CONDUCTING SENSITIVE SCREENINGS

COMPANION GUIDE

Consulting

INTRODUCTION TO THE COMPANION GUIDE

There is no “right way” to use this companion guide. Rather, there are innumerable “right ways” to use this companion guide! The guide is divided up into different sections, with self-reflection questions throughout. Many sections also have a corresponding video, which you can access through the links provided. The guide can be used just to read through or can be used as more of a workbook, by writing in your answers to the question prompts. No matter how you use it, we would love feedback or suggestions for future editions!
For a curated list of other videos, empathic communication resources, telehealth tools and more please visit **www.emorrisonconsulting.com.**

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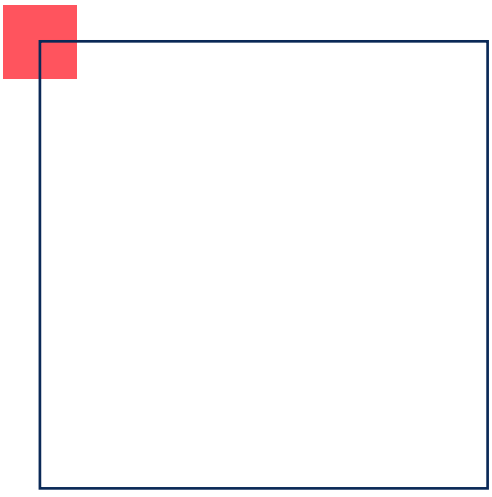
NOTICE



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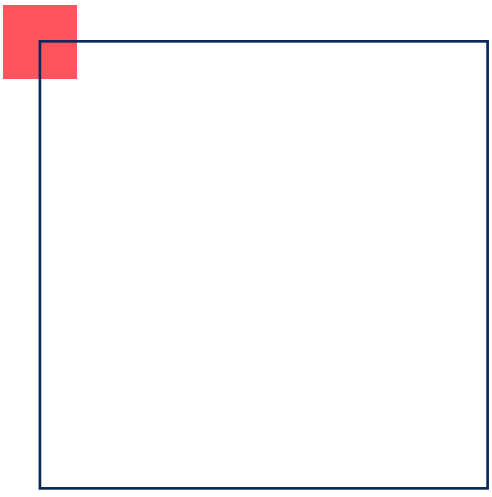

INTRODUCTION

The Purpose of this Companion guide

The purpose of this companion guide is to increase comfort and confidence in conducting sensitive screenings, especially in the era of telehealth. For the purposes of this companion guide, we define sensitive screenings as any screening that asks questions that might be considered invasive by some, or that are associated with historically stigmatized conditions or behaviors (such as substance use, mental health, intimate partner violence and trauma in childhood). This said, potentially any screening question could feel invasive or sensitive to someone depending on their history or life circumstances, so the **skills outlined in this companion guide are skills that can be applied to all health care screenings.** With the transition to telehealth, we are now being asked to conduct sensitive screenings over the phone (and occasionally using video), which has caused many of us to feel uncomfortable or awkward, since these modes challenge our ability to connect with people through facial cues and body language. This can feel anxiety-provoking for those of us tasked with asking sensitive questions. For these reasons, we designed this companion guide to be inclusive of conducting sensitive screenings in person, over the phone and on video in a way that is **trauma-informed**, where we feel supported, and people feel safe answering.

The "Why" of Screenings

All of us who work in health care know that screenings are a required part of our practice. Many of us know that we get reimbursed for conducting regular screenings such as the Patient Health Questionnaire-9 (PHQ-9), the Alcohol Use Disorders Identification Test-Concise (AUDIT-C), and the Adverse Childhood Experiences (ACES) questionnaire. With the ever-increasing demand for screenings, Medical Assistants (MA's) can develop to a sense of "screening fatigue"— feeling as though screenings are just yet another task to be completed. Importantly, patients may also experience screening fatigue! This underscores the importance of delivering screenings in a skillful, patient-centered way, and providing patients with information on the rationale for screenings. To do this,

we must also understand the actual rationale for screenings. Screenings are considered a "best practice" in health care in order to ensure that all people are asked important questions about their health, safety, and history.

> **Screenings ensure that the health care team doesn't forget to ask these important questions and that there is no bias regarding which patients gets asked specific questions and which do not. Universal screenings also ensure that we ask everyone the same questions in the same evidence-based way.**

For example, when left to our own devices, we may inadvertently change the wording of a question so that it prevents the disclosure of important information. Consider the difference between "You don't drink alcohol, do you?" versus a validated question like "How often do you drink a drink containing alcohol?" These two questions could elicit very different responses, on a critical health behavior.

In summary, there is only one reason we screen - to help people. And, we can only help people if they feel that they can share freely with us.

The "How" of Screening

The type of screenings we are talking about in health settings are 100% based on self-disclosure. This means that the only information we receive is from what the patient directly tells us. Our ability to help a patient rests totally on whether they share accurate, critical, information about their health. To get this information is harder than it sounds! Consider all the times we have not told a doctor, nurse or medical assistant the full truth about something. We might have fudged if our baby is off the bottle to a pediatrician or medical assistant, withheld information about how much we were drinking alcohol, checked "no" on something that was actually a "yes", neglected to mention that we use cannabis to sleep, or minimized how much screen time we allow our kids to watch. In short, we all have the same human tendency, which is not to share everything unless we are 100% sure of a few things:

1. **That we will not be judged**
2. **That the information will not be ignored**
3. **That the information will be kept private, and**
4. **That it "fits" in the environment (meaning, that there is a legitimate reason why it is being asked).**

Numbers 1 and 2 tend to be the most important for people. None of us would purposely convey judgment to people or ignore their self-disclosures. Unfortunately, it is all too easy to unintentionally communicate these things with our verbal and nonverbal cues. What we strive for is the opposite of judgment and ignoring - acceptance and acknowledgment. Both of these are key components of communicating empathy. Demonstrating strategies for conveying acceptance and acknowledgment in different screening situations and with different challenges is the focus of this workbook and the accompanying videos.

The Difference Between Screenings and Assessments

Before we get much further, we want to clarify the difference between a screening and an assessment. When we use the word "screening" we are referring to a brief, focused questionnaire typically developed and vetted by researchers to elicit critical health information from people in an accurate way. Screening is a process of asking the same questions (or giving the same test) to a large number of people, in order to find those who have undetected symptoms of a particular condition. For example, tuberculosis (TB) tests are screening tests to find who might have undiagnosed TB. The PHQ2 or PHQ9 are screening questions to find those who might have undiagnosed depression. We use "might" in these examples, because a screening tool rarely results in an actual diagnosis- instead, **a "positive" screen prompts the need for further assessment to see if there is a given diagnosis**. For example, a positive TB test prompts a lung X-ray, a positive PHQ9 (above 10) prompts a clinical assessment. Thus, screenings are critical in order to identify areas requiring additional assessment, support or intervention for our patients.

Concerns about Sensitive Screenings

Conducting screenings about "sensitive" topics has always been a source of anxiety and discomfort for health care workers. And with good reason: screenings tend to focus on deficits or "problems", rather than patient strengths! Unfortunately, the health care field has historically focused on identifying the things that are wrong, which never feels good to ask about, or to answer.

Additionally, many screenings ask about topics that may be considered intrusive, or even taboo, such as suicidality, sexual behavior, and more. Like we have mentioned, the purpose of screening is to find out information about someone so we can be most helpful to them. In medical settings, there is a long history of how asking sensitive questions for this purpose has gone well. For example, decades ago we started asking about I.V drug use and sexual behaviors such as the number of partners someone has had or their use of birth control, which has led to an increase in public health initiatives to support in lowering the spread of communicable diseases. Fifteen years ago, we started asking extensive questions about depression, which has led to a drastic expansion of the availability or mental health resources. More recently, we've started asking about alcohol and other drug use, anxiety, post-traumatic stress disorder, and now questions about childhood trauma and other difficulties, which will undoubtedly have further positive impact on care and services, as well.

> **All of this screening, at its best, lifts stigma and maximizes our ability to help others.**

There is also no doubt that many of us who work in health settings have mixed feelings, or negative feelings, about asking patients sensitive questions. Especially regarding the Adverse Childhood Experiences questions, or the related PEARLS questions, for children. Sometimes we feel nervous because we haven't asked anyone something so personal before. Or, we may feel it is rude, invasive, and maybe even harmful to the one being questioned because of the difficult feelings it brings up for the patient. Or, on the other hand, we may

have had our own experiences with trauma or behavioral health concerns in the past and asking these questions repeatedly as a part of our daily job duties is just an unwanted reminder of this.

Conducting screenings over the phone or video can complicate this. Most health care workers generally feel more comfortable conducting screenings in-person because we often have more time to connect with people (when we walk from the waiting room we can make small talk, when we come into the room we have a little more warm-up time, etc.), and this can make the screenings feel less intrusive. When we are on the phone or video we don't have this opportunity, meaning special attention is needed for sensitive screenings via telehealth.

The good news is, overcoming many of these concerns is something that it is very doable! At this point in health care history, screening for depression, anxiety, substance use disorders and childhood trauma appears to be our best response to addressing and eventually preventing the suffering that is caused by behavioral health conditions or adverse experiences. Also, while it is too early to see academic research in this area, it is possible that there are some unforeseen benefits to conducting screenings over telehealth, including people feeling more comfortable answering these questions over the phone, as it is a bit more anonymous, or perhaps people feeling more comfortable self-disclosing because they are in their home environments. Moreover, the problem-focused nature of screenings is something that we hope is changing, especially as many clinics are now incorporating screenings about resilience in their ACES questionnaires.

With all of this, **when we screen, we give our patients the message that we are inviting their whole self into the clinic-** that we want them to feel comfortable sharing anything they might be struggling with, especially those things that historically have been considered outside of the purview of a medical visit, such as their socio-emotional health. With skillful screening, we start the small steps toward working for a future where our systems may be so deeply integrated, racially just, culturally responsive, and deeply compassionate, that we can just ask: "How are you?" "What is important to you?" "What is troubling you?" and, "What can we do to help?" and people would feel could feel free to share as much or as little as they desire.

The Possibility of Helping and Healing

Every human encounter has the possibility of being an instrument for helping, healing, connecting and humanizing for both people involved in the interaction. Even day to day interactions at the grocery store, on the phone with customer service or crossing paths with a neighbor have this possibility. Moreover, we have all felt the sting when these frequent interactions are slightly prickly and the subtle numbness when these types of interactions are bureaucratic, lifeless, or transactional. It can be damaging. This is all even more important to remember when considering our interactions during the health care visit. All aspects of the appointment have a deep importance – the stakes are higher, people are vulnerable, and patients have fears. For this reason, **even the screening process itself can create transformative connection, promote healing, and affirm the good of the other.**

Screenings aren't just a step to getting help - screening, all by itself, can be the help. For some people, just being asked the questions on a screening can increase their understanding of their overall health. It may even be the first time someone has ever asked them about how they feel or about their childhood, which could start a cascade of self-reflection and growth. Having someone empathically respond to their answers might also be one of the first times they have felt listened to without judgment or advice. This can lead the patient to having the courage to talk to their healthcare team about how they have been struggling with things like food, substances or unhealthy behaviors. The point is, the 5 or 10 minute screening process deeply matters and can have a profoundly positive impact on the people we touch. The good work you are doing is important!

Preferences, Choice and Autonomy

While the focus of this companion guide is to help us feel more comfortable and confident in delivering sensitive screenings, we also know that some of us may never feel this way. Most of us make distinctions between a short term pain that produces a higher good (such as administering vaccinations to prevent an illness), and pain that harms, with no tangible or visible "higher good".

It is possible that some of us will feel that asking sensitive screenings is causing harm to patients or to ourselves, for a variety of reason.

If that is the case, we strongly encourage you to seek the support of your supervisor, or another trusted colleague. Many issues of discomfort around asking these questions can be worked through with good supervision. With that said, there also certainly may be people for whom engaging in an administering the screening will be harmful to themselves or interfere with their ability to deliver the screening effectively to patients. This is okay too and this person can still be a valuable member of their team and incredibly effective with patients. We must remember that the screening is only as good as the self-disclosures we get from the patient, so if someone is not able to effectively deliver the screening for whatever reason, it will be counter-productive. In such circumstances, staff are encouraged to communicate this to their supervisors and having the autonomy and right to decline to administer the screenings to patients if they choose.

As a final introductory note, throughout this guide, we have placed multiple video examples of how to execute the tips suggested. These videos were filmed to specifically illustrate how to implement the skills virtually due to the COVID-19 pandemic and unique challenges of telehealth. Applying the skills over video and in person will be the most similar but all of the examples will also be applicable to phone interactions, as well.

Think about a time when you've been asked sensitive screening questions in a medical setting. How did it feel?

If you were honest in your answer, what made you feel reassured and safe answering the question(s)?

If you were not completely honest, what got in the way of you feeling safe and reassured to answer the question?

TECHNICAL SKILLS

STEP 1: FOUNDATIONAL EMPATHIC COMMUNICATION SKILLS

- ☑ **Greet the patient.** "Hello", "Buenas tardes" or even "Hi"' works great. Genuine greetings are super important and frequently missed when we are in a hurry; consider how often people are asked "do you have an appointment?" as the first verbal interaction.
- ☑ **Introduce yourself** and who you work with. Once we say our names, we become less anonymous and more human to others. When we say who we are working with, people connect us to the doctor in their minds, and often mentally give us any existing trust and goodwill they have for the provider.
- ☑ **Use the peoples' names.** Use "Mr." and "Mrs./Ms." unless you've been given permission by the person to just use their first name. Using people's names is an important indication that we see them as more than just a patient, or a number; it demonstrates we see them as real, unique, whole person.
- ☑ **Show your face if possible:** If completing the screening via video platform, it is incredibly important to take our masks off when we are using video. It is very difficult for people to connect to us when they can't see our faces. If for some reason you cannot be alone in the exam room on video –or over the phone-, you can explicitly state the reason for keeping your mask on (e.g., "I'm sorry I'm a bit muffled right now. I have to keep my mask on for safety right now because there are other people sharing this office with me"). Of course, if the latter is the case, it is important to share that you are using headphones such that the patient cannot be heard by others in the room, protecting the patient's confidentiality.
- ☑ **Acknowledge the nature of the visit:** Especially if the first visit is over the telephone or video acknowledging the newness, strangeness or the difficulty often warms people up. You can say something like, "I wish I could see you! It is hard when we can't look at each other." or "I know It is likely still a bit strange to be doing visits this way".

- ☑ **Smile.** A kind smile is the single most important way we indicate goodwill to another person. When we smile, others mirror us and smile back, creating the foundation for an empathic bond. This is another important reason to remove masks during video visits (again, assuming we are alone in the room). When we are in person and are masked, we can say "I wish you could see me smiling at you", or "Just want you to know I'm smiling"
- ☑ **Acknowledge when you have to pause move, or look away:** If we have to look away from the patient, explain why we are not looking at them and what we are doing when we look away. If we are typing on the computer, explain why we are taking a pause to type in the patient's chart. If people feel we are distracted or multi-tasking on something that doesn't have to do with them, they will often not feel as comfortable sharing sensitive health information.

Step 2: Setting Expectations

Psychological safety and trust is a key component of effective screening. Helping people 1) anticipate what is coming, 2) understand the screeners are universal, 3) know how long it will take and 4) understand what is going to be done with this sensitive information, are all critical to ensuring people feel comfortable and psychologically safe answering invasive questions.

Example phrases:

- *Anticipate what is coming: "I'm going to ask you a series of questions about your health…"*
- *Universality: "We ask everyone these questions…"*
- *Anticipate: "This usually takes about 5 minutes…"*
- *What will be done with the information: "It is confidential health information that will be shared with your doctor in order to help care for you in the best way…"*

Step 3: Asking Permission

Asking permission to administer the screener acknowledges that people have a choice about what they share with their health care team. When we ask permission, it shows respect and also helps avoid flaring up someone's psychological resistance, which is a human tendency to push back when we feel someone is infringing on our boundaries.

Example phrases:

- *"Is it okay for me to start now?"*
- *"Can I go ahead and ask you these questions?"*
- *"Is it alright for me to share some information with you?"*

Step 4: Affirming Autonomy

Building off of setting expectations and asking permission, it is also absolutely okay for people to decide NOT to answer. They are not being difficult or "non-compliant" if they don't answer—it simply means they may not feel ready, willing or able to share this personal information. They may also be responding to a previous experience of feeling judged or ignored when they disclosed something to another health care person. Respecting patient autonomy is part of practicing trauma informed care and ensuring that we don't inadvertently break trust or re-traumatize people through the screening process.

Example phrases:

- *"It is totally your choice, you can stop if you'd like..."*
- *"Yes absolutely we can stop; you don't have to do this..."*
- *"...and if you want to stop at any time, just let me know, it is no problem..."*

Step 5: Explaining the "Why"

People are much more likely to share information with us if they understand the reason why, and specifically, if they understand that the reason is for us to be able to better care for them. Although the general "why" is the same for any screener (to obtain important health information that helps us provide better care for them) each screener has a more specific "why", as well. Most times, sharing the general "why" can be done in conjunction with the specific "why".

Example phrases:

- *"We ask these questions because alcohol and other drug use can impact our health in many ways."*
- *"We ask these questions because stress, depression or anxiety can be such serious health difficulties."*
- *"We ask these questions because difficulties that happened in our childhoods sometimes have negative impacts on our health when we are older, as well."*

Putting it All Together

- *"Now, I'm going to ask you a few screening questions about x, y, z (setting expectations). These are questions we ask everyone (showing non-judgment). The questions ask about important health information that will help us provide the best care for you (general "'why"). This will only take about 3-4 minutes (setting expectations). I'd also like to let you know that all of the information you share me will be confidential and only shared with your doctor in order to help care for you in the best way possible (safety). With that said, it is completely okay if you would like to skip or not answer some of the question, or stop altogether I ask (affirming autonomy). You can share with me only whatever you feel comfortable sharing (affirming autonomy). Do I have your permission to proceed with the screening?" (asking permission and affirming autonomy) .*

Video Example: This video shows what it looks like when we combine the 5 steps above. Try to take notes and notice when the provider completes each step. The video will start at about the 4 minute mark. Watch through the full example, until about 9:13.

Think of a time when you or a family member you were with was receiving care and a medical staff member asked permission before doing something. What do you remember about how it felt?

Delivering the Screener

Once we've obtained permission from the person and start reading the screening questions, it is important to slow down our usual pace. Most of the screeners have multiple choice answers and we need to allow time for people to understand the format of the screener. Remember, we may need to repeat the multiple choice answers various times for people. Even though we've delivered the screener hundreds of times, this may be very new to the patient!

Reflective Listening

Reflective listening involves repeating back what we have heard the other person say. This demonstrates that we are paying attention and that we want to make sure we've heard someone correctly. More importantly, it demonstrates hearing them is important to us and that we value what they've shared. When we are very skillful in using reflective listening, we can actually help others identify how they feel and what they are thinking, just by interpreting and reflecting

what they've already said. When reflecting, we can repeat back short answers, like "no" or "yes" or we can summarize and repeat back longer answers like in this example here:

- **Patient:** "….um, 4-5 drinks a week" Medical Assistant: "Yes, okay, 4-5 drinks a week, got it."
- **Patient:** "…no….." Medical Assistant: "It sounds like no, you haven't had any thoughts about that."
- **Patient:** "…..yes, we went hungry a lot as kids…." Medical Assistant: "Okay, yes, you have had periods in your childhood like this…"

It may seem simple, but simply reflecting or repeating back what we've heard people say can be incredibly validating and really help people feel like we heard them. What are your experiences of either using reflective listening, or having someone reflecting back to you?

Normalizing

Normalizing is the opposite of making someone or the issues they are talking about feel/seem bad, wrong or pathological. **Normalizing is letting others know that they're not the only ones to have ever felt this way, done this, or had this happen to them.** It is letting others know they are not alone. Maybe the same thing has happened to us or, even if it hasn't, it is something we can effectively empathize with. Normalizing strengthens the relationship with the patient, increases the likelihood of self-disclosure and encourages them to tell us more.

Example phrases:

- **Patient:** "Geez, these are personal". Medical Assistant: "I know those questions are really personal and can maybe feel intrusive."
- **Patient:** I'm just not sure, I don't know…."Medical Assistant: "….these questions can feel really hard."
- **Patient:** "Can you repeat the options? Sorry" Medical Assistant: "I know the answer options in this scale are complicated. Most people have trouble remembering them."
- **Patient:** *tears up*. Medical Assistant "These questions are hard for most people."

Video Example: In this example, the MA responds to the patient feeling confused during the AUDIT screening. As you watch, pay attention to what MA did well and where she could improve.

Appreciating

Appreciating is sort of a mix of thanking someone and acknowledging someone's effort. **It is a simple and powerful way to show empathy.** It also acknowledges that the person didn't have to do this - they didn't have to answer the questions, they didn't have to come to the appointment, and they certainly didn't have to be honest or share anything personal or revealing. By stating our appreciation, we are acknowledging all of this.

Example phrases:

- *"Thank you for sharing all of that information."*
- *"I appreciate your willingness to continue."*
- *"Thank you for doing this."*

Planning

Once we have expressed appreciation for the person completing the question, it is critical to tell the patient what we are going to do with the information. This will be different depending on the workflows in your system. In some organizations, if a patient answered many questions affirmatively/positively, the staff might engage in a warm hand-off directly to a behavioral health provider in the moment. In others, they may ask the patient if they would like to see a behavioral health provider in the future and make the appointment. In most systems, the staff will ultimately pass the screening information onto the medical provider. Whatever the workflow is, it is important to share this directly with the patient.

Example phrases:

- *"Thank you so much for sharing this information with me. Now I am going to go ahead and pass this information on to your doctor and they will follow up with you."*
- *"I appreciate you completing this with me. I'm going to share this with Dr. G. She will likely talk to you more about this."*
- *"Thank you for sharing this with me. We have behavioral health providers and counselors here who are really helpful with these types of experiences. Could I introduce you to someone right now? Or could I make you an appointment to see one of them so that you can continue to have the opportunity to discuss what came up in the screening?"*

Body Language and Tone of Voice

Research shows that we tend to believe what we see in someone's body language and hear in their tone of voice more than their actual words. An "I'm sorry" with a genuine look of concern and a slight lean in is believable. An "I'm sorry" with a surly tone and arched eyebrows is received entirely different. **To this end, it is important to remember that our body language and tone of voice can naturally communicate empathy when we are feeling open and caring of others. This is a bit easier to do in person, harder to do over video telehealth and can be quite difficult over the phone. Below are some tips to consider:**

Video and in-person: Eye contact provides the most powerful non-verbal way to convey empathy. Maintaining eye contact can be challenging: often times we need to look away from the video or in person to another screen or to grab papers on our desks. This is normal, and we can mitigate this by intentionally engaging in thoughtful eye contact at the beginning of the interaction, then explain when we need to gaze away from eye contact during the interaction. We can ensure that eye contact is continued periodically. When we need to look away consistently, we can narrate this to patients by saying something like, "I'm looking away to my computer screen so I can see the questions, just so you know."

Smiling is another powerful way to convey goodwill to someone non-verbally. Smiling is incredibly powerful in conveying empathy and has been researched extensively, and has been written about by many spiritual leaders of different traditions. It is sometimes referred to as "holding hands" without touching. Like eye contact, the most important time to smile is at the beginning and end of the interaction so that the patient can see your attempts to reflect goodwill.

Body posture is something that we can also pay attention to in person and over video. Open body posture that is "squared" to the person we are talking with also conveys engagement and care. Ideally, over telehealth, we want the camera at eye level, so the person isn't looking up at us, or down at us; we want to show our face and upper shoulders- if we are showing more than this, we are likely too far away; less than this means we may be too close. Likewise, leaning slightly forward, when sitting or standing, conveys empathy. On the contrary, crossed arms or side positioning can indicate disengagement or judgment. Leaning back can also convey a lack of engagement and, in some circumstances, judgment, as well.

Last, it is critical that our **voice tone**, as well as pitch and pacing conveys warmth, goodwill, and sincerity. As stated above, the way we say things has much more impact than the words we actually choose. Being mindful of this is something we can do over both video and phone.

Telephone: When we are just using the phone, we have unfortunately lost all non-verbal empathic communication strategies. For this reason, phone visits tend to be much more challenging for our patients and for us. For successful screening over the phone, we can double down on our verbal empathic communication strategies to make up for losing our non-verbal tools.

Reflective listening, for example, becomes much more important, as we lose the ability to nod and use eye contact as ways to convey deep listening. It is one of the empathic communication skills that takes the most practice and skill to use effectively. If you've shied away from it before, telephone conversations are the time to dive in and practice. Ideally, we are reflecting through summarizing what the patient has said, repeating back their exact words, and using double sided reflections.

We can narrate our non-verbal empathy. Smiling is so incredibly important in conveying empathy, we don't want to lose that on the phone. We can tell the patient we are smiling by saying something like, "I'm happy to be talking to you today" or "I have a big smile on my face right now, hearing you say that". Likewise, it is important to narrate the other things we are doing or the pauses we are taking while we are on the phone, since patients can't see what we are doing. To increase the patient's comfort during these pauses we can say something like, "I'm just getting settled here in the room" or "Give me one moment. I'm just bringing your chart up on the computer".

Sometimes, however, we are just bound to hit road blocks when we only have the capacity to talk to people over the phone. When we hear the other person trail off, when they are answering open ended questions with one word answers, or when there are long silences, we may need to jump in and ask "I just wanted to check in and see how you were feeling" or "Are you okay Mrs. Gomez"?

Can you think of a statement or comment that can be interpreted or received vastly differently depending on voice tone?

Describe an experience you've had as patient walking into a medical office- either one where the staff made eye contact, smiled, and had warm voice tone, or one where these things were absent.

COMMON MISSTEPS

Rushing

One of the main temptations when administering screenings is to want to move on quickly to the next question when we have a patient who wants to talk a lot or when a patient is sharing information we have a hard time hearing (such as when they are sharing about a trauma history with strong emotional content). On the contrary, sometimes we also want to rush through screenings when a patient is not disclosing anything at all, because we ourselves find the exchange awkward. At other times, rushing can also come about simply because we are always so pressed for time! In any case, while administering screenings we just have to embrace the fact that sometimes we need to slow down. **Sometimes it is better to not get all of the screening done than to go too quickly and risk damaging the relationship with the patient.** We can share with the provider where we left off, and know we did the right thing by not rushing.

Phone Example: In the second half of this video (starting at 2:06) you will hear an audio example of a phone call between an MA and a patient who has already been waiting 45 minutes for their appointment. You will hear how the MA handles this situation by trying to rush through the screening. What key steps did she miss in administering the screening? What could she have done better?

Not Responding

Not responding to important comments from the patient tends to be interpreted as ignoring or, at least, not acknowledging what the patient has shared. This can be interpreted as a lack of caring, and even of judgment. **The good news is that there are many short, quick responses between questions that tend to convey care, while not adding more time.** Just "thank you" after an answer is often great. Reflecting back what the person has said is also a good standard practice to acknowledge we had heard the patient correctly. This can take a bit of practice before it feels natural, as most of us aren't used to reflecting! Once you build the habit, it will come easy. It is usually better to say more than "okay" or "uh huh", as this is sometimes interpreted as judgment, especially on the phone when patients can't see our faces.

Skipping or Modifying Wording

Especially when we are in a hurry, or when we have a patient who is confused by the screening questions, most of us are tempted to change the wording, or sometimes to skip questions. Because the screening tools are validated by research, **it is important refrain from making these modifications.** If we are in a hurry, remember, sometimes we just need to embrace the fact that we need to slow down. If the patient is confused by the screening or doesn't understand some of the words, it is best to stop the screening process, normalize the experience for the patient so they don't feel embarrassed or shamed and just let a medical or behavioral health provider know that you weren't able to complete the screening.

Meeting People with a Mask On Over Video-Telehealth

We are all born with "'mirror neurons". These are the neurons that allow us to naturally empathize with others. They are also why our emotions and body language naturally change when we see someone is crying. They are also we usually smile back when someone smiles at us. **With a mask covering over half of our faces, not only do we lose the ability to show goodwill through a smile, our human brains tend to unconsciously think of people with face coverings as a threat** (think about Wild West bandits with bandanas over their faces, or bank robbers with ski masks). For these reasons, we need to make a conscious effort to pull our mask down when we are first meeting someone on the video. It is ideal if we are alone in a room, to leave it down through the whole screening process. If we are not alone, it is important to let the patient know we wish we didn't have to have a mask on when we are talking to them, and explain the reason for keeping it on. When we are in person and masked, we can acknowledge the mask "I wish we could see each others' faces! I am smiling at you…"

Making Judgments or Evaluative Statements about a Patient's Answers

Evaluative statements are those that indicate an opinion (whether something is good or bad, enough or not enough, etc.). Evaluative statements are contrasted by descriptive statements, which just describe what something is. A descriptive statement about how much alcohol someone drank in one week is "9-10 alcohol drinks a week". An evaluative statement about someone's drinking would be "9-10 drinks a week is a lot". We want to **avoid offering evaluations or judgments** when patients provide answers to screenings. Instead, simply reflect back what the patient has said by using their exact words or saying something like "You've given me a lot of information here (summarize what they said). I really appreciate you sharing this with me (appreciation)."

Video Example: In this video demonstration (starting at 23:20) you will see an example of the provider making an evaluative statement to the patient's report on how much they are drinking. How did the patient respond when they heard the evaluative statement from the provider? The provider makes an effort to repair the damage of the evaluative statement. How did it go?

Forgetting to Thank the Patient and Share the Follow-up Plan

We cannot emphasize enough the importance of expressing appreciation and clarifying the follow-up plan for people. When a patient shares sensitive information, it can feel scary and vulnerable. It's helpful to think of the information shared as a precious gift—we are now responsible for delivering it safely to the health care provider. (And, be sure we do actually alert the provider to positive screeners!).

What are your concerns about conducting sensitive screenings?

What are your specific concerns about conducting sensitive screenings over the phone or video?

What are your biggest challenges?

What if the Questions Cause Someone Start Crying?

First, it's important to remember that crying is a way of discharging emotion (like a release valve), so **it isn't necessarily a bad thing.** How we feel when someone is crying is usually determined by whether we feel the crying is harmful for them (in which case we feel awful when others are crying) or whether we feel it might be a good thing (in which case we tend to feel more comfortable with people crying). That said, crying can be a sign that the person is becoming overwhelmed, so it can be a good time to pause, reflect, and check-in with the patient about whether or not they feel comfortable proceeding. Often just taking a deep breath and having a couple phrases in our pockets to say, for example, a normalizing phrase ("this is really hard") or an appreciation phrase ("I so appreciate you sharing this") or a reflection ("it sounds like childhood was pretty tough for you") can help settle the situation. We also can remember that we don't have to actively work to get people to stop crying - typically people are trying to stop themselves and will be able to self-regulate back down with a little empathetic presence from ourselves. Moreover, when we find ourselves trying to stop someone else from crying, it typically reflects our own discomfort, and can actually inadvertently invalidate a patient's normal reaction and feeling state.

Video & Audio Examples: In this video you will see two examples of how a MA responds to a patient who is crying when completing the screening. In the first example, what did the MA do well? How did the MA make the patient feel comfortable? Is there any way she could have improved? In the second example, how did the MA respond when it was clear that the patient was having a difficult time with answering the screening questions? Is there anything she could have done better?

What have you noticed about how you feel when a patient starts crying?

What if I Trigger a Traumatic Memory? Won't that Traumatize my Patient?

This is a common concern, especially with the increased use of the ACES screening. It is important to remember that the vast majority of people, when asked about their experience with ACES screenings, express gratitude ("no one ever cared to ask me this information before"; "I thought I'd go to my grave and no one would know what happened to me"). Also, the majority of people who have had troubled childhoods, have healed, repaired, moved on, and are thriving- like most of us, who also have ACES! Many people who endorse traumatic experiences, are not currently traumatized by it.

That said, adverse childhood experiences are called that for a reason- they are painful and often traumatic experiences. Remember that expressions of distress (crying, for example) are not harmful for people and, as described above, can be a way of discharging painful emotions. If we follow the steps above (setting expectations, asking permission, and respecting autonomy), we are actually empowering the patient to answer questions when and how they feel ready.

What if They Start Talking and Won't Stop?

This is one of the most common difficulties! We all have stories of patients that kept us in an exam room, or on the phone, for what seemed like forever. It can be useful to remember that the overwhelming majority of people, if left uninterrupted, do not talk for more than 2 minutes at a time (there is good research on this!). We are usually in such a hurry in medical settings that even a patient talking for a full minute can seem like eternity. Once we've taken a breath and let someone talk for a bit and we can see that they are indeed talking for so long that we will have trouble completing the screen in a timely way, **we actually may need to interrupt.** There are a few ways of doing this delicately so that it lowers the chances we will wound the other persons feelings.

- ☑ **We can use humor.** This works especially well if we know the person. We can interject and lightly tease them about needing to move them along. "Okay, let me jump in just for a sec, you know I want to talk to you more, I always do! I've got to move us along a bit though, you know us, and we are always hopping along!'
- ☑ **We can use their name.** We all tend to respond well to our name "Glenda, I'm just going to jump in here, it sounds like you are having sleeping problems, I just want to make sure I have the answer write. I it 'almost every day?' some of the days?'…."etc.
- ☑ **We can remind the person we are just taking notes** for a longer discussion they will have with their provider. "Thank you so much for sharing all this information. I'm actually not able to jot down all of your answers on this short screening, they are really important and I think these would be great things to mention to your provider when you meet with them in a few minutes."

Video Examples: In this video you will see two examples of how the staff member politely re-directs the patient to the screening at hand. What techniques did the staff member use in each example? In one video she doesn't know the patient, and in the other, she clearly does. What are the differences between the strategies used?

What were you taught or shown about interrupting when you were a child? How do you normally handle people who are having difficulty stopping talking?

What have you found is useful in interacting with people who have trouble stopping talking?

What Do I do if Someone Discloses That They are Suicidal or are Experiencing Intimate Partner Violence?

First, remember that by getting a disclosure like this it means you have effectively created a safe space for a patient to share crucial and potentially life-saving information! Give yourself a huge pat on the back for creating an empathic

connection with this person! While a positive answer to a question about suicidal thoughts is definitely serious, it can also be helpful to remember that many people think about suicide or wanting to die, and it isn't an emergency. Of course it is serious and of course we need to ask more, and get them connected to help, however it doesn't always mean an emergency hospitalization is in order. In fact, if we indicate to patients that we are scared and that we feel it is an immediate emergency, it may scare them off from being willing to talk about it more. Remember that all disclosures about suicidal thoughts are voluntary- people do not have to share this, they choose to. Sometimes it might help to know too that we can't create suicidal thoughts by asking about them and we don't make suicidal thoughts worse by asking about them.

It is critical that your clinic creates protocols for how to manage these types of disclosures and for all high-risk scenarios. Before you deliver a screener, you can make sure you are very clear on your clinic's protocols for scenarios where safety concerns come up, especially if they are over the phone or video telehealth (for example, ensuring that you know the patient's location, ensuring you keep the patient on the line if they are actively suicidal, who to call to consult with if necessary, et). The same is true for disclosures of intimate partner violence and child abuse- clear protocols for what to do if high risk or reportable information is disclosed during a screening is a necessary pre-step to embarking on screening in the context of telehealth and in-clinic practice.

Video Examples: In the first half of this video you will see an example of a staff member who expresses some discomfort and makes a few mistakes when engaging with a patient who reports they are suicidal. Take note of what she could have done better. In the second half of the video, you will see how the staff member improved. What did this staff member do well when responding to the patient?

I'm Already Pressed for Time...All of These Skills Will Take Too Much Time.

This is one of the most common concerns of all staff and providers. While it is absolutely accurate that using these skills will take longer than buzzing through each question rapidly, the skills themselves do not take substantial time. It

cannot be stressed enough, that all screening questions are useless if the patient does not feel comfortable to answer honestly, so, in a way, it is our professional obligation to administer the screenings well – which involves using these skills to increase the likelihood of honest self-disclosures. **If we race through screeners with our masks on and a monotone, we may as well not have done it at all.** Having enough time to utilize effective communication strategies is not only staff's problem to solve, it is a larger organizational issue as well.

What if They Get Angry About the Questions?

It is always difficult to manage when a patient gets angry while we are trying to conduct a screening. Most of the time, we are "inheriting" someone's anger from something that happened to them at our organization before the appointment – such as if they had to wait over an hour to see their provider or were on hold with our clinic for a long time earlier that day, or they had refills that weren't filled…all things we don't have control over. Other times, the anger doesn't even have to do with their interactions with our organization at all. Sometimes people just come in irritable! And inevitably, sometimes the questions in the screeners themselves just rub people the wrong way. They may have rigid boundaries around how much they disclose about their personal lives or how they are feeling or they may just be particularly guarded about the specific things we are asking. There are three main pillars of effective interactions with others who are angry:

1) Diffuse as early as possible (don't ignore signs they are angry); 2) Apologize; and 3) Affirm autonomy.

Examples:

- ☑ **Sara:** "Hi I'm Sara, I'm Dr. H's MA."
- ☑ **Patient:** "I've been waiting for 45 minutes."
- ☑ **Sara:** "45 minutes! (reflection), I'm so sorry - we are so far behind today, I really apologize. (catch it early, apologize) Thank you for waiting (appreciation)."

- **Sara:** "When you were a child, did you ever go without food…."
- **Patient:** "What the hell sort of question is that?"
- **Sara:** "Oh my gosh, I know- these questions we are asking everyone now are so personal (normalizing). I'm sorry (apology), you do not have to answer any of these (affirming autonomy), would you like to stop? (permission/autonomy)."

Video Examples: In the first half of this video you will observe a staff member responding to angry patient over the phone. What did the staff member do well? How could the staff member have improved? In the second half of this video you will observe the staff member responding to a patient who is frustrated about her long wait and how this boils over into the screening process. Where did the staff member fall short? How could the staff member have improved in this scenario?

We are starting to screen for ACES- what is the difference between a de-identified screener and identified screener?

With the widespread implementation of ACES screening, clinics can decide whether to use the "identified" screener and "de-identified" screener. Using an identified version of the screener means that you will ask for a yes/no after each screening question in order to understand which ACES may have occurred in the patient's childhood, in addition to totaling the patient's score. Theoretically, this is so that the provider can provide specific support/intervention depending on the answers to the questions. **A "de-identified" screener asks the same questions, but instead of trying to identify which questions are true for a patient, only the total number of adverse childhood experiences is tallied, rather than distinguishing which answers were positive.** The reason for using a de-identified screener is based on the premise that the negative health effects of ACES are based on the cumulative number of adverse experiences someone experiences in childhood, rather than the specific types of events. Either way, the purpose of this screening is to enable medical providers to follow-up with a deeper conversation about ACES, toxic stress, and resilience, and elicit any

further information necessary for intervention and support. More information on ACES can be found **here**.

Implementing the de-identified screener over the phone can be confusing to patients, so explaining how to tally the total score, and that patients do not need to disclose their specific answers to you is critical. If you are administering the de-identified screener to a patient under the age of 18 and they do provide a verbal "yes" response (or in some other way confirm an incident of abuse or neglect), be sure to follow all the policies and procedures of your organization in regards to making a mandated report.

Video Examples: Take a look at the examples in this video. In the first example video, you will see how the staff member explains the "de-identified" screening to the parent of a patient, who is scoring the items for her son. What did the staff member do well? How could they have potentially improved? In the second video, the staff member shows what it looks like to administer an "identified" screening. How does this impact the screening process? What did the staff member do well? How could they have improved? Lastly, starting at about the 10:00 mark, you will see one last example of how a staff member attempts to explain a "de-identified" screening. What could they have done better in this scenario?

What if the patient is low literacy, or for linguistic or cultural reasons, doesn't understand the questions?

The screeners were designed to be conducted using the exact wording written (see 'modifying the wording' above). **If the person doesn't understand, it is best to stop the screener** (rather than continuing and getting incorrect responses) and tell the provider. Most people who have low literacy feel some embarrassment or even shame about this, so normalizing is an important way to communicate empathy in this moment.

Example phrases:

- *"[patient doesn't understand what is being asked]. No problem, these screenings can sometimes use language and words that are odd or difficult to understand. I'll go ahead and note in the system that we briefly touched on some of these questions and your provider can have a more in depth conversation with you when you all meet together."*

TAKING CARE OF OURSELVES

Practicing Cognitive vs. Affective Empathy

Sometimes we might feel like we have "too much" empathy. This often manifests in us feeling drained or even taking on the pain that others experience. This type of empathy is often referred to as "affective empathy". **This type of empathy is distressing- it actually lights up the part of our brain the feels pain.** "Affective" refers to feelings, so this type of empathy means that we actually feel what the other person feels (feeling hopeless when they feel hopeless or feeling abandoned when they feel abandoned). This can be a sign of "vicarious trauma" (or becoming or feeling traumatized by our patient's painful stories) and often leads to burn out. Or, on the other hand, in an effort to combat the intense affective empathy we are feeling, we might resolve to "hardening up" to protect ourselves from further pain. This can impact our ability to respond effectively to others when they need an empathetic presence.

"Cognitive empathy" is something a bit different. "Cognitive'" refers to our thinking, so it means that we take the perspective of the other person in an effort to understand where they are coming from and how they might be feeling, but we don't necessarily "feel it" ourselves. Practicing cognitive empathy, where we listen deeply, step in to the world of the other and imagine how they feel, without actually feeling the exact same feeling, helps us feel connected to the other person, but not overwhelmed or drained. This type of empathy is actually related to job satisfaction rather than burnout. All of this doesn't mean we are working to not feel empathy when we hear about something difficult, it just

means that we are working towards not experiencing intense distress when we hear about something that is challenging. To practice cognitive empathy we can do the following:

- ☑ **We can get help for our "hot spots" that trigger our affective empathy.** For example, if I feel affective empathy every time I hear about an abused child, it might mean I could benefit from therapy or doing my own healing work on my own childhood abuse.
- ☑ **We can practice "Name it to tame it"**, which is a classic therapy phrase that refers to the power of naming what we are feeling. It involves naming how we are feeling and trying to identify why once we realize we are feeling distressed. So, in practice it might look something like this: "Ah, I'm feeling trapped and hopeless. This probably means Mrs. Gomez said she was feeling this way when I was talking to her earlier". Just simply naming how we feel tends to give perspective and give us a little space around the emotion, which shifts us back towards cognitive empathy.

When do you most often feel affective empathy? Some examples are: when men are crying, when my kids are emotionally hurt, or when people seem overwhelmed.

How do you normally soothe yourself when you are distressed? List as many things as you can think of.

Our own ACEs or Behavioral Health Symptoms

It is important to acknowledge that the vast majority of us have lived experience with mental health conditions, substance use disorders, and adverse childhood experiences (either having experienced one or more of these ourselves or within our families). Thus, asking these questions or hearing or seeing a patient's response can potentially "trigger" our own reactions. It is important to check in

with ourselves frequently and, if needed, seek out our own professional support through Employment Assistance Programs or personal therapy when we realize we have our own experiences to process or behavioral health symptoms to address. If we are in this field, it is probably because we are natural caregivers. Remember, we don't always have to care exclusively for others; we can prioritize caring for ourselves too.

Practical Strategies to Take Care of Ourselves

"Self care" is easier said than done. In general, self care strategies are only helpful if they are practical, we actually use them, and if we are encouraged to do so. We have all heard about how important it is to practice self-care in our personal lives, such as treating ourselves to a day of relaxation, engaging in regular exercise routines, and leaving time each day for our families, friends, hobbies, or spiritual practices.

Due to the nature of working in the health care setting, we are also bound to encounter times when we need to take a self-care moment at work to re-center ourselves due to being overwhelmed by the high levels of stress or the acute needs of patients. For this reason, we need to not only have a few practical, easy-to-use, self-care strategies at our disposal (such as deep breathing, taking a quick walk to the corner coffee shop, or texting quickly with our friends or family) but we also need support from our co-workers, supervisors, and workplace to engage in self-care when needed.

Everyone is different in terms of what is helpful to them in times of stress or distress. Continuing to listen to ourselves, mentally, emotionally and physically (our bodies actually tend to be the first messengers to let us know how we are feeling and what we need), is the first place to start. **At work, one helpful strategy is to have at least one identified person who we trust that we can go to in order to de-brief after difficult interactions and help us stay accountable on our self-care "time-outs".** Beyond that, each individual will have to identify their specific self-care strategies that bring them back to "center".

With that said, this companion guide is continuously evolving. We would love any and all feedback and suggestions you have in regards to self care strategies.

Please send us ways that you take care of yourselves, practice self-compassion, regenerate, rest and repair, at work and at home. We'd love to include an exhaustive list in version two of this guide!

Video Example: In this video, you will see a positive example of two co-workers utilizing their "self-care buddy". What positive ways did they utilize each other to promote self-care? What is one thing you can do at work sometime this week to practice your own self-care or support your co-workers' self care?

Concluding Thoughts

We hope that this workbook has been helpful to you in learning how to approach sensitive screenings, especially in this time of telehealth. The work that you do is very important and interacting with people around these topics and themes is not easy. We wish you all well in this work. Please do not hesitate to reach out to Elizabeth at EM Consulting (**www.emorrisonconsulting.com**) with any questions or feedback you may have. Please also take a look at our websites **www.emorrisonconsulting.com/resources/** for a host of other tools and information that can help you in this work.

APPENDIX: LINKS TO VIDEOS

Sensitive Screening by Telephone, Video

Audit, Video, Patient is Confused

PHQ-9, Video, Long Talking Patient

Audit screening, Telephone, Mad Patient

ACES Screening, Video and Telehealth, Patient Crying

Suicidal Question, Video, Patient Answers "Yes"

Full PEARLS + Resilience, Video

PEARLS Resilience De-identified, positive and negative

Self Care Buddy Moment, Co-workers