Hello and welcome to yet another training hour with me.

This time we are going to talk about screening

and orienting patients to virtual mental health care.

And similar to the other ones, this is not the first

time I am recording this video, so bear with me.

I think we're going to get through it this time.

Alrighty.

So in this training, we are going to

review the ethical and practical guidelines for screening.

The importance of screening for fit.

How to screen for fit?

What are basic screening questions?

What are advanced screening questions?

Responding to patients who are not a good

fit, and then protocol for when we do

have patients in the virtual program who are

higher acuity than we would typically take on.

And just how do we approach that

and orienting patients to virtual program?

All right.

So again, welcome to Discovery Behavioral

Health training on screening and orienting

patients to virtual mental health care.

In this training, we will review the ethical

and practical guidelines around screening for fit.

We will review what happens when

we accept patients we wouldn't typically.

And lastly, we're going to review

how to Orient patients to treatment.

Our learning objectives are the ethical and practical

guidelines for screening basic and advanced screening responding

to patients that are not a good fit,

treating patients who are higher acuity than we

would normally take, and orienting patients to program.

Here are at least five of the questions you will

be able to answer by the end of this training.

What are the ethical

considerations related to screening?

What are the screening questions I should know?

How do I handle it when a

patient is not appropriate for program?

How do I support a patient who is

higher acuity than we would normally accept?

And how do I prepare patients for virtual programming?

So we're going to start by looking at

a couple of the ethical well, we're going

to start by looking at this ethical guideline.

So this is from the

National Board of Certified Counselors.

So if you wanted to become a board certified telemental

health clinician, you would do that through the MBCC.

They were one of the first organizations

to put out practice guidelines for telemental

health or just telehealth in general.

And that being in the behavioral healthcare realm, I'm

going to review their criteria specific to screening and

then the guideline itself, or like the set of

guidelines will be attached to this training.

I chose to include them here just because they

do have a specific guideline for screening, whereas a

lot of the other practice guidelines do not.

And it was just another way for me to

put one less practice guideline in that other training

since there was just an abundance of them.

All righty, so ethical and practical guidelines

for Screening During the screening or intake

process, NCC shall provide potential recipients with

a detailed written description of the distance,

counseling process and service provision.

This information shall be specific to

the identified service delivery type and

include considerations for that particular individual.

These considerations shall include the appropriateness of

distance counseling in relation to the specific

goal, the format of service delivery, the

associated needs, for example, computer with certain

capabilities, et cetera, the limitations of confidentiality,

Privacy concerns, the possibility of technological failure,

anticipated response time to electronic communication, alternate

service deliveries, and any additional considerations necessary

to assist the potential recipient in reaching

a determination about the appropriateness of the

service delivery format for their needs.

Ncc shall discuss this information at key times

throughout the service delivery process to ensure that

this method satisfies the anticipated goals.

And if not, the NCC will document the discussion

of alternative options and referrals in the client's record.

There's obviously a number of people that are

participating in the screening process, from the call

center to the treatment center itself, and everybody

needs to be on board here.

Let me just go ahead and. Oh, perfect.

A lot of this documentation is coming from the

welcome orientation packets, and we're going to take a

peek at what some of those look like.

And then other than that, it is coming from

the conversations we're going to have as they're admitting

to the program, as they're going through that intake.

And we've talked at length of some of

the specific consent considerations that need to come

into play when we are virtual. And all of that goes

into meeting this ethical guideline.

There are other ethical

guidelines related to screening.

Some of them are in those practice

guidelines we've gone through and make sure

you know them for your specific discipline.

But we're going to go through how to

screen ethically throughout this training as well.

Another resource that you have on ethical

and practical guidelines for screening is going

to be through the Ata.

So the Ata is the American Telemedicine Association.

They have a collection of screening resources.

Now, you do have to make an account with the

Ata in order to view these resources, which can be

a little frustrating, I would say, of the many organizations

that are out there that support telehealth, the American Telemedicine

Association would be a great one for you to be

a part of, for you to be receiving those emails

and for you to set up an account with just

so you have access to those documents.

And I included that link here.

Also, I already said this previous slide, but I'm going

to say it again, just because it is that important.

Make sure you know your specific disciplines,

guidelines around everything telehealth, but screening included.

All right.

Moving right along.

So the fact is there is no absolute rule out

diagnosis for telemedical health, so there's no one diagnosis that

cannot be treated in some way via telemental health.

And this is not my opinion.

This is what the research has says.

The television or telemental Health Certification Institute

does put forth five screening considerations, and

I'm going to review those with you.

And once again, these are not rule outs, but these

are things we need to really pay special attention to

to make sure that the patient is receiving the right

form of care that is going to help them get

closer to their goals or just to be safe.

So the first one is

treatment goals and presenting concern.

So what are they wanting to work towards

and what are the barriers that they're experiencing

and getting closer to that goal?

Are those appropriate things that we

can treat through telemental health?

With the resources we have, with the team we

have, with the expertise we have, we'll talk what

some of those deeper considerations might be.

One of them, for example, is going to be psychosis.

So if we have somebody who is an active

psychosis and they're having persecutory delusions about technology, meaning

they're afraid something bad is going to happen to

them because of technology or technology is out to

get them, that might roll out telemetry health, and

that's kind of a specific and extreme case.

But those cases are going to crop up and we want

to make sure that if we're not the right fit for

them, we get them connected with who is clients risk.

We've talked about this at length in

a lot of ways as well.

But if they are somebody with really intense

active suicide allottee, if they are somebody with

very impulsive self injurious and self harm tendencies,

we may need to find other options.

Telemental health might not be the best thing

for them, especially if they are not located

close enough to emergency resources, the client's location.

Now, this does come to geographic location,

especially if there's no Internet in that

area or something like that.

But it also has to do with who are they surrounded by?

Are they in a home where there's a lot

of domestic violence or just abuse in general, and

they're not going to be safe enough in that

space to talk about what they need to talk

about that might roll out telemental health.

The clients technology, do they need at least

a cell phone or at least a laptop

to participate in the virtual program?

And if they don't, do they have

access to that in some fashion?

If not, telemetry health is not going to be

accessible to them and then payment and reimbursement.

If they are using insurance,

does it cover telemetry health?

If they are not using insurance, are they able

to afford some mental health via private pay?

How is that going to work for them?

How do we get them connected with somebody who's

going to be able to provide those services affordably?

Or how do we figure out a special

case agreement or something so that we can

be the one providing those services?

And of course, at the end of the day, our business,

we are a health care business, but we are a business.

How are we going to get reimbursed.

How are you going to pay

our employees all of that jazz?

Take my coffee and we'll keep going.

All right.

The importance of screening for Fit I have no idea.

No doubt you guys know just how important this

is, but we're going to go over it nonetheless.

So screening for Fit is an ongoing process.

Obviously, it's one of the first steps that patients are

probably taking as far as participating in some sort of

screening to see if this care is right for them.

But it's also their chance to interview us.

They're screening us, too.

So that rapport building process starts

from that screening phone call.

How are we building trust with them?

How are we building that confidence that we are a

safe place of professionals who are able to help them

directly or connect them with somebody who can?

Screening is important to protect the patient,

the provider and the mail you.

So of course it's important to protect the patient.

We don't want them at a level of care or in a

delivery of care style that's not going to keep them safe, and

that's not going to bring them closer to their goals.

We also don't want providers to be feeling that

burnout of working with patients who are not appropriate

for our care on an ongoing, extensive basis.

We cannot always prevent those things.

But at points where we can, we want

to make sure that people are really connected

with who they need to be connected with.

We don't want providers to be having to push their

boundaries to care for somebody that is, again, with that

really high intensity suicidality or anything like that.

If we can help it, it's going to happen.

We work in the mental health field,

but it should not be the norm.

It should be the exception.

And the Milieu, we want to bring patients in

that are going to be able to support the

other group of patients we are working with.

An example of this would be we

don't want somebody with a very severe

eating disorder in an intensive outpatient program.

So somebody that has maybe severe malnutrition, they

are not able to complete any meals.

They need a feeding tube.

Definitely not going to be appropriate

for an intensive outpatient program unless

there is some special case there.

Which not to say that that

doesn't happen because it does.

But in general, they're not appropriate for

the intensive outpatient program where patients are

mostly able to get through their meals.

They do need some support.

Obviously, that's why they're getting care.

But they're for the most part medically stable.

They're able to manage their behaviors to some degree.

And if we bring in that person with that

higher acuity, that could trigger them, that could bring

up a lot of competition, that could start making

them feel that they're not sick enough and that

could bring the whole Mil, you down.

We don't want that.

Screening is an ongoing process.

We are constantly screening our patients and they're constantly screening

us, for that matter, to make sure we are still

the people that can support them and making sure we

are still the right people to support them.

So these are things we're constantly looking at.

We're constantly checking in about these

questions, and obviously life is crazy.

It changes all the time.

Just because we are in a place right now

where we can do virtual does not mean six

months we'll be in that same place.

Or just because we're in a place right now

where we can't do virtual does not mean in

six months it won't be an option.

We need to make sure that every step

of the screening process, we are building trust.

We are building confidence in our ability to

provide good, respectful, dignified, high quality care and

that the patient knows where they can come

and when they can come to us.

There's our gorgeous call center representative here.

Perfect.

A little bit more on the

importance of screening for Fit.

We really want to be looking at

the level of risk, especially with diagnoses

like eating disorders or substance use.

Obviously, the opioid epidemic has led to

opioid use disorder has the highest mortality

rate of any diagnosis in the DSM.

It did surpass anorexia nervosa.

If that severity is very high and they need

detox, definitely don't want them in an intensive outpatient

virtual program or a partial hospitalization program.

We want them where they need to be.

We want them where they can get the medical treatment.

They need psychosis.

If somebody has schizophrenia and it

is well managed, it is medicated.

They do not have active dilutions or hallucinations.

Virtual may be totally appropriate if they are

not taking medication, if they do not have

the schizophrenia or just the psychosis in general,

psychosis can exist outside of schizophrenia, of course.

Well managed.

We don't want them in virtual program.

It's not going to be the best thing

for them, and we want to get them

connected with where they're going to be successful.

Medical instability.

Somebody with very severe epilepsy who does

not live close to medical resources, they're

going to need something else.

They might need a PHP program

with boarding or something like that.

If they don't have one in their area, we

can do everything we can to support them and

make sure they get where they need to go.

But we want to be aware that we

are limited in our ability to medically stabilize

through telemedical, health, suicidality, and homicidality.

I think these are easy to understand.

If they are actively suicidal or homicidal and there's

no ability for us to support them, we want

to get them connected with those appropriate resources, just

as we would any other time.

Self harm is something we want to

assess the level of risk for.

What is the frequency of self harm?

Do they have coping skills they

can use to minimize self harm?

How severe is the self harm?

When they do engage in self harm,

how likely are they to self harm?

How likely are they to engage with

their support system when they have urges?

All of these things are things we need to look at.

Now if you're somebody from our call center

and you're like, I don't know how to

set for that stuff, that's totally okay.

If you're ever on the cusp and you're just not sure,

keep them connected with the program, let them go ahead and

do that screen and they'll be able to help you decide

if that person is right for the program.

Risk of the originating site. So what is going on?

If that clients Homebase again, is their abuse

in the home that would make it so

participating in virtual program is not safe.

Things like that, are they

consistently not at their home?

Are they often out of state?

That would be a potential rule out.

They're going to need some sort of

care that allows them that flexibility.

And potentially being in an IoT program or a PHP

program might not be that fit for them right now.

Now, sometimes we can help them get to that place

in their life where it is and we can totally

work it out and other times we can and we

need to get a little bit more creative.

So play it by ear.

The clinician's ability to respond to crisis events.

So we want to maintain these boundaries.

We don't want our clinicians working on

all hours of the day ever.

Like, we want them to be working when they're supposed

to be doing working hours and to be resting, taking

care of and enjoying their lives outside of that, we

are not on call 24 hours therapist.

And if that's what they need, if they need

somebody who is able to respond to crises like

that, we're going to get them connected elsewhere.

The ability to elevate levels of care when appropriate.

If we are bringing somebody in whom we know is on

the cusp and there's a chance they might need a higher

level of care, are we going to be able to get

them there in a timely manner in a safe manner?

If not, is this really the best decision for them?

And then willingness to agree

to an emergency management plan?

So if they have stuff going on but

they're like, you know what, it's okay.

I'm going to reach out to my support system.

I am in full agreement with this plan.

I'm going to participate in making this plan great.

That could change the tide of things if

they're like, no, I'm not interested in that.

I will not follow that emergency management plan.

I have no interest in making that.

That's going to turn the title a little bit too.

All things to consider.

So let's talk about how to screen for fit.

So first of all, we're building rapport.

We always want to start with a positive.

And that's going to look like, oh, my gosh.

Thank you for taking this step

to make your life better.

Thank you for taking this step to work towards this.

I know this must have been

so hard to make this decision.

Next, we can hear smiles, and this sounds a

little silly, but there's a lot of tests that

say that this is very much true.

You can tell just by the sound of someone's

voice oftentimes how they might be looking at you.

So can you hear it when I'm smiling, when

I'm bubbly, you know that I'm talking to you.

You know that I care.

You know that I'm engaged versus I'm exhausted.

I've had a really long day.

Like, hey, man, how can I help you?

You're going to hear that too.

And that's not going to make you as

excited or willing to share what's going on.

Also, we are Macy's, not Bloomingdale.

So I got this idea from the wonderful

Jennifer Hanshaw, and I think it's actually like

Miracle on 34th street as well.

I could be making that up, but it's this idea

that when you walk into Macy's, if they don't have

what you need, they're going to help you find it.

If you walk into Bloomingdale, they're going to say,

we don't need that or we don't have that.

Good luck.

We are Macy's.

We are perfect.

Tell us what's going on.

We can help with that. Okay.

There's other pieces to that we'll get

you connected with who can help?

We're here for you.

We don't do that. Good luck.

Curio that's not the DBH brand.

That's not what we want to put into the world.

And even from that get go, even if

you only talk to that call center representative

one time or that outreach representative one time,

that's a piece of everyone's treatment team.

And that's a piece of that rapport building.

And that trust that you have.

That Discovery Behavioral Health or center for Discovery or Discovery

Mood and Anxiety or park is going to be able

to meet your needs and that they are a trustworthy,

reliable organization that can help you with an incredibly delicate

and vulnerable part of your life.

A little bit more on how to screen for fit.

We want to set limits, so

screening is not a counseling session.

Let them know if you have 15 minutes. Hi.

Thank you so much for calling.

I'm so proud of you for taking this step.

Do you have about 15 minutes to

go through some screening questions with me?

Set that limit right then and there.

Don't allow the call to go on for an hour and a half.

It's not a counseling session.

Calm and confident manner.

Even if you don't feel confident

in answering that particular question. I hear you.

What an important question. Great question. Ask.

I will get that information for you.

A lot of times they're calling

us at the absolute lowest.

They are not in a good place.

They are frustrated.

They might be sad, they might be scared.

And we don't want to meet that fear, that anxiety.

With more fear and anxiety, we're going to be calm.

We're going to say, okay, yeah, I hear you.

Yeah, that sounds tough.

But I tell you what, we have resources for you.

We're going to help you change that tide, whatever

it is, and then end on an empowering. No.

So just like we want to start with a

positive, we want to end with a positive.

We want to acknowledge just what they're going through.

Like, man, that sounds so exhausting.

That sounds so frustrating.

That sounds so scary.

However, we just took the first

step to getting your help.

It's going to be more okay in a couple

of days or when we get you into treatment

than it has been for a long time.

Something as simple as that.

Nothing extraordinary, nothing.

We're going to save your life or something we can't

promise, but it's going to be a little bit better.

You're going to have a bit more support.

You're going to have a safe place, whatever that is.

Let's talk literally about

our basic screening questions.

So first of all, does

the patient prefer virtual programming? Wonderful.

We have virtual programming.

Let's get you connected.

Is the candidate clinically and

medically appropriate for virtual program?

So we've talked about this a little already.

Basically, are they going to be able

to be successful with virtual programming?

Is this a place they're going to be able to thrive?

They're going to be able to meet the treatment

team virtually and do what they need to do.

Is the candidate reasonably motivated for recovery?

Is this the candidate that we believe is going

to shut that laptop every time they get frustrated

because they don't want to be here?

Virtual is probably not for them.

Is this a candidate that's like, I want to get better.

I know I'm sick.

I want to work on it, or I just

know I want to make my life better. Perfect.

Virtual is going to be a great fit.

Does the patient have a support system? I missed one.

Does the patient live far away

from any in person program?

No worries.

Care is still accessible to you.

You still have a place you can heal even if you can't

go in person or even if you can't get to that program.

Let's set you up with virtual.

Does the patient have a support system and medical

resources near them in case of an emergency?

So what I mean by this is, is there some sort

of geographic hardship or are they in a medical desert?

And this is really going to come

into play when we have those higher

Acuity patients struggling with more intense issues.

If it is going to take 30 minutes for

an ambulance or any medical professionals to get to

them with where their originating site is, we might

need to figure out something different.

Do they need to go to a site in their

town but that is closer to emergency services, for example?

They'll still be doing virtual, they'll still be participating

in our program, but they're at a site that's

closer to resources if they need them.

There's things that we can

work out within that criteria.

But if they are super high suicide or medical risk and

they are in a medical desert, they have no resources.

I can get to them quickly and help them.

We might need to consider other options.

This is always a case by case scenario.

Okay, let's talk through advanced screening questions.

So I pulled these from the

center for Discovery new Phase system.

So these are our questions of stepping into

IOPB, which is our lower acuity IOP program.

So it's still IOP.

They're not separate, but thinking of Iopa as

they might need five to six days.

They're still nowhere near being ready for traditional outpatient

treatment where they're going to see a therapist once

or twice a week and then IOPB.

Like we're really getting a handle on coping skills.

We're really doing the thing.

We're working towards recovery.

We're still struggling, we still need support, but

we're starting to put our hard work into

action and really make those changes alright.

So is so and so struggling with an eating

disorder while being able to self manage urges to

self injure and keep themselves physically safe?

Now this is from CFD, but you could use

this in Discovery mood and anxiety just the same.

If So and So struggling with depression while

being able to self manage urges to self

injure and keep themselves physically safe can be

used in our substance use brands?

If So and So struggling with a substance

use disorder while being able to self manage

urges, and while being able to manage urges

to self injure and keep themselves physically safe.

Goodness gracious becomes a tone

twister after the third read.

If so and so able to follow

facility rules about dress code, cell phone

usage, group participation and attendance?

Is so and so willing and able to follow most

of the meal plan or most of the treatment plan?

Is so and so able to demonstrate flexibility with

eating times and situations, but with groups changing in

situations, any of that, with routines changing or schedules

changing and still manage things, is so and so

able to complete most of their meals and snacks

outside of program, even if it's difficult this time?

Is so and so able to complete most of

their therapeutic homework or treatment work outside of program?

Are they able to stay sober

even if it's difficult at times?

Is so and so mostly medically stable?

From their eating disorder or

from their mental illness?

Or from their substance use behaviors with

little to no engagement and behaviors?

And these are specific to the eating disorder?

No purging lacks of use, diuretics,

restriction, or dysfunctional exercise behaviors?

And you can just interchange those behaviors

with whatever's going on with any diagnosis.

You could do it for OCD, anything?

If so and so mostly able to combat eating disorder urges

most of the time outside of the three hour program.

Switch that with sobriety.

Switch it with mental health disorder.

Is so and so able to use some coping

skills when experiencing whatever disorder urges or in distress?

Is so and so willing to collaborate with

their support system to create a prorecovery environment?

Is so and so working with an outpatient psychiatrist?

And can they schedule an

appointment within the upcoming month?

Almost three of these is so and so

working with an outpatient therapist or dietitian.

Are they able to complete admission labs

and ongoing labs, including and to provide

the team with medical documentation?

Are they willing and able

to complete treatment assignments?

Do they live too far too

reasonable to attend in person program?

Do they live reasonably close to an in person program?

It's still prefer virtual.

Would virtual make recovery more accessible for them?

All right, so let's say you screen them

or they were a patient already in your

program and it's just not working out.

They've turned out to not be a good fit.

What we want to do in

these situations is we're almost there.

What we want to do in

these situations is use our empathy.

I know this has been really hard for you.

I know what you're going through is very tough.

You have not been able to find resources or

you've put a lot into this program and you're

just not seeing the results you want to get.

Let's talk about why.

Maybe it's a commitment issue.

Maybe they're not right for the program

because they don't have the technology they're

going to need to participate.

We want to be pretty black and white about that.

We want to give an explanation.

We don't want to just say, no,

you're not a good fit, Sousaq.

Like, good luck.

We want to say, this is why.

Because it might be something they can change or work on,

or it might not, and they need to know that, too.

There might not be an improvement for the

geographic situation, but there might not be a

potential solution to a medical problem.

But we want to let them know what that rule out

is and then explain why it's in their best interest that

the virtual program is not the fit for them.

It's not the choice for them.

It's not the treatment option for them.

And we do want to talk about what is

going to make virtual option in the future.

So if X changes, then virtual is always here for you.

And if it doesn't, let's help you

get to where you need to go.

We're never going to leave clients without referrals.

We just talked about that.

So providing some alternative next steps.

So this didn't work out.

Let's try another treatment style.

Let's try coaching.

Let's try an Ava therapist.

Like, it's going to depend situation by situation.

We want to try and keep

them within Discovery Behavioral Health.

We trust our network.

We know our network.

We have so many resources.

And if we can't, we also have great community

connections and we can still find them a place.

They're going to be able to work towards recovery.

We want to do our best to create warm hand

offs to connect them directly with the next person that's

going to be able to support them, to not make

them feel like, well, you're just on your own.

Again, how can we really facilitate getting them to that

next place, especially when we're not the right fit?

I also included a link just

in case suicidality is that rollout?

This is a really wonderful website.

It now matters now.

It has video resources, all sorts of stuff for

when patients are in that high suicidality, that active

suicidality or even passive suicidality place or their support

system is worried about them being in that place.

And if that's the rollout, we're going to provide

resources like this, along with other reputable resources we

believe will be able to help them.

Okay, I'm going to take a little break here, and then we

will finish up just in a few seconds for you all.

And we're back in a slightly

different space, but we are back.

All right, let's finish this training on screening

and orienting patients to virtual protocol for patients

who are higher risk than usual.

Again, this is meant to be the exception, not the rule.

However, we know because our mission is access

to care and access to virtual to inclusive

and virtual care via an intentionally designed program.

There will be times that we're going to take

patients that are higher acuity than we would prefer,

a higher acuity than we might normally take.

And most of those pieces of language aren't

perfect to what I'm getting at here.

But we know that we work in the mental health field.

We know that there are people that need care, that

have not been able to get it elsewhere, and that

we can help them to harm, reduce, and we can

support them and potentially getting to that next step.

So let's talk a little bit more about that.

I did ask for somebody on the front lines

to be the one to put this presentation together,

and I really leaned on our executive directors, who

will be running the in person and virtual programs

for center for Discovery, because you guys are the

first round of these newer programs.

And Jennifer Houndschild really stepped up to

the plate to make this presentation.

So these are her words.

I really appreciate her taking the time to do this.

And this presentation and this material will

also likely be something you see again

from your own executive director.

All right, let's get into it.

Access again.

I told you I stole this from Jen and

I also believe it's in movies like Miracle on

34th street, because it's just that universal.

We are Macy's.

We are not Bloomingdales.

If you come in and you ask us for tires,

we're not going to have tires, but we can tell

you probably where to get them or who's going to

tell you to be able to get those tires.

We're not going to tell you you're out

of luck, because that's not what we do.

We connect people to quality, to high quality and

inclusive care, and that access is the most important

piece, and that's what makes us discovery.

All patients are welcome.

We are not saying that every patient is right for us.

What we are saying is that we

were hired because we trust ourselves.

We trust our staff that they have appropriate clinical

judgment and that they can handle these tough cases

because we are the place that people are often

coming where this is their last try.

They've been other places they haven't had success,

but they know that center for Discovery or

the discovery mood and anxiety or that your

substance use Brand New Life has the reputation,

has the experienced clinicians to help them.

We're going to strive to provide the tools to

help our clinicians make decisions and the tools to

support the patients that are in unique situations.

And we know that we treat cooccurring diagnoses.

There's going to be a lot of unique situations.

And obviously this is exciting to me.

I like treating complicated cases.

I like working with it.

I like figuring that out.

I think that's like the ultimate

version of client centered care.

I know that's not everybody's stick, but that

is what we do here at center for

Discovery and Discovery Behavioral Health as a whole.

And that's why I have always aspired to be kind

of right where I am and to be with a

company that I think lives up to that reputation.

We want to be mindful of the black

and white application of level of care.

Humans are not black and white.

Treatment is definitely not black

and white and neither diagnoses.

So just like I said before, just because somebody has

schizophrenia, that does not mean we can't help them.

It all depends on what is being

managed, where, what is the severity?

How close are you to access your resources?

It's always going to be case by case.

There's never going to be a case where, because of this

one facet, there's nothing we can do to help you.

You're on your own.

We're always going to help you figure something out.

We at least want to inspire hope that things

can get better and that treatment will be able

to bring you to a life closer to a

living or bring our patients closer to that life.

And I want to talk you guys through

just a little bit more of that messaging.

So we strive to let me move my personal

camera here so I can see a little better.

We strive to provide the patient a chance to try the

level of care they're motivated to attend if it's safe.

So maybe they're not ready for PHP.

They're not ready for a six hour

commitment, but they're ready for ILT.

And if it is medically appropriate, let's bring them

in and then let's do that motivational interviewing like,

let's do the CBT work that is going to

bring them to and accelerate their willingness to participate

in the care or whatever it is for them.

We are also on a harm reduction approach.

We know that full recovery is possible.

We also know that full recovery is

an incredibly difficult thing to get you.

And our goal is to improve.

Of course we want to save lives,

but that's not always what is necessary.

We want to lead to some improvement.

We want to reduce harm.

We want improvement.

And sometimes that is the best that that

patient is going to be able to do.

And it might not feel like a big deal, but it is.

That's still something that is a

little simpler in that person's life.

It's still a little bit more hope they had before.

That's still a little bit more trust in this

system that we work in to help them.

We want to give patients a chance.

We want them to see themselves trying to

build up that self efficacy or that belief

that they can do difficult things.

And if we turn them away, that's telling them

you can't, you can't do this, there's no option

for you, and there's nothing more hopeless than that.

That behavior activation can really start a cascade of successes

for them, and we want them to get there.

We want to set the expectation that if you

need a higher level of care, that's not failing.

That's just figuring out where you need to go.

That's just more information.

All information is good information.

Just because we need to step somebody up doesn't

mean we fail, that our job is clinician.

It doesn't mean that the patient

failed at their job in recovery.

It means that we've identified their needs are greater than

a certain level of care, and our plan is to

step them up, get those needs, and then we're here

to support them when they step back down, if appropriate.

We also want to set realistic expectations

within the treatment plan and team.

So we're setting smart goals.

We are not going to set the expectation that if

you haven't completed your AA, we want you to go

to Harvard by the time that you leave treatment.

Not to say that can't happen, but that

might not be a realistic, attainable, time sensitive

goal to set while they're in treatment.

What is?

Maybe the goal is just looking into programs.

Maybe the goal is initiating a conversation with a

counselor, a part of this program, whatever that incremental

step we can take to get the ball rolling

we want to prioritize managing co occurring problem behaviors

based on what is the most life threatening.

So that what I mean is we're triaging.

So just like when somebody comes into an Er or a

number of people come into Er, we're taking that person back.

That is having a heart attack.

We're taking the person back that if they don't get

care right now, that is going to hurt them or

that is going to put their life at risk.

And we're going to do that with individual

problems a person is having as well.

So if you're having suicidality, that is going to

take active suicidality, that is going to take precedent

over maybe the stress you're having at work.

We're going to talk about the suicidality.

We're going to triage that we're going to

prioritize that problem and reduce the harm there.

And then we will get to the stress

you're having it work every day a patient

is in treatment, we are helping them.

It might not always feel like that.

It might feel like we are

really stuck with this patient.

We might feel very frustrated and be hard on

ourselves that we can't do more for them.

And maybe it's not just about them.

Maybe it's about the system.

But know that whenever they are connected to us,

whenever they are connected to treatment, connected to a

safe place that is helpful, give yourself the Grace

to know that you are helping just because they're

there, just because they're in program, that's much more

support than they've had before.

That's much more expertise they have

surrounding than they've had before.

And hopefully that's a lot more hope

for their lives than they've had before.

However, there are still exclusionary criteria and we've already

gone over some of this, but we're going to

touch on a couple of things anyway.

So schizophrenia, that could be a rule out, especially

if the schizophrenia is not being medicated, especially if

the schizophrenia has active delusions and hallucinations, it's not

going to be appropriate for virtual and it might

just not be appropriate for this treatment setting because

they may need inpatient.

They may just need other things, immediate

risk to hurt themselves or others.

Profound cognitive impairments.

So somebody with a severe disability or severe special needs who

maybe is nonverbal, who is not able to intake the information

and the way we have it set up in program, we

want to get them connected with other resources.

Now, I do want to be clear.

Just because somebody has a severe cognitive impairment,

this could be a traumatic brain injury.

It could be more severe on the autism spectrum.

It could be cerebral palsy.

Does not mean they don't get depressed.

It does not mean they don't have eating disorders.

It does not mean they

don't struggle with substance use.

I think one trap we fall into is

thinking like, okay, they have a disability, so

they're not struggling with these other things.

And we stop looking at that.

That is not the case.

I work with people with down syndrome

who have anxiety and depression all the

time on the spectrum, you name it.

We do want to make sure that they are

in the right programs for them, though, with people

who have expertise in working with whatever that cognitive

impairment is and that are able to support them.

And being in this type of program or being

in this type of program, it just depends on

where you are in the company might not be

the right fit, non ambulatory, so nonverbal stuff like

that, severe intellectual or developmental disorder that goes along

the lines of cognitive impairments, a severe learning disability,

support needed to complete their activities of daily living.

So if they have like a pair of professional

that's with them all the time that they need

to be next to, and that would create a

Hip, a violation for the other people in the

group therapy, that's not going to be appropriate.

And these are all case by case basis.

I always think of us as the

inclusive treatment center, like across the board.

And sometimes inclusive means connecting them with the sources where

they're going to get the best care and not pretending

that we can do everything or not pretending that we're

going to be the experts for them.

So being inclusive is not trying to

make them fit into our program.

It's helping them find a place that is built for

them, if that exists, or helping them build a unique

treatment approach that's going to work for them.

Let's talk about some of the

why many specifically to virtual.

One of the big pushes for virtual

is we don't have space, and this

is not a discovery behavioral health problem.

We see over 2000 patients a

day across the United States.

This is a mental health care problem.

Many of the programs out there are totally at capacity.

They are full.

They have wait lists that are five, six months long.

These patients need care now.

Of course, it's not unlikely they are going to need

care in five to six months, but the situation may

have elevated to a very severe point by the time

that we're able to get them in the doors.

Virtual is a way to get them into care

and to get them access to care, hopefully much

quicker than we would have anticipated, hopefully quickly.

I'll just say that another thing this is

leading to is patients are escalating an acuity.

They're coming in with more

intense problems than we saw.

Prepanddemic eating disorder, substance

use, mental illness.

All of these things got worse in the pandemic.

So the patients that are coming

through our doors now are sicker.

They're dealing with more intense problems than we saw

precobid, and we have to acknowledge that and embrace

it and be ready to deal with it.

Some have waited weeks or months to get

into treatment with us, meaning by the time

they originally screened and were appropriate.

The time they come to us and they

hop on the screen, they may not be.

And that's why that screening is ongoing.

So we want to be able to

get them in as soon as possible.

And another thing we need to keep in mind when

we do have higher Acuity patients of like, this is

just where they are at right now, and we need

to meet them there to the best of our ability.

We need to harm, reduce.

We need to set attainable expectations, and then we need

to work with our treatment team to decide at the

higher level of care is necessary, how do we stabilize

this patient until we can get them there?

All of that jazz while we're waiting to

admit, we know that our patients continue to

struggle and their struggle increases, things get worse.

This is why we are essential, and these are just

some of the things we may come up against.

And there will be other factors

that come into play here, too.

The point of virtual is to expand access to care.

We're going to do our best to do that, to

keep it manageable, to keep everybody at the level of

care that we're able to serve them at, understanding that

there's going to be unique challenges here.

But that's why each of you is

hand selected for this program, because we

believe that you can handle these challenges.

And we know that you're passionate

about inclusive and accessible care.

Not appropriate or a chance to

evaluate our expectations and get creative.

So it is appropriate to proceed with

treatment at the outpatient level of care.

Once you've checked the following medical stability,

the patient falls within our level of

care guidelines or the patient's TCP.

So like their doctor and leadership team has deemed that

the patient is stable enough to be treated with us.

Good to go.

Dietary or meal plan intake is adequate to

maintain safety, so they're not on hunger strike.

They're not in need of a

feeding tube or medical stabilization.

They're able to at least manage some of

their self harm behaviors or if they're dealing

with other obsessive compulsive behaviors, they have those

managed to like some degree.

Obviously, weight restoration is important.

We're talking about eating disorder or treatment, so

we need to be seeing some progress.

And you can set ramifications around that too of

like, if we don't get to a certain point

in our treatment, maybe it's weight restoration, maybe it's

behavior reduction by X amount of weeks.

Then we're going to have the conversation

on higher level of care patient. Are you okay with that?

Are you on board with that?

Do you understand why that's important?

Are you committed to trying to help us do what we

can at this level of care and in agreement that there

will be steps taken if this is not the right fit,

perfect clinical so enough engagement to maintain safety so they are

engaging with program in a way that we can guarantee their

safety, or we can have a very clear picture of how

to support them in maintaining their safety.

For the Milieu, the behaviors do

not continuously negatively impact the Milieu.

So the patient receives feedback

appropriately from their peers.

They interact appropriately from their peers.

They don't distract their peers from treatment, and they

don't cause additional harm to those in treatment.

Next, we want to make sure that

we're seeing progress after two weeks.

So some measurable progress is observed.

And this could be treatment commitment.

It could be whatever you're setting forth in that treatment

plan, more hopefulness, more of a willingness to take direction

from the treatment team, or even if it's just harm

reduction, we're seeing less effects of whatever they're dealing with

and then considering a step up plan, submitting requests for

that higher level of care, step up, initiating that process,

everything you need to do to make sure that we

have plans in place to get them where they need to go.

If they're not right for our program

as far as challenges talked to leadership.

So talk to them about how

do we manage these expectations?

How do I manage my expectations?

I don't feel like as a therapist, I'm doing what I

need to do for this patient, like seek supervision and your

supervisor is going to go you are you're harm?

Reducing some care is better than no care.

Your job is not to save this patient.

Your job is not to save every patient.

Your job is to harm reduce.

Your job is to make sure we're not causing harm

and to continue building their face that if they stick

to treatment, it's going to make their life better.

It's going to make their life more manageable, whatever

it is for your specific discipline, when the presenting

behaviors are different than what we expect.

So maybe disruptive or maybe we're just

seeing more behaviors than we originally reported.

Maybe we have somebody who's a poor historian, and a

lot more is cropping up than we initially expected.

That's an ongoing screening process. Okay.

We've seen a little bit more about

what this patient is dealing with.

We're seeing a little bit

more about their presentation.

Can we address it appropriately?

Can the patient become more appropriate for treatment within a

certain amount of time that we set maybe two weeks

to engage with a success plan, whatever it is, and

if not, okay, what are we going to work towards?

Where are we going to get you?

Where do you need to go?

What happens if we can check those boxes for safety?

But they're not making any progress?

No matter what we do,

we're not seeing any improvements.

Have a conversation with that treatment team.

Is there anything we can add?

Do they need an occupational therapist?

Do they need vocational rehab?

Do they need a behavior analyst, or

do they need another type of program?

Is what we are offering just not going to be what is

going to work for them, what they're going to be able to

put their trust and their buy in into, and how do we

get them connected with where they need to go?

If a PCP continues to clear a patient for

outpatient when they really need a higher level of

care, let's get them connected with somebody that is

more informed as to the specific diagnosis.

So an eating disorder, informed

PCP Health informed PCP.

If they're not seeing a clear picture of this

patient, how do we increase that collaboration of care

between the treatment team and those outpatient providers so

that we all share the vision of the treatment

for this patient and make sure that they feel

supported by each member of the treatment team and

that they are set up for success?

Access is not only for our patients, but access

to our team and leadership is for all.

Our leadership at Discovery

Behavioral Health is incredible.

Every leader that is going to be overseeing one

of these intentional virtual programs is a rock star.

They have been selected by the

operations leaders to do this.

We know that they are very good at their jobs.

They have had very high performance and

they have served their teams very well.

They will continue to do so, and

you have full access to them.

You also have full access to people like me.

If you have an issue that you feel I would

be able to support you with, please never, ever hesitate

to email me or give me a call or teams.

I think CFD and DMA and the SCD brands

and Discovery MD are all very everybody is ready

to jump in and support wherever they can.

I don't think anybody's too good to take out the trash.

Nobody is too good to provide supervision.

Nobody is too good to be someone to vent.

Nobody is too good to work on a smaller project with.

We are all here to support you.

You have access to us just like

you are providing access to the patients.

We are here to ensure that you

are given the tools you need.

You are heard and you are supported.

You have a very difficult job.

You have chosen a very difficult field and that's

because you are a hard working, incredible person who

wants to make a change and we want to

help you be able to do that.

We also promote balance.

We don't want you to be working all the time.

We don't want you to be stressed all the time.

We know this is a stressful career.

We know this is an overwhelming career.

We also want to help you be able to take time off.

We want to help you be able to find balance.

And if that's something you're struggling

with, let your team know.

They will be able to put a plan in place

for you too, to help you be more successful in

this role to prevent burnout, to minimize burnout.

We know at some point burnout is unavoidable.

It's a part of life.

It's a part of this profession.

How do we recover from burnout?

Just make sure you are the best of your ability.

Being open.

Find somebody within the company, within the organization

you feel comfortable going to with these things

and collaborating with so we can all have

a successful, healthy experience in providing this access.

Self care is a right.

It's not a privilege.

It's not something you need to earn.

It's not something you get if you work hard enough.

Self care is something you have the right

to at all points in this process.

And if you don't feel that that

is the case, let us know.

We can support you.

You cannot give to your patients

without giving to yourself first.

You cannot pour from an empty cup.

You have to put your oxygen mask on first.

I don't know how many of these metaphors are out

there, but the fact is we've had to find so

many ways to say the same thing over and over

and over again, which is if you don't take care

of yourself, you cannot do this work.

You might be able to get away with it for a

short period of time, but it is going to affect you.

You can only take your patience as far

as you are willing to take yourself.

And if you can't care for yourself, if you can't keep

yourself well, that is going to show up in your work.

It is going to make you feel even worse.

It is going to show up in your team.

And that's not what any of us want

for the experience of being health care providers.

Let us know how we can support you.

And please, please put your

own selfcare plan into action.

That is always something I ask about interviews.

I want to know that people know how to do

this for themselves, that they know how to take care

of themselves, that they know how to stand up for

themselves and to create boundaries for themselves.

That is the most critical factor to success in

this role or any healthcare role, in all honesty.

All right, we're going to look at one last thing.

So this is how to Orient patients to virtual.

So I pulled together three resources for you guys.

Now, these are resources.

I don't want you giving these to patients.

These are for you.

Patients are going to get their own versions of these.

So we have the Outpatient welcome packet,

and then we have the center for

Discovery Telehealth Outpatient welcome packet.

They are similar, but each of these things

has their own features I find very helpful.

So I included both.

And then we have our Zoom 101 for clients and families.

And we did go through that in a major

way in the technology implementation and workflow training.

So I'm not going to harp on it too much.

Let's take a quick peek at that,

and then we'll wrap up here.

I closed it. Should know better.

All right, here it is.

And again, this will be attached to this training.

So we have our outpatient packet, so

we have a message from your team.

And this is the kind of messaging

we all want to be focusing on.

If you are in a reactive program, we have our

COVID-19 adjustments, meaning you're not a new program that's only

virtual and going to be virtual all the time.

You're a reactive program and

that something has happened.

There's a covert exposure, there's something wrong

with your facility, and you guys are

going to virtual out of necessity.

Our commitment to inclusivity, to Hayes,

to gender affirming care, point of

contact, everything else that's in here.

Program guidelines or drug and

alcohol policy, clinical guidelines contraband.

Again, this is still contraband for virtual,

but it's definitely contraband if you're gone

in person group guidelines, what to expect

from an outpatient dietary program.

All that jazz.

I have the most visibility and access very

clearly to the center for Discovery materials.

Your materials are going to look different.

This is just a resource for you.

If you are not in center for Discovery, if you don't

have a resource like this and you want to work with

me on developing one, I would absolutely love that.

I'm here to support you with that, too.

I'm a little concerned you can't see it.

I apologize.

I've just been scrolling.

But just in case you all didn't see

it at all, here's the Outpatient welcome packet.

Again, it's from center for Discovery.

I mentioned some of the things that are in

here, and then we have our telehealth specific program,

which is has some additional things in here.

It has some different virtual specific language, how

the virtual platform works, all of that jazz.

Our client Bill of Rights.

I try to include examples of that.

This is just an example schedule.

If you are with center for Discovery,

your schedule very may well look different.

So don't be beholden to this.

It's just an example.

And then we have our Zoom 101.

Okay.

That resource is best for you

to go through for yourself.

I don't want to just read it all to you.

And a lot of it you've gotten in other places in

this training as well, but you do have that there already.

We're almost done.

So screening and orienting patients to virtual

is critical to the patient experience.

We reviewed some of the

ethical criteria pertinent to screening.

We also reviewed basic and advanced screening and

the protocol for treating patients who are higher

acuity than we would normally work with.

Lastly, we talked through orienting patients to treatment

and the resources you have to do.

So screening and orienting patients to program isn't art

and a skill that will develop over time.

It will very much become second nature.

At first it might feel a little clumsy, but

you're all going to get the hang of it.

And if you're transitioning from an in person to

a virtual program, you know how to do this.

It's just helping them really

figure out the virtual world.

But I have complete faith and no doubt

that all of you will be successful.

If you find that you need

additional tools, please reach out.

Let me know and we can get this for you as always.

If you have questions concerns, please reach out

to me via email apiator@discoverybh.com and then here's

our resources and here is our dancing Queen.

Other than that, I'll see you in the next training.

Bye.