Behavioral Health Trainee Manual

Training Year 2023-2024

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Visit here for additional site information

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Program Participation Expectations

Development of Group Curriculum and Implementation

By October 2, trainees will work with the group facilitator to choose a group of interest to co-facilitate. Trainees also have the opportunity to build and run their own group of their choice. Review the current groups by visiting: https://www.chc1.com/what-we-do/our-services/behavioral-health/groups/#below

Trainees 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.

Didactic Participation

A month ahead of time, the program specialist will send you a list of didactic topics for the next month. We ask trainees send the program specialist the name of at least one patient to discuss related to the topic.

Didactics or grand rounds that are hosted by other agency departments may require you to register for them on the Weitzman Education Platform.

Multicultural Case Conference

Trainees will attend a monthly one hour meeting to discuss issues related to identity, bias, and clinical factors affecting treatment or supervisory dynamics. Trainees are encouraged to present a case they seek guidance on, want to process, or feel there is notable countertransference regarding these multicultural topics. The trainee may ask the group questions to focus feedback. 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 in-person clients can have their sessions recorded. It is highly recommended that during a client's initial visit, trainees explain observation is to receive feedback from their supervisor or in-group supervision. Trainees should review the consent to record form with the client and have them sign it if they consent at that time. Maintaining a list of consenting clients will expedite scheduling observations for evaluation periods. It is recommended trainees complete an observation by early November, early March for all trainees; and July for residents only.

Telehealth sessions are not permitted to be recorded and need to be observed in live time. If a client consents to record sessions, trainees will need to retain the signed consent for recording form and keep that form in the client's documents.

Reflective Journaling

Trainees are required to submit journals, and can use it to reflect on any aspect of their experience both in or out of CHC relevant to their training and development. Once a month, there will be a mandatory prompt regarding provider resilience as part of an ongoing project throughout the year. If a trainee cannot identify a topic they can request topic ideas from the training director or from their supervisor. Trainees are asked to not provide identifiable information for clients or staff on their journals. Trainees are encouraged to share thoughts on all aspects of the training experience, however, trainees should not feel they need to wait until journals to process or ask questions about a particular topic. Journals are reviewed by the program director, group supervision provider, program specialist, and Chief Behavioral Health Officer, who may reach out to a trainee with a response if they have one. To avoid losing work, we recommend trainees type the journal entry outside of New Innovations and paste into the platform.

Supervision (Individual and Group)

Trainees will meet with their individual supervisor(s) at least weekly and participate in a weekly group supervision with their entire cohort. This time will be utilized for a number of topics, including but not limited to: case discussions, transference and countertransference, the identities of both you and your patients as well as group process. Content discussed in individual and group supervision can be requested to remain confidential. Items discussed in both group and individual supervision will remain confidential, unless the supervisor determines that there is something that would be beneficial for you to address in individual supervision from group supervision, or to be discussed with other supervisors in the monthly supervisory meeting. For group supervision, the facilitator will make you aware that they will be discussing the area with your individual supervisor for follow up in individual supervision.

Supervisors of trainees meet monthly to discuss dynamics in supervision, focusing on improving approaches to supervising the trainees 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.

Trainee Presentations

All trainees will present on a clinical topic of their choosing to present to their fellow trainees, 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).

Optional Program Elements

Mentorship

Trainees will be asked at the beginning of the year the 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 trainee based on these areas of interest. A mentorship is an informal relationship with a colleague who holds no evaluative capacity over the trainee and can provide support and guidance with goals and other areas within and out of the context of the CHCI environment. If a trainee's first language is Spanish and the trainee 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.

Multicultural Committee

Trainees can apply to take part in CHCI's multicultural committee. This committee meets monthly and consists of program alumni, program staff, and trainees, and focuses on ways of continuing to develop and improve training, recruitment and retention to address aspects of multiculturalism and diversity. To apply, you can send an email to the program specialist with a statement of interest in joining the committee, including personal and professional experience that makes you a good fit for being a part of the committee.

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 additional information on ECHO topics, here.

1) Trainees can choose one ECHO to attend regularly or occasionally. They can switch to a different ECHO six months into the program.
2) **Trainees are encouraged to give one case presentation in ECHO during the training year.**

ECHO Offerings:

These are the ECHO sessions that are open to behavioral health trainees, though there are other offerings in the Weitzman Education Platform.

Weitzman ECHO Medication Assisted Treatment (MAT)
4th Tuesday; 12:30-2 PM ET

These sessions provide the front-line primary care provider and team with the support and expert advice that they need to gain confidence in their management of opioid dependence with buprenorphine.

Weitzman ECHO Key Populations

Every Friday; 1-2 PM ET, except for the fifth Friday in month

These session provides access to a multidisciplinary team of experts who provide guidance to help address questions on HIV prevention, screening, and management, viral hepatitis screening and treatment, substance use disorder management, LGB and Transgender health including gender-affirming therapy, and STI screening and treatment among other topics.

Childhood Trauma ECHO

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

Returns October 20, 2023

Complex Integrated Pediatrics ECHO

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

Returns October 18, 2023

These sessions provides an exploration of a variety of medical and behavioral health topics designed to improve the quality of care and clinical outcomes for rural and underserved children and adolescents. The curriculum addresses topics such as pediatric obesity, school violence, anxiety, asthma, dermatology, and suicidality.

Psychological Assessment

Testing is an optional experience at CHCI for psychology trainees. Testing materials are located currently at the Hartford and Norwalk CHCI locations. If a trainee is interested in pursuing psychological assessment during their training year they can contact the training director for a testing referral and access to materials. The trainee will be assigned a testing supervisor. They will be expected to coordinate directly with this supervisor to meet: 1) Initially to make a plan for testing 2) After the psychosocial evaluation is completed 3) After initial round of testing and 4) After initial report draft is completed. Trainees are expected to complete a first draft of their report within four weeks of final testing completion. Trainees are only permitted to take one psychological assessment case at a time. Testing for residents occurs on didactic day and it is not billable. A visit note is expected to be completed for each encounter.

Evaluating Your Training 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 Training Programs utilize a software platform called New Innovations for our evaluation activities such as competency and didactic evaluations, 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
Didactic Evaluations
Competency Benchmark
Evaluation of Supervisor
Supervision Form ***Master's level students use Quickbase via this link:** **https://chc1.quickbase.com/db/bq82d8bgt?a=nwr**

Additional evaluation and due dates are in your program-specific packets.

Didactic Evaluations – **Submit an evaluation immediately after the didactic ends to provide feedback on content and delivery.** Completed evaluations are sent to the presenter, Training Director and the Chief Behavioral Health Officer a week and one day after the didactic; we want to send comprehensive feedback from as many attendees as possible. Particularly for repeat presenters, this is helpful feedback to make adjustments to future presentations. Your feedback is a critical component of continuous programmatic monitoring and improvement.

Competency Benchmark – This evaluation provides an opportunity for your supervisor to assess your current level of skill in key program competency areas that are deemed essential to master as a well-developed and competent provider in this setting at your training level.

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.

Supervision Form – An individual clinical supervision form is required by state and accreditation organizations for all unlicensed providers (trainees). Trainees are required to complete a form for every supervision session. It is recommended to complete them toward the end of the supervision session. The supervisor will sign off on the form. All successfully completed supervision forms are sent directly to specific personnel to archive for auditing purposes by DCF, JCO, and DPH. Trainees should complete a supervision form even if they did not meet with their supervisor; noting the reason in the form (ex. PTO, holiday, etc). If supervision is a make-up session, trainees can contact the Program Specialist to add an additional form for that week.

Additional Training Program Information

Agency Cultures

Each trainee will work at a clinical site. Throughout the year, trainees will experience similarities and differences in the culture and operations at each site and between departments. Trainees are welcome to bring up concerns related to site operations in supervision, but trainees 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.

Commitment to Diversity and Multiculturalism

Our trainees, 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 communicating with colleagues, we encourage trainees to use supervision and consultation to discuss how aspects of their identities may be interacting with others' identities. Everyone holds blind spots, biases and growth areas; we recognize discussing these may cause feelings of vulnerability. It is the program's responsibility to create a safe atmosphere to process these areas. If a trainee experiences concerns with how an aspect of their or others identities are addressed, they are encouraged to discuss this with their supervisor, the training director, or the Justice, Equity, Diversity and Inclusion (JEDI) Officer. We value creating an environment of learning and growth where trainees are welcome to respectfully share their opinions and contribute to the process.

CHC's **Commitment Statement to Diversity** is the following:

Community Health Center, Inc. is committed to advancing its values of justice, equity, diversity, and inclusion (JEDI) across the organization. We acknowledge, embrace and value the diversity and individual uniqueness of our patients, students, employees and external partners. CHC strives to foster a culture of equity and inclusion in broad and specific terms.

Our commitment to justice, equity, diversity and inclusion presents itself in our quality health care delivered to our patients, our passion for inclusive excellence for our employees, the learning environment we foster for our students, and the attention paid to our equitable and inclusive policies and practices across the organization.

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.

If a trainee believes that a client is psychiatrically impaired and in need of an emergency evaluation, they must contact their supervisor immediately. The supervisor will help make the determination and identify the process for evaluation documentation. If the trainee's supervisor is unavailable, they must reach out to the Onsite Behavioral Health Director, another supervisor, or licensed staff member at their site, and they will assist the trainee. Trainees are also required to contact their supervisors immediately if they feel they may need to make a Department of Children and Families (DCF) report.

Policies

DCF Reporting Policy

Mandated Reporting Information:

CHC maintains four policies on clinician responsibilities on reporting abuse, which are located on Sharepoint:

- **Recognition and Reporting of Abuse**
- **Recognition, Assessing and Intervention in Suspected Domestic Violence**
- **Recognition, Assessing and Intervention in Suspected Child Abuse**
- **Recognition, Assessing and Intervention in Suspected Elder Abuse**

Trainees are required to consult with their supervisor(s) prior to making any reports related to the suspected abuse of a child or older adult. When a report of suspected abuse of a child is made, trainees are required to send a telephone encounter (TE) to the Chief Behavioral Health Officer with the drop down option *136-DCF Report* as numbers related to reports made are needed to be tracked. No specific information in this TE is necessary other than that the report was made.

Discriminatory Behaviors Policy

Experiencing Discriminatory Behaviors from Clients or Staff

To thrive in the training year, trainees need to feel safe and supported where they work. Though the hope is that discriminatory behavior will not occur, trainees may experience this and the aim is that trainees are aware that they have options in addressing this behavior. Should this occur, they are encouraged to seek consultation (either in live time or after the incident depending on the nature of the behavior and situation) from their supervisor(s). They may be advised to submit an incident report and/or a bias incident response report. Please also reference CHC's **Whistleblower Policy,** in Sharepoint, for additional information.

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 trainees. Also, all paperwork completed for patients must be cosigned by a supervisor.

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.

Clinical Resources and Expectations for Treatment

Introducing Self to Clients

Trainees are required to inform clients that they are in training, and are under supervision, and provide their supervisor's name. They are additionally expected to inform clients that they are in a one year placement and process this with clients throughout the year.

Hello, I'm___________ a (practicum student in training or postdoctoral resident) working under the supervision of Dr.(s) __________.

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 provider who completed a doctoral or medical program tend to first introduce with "Dr. First Name, Last Name," which gives the patient a bit of a choice in how to address us.

Case Maintenance

Trainees are expected maintain an ongoing client list with basic demographic information, treatment plan start date, and care plan review due date. Trainees will discharge patients that end or discontinue treatment after not being in treatment for ninety days.

Appendix B: Note Considerations

To Do List for Writing a Note:

For Intakes:

1) Review rights and responsibilities form, have client sign (either remotely or in person).
2) Confirm telehealth consent form is completed.
3) Have client complete any ROIs for coordination of care or obtaining records.
4) At end of visit have client sign care plan form after completing care plan with the client.
5) In creating goals:
    a. The client needs a problem for each diagnosis.
    b. Goals can be deferred but have to be documented.
    c. Goals are in the client's own words.
    d. For children you need a goal related to the family.
    e. Objectives must be measurable, using Mirah or other measurements we are using
6) Then review steps for writing a note:

Steps for writing a note:

1) Confirm you have all templates needed:
    a. Intake or progress note template (can pull through last note if progress note)
    b. Telehealth consent template if remote.
2) Login to Mirah and review data for client. Add to the note if Mirah was completed, copy and paste the Mirah summary.
3) Update chief complaints, assessment and body of note, complete all prompts.
4) **<u>Make sure the provider on the note is listed as your supervisor (can change in ECW or in centricity).</u>**
5) Confirm telehealth consent is filled out and is appropriately video or phone and matches billing code needed.
6) Update care plan review as needed.
7) If client has active suicidality, they need a care plan goal related to addressing the suicidality.
8) Pull through and update care plan progress.
9) Complete Recovery in Action plan as relevant
10) Make sure billing code is in there with billing modifier as needed for remote visits, depending on type of visit
11) Review note for accuracy, spelling and grammar prior to locking
12) Assign to supervisor for review

Sample Note Writing Workflow:

Before Meeting with the Patient:

Step 1: Review the chart, read any recent visits that might be relevant to review (i.e. psychiatry, medical)

Step 2: Review the MIRAH survey – was it completed? If yes, review relevant data. If no, encourage patients to do them.

Step 3: Review the most recent therapy note (if applicable). There is an option to merge in the most recent note, or use anew note template.

Step 4: Adjust the date and start time for the note.

While Meeting with the Patient

1) Take notes into the ECW template while maintaining eye contact as best you can. Notes can be bullet point or full sentences. Your ability to do this will be based on your typing speed and coordination skills.
2) Review and discuss the MIRAH survey and anything that stands out, if applicable.
3) Do great therapy ☺
4) **SCHEDULE THE NEXT SESSION IN CENTRICITY BEFORE ENDING THE SESSION**

After Session

Edit, type through, and finalize the note. Make sure it would make sense if anyone else read it, and that they could glean what happened in session. The goal is to document what happened accurately, to keep a record of what transpired, and capture the therapeutic elements of the session. Imagine if an auditor or colleague reviewed the note – would it be useful to them?

Before locking the note:

- Review your note to make sure it is accurate.
- Make sure your note is written in a way that ties in with the patient's care plan goals, objectives, etc.
- Other details: Include any details around technology issues that may have happened, if other people were present (i.e. a supervisor, patient friend, parent.)
- Merge in the relevant care plan goals into the note.
- Ensure the correct date, start and stop times are indicated, as well as the correct billing code and modifiers.

- If indicated, send a TE or note to anyone who may need one (i.e. did they run out of medication? Send a TE to psychiatry provider.)

- Remember to add your supervisor as the responsible party in Centricity (if not, it will default to the PCP and only the PCP will be able to unlock the note)

Common note errors:

- Informal language

Typos, grammatical errors
Using incorrect patient pronouns

- Forgetting to add supervisor as the responsible party in Centricity
- Incorrect billing codes

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.

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.

<u>Appendix C: Sample Intake Documentation</u>

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

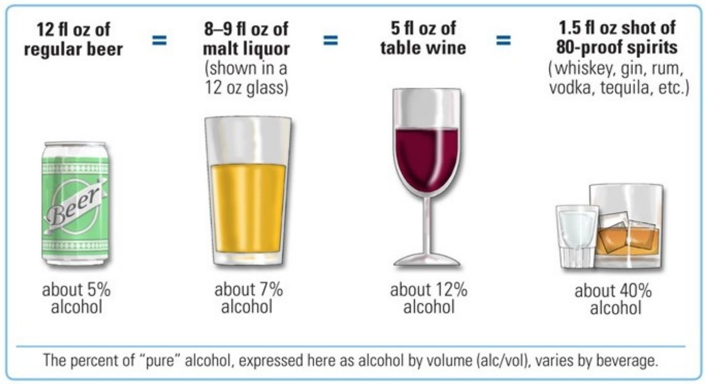
[Use this image/chart when assessing alcohol use. One standard drink = 1.5oz of spirits = a 5oz glass of wine = a 12oz beer]

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.

<u>Group Referrals</u>
***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 <u>www.chc1.com/groups</u>]

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*

<u>Behavioral Health Tx</u>:

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.

<u>Substance Abuse</u>:

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*

<u>Mental Status</u>:

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*

<u>Suicidal/Homicidal Assesment</u>:

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

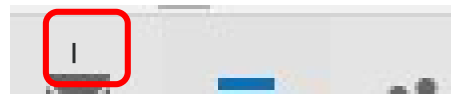
Goal:I want to feel less sad Objective:Patient and family will identify his symtoms of sadness and trauma over the next three months as evidenced by parent and child report

Notes:

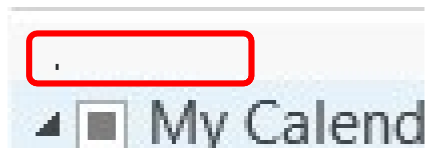
Appendix D: BH Trainee guide to Recording sessions

First Time Setup

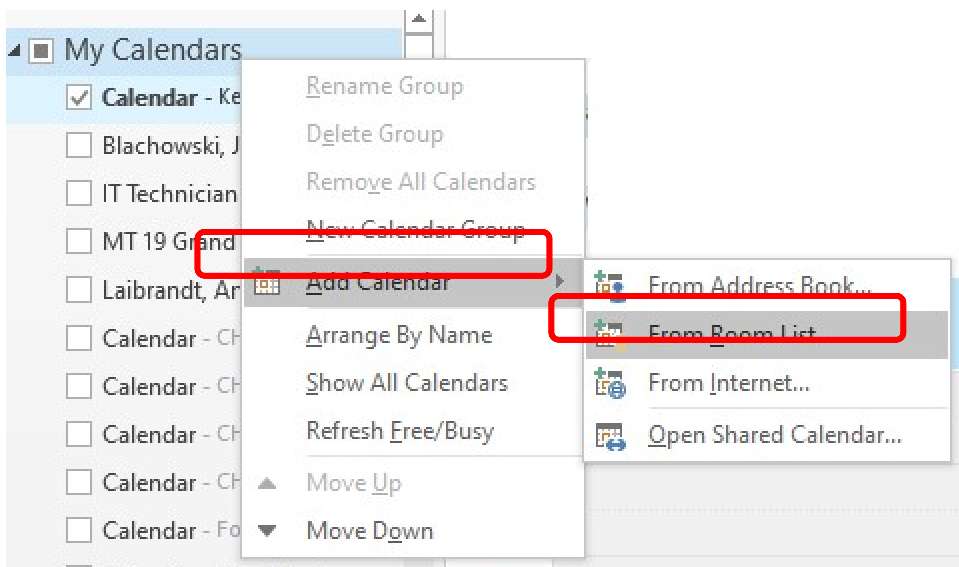
- Open Outlook
- Left Click on the Calendar at the bottom left hand corner



- Right click on the My Calendar Tab



- Select Add Calendar From Room List



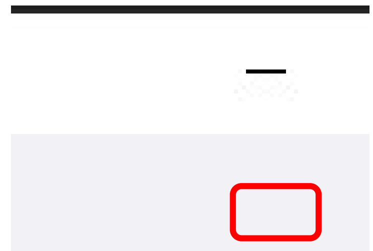
- Add Rooms BH Recording 1, BH Recording 2, BH Recording 3, BH Recording 4

Configure Zoom Recording

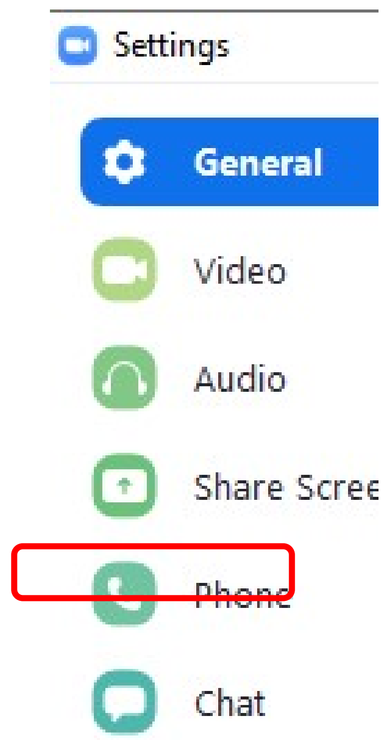
This needs to be done once per computer

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

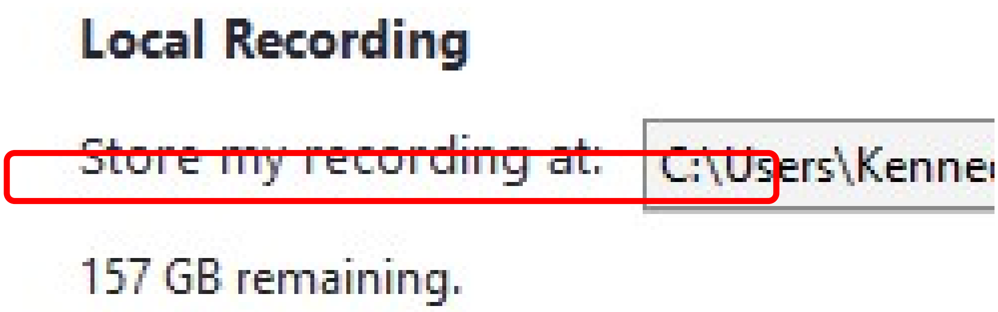
- Open Zoom
- Log in with any account
- Click on the Settings Icon



- 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

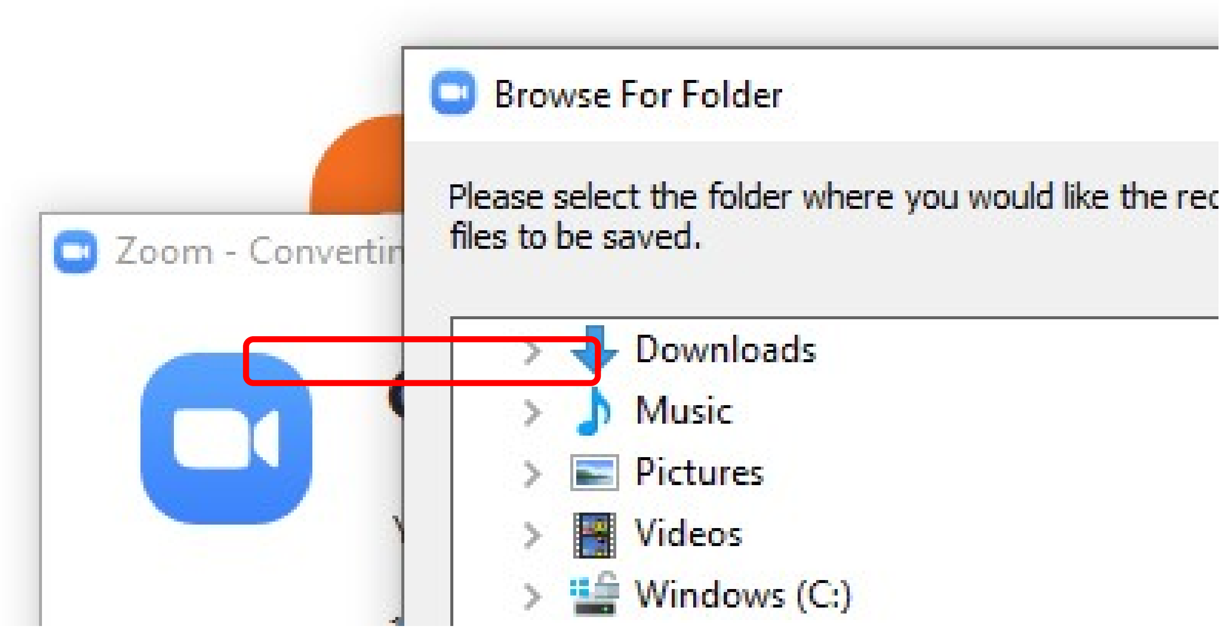
  BHRecord4@chc1.com

Password is Purple1234!

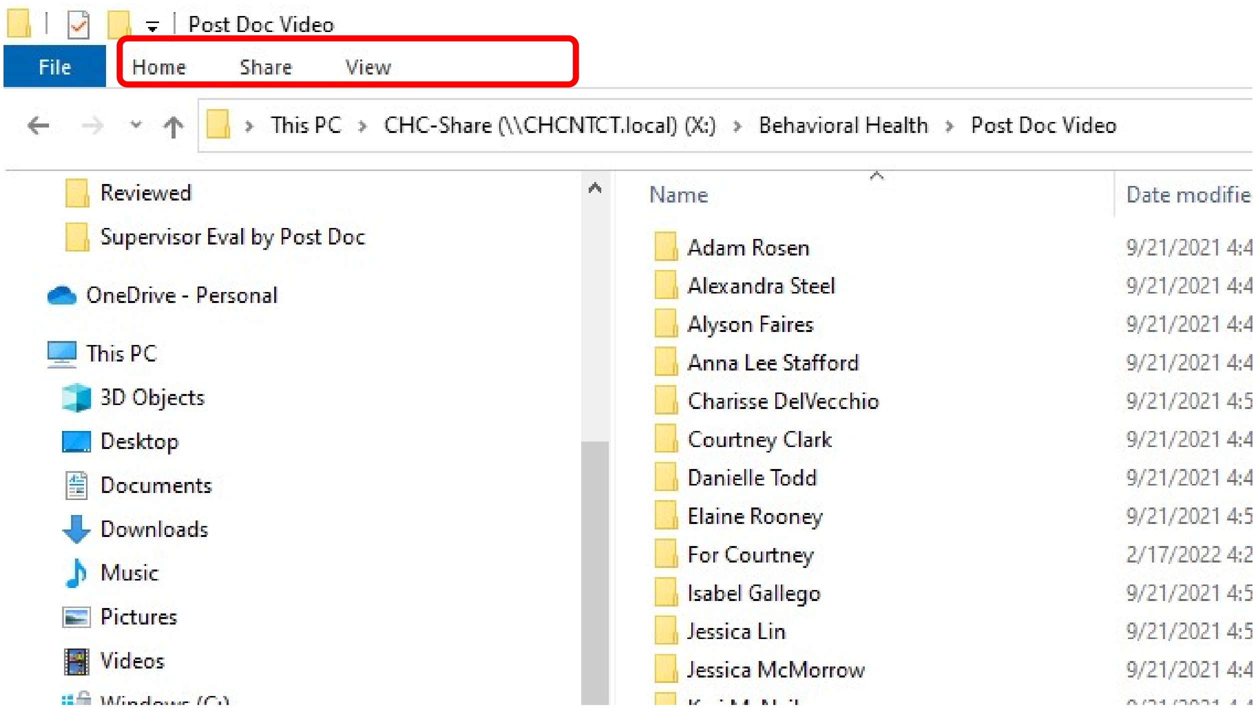
- Start a new meeting

- 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

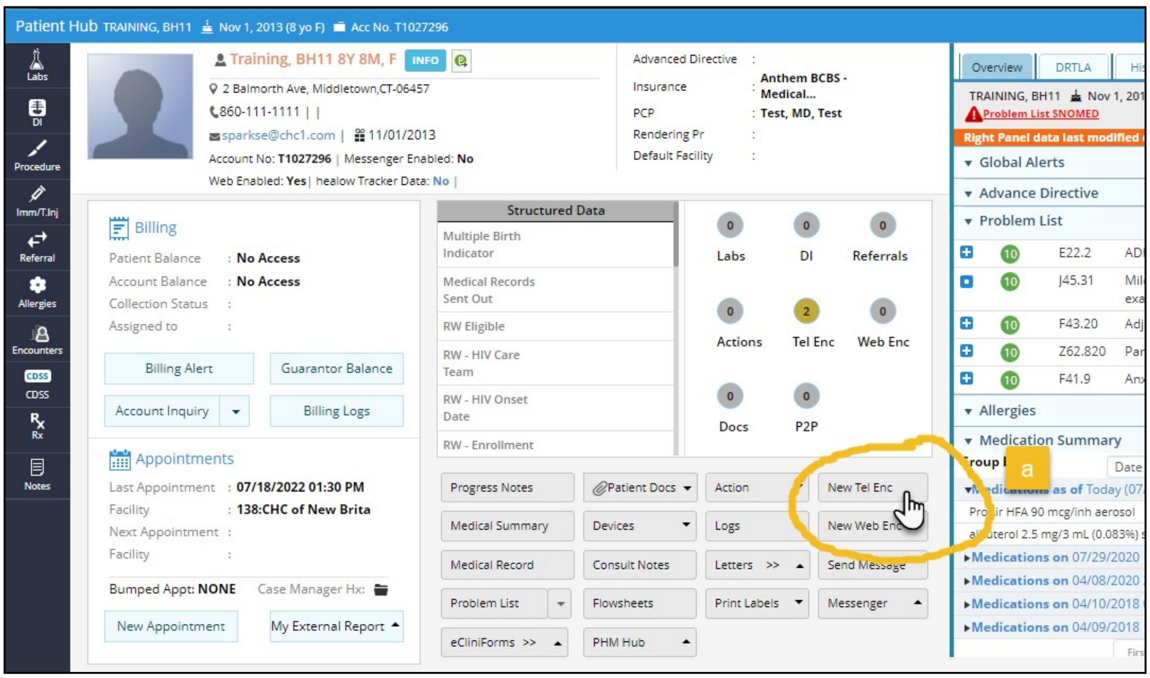
Appendix E: Discharges and Supervisor Note Review

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

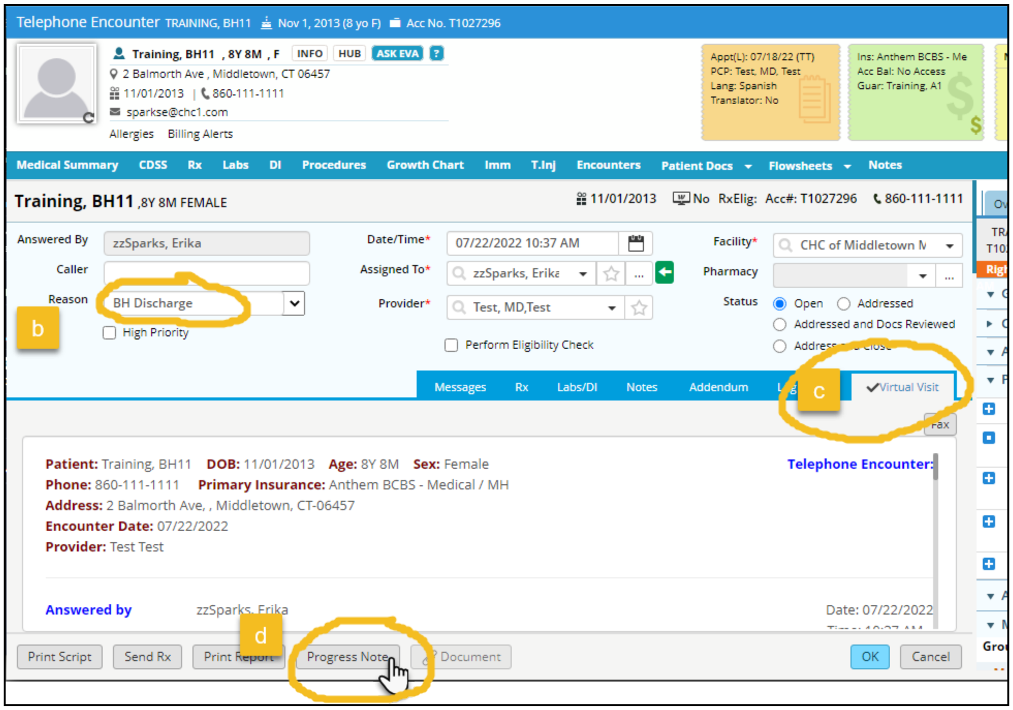
a. Open up the patient Hub and click New Telephone Encounter.



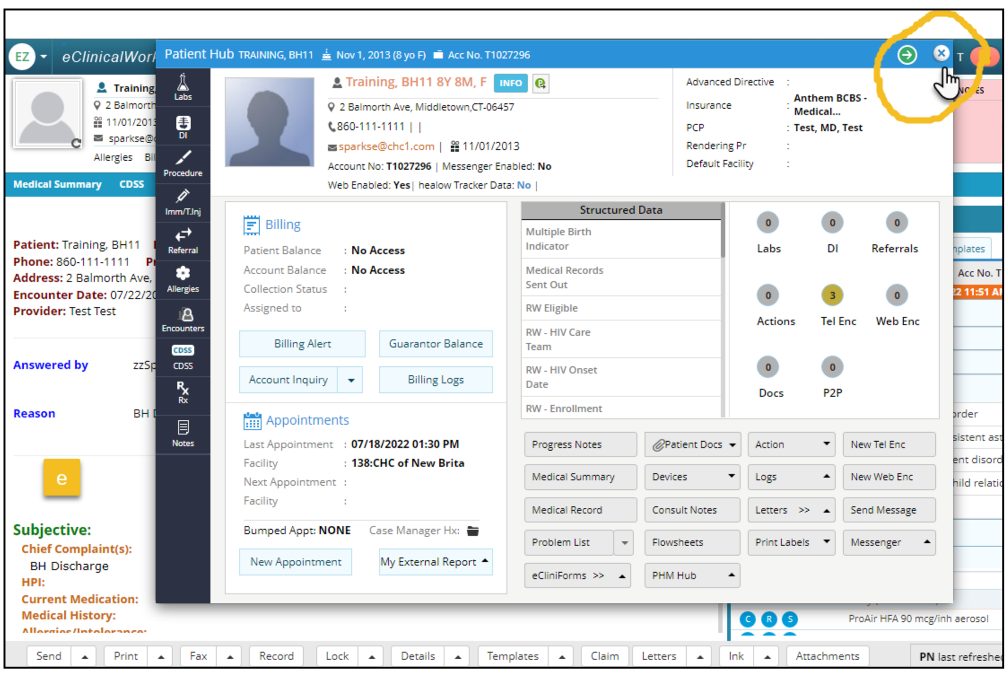
b. Select "**BH Discharge**" from the Reason field.

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

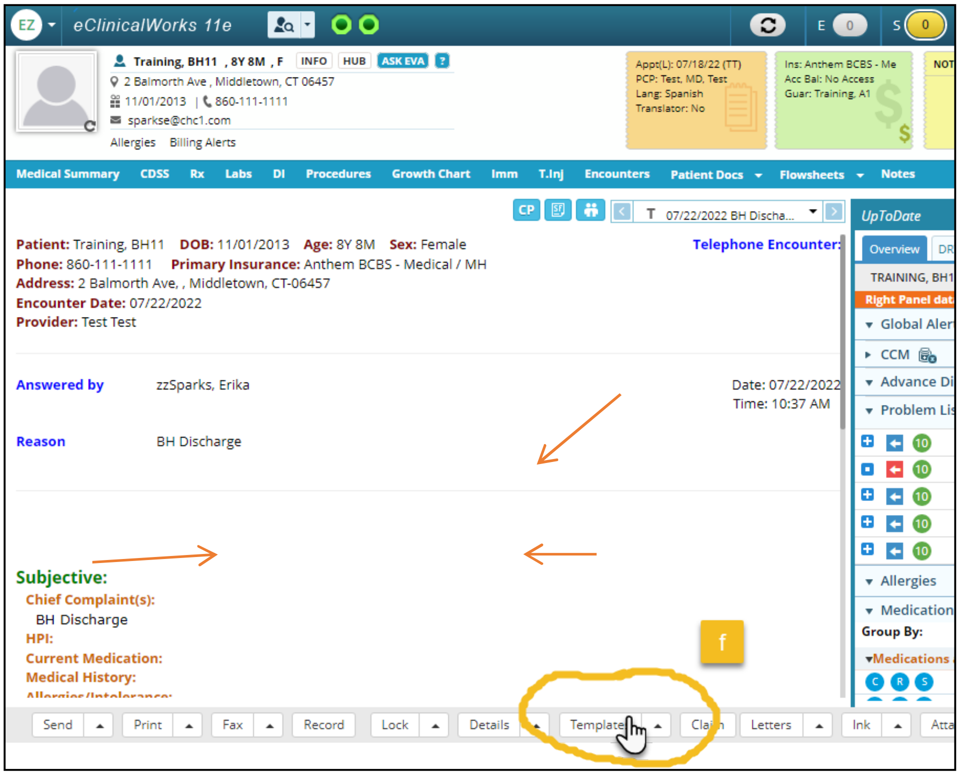
d. Once in the **Virtual Visit** tab, click the **Progress Notes** button at the bottom of the screen.



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.



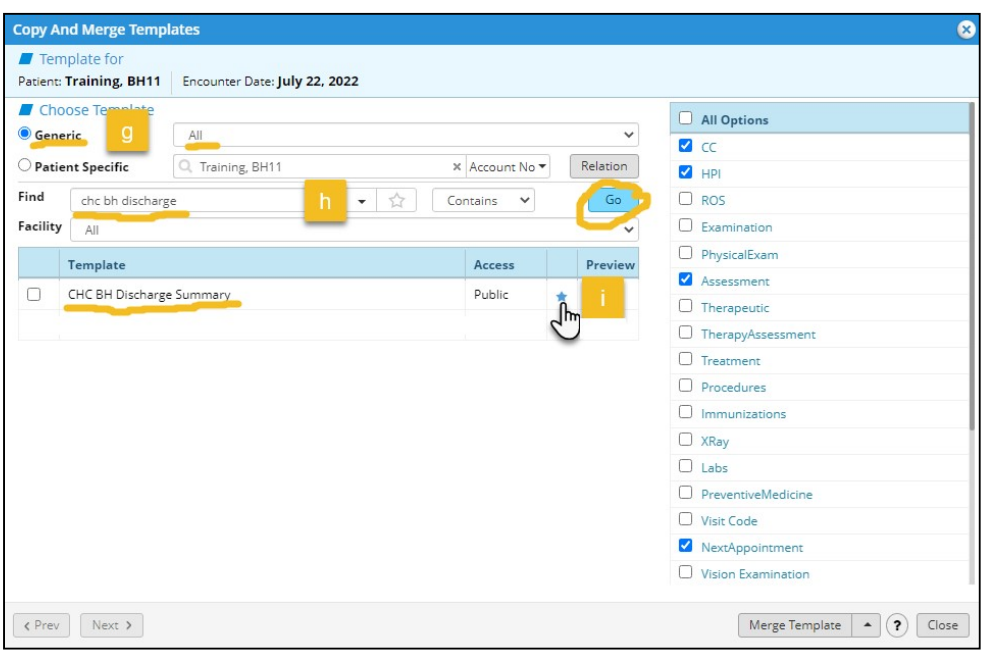
f. Click the **Templates** button to merge the **CHC Discharge** template.



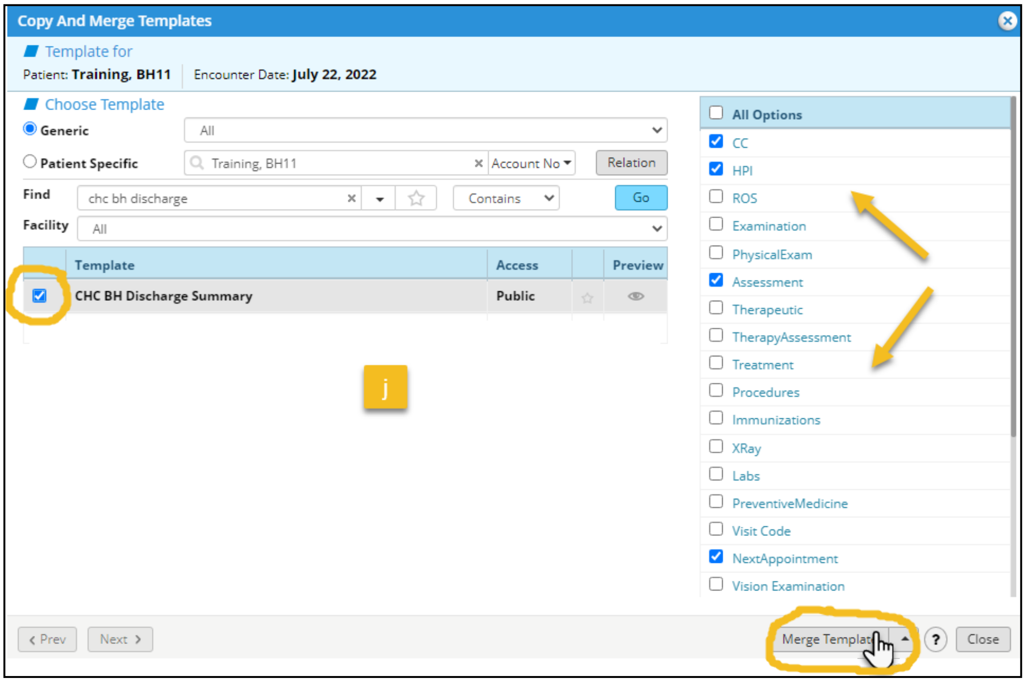
g. In the **Choose Template** pane, select **Generic**, then **All** for the **Category** field.

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

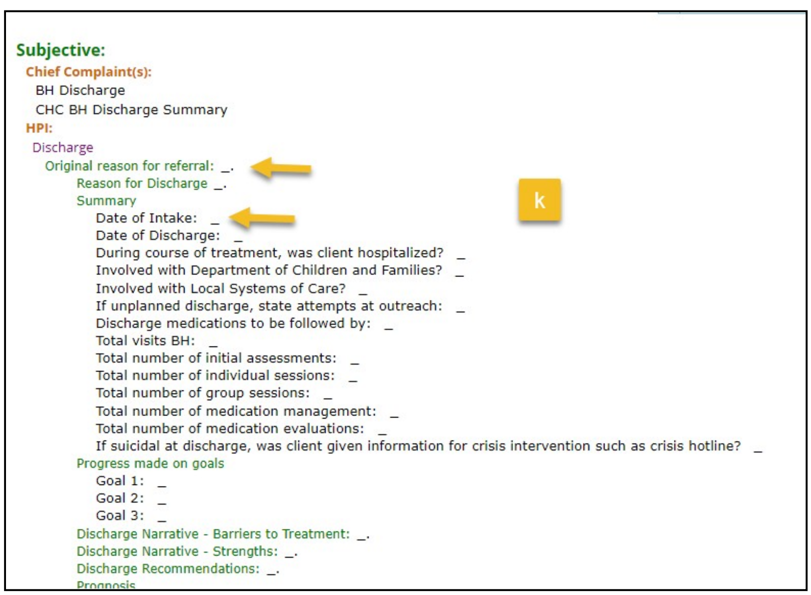
i. Select the **CHC BH Discharge Summary** template and click the **Star** icon to make it a favorite template.



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.

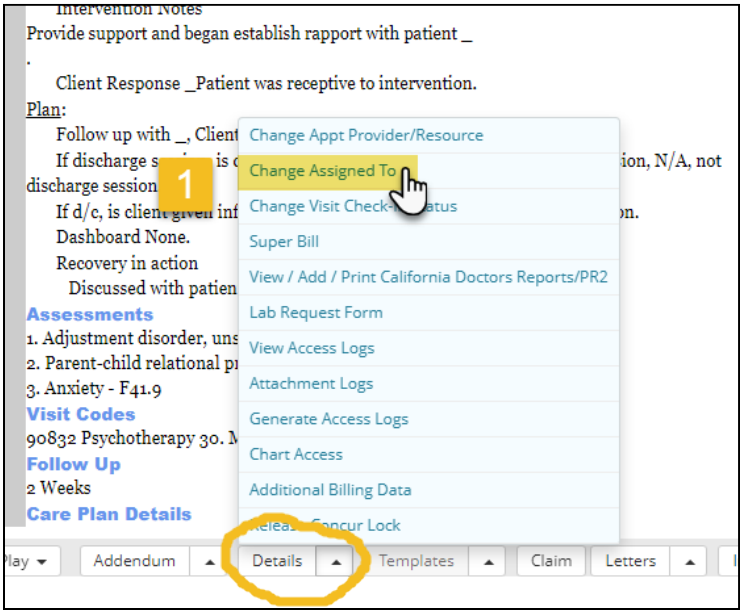


When finished, lock the note to address the Telephone Encounter.

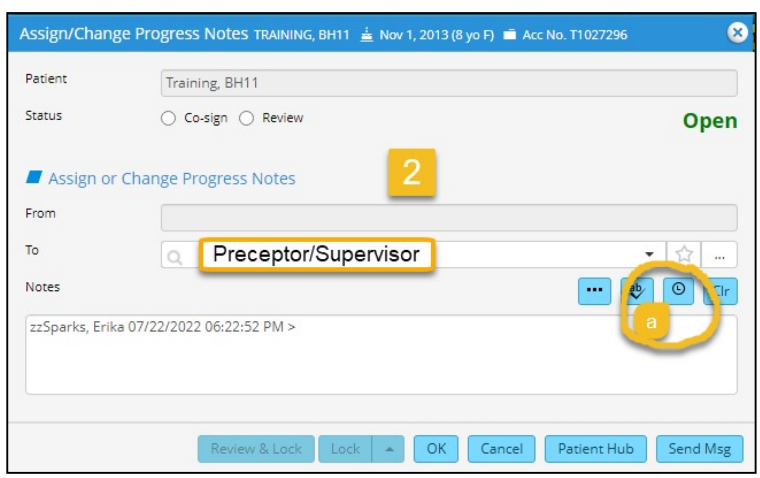
How Trainees Can Assign their Completed Note to Their Supervisor:

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

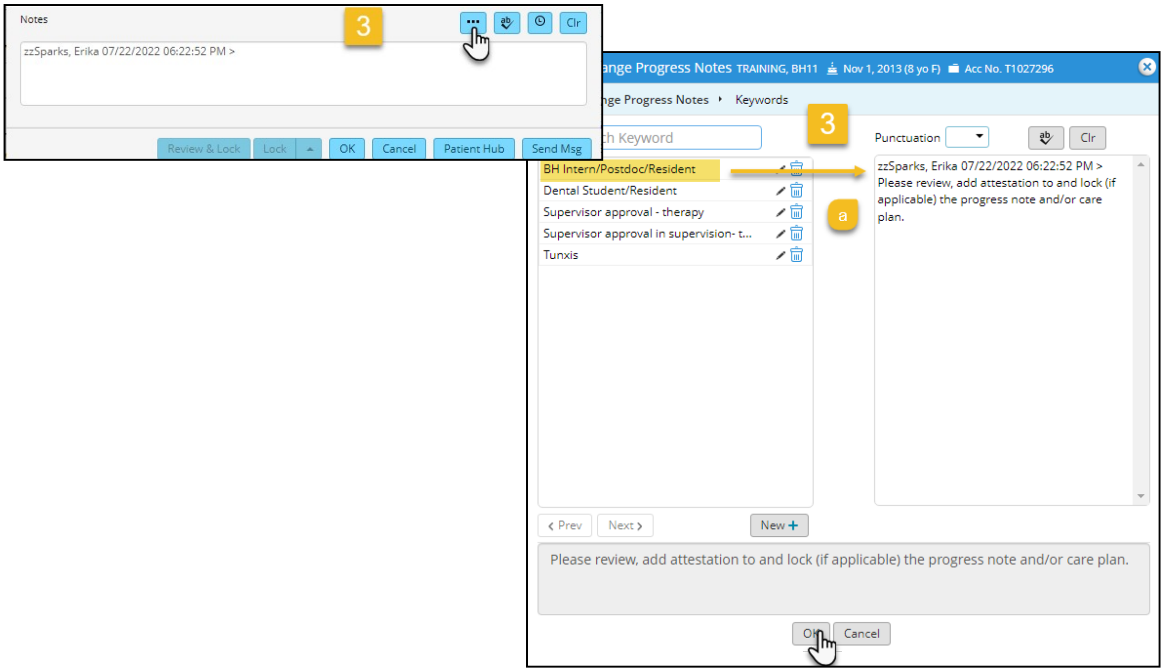
1. To assign the note, click the **Details** drop-down arrow, then select the **Change Assigned To** option to open the window:



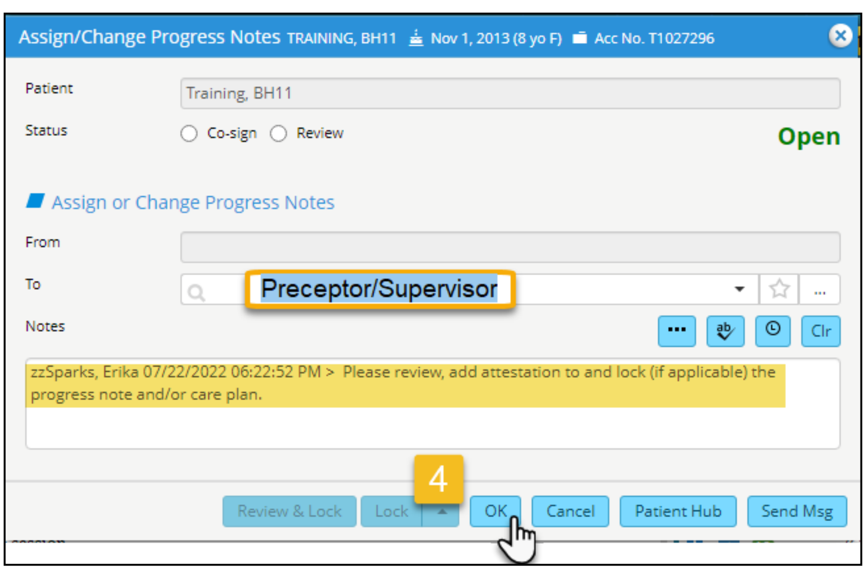
2. In the **Assign/Change Progress Notes** window, use the **To** drop-down arrow to select your supervisor.
    a. Next click the **Time Stamp** icon.



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.



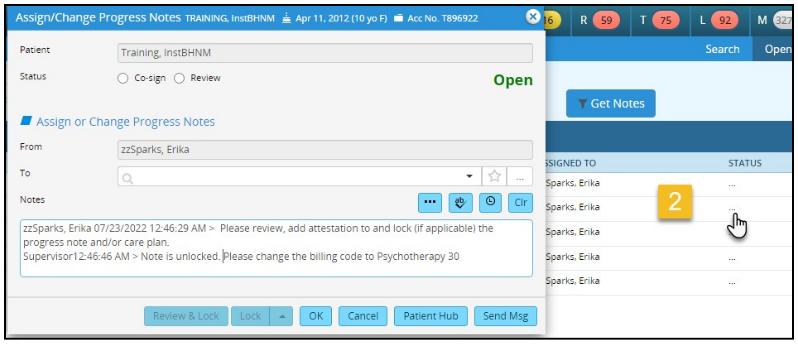
4. Returning to the **Assign/Change Progress Notes** window, click the **OK** button to close. This will transfer the note to the Supervisor.



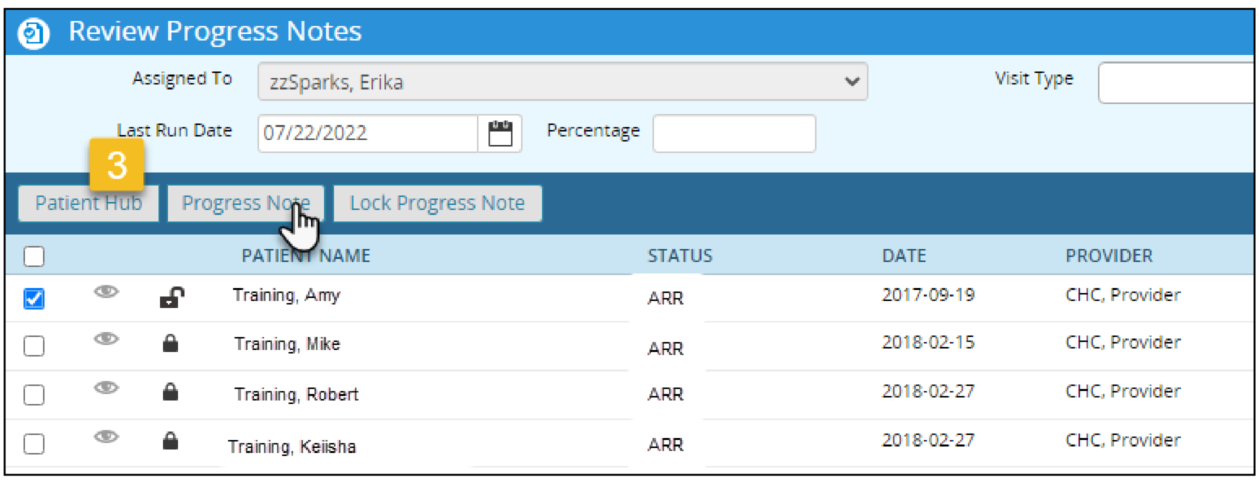
For Trainee: If Changes Needed – How to Access a Re-Assigned Note:

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 F: Presentation Guidelines

Basics

- 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

- A week 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.
- 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