendar at the bottom left hand corner



- Right click on the My Calendar Tab



- Select Add Calendar From Room List



- Add Rooms BH Recording 1, BH Recording 2, BH Recording 3, BH Recording 4

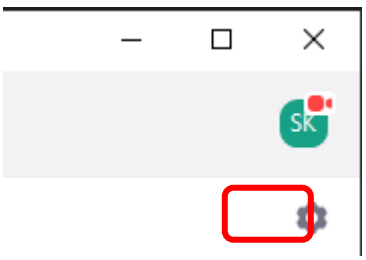
CONFIGURE ZOOM RECORDING

This needs to be done once per computer

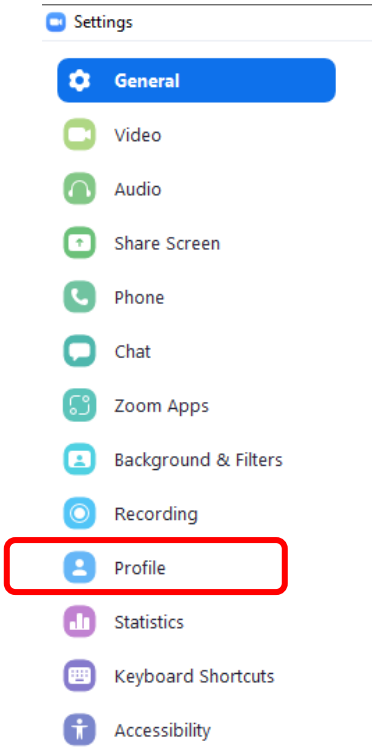
If you are using a different computer than normal you must do this step again

- Open Zoom

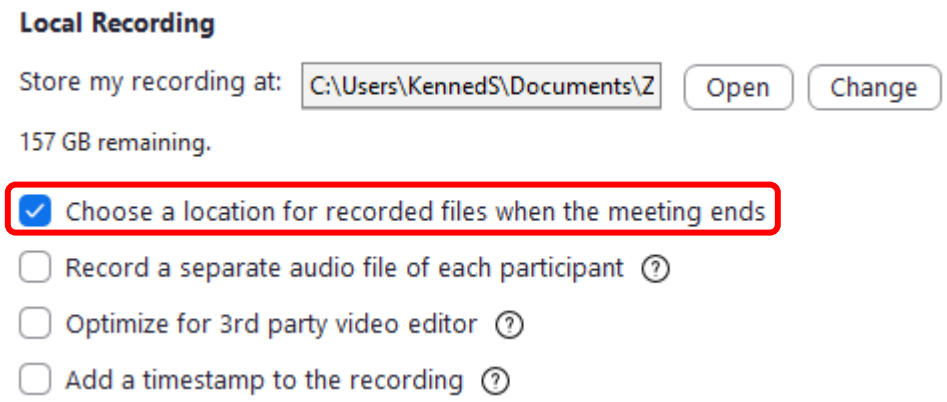
- Log in with any account
- Click on the Settings Icon



- Go to Recording



- Check the box “Choose a location for recorded files when the meeting ends”



EACH TIME BEFORE YOU RECORD A SESSION

Scheduling a zoom to record a session

- Open outlook
- Navigate to the newly added calendars
- Schedule a meeting at the time you need ensuring you do not double book a recording session
- You much book each session in Outlook to ensure no one else uses the same account and accidently ends your recording

RECORDING THE SESSION

Open Zoom

Plug in the USB table top microphone

- Log in with the appropriate login that you have scheduled in the outlook calendar

  BHRecord1@chc1.com

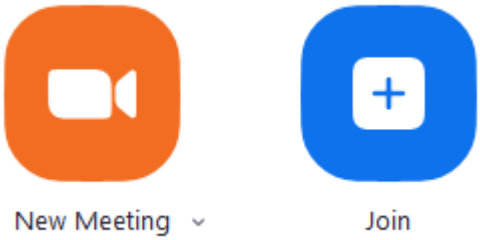
  BHRecord2@chc1.com

  BHRecord3@chc1.com

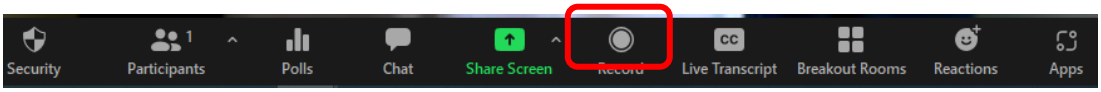
  BHRecord4@chc1.com

Password is Purple1234!

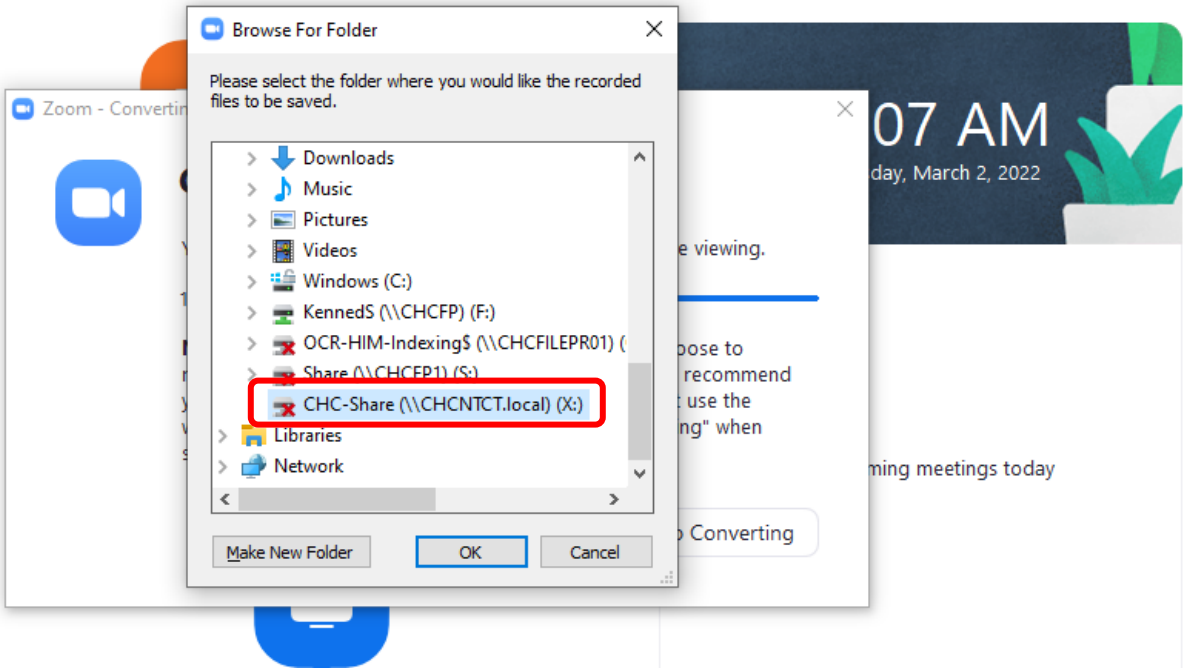
- Start a new meeting



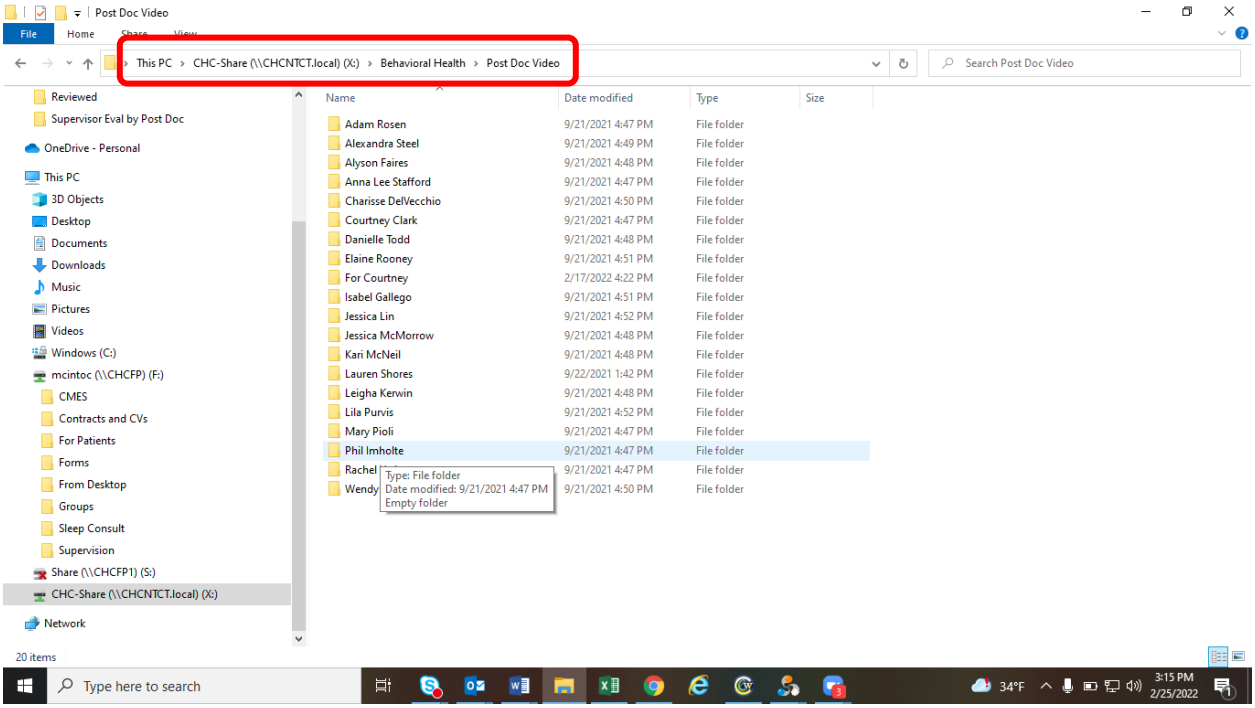
- Select Record



- When meeting ends Select X drive folder to save to



- X drive folder location is Critical, folders are located at X:\Behavioral Health\Post Doc



Video\Your Name

APPENDIX E: Sample Intake Documentation

Adult with Substance Use

Refer to notes in bold and green for guidance on the sections.

Int MH 60 Phone: Dariush Fathi, PsyD

[While you begin, get informed consent for treatment. Discuss the limits of confidentiality. Confirm their email address and email the Docusign informed consent to them and confirm they received it.]

CarePlanProblems

Problem:drug use

Goal:abstain from drug use Objective: Patient will demonstrate 6 months of sobriety from drug use as evidenced by self-report and lab results

Notes:

Problem:Drug use

Goal:Abstain from drug use Objective:Patient will report learning 3 strategies for coping with urges and cravings

Notes:

Reason for Appointment

1. Tele Phone BH Adult Visit

[Whenever scheduled a phone session, do mention and offer Zoom as an option "We also have zoom video as an option." This patient stated she preferred to do phone today, but agreed to do Zoom at the next session.]

2. Client name: Firstname Lastname Was seen by: Dariush Fathi PsyD on Date: 4/27/2022

3. I need to be on a MAT maintenance program, I recently moved back from California

4. Opioid and other drug use

5. Anxiety

[Important to list any of the patients presenting complaints here in the "chief complaint" section]

History of Present Illness

BH VISIT DURATION:
Visit Times
Start Time *9:30am*
End Time *10:30am*

Hx of Present Illness: **[Throughout this section, assess the history of EACH presenting complaint. As you can see here, history of both anxiety and substance abuse are listed]**

History of present illness I went to California for rehab in 2014, and stayed there for 9 years (patient was 21.) No prior bh treatment history before this time.

I was sober on and off for that time, initially for 18 months. 18 months was the longest period of sobriety

Patient states she has always had anxiety "since I was a little kid." She states she just gets "very nervous" and feels that way out of nowhere.

Did detox, inpatient, outpatient, IOP for addiction. Did a 6-month inpatient to IOP program in 2018-2019.

Family's/Client's understanding of illness

[Note – assessed both understanding of substance use and anxiety]

I started doing 'Roxys' in college when I was 18. I did uppers (cocaine), then downers. Was using to party and stay up late. Had a partial scholarship, full time school and 2 jobs.

Reasons for anxiety - unknown

Setting in which symptoms occur At home, In public.

What aggravates the symptoms Unknown what causes her anxiety

Has an avoidance pattern, avoids problems. Thinks she developed a physical addiction by

Severity of symptoms Causing emotional distress (anxiety).

Life events occurring at the time of symptoms unknown

Referral

Referral Source: *Self/Family* _

Reason for referral addiction treatment.

Behavioral Health Tx:

Currently in Tx No.

Past BH Tx Multiple Inpatient rehabs, IOP, and outpatient programs for substance al

Name of previous therapist No recent primary therapist

Previous therapist:

[Important to get an ROI for most recent therapist and/or treatment center, by emailing it to patient's Docusign or in person having them fill out a paper form]

ROI obtained ROI Sent for most recent rehab program via DocuSign to patient.

Lifetime Psychiatric Hospitalizations

hospitalization *0*

PCP name and address CHC based.

Date of last physical

Date of last physical *Within the last year*

PCP Release of information Patient in treatment at CHC.

Substance Use:

[Be sure to assess ALL of the drugs in this section. I usually start this section by saying "Next I am going to ask some questions about any substance use. Have you ever used Tobacco?... Have you ever used alcohol? Have you ever used Cannabis/marijuana…?

If the patient says "I have never used alcohol or any drugs" then you could make a note of that and skip this section.]

Tobacco

Have you ever, even once, used any tobacco? *Yes*

Age of First Use? *18*

What is your use pattern? *Daily or nearly every day half a pack a day*

How do you take this drug? *Smoking*

Where do you get this drug? *Store*

Do other members of your family use this drug? *Yes mother but mother quit*

Have you ever attempted treatment for this drug? *No*

Alcohol

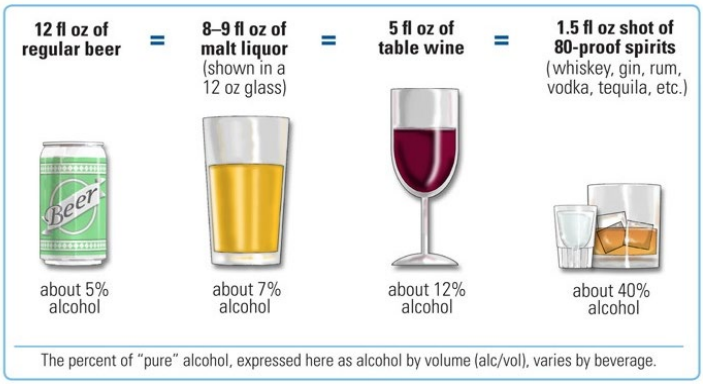
[Use this image/chart when assessing alcohol use. One standard drink = 1.5oz of spirits = a 5oz glass of wine = a 12oz beer]

Have you ever, even once, used alcohol? *Yes*

Age of First Use? *18*

What is your use pattern? *Twice per year or less*

How do you take this drug? *Oral/swallowed no history of problem alcohol use reported*



Cannabis

Have you ever, even once, used any Cannabis? *Yes*

Age of First Use? *18*

What is your use pattern? *Recreationally*

How do you take this drug? *Smoked*

Where do you get this drug? *Store Last used Nov 2021*

Do other members of your family use this drug? *No*

Have you ever attempted treatment for this drug? *Yes*

Heroin

Have you ever, even once, used Heroin? *Yes*

Age of First Use? *22*

What is your use pattern? *Daily or nearly every day daily at 23*

How do you take this drug? *Smoked*

Where do you get this drug? *Drug Dealer*

Do other members of your family use this drug? *No*

Have you ever attempted treatment for this drug? *Yes*

What have you tried and how helpful was it? *Inpatient, IOP helpful.*

[It is very important to make a note of when a patient last used each substance that i

concern.]

Last used heroin in March 2022

Cocaine

Have you ever, even once, used Cocaine? *Yes, began using cocaine at age 18*

Age of First Use? *18*

What is your use pattern? *Daily or nearly every day*

How do you take this drug? *Snorted*

Where do you get this drug? *Drug Dealer*

Do other members of your family use this drug? *No*

Have you ever attempted treatment for this drug? *Yes*

What have you tried and how helpful was it? *Rehab/Treatment. Last used at age 21*

Prescription Opiates

Have you ever, even once, used any Prescription Opiates? *Yes*

Age of First Use? *18*

What is your use pattern? *Daily or nearly every day*

How do you take this drug? *Oral/swallowed*

Where do you get this drug? *Drug Dealer*

Do other members of your family use this drug? *a cousin*

Have you ever attempted treatment for this drug? *Yes*

What have you tried and how helpful was it? *rehab, IOP, outpatient. It was helpful, got me clean.*

Last used in March 2022 **[Indicate when they last used – if recent highlights that the substance is still an active concern]**

Inhalants

Have you ever, even once, used any Inhalants? *No*

Ecstasy/Club Drugs

Have you ever, even once, used any Ecstasy/Club Drugs? *Yes*

Age of First Use? *18*

What is your use pattern? *Recreationally*

Where do you get this drug? *Drug Dealer*

Do other members of your family use this drug? *No*

Have you ever attempted treatment for this drug? *No*

Steroids

Have you ever, even once, used Steroids? *No*

PCP

Have you ever, even once, used PCP? *No*

Hallucinogens

Have you ever, even once, used Hallucinogens? *Yes*

Age of First Use? *18*

What is your use pattern? *Recreationally*

Do other members of your family use this drug? *No*

Have you ever attempted treatment for this drug? *No*

Methamphetamine

Have you ever, even once, used Methampetamine? *Yes*

Age of First Use? *23*

What is your use pattern? *Daily or nearly every day daily at age 24*

How do you take this drug? *Smoked*

Where do you get this drug? *Drug Dealer*

Do other members of your family use this drug? *Yes a cousin*

Have you ever attempted treatment for this drug? *Yes Last used in December 2021*

Prescription Amphetamines

Have you ever, even once, used any Prescription **Amphetamines?** *Yes experimental use in college*

Where do you get this drug? *Drug Dealer*

Do other members of your family use this drug? *No*

Have you ever attempted treatment for this drug? *No*

Anxiolytics/Benzodiazepines

Have you ever, even once, used **Anxiolytics/Benzodiazepines?** *No*

Sedatives/Barbiturates

Have you ever, even once, used any Sedatives/Barbiturates? *No*

Over the Counter Drugs of Abuse (DXM, Triple C, etc.)

Have you ever, even once, used any Over the Counter Drugs of Abuse (DXM, Triple C, etc.)? *No*

Are you having any detox symptoms from any of these drugs? No.

Has anyone ever thought you had a problem with these drugs? Not asked.

What problems have you experienced as a result of drug use? Incarceration, job loss, family is

[Important to ask these questions at the end. How motivated are you to quit drugs/alcohol?
Optional: you can use scaling questions "How motivated are you to quit alcohol, from 1 – definitely not motivated, to 10, extremely motivated?"
"How important is it for you to quit drugs from 1 – not at all important, to 10, the most important thing in your life?"]

How motivated are you to quit using these drugs? I want to quit, I'm trying to quit.
Motivation: 6.5-7/10. Still having cravings and urges
Importance: 7/10.

Addictive Behavior: [Do assess this section by asking "Do you have any other kinds of addictions like video games, pornography, food,… etc"]

Denies : Problem Gambling.
Denies : Gambling: during the past 12 months, have you become restles.
Denies : During the past 12 months, have you tried to keep your famil.
Denies : During the past 12 months, did you have such financial troub.
Denies : If yes to any of the gambling questions, was referral given .
Denies : Assessment of other addictive behaviors none.

Legal Involvement:

Legal History
: *Yes (specify) Has 8 felonies: possession with intent to sell. Arrested twice, was on probation, violated probation many times. Was incarcerated around 12 times.*
Arrested in the 12 months prior to admission? *Yes in May 2021 due to a car accident, had a warrant*
Number of times arrested in 30 days prior to episode start date: *0*
During past 12 months, has client been detained or incarcerated? *Yes spent 7 days in jail in May of 2021.*
During this episode of care, has the client been arrested? *No*
Number of times arrested in 30 days prior to episode end date? *0*
During this episode of care, has the client been detained or incarcerated? *No*
Pending Charges
: *Yes (specify) violation of probation, but states it is a paperwork error*
Current Probation/Parole
: *Yes is on probation but an error in paperwork, she states. Does not have a PO*
Current Attorney/Public Defender
: *No*
Arrested in the 12 months prior to admission
: *Yes*
Arrested in 6 months prior to admission
No
Hx of Incarcerations
: *Yes (If Yes, Specify dates, charges, and prison) Multiple incarcerations for drug related charges. Longest period of incarceration was in 2020 for 4-5mo. Most recently incarcerated in 2021 for 7 days*
During past 12 months, has client been detained or incarcera
_ *Yes*
During past 6 months, has the client been detained or incarc
Detained/incarcerated *No*

DCF Status:

DCF involvement No.

Personal History:

Natural Support System/Community Involvement Family.
Strengths Hard working .
Residency in the United States
Residency *Entire life*
Living arrangements
living arrangements *Private Residence*
Marital Status , Single.
Employment Part time employment, working for a family's catering company.
Education Partial college completion.
Family make up none.
Risk factors present , Poor impulse control.
Nutritional Assessment Normal.
If concerns noted re: nutrition, referral to Registered Diet , N/A.
Preferred language , English.
Preferred method of learning Visual , Written , Audio.
Italian and Puerto Rican. **[Verbally assessed, "what is your cultural background?"]**

Trauma Hx:

ACE Survey **[I usually start this section by saying "Next, I am going to ask questions about any challenging experiences during childhood"]**

Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you? OR act in a way that made you afraid that you might be physically hurt? *Yes mother was verbally abusive growing up*

Did a parent or other adult in the household often Push, grab, slap, or throw something at you? OR Ever hit you so hard that you had marks or were injured? *Yes corporal punishment but no marks left (described it as spanish/cultural)*

Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? OR Try to or actually have oral, anal, or vaginal sex with you? *Yes was molested by an older cousin for a period of time. Patient was in elementary school, around 7-8. Does not think it had an impact on her*

Did you often feel that no one in your family loved you or thought you were important or special? OR Your family didn't look out for each other, feel close to each other, or support each other? *No*

Do you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? OR Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? *No*

Were your parents ever separated or divorced? *Yes parents divorced when pt was 5yo, they were married 2 years. She then had to transition to different homes. Was a*

difficult transition with shared custody

Was your mother or stepmother: often pushed, grabbed, slapped or had something thrown at her? OR Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? OR ever repeatedly hit over at least a few minutes or threatened with a gun or knife? *No*

Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? *No*

Was a household member depressed or mentally ill or did a household member attempt suicide? *Yes thinks her mother has borderline personality*

Did a household member go to prison? *No*

ACE Total: *5*

Is this an area you would like to address in treatment? *Yes*

Adult Trauma: [Assess by asking "Have you ever had any traumatic experiences during your adult life"]

Patient states she was robbed on one occasion at knifepoint for drugs. She states that while the experience was upsetting she does not have any post-traumatic symptoms pertaining to this event

Exploitation

Has anyone ever taken and kept your identification, for example, your passport or driver's license? *No*

Have you ever had sex for things of value (for example money, housing, food, gifts, or favors)? *No*

When working, has someone ever: *No*

Mental Status:

Appearance Unable to assess - phone session. **[Can't assess appearance on a phone call]**

Attitude , **Cooperative**.
Affect , Appropriate.
Motor Activity , Calm.
Eye Contact , Appropriate.
Mood , Euthymic.
Speech , Normal.
Thought Process , Intact.
Thought Content , Logical/Coherent.
Disturbances of Perception , Not present.
Memory , Intact.
Cognitive Function , General Knowledge Intact.
Abstraction , Intact.
Judgement , Moderate Impairment. **[Assessing Judgment: Based on the information you have gathered, do they have impaired judgment (i.e. recent history of making poor choices, irrational actions, risky behavior.)]**

Insight , Moderate Impairment. **[Assessing Insight: Insight refers to how well a person understands themselves, their thoughts, feelings, and behaviors. It is their understanding of why they feel the way they feel, and why they do the things they do.]**

Reliability , Reliable.
Orientation , Oriented to time, place, person.
Pain Assessment
Pain *0*

Suicidal/Homicidal Assesment:

Suicide-Protective factors No history of suicidal concerns.
History of Homicidality
: *Hx denied*
Present Homicidality
: *Denies*
History of Assaultive Behavior
: *no*
Gun Ownership
: *no*
If suicidal, referral information such as hotline given? N/A.
Columbia Suicide Severity Rating Scale Assessment **[Answered No/NA for the rest of these questions because a suicide history was denied]**

Have you wished you were dead or wished you could go to sleep and not wake up? *No never*

Have you actually had any thoughts of killing yourself? *Not asked*

Have you been thinking about how you might do this? *Not asked*

Have you had these thoughts and had some intention of acting on them? *Not asked*

Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? *Not asked*

Have you ever made a suicide attempt? *Not asked*

Have you ever done anything to harm yourself? *Not asked*

Have you ever done anything dangerous where you could have died? *Not asked*

Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything? *Not asked*

Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)? *Not asked*

Suicide Risk: *Low* _

Spirituality/Religion:

Is spirituality/religion important part of your life? , No. Grew up Catholic but not

religious.

How does spirituality/religion impact your mental health? N/A.

Leisure Time Assessment:

What do you do in your free time? TV, play games on her phone. Not allowed to go anywhere by her parents for fear she will relapse .

Would you like a leisure time goal part of your careplan? , No.

With whom do you spend free time? , Family.

What would you like to be doing in your free time?

Mother doesnt want her going out on her own right now.

Medications/Medication Adherence:

Medication Adherence , Yes, as reported by client.

Allergies to food , None reported.

Allergies to medication Immitrix and prednazone.

Per client, current medications and reason (Medical, BH and 12mg suboxone, 50mg of seroquel at night for sleep

.

Case Formulation: [First paragraph should capture all demographic information and brief reason for entering treatment]

: Firstname Lastname is a 28-year-old single mixed ethnicity female (Puerto Rican and Italian American) self-referred to CHC's suboxone program following completing rehab and detox. She reports a significant history of opioid addiction (pills and heroin) and methamphetamine use. She also states she has struggled with anxiety since childhood.

[The body should summarize the intake, explain the areas of concern in a narrative format for any presenting complaint. Note the first paragraph talks about substance abuse, the second paragraph talks about anxiety. Reading these, the reader should expect that there will be substance use diagnoses and anxiety diagnoses.]

Ms. Lastname began using drugs when she was in college at 18 years old. She recalled she was working two jobs while in college, and began taking cocaine regularly to be more productive and active. She then started using opioid pills and other drugs. At age 21, she dropped out of college and her family sent her to rehab in California. She

lived in California for 8 years where she engaged in periods of significant substance use (opioid pills, meth, and heroin) and was in and out of rehab and treatment programs. She had brief periods of employment during this time. She also incurred several legal charges and issues related to using and selling drugs. Ms. Lastname stated she returned to CT in December of 2021 upon deciding she wanted to be closer to family, and to stop missing important life events due to substance use. She reports using while in Connecticut and recently went to a rehab/treatment program in Hartford, CT, successfully completing the program. Upon her discharge, she decided to come to CHC for relapse prevention support. She reports she has not used any drugs since March, 2022, and but is still experiencing urges and cravings.

Patient reports a history of anxiety concerns since her childhood but had limited understanding of the causes of her anxiety. Upon assessment of adverse childhood events she had an ACES score of 5. She noted her parents' divorce was stressful, and also noted a history of molestation by an older cousin. She denied any connection between these concerns and her anxiety.

[End the case formulation with discussing next steps/summary of recommendations.]

Ms. Lastname was recommended to participate in a relapse prevention group, and individual therapy weekly to address her anxiety concerns and for additional relapse prevention support. She expressed understanding for treatment rationale and was in agreement with the plan.

Treatment Goals (in patient's own words): My goal is to be an active member of my family and society in general. I have a 13 year old brother and want to be involved with his life. .

Deferred Goals (and rationale): Patient states anxiety is not a concern for her at this time. Goals for anxiety management deferred.

Disposition:

[At this point, you want to explain to the patient what are your recommendations for treatment.
You want to think about which Group Therapy treatments could best help with the patients symptoms, and explain why. And you want to mention if you are

recommending individual therapy and/or a psychiatry evaluation, and explain why.

In this case, I recommended the patient for individual therapy (for relapse prevention and to address her anxiety), along with group therapy, for relapse prevention.

Group Referrals
***Note, it may take extra effort to encourage the patient to be open to group therapy as a treatment. The key is to make sure the rationale for your recommendation is well explained and to make a connection to why the group could help with their symptoms, concerns**
****If a patient agrees to try or attend the group, the next step is to create a TE titled "Referral for: Group Therapy" and assign that TE to the group leader. The group leader will then call to schedule an appointment to screen the patient for their group**
For a list of groups visit www.chc1.com/groups]

Intake Recommendations/Care Plan

: *Individual Therapy (weekly-biweekly), Group Therapy (weekly)*

Disability Not asked.

Community Supports/Referrals to be made none at this time.

Specific Criteria for Discharge treatment goals met.

Anticipated Date of Discharge

Date: *04/27/2022* _

Group Appropriateness

[Indicate here which groups you are referring the patient to and other groups they may be a good fit for]

Group Appropriateness *Appropriate for substance abuse group Yes- appropriate for MAT Relapse prevention group*

Dashboard None.

Informed consent reviewed with client and/or guardian, Yes.

Therapist has discussed the benefits and risks of care, trea , Yes.

Client has psychiatric advanced directive

Psychiatric Advanced Directive discussed with patient: *Patient declines completion of Advances Directives form at this point in time.*

Social Elements Impacting Diagnosis

: *Unknown*

TeleHealth Session :

Phone Verbal Consent

My Name is __. This visit is occurring via phone. We can have this telehealth visit today because of a law that expires on June 30, 2023. You can opt-out or refuse at any time. Do I have your consent (or consent for your minor child) for this phone visit? Please verify your Name and Date of Birth _ ***verified***

Received verbal telephone consent from patient, parent and or guardian *Yes*

Notice of Privacy Practices were reviewed and verbally acknowledged by patient and/or parent or legal guardian *Yes*

Patient made aware that the Consent to Treat Document and NPP is available to view on chc1.com *Yes*

TeleHealth Visit Verifications

Patient joined from a secure and private location *Yes*

Patient Location *Home*

Other individuals were present for the visit with patient *No*

Is Patient a minor *No*

CTBHFORM:

Social Elements Impacting Diagnosis

Check all that apply: *Problems related to interaction w/legal system/crime*

Assessments

1. Opioid use disorder, severe, on maintenance therapy - F11.20

[Always include Tobacco Use Disorder if the patient is a smoker. Be sure to include all DSM-5 diagnoses the patient meets criteria for]

2. Tobacco use disorder, moderate, dependence - F17.200

3. Amphetamine use disorder, moderate - F15.20

4. Anxiety disorder, unspecified type - F41.9

Rule out PTSD.

[You can write in text a "rule out" if you intend to explore/rule out a possible diagnosis in the near future.]

Visit Codes **[Always include the Diagnostic Evaluation No Medical as the code for an intake. Modifier should be CR for phone sessions or 95 for video]**

90791 Diagnostic Evaluation no Medical. Modifiers: CR

Follow Up

1 Week (group and individual therapy)

Sample Child Intake

Reason for Appointment

1. Initial Assessment and Treatment Plan

2. (BH Visit) Client name: John Doe Was seen by: Mary Elizabeth Pioli, PhD on Date: 2/21/22 Under the Supervision of: Dariush Fathi, PsyD

3. Tele Video Child Visit (BH)

4. Live Video visit: Patient and or Guardian viewed providers name in the virtual waiting room

Assessments

1. Moderate episode of recurrent major depressive disorder - F33.1 (Primary)

Follow Up

2 Weeks

History of Present Illness

BH VISIT DURATION:

Visit Times

Start Time *1:00, PM*

End Time *2:00, PM*

Hx of Present Illness:

History of present illness is Jacob reported, "I don't know." Mother, Tara reported symptoms consistent with a moderate episode of recurrent major depressive disorder, "I think Jacob has been very sad and he reported to me that he would like to try medicine... He has a lot of thoughts about the trauma in his past." Jacob said, "I can't keep everything in." Jacob reports feeling moderately sad across settings, including difficulty falling, decreased sleep, and crankiness when he wakes up. Jacob reported that he has had a decreased academic performance from feelings of sadness (drop from C to F in English). Jacob and his mother agree that the symptoms started two months ago. Family's/Client's understanding of illness Jacob believes that the symptoms began due to puberty, "I have been thinking bad thoughts. I am more overwhelmed and want to get the truth out

more often." Tara reported, "Jacob has not talked to his dad in over a year and a lot happened... supervised visits started in December and Wellmore IICAPS ended at that time as well. We are on a waiting list for them to come back again. We had been on Family and Children's Aid but we reached our six months maximum.". Setting in which symptoms occur Across settings. What aggravates the symptoms School, mainly homework. Severity of symptoms Disruptive in school/work, Causing emotional distress. Life events occuring at the time of symptoms Supervised visits began. effect of family on child's condition Family provides meaning support/advocacy. effect of child's condition on family Tara reports, "Sometimes I don't know how to handle it because I have depression and anxiety. Sometimes he hugs me and says thank you for calming me down so it hurts me when I cannot be calm and get him through these situations. I will just start crying and then he can't open up to me because he is afraid he will make me said.". Family expectation of treatment Jacob reported, "I don't know." Mother reported, "To not feel sad all the time.". Referral

Date of Referral: *02/10/2022*

Referral Source: *Self/Family*

Client's primary presenting problem

Primary *Depression*

Client's secondary presenting problem

Secondary *School Problems*

Behavioral Health Tx:

Currently in Tx No. Past BH Tx Katharine Juppe, LPC (since second grade). Name of previous therapist See prior. Previous therapist: ROI obained Yes. Psychiatric Hospitalizations

Number of lifetime hospitalizations: *2 24 hour holds, Once in PA with dad (March, 2020), here (February, 2021). Jacob reported, had suicidal thoughts from 5-9. Hospitalized in 2021 , "wanted to hurt others." School called 2-1-1*

Number of hospitalizations in 6 months prior to admission: *0*

Number of ED evaluations in 6 months prior to admission: *0*

Number of out-of-home placements: *0*

Number of out-of-home placements in 6 months prior to admission: *0*

During this episode of care, how many times has the client been hospitalized (inpatient) for psychiatric or behavioral health reasons? *0*

During this episode of care, how many times has the client been evaluated in a Hospital Emergency Department (ED) for psychiatric or behavioral health reasons? *0*

Psychiatric Hospitalizations in last 6 months

hosp *0*

Emergency Room for psychiatric reasons in past 6 months Not asked.

Lifetime Psychiatric Hospitalizations

hospitalization *2*

PCP name and address Richard Auerbach, Newtown then Minhas at CHC. Date of last physical

Date of last physical *Within the last year*

PCP Release of information obtained Patient in treatment at CHC.

Substance Abuse:

Denies : Has anyone, including you, ever thought you had a problem wi.

Denies : Have there been any negative consequences from your use of a.

Denies : Problems with Alcohol and/or Drugs.

Denies : Six months prior to admission, alcohol / drug problem .

Denies : Detox symptoms present today.

Denies : Past alcohol and / or drug abuse history.

Denies : Tobacco.

Denies : Alcohol.

Denies : Caffeine.

Denies : Inhalants.

Denies : Cannabis.

Denies : Ecstasy / Other club drugs.

Denies : Cocaine.

Denies : Heroin.

Denies : PCP.

Denies : Hallucinogens.

Denies : Amphetamines.

Denies : Methamphetamine.

Denies : Ketamine.

Denies : Barbituates.

Denies : Methadone.

Denies : Prescription Opioids.

Denies : Over the Counter.

Denies : Motivation for Treatment.

Addictive Behavior:

Denies : Problem Gambling.

Denies : Gambling: during the past 12 months, have you become restles.

Denies : During the past 12 months, have you tried to keep your famil.

Denies : During the past 12 months, did you have such financial troub.

Denies : If yes to any of the gambling questions, was referral given .

Denies : Assessment of other addictive behaviors.

Legal Involvement:

Denies : Legal History.

Denies : Pending Charges.

Denies : Current Probation/Parole.

Denies : Current Attorney/Public Defender.

Denies : Arrested in the 12 months prior to admission.

Denies : Arrested in 6 months prior to admission.

Denies : Hx of Incarcerations.

Denies : During past 12 months, has client been detained or incarcera.

Denies : During past 6 months, has the client been detained or incarc.

DCF Status:

DCF involvement History of DCF involvement, when Jacob was three years old. DCF Status of client: *Not DCF*

Personal History:

Birth Complications Yes, Jacob was three days late, induced due to non-movement, cord wrapped around neck, C-section. Developmental Milestones Delayed, across physical, social, speech

Birth-three starting at six months. Early Childhood Continued service to reach milestones

Nurturing families until 5. Preschool in Danbury (Great Plain Elementary). Natural Support System/Community Involvement Boy Scouts, Baseball (Fall and Spring), Afterschool activities-chess, gamers club, exercise. Strengths "Smart, good singing voice, can do voices, meditate, can keep myself calm, can make others calm, I can help people, I can help people with school." Jacob reports, "Mommy makes me happy." Tara reports, "My big heart, my patience,

creative.". Relationship of Primary caregiver to child

Relationship *Birth Mother*

Residency in the United States

Residency *Entire life*

Guardian Service Need

Needs *None*

Parental Involvement Mother involved,, Father involved. School

Current school grade or highest completed: *Grade 7 7th*

Parent/guardian rating of attendance, last 12 months: *Good (few or no days missed) 6 absences, COVID positive Tuesday of last week*

Suspended/Expelled 12 months prior to admission? *No No*

Issues that impact client's functioning at school: *Yes: Academic Issues Emotional*

Special Ed Services Received Special Education Teacher: Reading, Writing, Social Group(Counseling/SW/School psych- every Day 4). Risk factors present Age: (Under 24/over 65), Male. assessment of play and daily activities child engages in age appropriate peer activities. Nutritional Assessment Parent reports concerns regarding nutrition/diet (taking gummy to compensate for low fruits and vegetables). If concerns noted re: nutrition, referral to Registered Diet Yes. Play/Daily Activities Age appropriate friends/play activites. Impact on School Functioning

Are there issues that have a significant negative impact on the client's functioning at school? *Yes: Academic Issues, Yes: Social Issues, Yes: Emotional*

Preferred language English. Preferred method of learning Visual, Written, Audio. Trauma

Hx of Traumatic Experience: *"I don't want to talk about it."*

<u>Trauma Hx</u>:

ACE Survey

Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you? OR act in a way that made you afraid that you might be physically hurt? *Jacob declined screener. "I don't want to talk about it."*

Exploitation

Has the child posted or sent sexually explicit material of themselves to others? *Not asked*

Does the child have a history of multiple runaways? *Not asked*

Has the child been in possession of money, cell phone or other items that cannot be explained

or accounted for? *Not asked*

Is the child reluctant to speak about injuries, bruises or tattoos? *Not asked*

Mental Status:

Appearance **Well groomed**. Attitude **Cooperative**. Affect Appropriate. Motor Activity Calm. Eye Contact Wavering. Mood Euthymic. Speech Normal. Thought Process Intact. Thought Content Logical/Coherent. Disturbances of Perception Not present. Memory Intact. Cognitive Function General Knowledge Intact, Simple Calculations Intact. Abstraction Intact. Judgement Intact. Insight Minimal Impairment. Reliability Reliable. Orientation Oriented to time, place, person. Pain Assessment

Pain *0*

Suicidal/Homicidal Assesment:

History of Suicidality Ideations (see above). Present Suicidality

: *Denies*

Suicide- Risk Factors History of MH disorder, particularly clinical depression, maternal history of attempts. Suicide-Protective factors Not asked. History of Homicidality

: *Ideas see above*

Present Homicidality

: *Denies*

History of Assaultive Behavior

: *no*

Gun Ownership

: *no*

If suicidal, referral information such as hotline given? No. Columbia Suicide Severity Rating Scale Assessment

Have you wished you were dead or wished you could go to sleep and not wake up? *Yes ever*

Have you actually had any thoughts of killing yourself? *Yes ever*

Have you been thinking about how you might do this? *No never*

Have you had these thoughts and had some intention of acting on them? *No never*

Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? *No never*

Have you ever made a suicide attempt? *No never*

Have you ever done anything to harm yourself? *No never*

Have you ever done anything dangerous where you could have died? *No never*

Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything? *No never*

Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)? *No never*

Suicide Risk: *Low*

Spirituality/Religon:

Is spirituality/religion important part of your life? Not asked. How does spirituality/religion impact your mental health? Not asked. Would you like a spirituality/religion goal included in your Not asked.

Leisure Time Assessment:

What do you do in your free time? Boy Scouts and a series of afterschool activities. How do you think these activities impact the issues for w Makes it better. Would you like a leisure time goal part of your careplan? No. What would you like to be doing in your free time? .

Medications/Medication Adherence:

Medication Adherence Not applicable. Allergies to food None reported. Allergies to medication NKDA. Per client, current medications and reason (Medical, BH and No meds at this time.

Case Formulation:

: Jacob is a 12 year old Caucasian male who lives with his mother and cat in a private residence in Sandy Hook, CT. His mother is in treatment at CHC with Angela Molnar, LCSW (provided consent for collaboration). When asked why he is presenting for treatment at this time, Jacob reported, "I don't know." Mother, Tara reported symptoms consistent with a moderate episode of recurrent major depressive disorder, "I think Jacob has been very sad and he reported to me that he would like to try medicine... He has a lot of thoughts about the trauma in his past." Jacob said, "I can't keep everything in." Jacob reports feeling moderately sad across settings, including difficulty falling, decreased sleep, and crankiness when he wakes up. Jacob reported that he has had a decreased academic performance from feelings of sadness (drop from C to F in English). Jacob and his mother agree that the symptoms started two months ago . Jacob has been hospitalized for depressive episodes in the past, including in 2020 and 2021 for suicidal ideation and a desire to harm others. His mother reported that he was prescribed Seroquel after Jacob's report of auditory hallucinations, but that it worsened them and they discontinued all medications. He denies current

SI/SH/HI or auditory hallucinations. Mother reported she is interested in a medication evaluation, but is willing to wait until one is hired for Danbury. She reported that they are on a waitlist for IICAPS as well and that the last course ended after six months (maximum time). It is recommended that further trauma history be taken as Jacob was resistant to discussing at time of intake and there was not time for mother's report of the events. It is recommended for Jacob to have at least bi-weekly individual therapy, as he has group social skills work and supports in school, but is struggling with depressive experiences at this time. Treatment Goals (in patient's own words): "To feel less sad.". Deferred Goals (and rationale): None.

Disposition:

Disability not applicable. Family expectation for and involvement in treatment Family agrees to attend family therapy. Community Supports/Referrals to be made Medication evaluation, when available. Specific Criteria for Discharge Jacob will have an alleviation in depression such that he is able to resume pre-depression functioning in school or starts IICAPS. Anticipated Date of Discharge

Date: *2/21/2023*

Group Appropriateness

Group Appropriateness *Client has previously attended group therapy*

Dashboard None. Informed consent reviewed with client and/or guardian Yes. Therapist has discussed the benefits and risks of care, trea Yes. Client has psychiatric advanced directive

Psychiatric Advanced Directive discussed with patient: *Patient declines completion of Advances Directives form at this point in time.*

Social Elements Impacting Diagnosis

: *Unknown*

Recommendations None at this time (specify reason).

CTBHFORM:

Referral Source

: *Self/Family*

First Contact Method

: *Telephone*

Referral Type

: *Routine*

1st appt offered *02/21/2022*

1st appt accepted *02/21/2022*

First Face to Face *02/21/2022*

Number of no shows/Cancel *0*

Member's Risk to Self

: *1 = Mild or Mildly Incapacitating*

Member's Risk to Others

: *1 = Mild or Mildly Incapacitating*

Mood Disturbance (Depression or Mania

: *2 = Moderate or Moderately Incapacitating*

Weight Change Associated wth BH Diagnosis

(if 1 or higher selected, please complete ALL following questions) *0 = None*

Anxiety

: *1 = Mild or Mildly Incapacitating*

Medical/Physical Conditions

: *0 = None*

Psychosis/Hallucinations/Delusions

: *0 = None*

Substance Use/Dependence

: *0 = None*

Thinking/Cognitive/Memory/Concentration

: *1 = Mild or Mildly Incapacitating*

Job/School/Performance Problems

: *2 = Moderate or Moderately Incapacitating*

Impulsive/Reckless/Aggressive Behavior

: *0 = None*

Social Functioning/Relationships/Marital/Family Problems

: *1 = Mild or Mildly Incapacitating*

Social Elements Impacting Diagnosis

Check all that apply: *Problems related to the social environment*

Activities of Daily Living Problems

: *0 = None*

Legal

: *0 = None*

Impairments Related to Loss/Trauma

: *1 = Mild or Mildly Incapacitating*

Co-occurring mental health and substance use conditions

: *No*

<18: SED

: *No*

<18: Co-occuring Disorder

: *Yes*

<18: Living Situation

: *Private Residence*

<18: Arrested within the last 12 months?

: *No*

<18: Suspended/Expelled within the last 12 Months

: *No*

<18: Enrolled in school?

: *Yes*

<18: If enrolled in school, has been suspended?

: *No*

<18: If enrolled in school, unexcused attendance problems?

: *No*

<18: Behavior resulted in new legal problems?

: *No*

<18: New legal charges?

: *No*

<18: Family member involved in peer support activities?

: *Yes*

<18: Actively involved in organized recreational activities?

: *Yes*

<18: CP goal- involved in org recreational activities?

: *No*

<18: During the past 3 month, therapist communicated with:

School regarding care and treatment *No*

DCF regarding care and treatment *Child not DCF Involved*

Probation/Parole regarding care and treatment *Child not involved with probation/paroled*

<18: In past 3 month, therapist communicated with PCP or medical provider *No*

Obtained consent to contact

School *Yes*

Medical Provider *Yes*

Previous BH Provider *Yes*

Treatment developed w/patient/guardian w/time goals : *Yes*

Documented goal oriented treatment plan created : *Yes*

Anticipated date of achievement for treatment plan : *04/21/2022*

Medication eval or treatment : *Yes*

Peer Support information Given : *No*

Family participation : *Yes*

Family involvement, are members receiving treatment : *Yes*

Indicate degree of progress from previous registration : *None*

Treatment Modalities to be used for this request:

Family? *Yes*

Frequency: *Other (use Notes to specify) as needed*

Individual? *Yes*

Frequency: *Other (use Notes to specify) bi-weekly*

Group? *No*

Medication Management? *Yes*

Frequency: *Other (use Notes to specify) when one is hired*

TeleHealth Session :

Video BH Verbal Consent

This visit is occuring via Video. We can have this telehealth visit today because of a law that expires on June 30, 2023. You can opt-out or refuse at any time. No system is 100% secure but this is being conducted on a HIPAA Compliant platform to protect your confidentiality. Do you consent to Video (or consent on behalf of your minor child)? Please verify your Name and Date of Birth. .

Notice of Privacy Practices were reviewed on video and verbally acknowledged by patient and/or parent or legal guardian *Yes*

Patient made aware that the Consent to Treat Document and NPP is available to view on chc1.com *Yes*

Patient, parent or guardian provided informed consent for Video appointment *Yes*

TeleHealth Visit Verifications

Patient joined from a secure and private location *Yes*

Patient Location *Home*

Visit Codes

90791 Diagnostic Evaluation no Medical. Modifiers: 95

Care Plan Details

CarePlanProblems

1. Depression

Goal:I want to feel less sad Objective:Patient and family will identify his symtoms of sadness and trauma over the next three months as evidenced by parent and child report

Notes:

APPENDIX F: Sample Progress Note Documentation

Sample Progress Note #1

Client report Pt provided updates since his last session, and processed at length his thoughts and feelings to issues with his mother, specifically feeling like she does not validate him or understand his issues. This clinician and pt explored specific examples throughout his life when he felt invalidated or neglected by her, and discussed ways in which he has attempted to communicate his feelings to her. This clinician and pt also explored how his interpersonal style, personality dynamics, and communication style impact the ways in which others respond to him. Additionally, this clinician and pt attempted to discuss alternative ways he can talk with/communicate with others. =

Intervention Notes Elicited updates since his last session. Processed current thoughts and feelings. Provided validation and support. Reiterated boundaries of the therapeutic relationship, and discussed how such boundaries can be maintained in sessions. Attempted to engage in perspective taking. Explored issues with his mother. Discussed examples of invalidation and misunderstanding throughout his life. Reflected on the impact of his personality dynamics, interpersonal style, and communication style. Discussed alternative ways to communicate with others.

Sample Progress Note #2

Client report Pt provided updates since her last session, and processed her thoughts and feelings related to continued experiences in her romantic relationship. This clinician and pt explored pt's surprising reactions to such experiences, and connected such reactions to internalized embarrassment and shame. Additionally, this clinician and pt reflected on pt's desire to have a positive romantic relationship given her previous relationship histories, and explored whether this desire is impacting her ability to perceive behaviors/situations accurately or if it is impacting/clouding her judgment.

Intervention Notes Elicited updates since pt's last session. Provided validation and support. Processed thoughts and feelings. Engaged in perspective taking. Explored continued worries/concerns about new romantic relationship and discussed additional "red flags"/concerning experiences. Explored pt's surprising reactions to such experiences. Reflected on pt's internalized shame and embarrassment. Explored pt's desire to have a positive romantic relationship and discussed how such desire may be clouding her judgment. Assessed for risk/safety.

Sample Progress Note #3

Client report Pt provided updates since her last session, and processed her thoughts and feelings related to recent legal proceedings. Pt shared ways in which the custody battle continues to cause frustration and resentment. This clinician and pt explored pt's conflicting feelings (i.e., wanting the legal issues to be over while also wanting the stipulations to be fair and appropriate), and discussed ways in which she continues to advocate for consistency and structure for her daughter. Additionally, this clinician and pt discussed ways in which she can continue to work on moving forward (i.e., taking the nursing boards, finding a job, focusing on daughter's needs, etc.).

Intervention Notes Elicited updates from pt since last session. Provided validation and support. Normalized thoughts and feelings. Processed continued issues related to divorce process and child custody issues. Engaged in perspective taking. Explored ways in which she manages her conflicting feelings while also advocating for structure and consistency for her daughter. Explored ways in which she continues to work on moving forward for herself and her daughter.

Sample Progress Note #4

Client report Pt provided updates since his last session, and shared his completed homework (working on a self-compassion writing exercise). This clinician and pt explored pt's difficulty with engaging in such an exercise and connected such difficulty to pt's overall difficulties with taking other people's perspectives. This clinician and pt reflected on pt's difficulty with cognitive flexibility and explored ways in which pt can practice such a skill. Additionally, pt shared that he has been more open with his education counselor, and this clinician and pt processed pt's thoughts and feelings about it while also discussing on the impact it may have on their overall relationship as well as the difficulty pt has with being vulnerable with other men.

Intervention Notes Elicited updates from last session. Processed current thoughts and feelings. Provided support and encouragement. Continued to discuss black and white thinking patterns and their impact on seeking alternative and helpful solutions to issues. Engaged in perspective-taking. Engaged in identifying cognitive distortions and negative thinking in the moment as well as engaged in thought re-framing in the moment. CBT skills provided. Explored completed homework and discussed difficulty with doing so. Connected such difficulty to overall difficulties with taking others' perspectives. Explored ways in which pt can practice cognitive flexibility. Explored pt's

decision to be more open with his education counselor. Reflected on pt's difficulty with being vulnerable with other men while also reflecting on the impact that doing so can have on his relationships.

Group Progress Note Example:

1. (BH Group Visit) Client name: Patient Name Was seen by Provider/Student Name on Date: 00/00/2020

2. Group Name:Adult Depression Group

3. Depression Symptoms

History of Present Illness

Assessment:

Orientation Oriented to time, place, person.

Mood Euthymic.

Affect Appropriate.

Speech Normal.

Thought Process Intact.

Judgement Minimal impairment.

Insight Minimal impairment.

Suicidal Concern Pt denied current SI, plan, and intent.

Homicidal Concern Pt denied current HI, plan, and intent.

Medication Compliance Yes.

Domestic Violence No.

Pain Assessed: *0*

Patient Education Yes.

Progress towards treatment goals

Progress *Mild*

Reported Psychiatric Hospitalization(s)

Hospitalization(s) *None reported*

Social Elements Impacting Diagnosis

Problems related to the social environment, Problems with primary support group

Expected Date of Discharge:

Duration *04/2020*

Intervention:

Client report Pt engaged in check-in exercise with group facilitator and peer, and shared updates on how she handled conflict with another member within her recovery group. She expressed feeling proud that she was able to appropriately confront this member, and pt processed her thoughts and feelings about the situation within the group. She was receptive to support and feedback from other group members, and also provided support to the other group members. Pt engaged in a discussion about control and acceptance, and how accepting that she doesn't have control over everything has helped her with her depression as well as her recovery.

Intervention Notes The group consisted of four members today. Engaged in check-in exercise to elicit updates since last group session. Provided support, encouragement, and validation. Discussed/identified cognitive distortions. Discussed concept of radical acceptance and how such acceptance impacts choices in life. Explored connection between acceptance and control, and how this impacts their depression.

Client Response Pt was cooperative and engaged.

Plan:

Follow up with Pt in next visit.

If discharge session, is client being given referral? N/A, not discharge session.

If d/c, is client given info for crisis intervention? N/A, not discharge session.

Dashboard None.

Care Planning:

Care Plan

Modality of Treatment *Individual, Group, Psychiatry/Medication Monitoring*

Frequency of Treatment *Weekly, Every two weeks, Monthly*

Expected Duration of Treatment *04/2020*

Amount of Visit Duration *30 and 45 minute sessions, 45, 60, and 90 minute group sessions, 20 and 30 minute medication monitoring sessions*

Review Schedule:

Last Review *04/22/2019*

Next Review *07/22/2019*

WHO Note – Referral Out Example:

History of Present Illness

Assessment:

Orientation Oriented to time, place, person.

Mood Depressed.

Affect Flat.

Speech Normal.

Thought Process Intact.

Judgement Minimal impairment.

Insight Minimal impairment.

Suicidal Concern Pt denied current SI, plan, and intent.

Homicidal Concern Pt denied current HI, plan, and intent.

Medication Compliance N/A.

Domestic Violence No.

Pain Assessed

: *0*

Social Elements Impacting Diagnosis

Problems related to the social environment

Child Abuse-Sexual Unknown.

Child Abuse -Physical Unknown.

WHO :

Type of WHO:

Reactive WHO: *Referred in by Medical*

Reason Seen: During a medical appt, pt and pt's guardian expressed a desire to get connected with psychiatric medication management. Pt also expressed a history of depression, suicidality, and self-harming behaviors.

Intervention: Assessed for mental health concerns. Assessed for risk/safety given her recent report of SI and self-harm, and identified crisis intervention strategies with both pt and pt's guardian (911 and 211). Provided validation and support. Discussed BH services at CHC, and explored expectations of pt and pt's guardian. Discussed policies and procedures related to engaging in both individual therapy and medication management. Discussed with pt and pt's guardian alternative

options for psychiatric medication management (i.e., outpatient psychiatric medication prescriber, St. Vincent's IOP) given pt and pt's guardian's desire to continue behavioral health treatment with her current outpatient therapist.

Client Response: Pt was cooperative and engaged.

Strengths Family support.

Barriers to treatment None reported.

Current BH services BH client at another agency (ROI obtained).

Disposition:

WHO Recommendations/Care Plan

: *Currently receiving BH care elsewhere (specify where): Dr. Penny Mathews, outpatient therapist*

: *Refer to higher level of care (specify where): St. Vincent's IOP*

Case Formulation:

:Firstname Lastname is a 16 year old female who was seen for a reactive WHO due to a history of depression, suicidality, and self-harming behaviors. Additionally, pt and pt's guardian expressed desire to get connected with psychiatric medication management. Pt reported that she has been seeing the same outpatient therapist, Dr. Firstname Lastname, since she was in the third grade and does not have a desire to change therapists/transfer individual therapy to CHC. This clinician discussed CHC's policies and procedures related to the need to be engaged in individual therapy at CHC in order to be seen for psychiatric medication management. Pt and pt's guardian verbalized understanding, and this clinician discussed with pt and pt's guardian alternative options for such services (i.e., St. Vincent's IOP, outpatient psychiatry through Husky). Pt's guardian was provided with the phone number for the intake clinician at St. Vincent's IOP as well as information regarding how to find psychiatric medication prescribers through pt's insurance. Additionally, an ROI for pt's current therapist was obtained, and this clinician discussed with pt's current therapist the plan/information discussed with pt and pt's guardian. This clinician assessed for current risk/safety, and pt denied current SI, plan, and intent as well as past and current HI, plan, and intent. Pt also denied thoughts/desires to self-harm and reported that her last self-harming experience was "a day or so ago." She denied past and current AH/VH. This clinician discussed with pt and pt's guardian the recommendation for a higher level of care at this time given pt's urgent needs, specifically medication related, and pt's guardian agreed to reach out to St. Vincent's to inquire/discuss further with pt's outpatient therapist. No further BH appts were scheduled at this time, but pt and pt's

guardian were encouraged to engage in BH treatment at CHC should their needs and desires change.