Matt Brandenburg

All right, today we are joined by Sam Troia and Michael Tamboni. Sam, Michael, thank you both for being on the show and sharing some of your knowledge and expertise with us today.

Sam

Absolutely.

Michael Tambone

thank you for having us

Sam

Yeah. Thank you so much, Matt.

Matt Brandenburg

Of course, it's it's my pleasure um that you two are an occupational therapists specializing in psychiatric neuro rehabilitation for people with severe mental illness. um This is a really interesting field of practice, an area of practice. I want to start this interview by asking what motivated you both to focus your scholarship and your practice on mental health.

Sam

So for me, it's very personal. In college, my wife was diagnosed with bipolar two disorder. And I found that her recovery process, her navigation of the mental health field was incredibly difficult.

So I actually, when I went to OT school, I want to do everything in my power to not be in mental health. I did a mental health field work and then wanted to do everything in physical rehabilitation, neuro rehabilitation, and that's where I put all my attention and energy. But I just found myself coming back to this population that has just such a dire need. And I saw how hard my wife struggled. I saw how hard my friends struggled and other family members struggled. And I really wanted to make it a little less difficult for this population, these individuals, and have a stronger recovery plan for them. uh, in college, oddly enough, my wife and I started a, we brought a mental health advocacy group to campus for students and active minds chapter. And then once we finished that up, we, once we graduated, we actually handed it off to Michael. So Michael and I have been doing this work together for quite some time now.

Michael Tambone

Yeah. Thank you for sharing, Sam. A little bit about kind of my background as well. My family also has a long history of mental illness with addiction, debilitation, um and there weren't really many systems in place. So I've been really wanting to um to study psychology. I majored in that in undergrad, um helped with that chapter of active minds with Sam and Katie, which was incredible, and seeing the advocacy and seeing that other people really want to know more. um But again, continue that psychology background through my OT school experience and then my doctoral capstone project was on screening people for mental health issues with coming in for phys rehab. So um kind of identifying those factors and people that are able to talk about it as much because they come in for exercise or for hand therapy. And I was able to do that in Kansas City with a really great clinic and they were very welcoming and kind of let me do my thing and meet everyone there. so

Matt Brandenburg

That's amazing. You both are such wonderful examples of identifying a gap um in your personal lives or in your, you know, education and in your career and then taking steps to fill that gap, to advocate for increased access, accessibility to services and ah developing programs that can ah help people ah with mental health disorders. um What would you say is kind of occupational therapy's role in mental health and and specifically in psychiatric neuro rehabilitation?

Sam

Yeah. So our job as OTs in this field is really to take a look at everything that a client needs to do in a day, everything that a client wants to do in a day and figure out what are the cognitive, emotional, physical, environmental, and emotional elements, preventing them from being able to address those ADLs and IADLs. We take a biopsychosocial approach where will start really from the ground up and say, all right, how are you caring for your body? What does your sleep, hygiene, movement, nutrition, hydration, access to sunlight, socialization, stress tolerance, and overall health look like? We start there, and then as the psychiatrists are helping an individuals get stabilized, we're stepping in to say, okay, but are you sleeping? and Are you eating appropriately? Do you have friends? And we're providing that holistic approach that often gets missed where individuals are provided medications but not taught the skills needed to go out and live. Once someone is stabilized, there are often times cognitive impairments that are underlying, underlining, making everyday activities significantly more difficult. So we can apply this neurorehabilitation approach to facilitate cognitive remediation or cognitive compensation along with habit formation to get people in a place where Oh, now they're taking a morning walk.

Their sleep is more regular. They're accessing and individuals in the community. um They're able to manage their stress. So that's really what we found as our primary role in this field is starting with the body, how they're caring for themselves, how are they accessing the community and engaging in social activities.

And then we take a meta-cognitive approach to see how are you How do you see yourself? How do you establish your own goals? How do you reflect and grow?

Matt Brandenburg

I love that. Thank you so much. and i you know That's one of the reasons I love occupational therapy so much is even in this ah very specialized practice area of psychiatric neuro rehabilitation, the approach is very much holistic and very much emphasizes um you know the carryover, as you said, of of healthy habits to to improve overall health and and overall outcomes.

um I love that focus of of both your um approaches. Why do you feel it's important for OT professionals to study and apply evidence related to mental health approaches and interventions when they're working with ah clients who have mental health disorders?

Michael Tambone

So this might sound like a basic answer at first, but I believe it's just important to find the best evidence for what works. um The area is growing, so it's important to know best practice in order to get the best results, and it's important to know what research is out there in order to change our approach. SAM and I are no um We don't like doing the same thing twice always. and We really like to trial new things that may work better for individuals. And as occupational therapists, again, you're gonna hear the word holistic a lot, but our scope encompasses a really holistic ah approach, so it encompasses more than we realize. So new literature is coming out consistently. We've seen that on the state level through in the Nebraska OT Association and the national level at IOTA.

It can be easiest to stick to what we know to get somewhat consistent results, but applying evidence-based practice, traveling different approaches, it can lead to better outcomes, and we've seen that. And that ultimately leads to a better quality of life for our patients. um And this is a very, this population um is very critical. There are a lot of things that could be happening, a lot of social determinants that um may just be caused by systemic problems. And we're really trialing new things to see where we can grow in order to get the best results for our clients.

Matt Brandenburg

I love that. I love that, Michael, where your approach is holistic and you're trialing um the best interventions to help individual clients, but at the same time, addressing some of those systemic um issues that that make it difficult to access care or to receive quality care or um you know the appropriate follow-up to care. um and I love how you mentioned that you and Sam don't like doing the same thing over and over. and You know, it it makes sense to me that that you work to develop um your own program ah to kind of fill a gap in the continuum of care um for psychiatric rehabilitation in Omaha.

Can you introduce us to this program, how you two really collaborated to start this project and and kind of what's been going on over the past couple of years with it?

Sam

Yeah. So in May of 2022, I became full time at last and hope recovery center working in our inpatient psych facility. But before that, I was working at the level one trauma center on our ICU and ortho and orthopedic floor. And we would get these evaluations and we'd go in and we'd say at the psych facility, we'd say, yeah, the individual can put their pants on so we can sign off. Yeah. The individual can get up and walk. So we would sign off.

And I identified, yeah, but that doesn't mean they can function. So I asked my supervisor if I could go two days a week just to build a caseload and see if there was a need. And what I found is that the need was significant. So I began doing functional cognitive assessments. I began doing um more ADL assessments. And what we're seeing is that along with the cognitive and psychiatric, there were a lot of physical needs in the psychiatric population that were not being met. So in May, my supervisor agreed to let me come on full time. And I kind of called Michael relatively quickly after that. And I said, buckle up, buddy. I'm going to need some help. So there are 62 beds in this facility. When Michael came on, we started providing interventions two times a week, seeing about 20 to 30 patients on our caseload.

And now we're up to three OTs. The issue that, so that we can see as many people as we can and then acute crisis stabilization. The issue we're running into is that you know Michael and I identified we can't provide the change we want to see in three to seven days. That's just not sustainable. It's like having someone having a stroke, them coming in, getting stabilized. The OT does their assessment and we tell them to go home and get better. So that's when Michael and I decided to build the outpatient program, which I'll let him lead.

Michael Tambone

Yeah, so I want to circle back really quickly to that phone call. I remember where I was. um Sam and I have kept in contact. um And we're just really excited to kind of to do this work. So I appreciate you um bringing me on. um We were able to kind of grow caseload and run groups there as well. But as Sam was saying, we saw a need um to reduce hospitalizations to um to better serve our clients throughout the continuum of care. So the outpatient program was developed um where we see patients on a weekly basis, usually three to four months and we tried to do. Where again, we start with kind of a motivational interview to determine where their needs lie. We come up with the goals together, and those can be physical, social, um even financial goals. We can work on budgeting. We can work on a whole lot of things. um But it allowed us a time to see patients weekly outside of the hospital setting to develop a more consistent routine um to help those with severe and persistent mental illness in order to break that cycle of rehospitalization and better support the well-being of clients outside of the hospital setting. so We saw a lot of rehospitalizations of patients that, again, had a lot of those systemic issues or maybe didn't know what to do when they had a time of crisis. so The hospital was the easy answer. So we try to come up with ways um around that. Whereas if they need hospitalization, please come in. We say that every time um to make sure that they're cared for.

But we want to work on the holistic approach. So we start with motivational interviews, some assessments to COPM in order to assess what goals will be most beneficial.

We don't want to make goals that someone doesn't want to do. That doesn't sound like a great time for anybody. So we really want to um work with them to see where they want to grow and if they're willing to grow with us. um So after that initial interview, we work on habits, routines, ah functional cognition, if they need that as well. um Say someone has a problem with the memory and attention. Maybe they forget to take their meds. So we work on medication management while building that into a routine. um We focus on the body quite a bit as well. That could be exercise, self-care, hygiene, sleep. And then we go toward those higher level things like writing goals for yourself. So when you leave this program, how are you going to um assess and figure out what your next steps are without us here. we can't I wish we could do it forever, but we really want them to, quote unquote, graduate from this program in order to have a better understanding. and We can work on social skills training.

We do that quite a bit as well. Sensory integration. I don't know. We do a lot of things very specific to the clients themselves, and I really like that individualized approach. We're not doing the same thing with clients every day. um There may be themes, but Again, where their needs lie, we try to figure out how to best support them outside of the hospital. um And we really like seeing them outside of the hospital because we can work on life skills that involve their daily day-to-day routines. So yeah, it's been really, really wonderful to get to to get to grow this. We've been very lucky, very fortunate.

Sam

And the exciting part is that it's working. When I first came on in May of 2022, the average length of stay for an individual on OT caseload was astronomical. It was 30 days. 30 days because no one was getting them up, their replacement issues. They needed an OT referral to get them to a skilled nursing facility. But now that we have a strong presence at Lasting Hope, the average length of stay for people on OT caseload is eight eight days. So we're able to get people up through a mix of motivational interviewing and motivational interviewing, sensory integration, all those things that Michael was talking about. And we're able to be a constant presence to help motivate them in their recovery. And like Michael was saying, once we get them out of the hospital, we're building the infrastructure to keep them out, to keep them engaged in the community.

Michael Tambone

Yeah, and I want to add some more as well. With this program, we've been very lucky with the psychiatrists we have that trust in us and trust in the process. so they With the presence we have at inpatient, hum they call on us to help with specific individuals. And then they also know who to reach out to us to add on to our outpatient list. And we've also talked with different hospitals in the system, um different mental health practitioners to see if their clients will benefit. Because we like to do it in tandem with therapy. um where what they're working on is different than what we're working on, we like to do the functional aspect of it. And hopefully that combination, it it works. It does work. We see it at work. So it's been really, really wonderful.

Matt BRandenburg

ah that That is wonderful and I love the aspect of ah collaboration of with other professions and within that that health system. um That reduction in length of stay is amazing. That number really jumps out. That reduction from 30 days all the way down to eight. um You mentioned that um enhancing habits and routines is is pretty um Key in your approach to care, um what kind of are the evidence based strategies for habit formation and development that you're implementing and and seeing such success when working with clients?

Sam

So we took the work of James Clear and his great book, Atomic Habits, and we turned that into a turn that into an and intervention slash evaluation protocol of sorts. So our goal is to bring awareness to healthy habits, unhealthy habits, neutral habits, bring awareness to how these habits are coming to be,

And then we help them identify the strategies to change those habits, whether they want to make them, whether they want to break them. Then we reflect reflect on, is this working? Is this not working? And then we change again. James Clear has this line about making yourself, helping yourself get 1% better each day. So we provide these small incremental changes, the 1% each day, to really help people see the potential of compounding change, compounding interest.

And what starts as each day I come in with blankets and towels to get you to wash your face at the edge of the bed ends with a shower and an exercise with me out in our courtyard. But it doesn't start that first day. So I'd say the strongest evidence we use starts with James Clear and has brilliant work. and really touches on all of the cognitive remediation principles and neuro rehab principles required of mass practice, errorless learning. With the habit cycle, which I'm sure we'll get into in a bit, there are these four elements that we go over with and and and with an individual addressing what is the cue that sparks the desire for an activity or a habit. What is the craving associated with it. So the cue leads to a craving. That craving leads to a response. That response leads to a reward or some reinforcement. And then we cycle through that and identify, okay, so where did this cue come from? Was it a random thought that popped into your head? Was there something in your environment that you saw for the first time? And then you begin to make those changes that you want to see. And we'll get into more of that I'm sure later.

Matt Brandenburg

and Absolutely. To follow up with that, um would you say, you know, this habit cycle of of cues, craving responses and rewards in in your approach? Are you more identifying kind of maladaptive habits and and helping patients to, you know, kind of change or or decrease um the, you know, the follow through of this habit cycle or are you more helping them to develop new healthy and and sustainable habits that are going to improve their overall health in the long run.

Sam

Yeah, not to not to sound too OT here, but it really depends. I would say we really, we really do both.

We try to walk and shoot down at the same time where when we come with the belief that everything we do, everything we think and everything we say is based out of a habit, we can begin to identify like, oh, the machine is running without our knowledge.

So if we can slow everything down and say, all right, like my individuals who are battling the substance use. I had one gentleman who he relapsed and came back to our hospital. He said, I don't know what happened, Sam. I made it three months sober. And I just went to the gas station to get a bottle of water. And I walked out with a bottle of vodka. I don't understand what happened. And when I brought it to his awareness, like, well, what was behind the counter? I said, oh, all the vodka was there. He was queued immediately. And we bring their awareness to all of the cues in their environment between unhealthy snacks at the front of a grocery store, right? The the checkout line. um The way grocery stores even lined up so that the most unhealthy things are within eye level because it's the most cost effective.

And then the things that are healthiest for you kind of brush to the sides. So when you identify where these cues are coming from, you can begin to make the changes and manipulate the cues in your favor to the best of your ability. Or if a thought pops in their head, a negative self thought, it's like, okay, that is just a random cue. And then we begin to dive into, okay, so what are you craving? Do you want more of this feeling? Do you want to avoid a feeling?

And then where we thrive as occupational therapists is, okay, so how do we respond to that? What's your response to a negative self thought? And then we identify, so what's being reinforced? What's the reward associated with the activity that you just did? Because the next time you go to a gas station, the cycle is going to run. The next time you walk into a grocery store, the cycle is going to run. So we'll use these tools to place your shoes in an obvious place. your workout shoes an obvious place. Pack your exercise bag in a space that you see it all the time. And then we build that, we make it very obvious the healthy habits that they want to create. And then we hide the habits that they want to break. And then we continue on this song and dance until all the healthy habits that they hope to achieve are moving like a machine, and then we create more friction between they have they have the maladaptive habits that they hope to break.

Michael Tambone

Yeah, and I want to add onto that as well. um In terms of outpatient sessions, one session starts with habit formation and ah reduction with unhealthy habits, but it starts with the patient identifying their day-to-day routine. It starts with the question, how do you spend your day? What does an average day look like to you? um And then we work through that. So we talk about the healthy and the not as healthy habits. um and As Sam was mentioning, we work to increase the number of cues for the good ones and reduce the number of cues for the bad ones. um For example, I had a patient who was working at nine to five and doing fairly well, except on the way home, um this patient would see a gas station and that gas station would queue this person to pick up drinks. So we found a new route home. um Just something as simple as that while not taking away from their meaningful occupations on of work and then hopefully adding some more meaningful occupations to almost um fill up time and um reduce the more harmful negative habits that they were experiencing.

Matt Brandenburg

I love that. Those are are such powerful examples, you know, i did did it brings to mind that phrase, a journey of 1000 miles starts with just one step. and And I can really tell that building awareness of these, you know, hundreds, maybe thousands of cues that occur just in daily life can be really empowering to someone ah to begin to um be more aware of them, to recognize them.

And then, ah you know, change their behavior, change you know their their environment to to ah avoid those cues or to add new cues. It sounds like a very empowering approach to care. um How do you use ah technology to kind of support the implementation of of this type of approach and to improve overall occupational performance and health outcomes in your program?

Michael Tambone

you I'm just going to add on. There's a lot to this. It's great. um In terms of technology, the cell phone is a very powerful tool. um We can use it for a variety of things. We mainly use it for the habit formation aspect. And we use an app that we like to utilize that helps cue for those habits, as well as track those habits, which kind of builds builds in a reward in itself. um But we can use the phone in a variety of ways too. We can use alarms for medication management. We can name the alarms after the medication. It's just using what you have in front of you and something that's pretty much always on us in order to give better access to a queue. um So, for instance, if Someone has trouble remembering to brush their teeth. We like to say, put a cue somewhere you'll see in the morning. So maybe they'll go to the bathroom, they see a sticky note on the mirror. That's wonderful, and it works for a lot of people. um But someone that may not have that quick and easy way of knowing exactly what they're going to do in the morning, the cell phone's usually there. um And again, it can be that alarm, it can be that reminder, and kind of build that into a routine so they don't have to use and rely on the technology as much as they do later on down the line.

Sam

So there are, Michael, great, great points. I think there are four, from James Clear's work, there are four strong laws to help make a habit.

And technology is very helpful and can be harmful in making this possible. So the four laws are, one, make it obvious, two, make it easy, three, make it satisfying, and four, make it attractive.

When we get these cues from our phones, from an alert from X or Twitter, we get an alert from Facebook, it's an obvious, hey, there's something for you to see. And it becomes easy for us to look at. And it's satisfying because it's built for us. And it's attractive because it's a reflection of the things that we want to see, whether we know it or not, based off the algorithm. And at times, we can identify, oh, this is a problem. I'm spending way too much time here. It's too obvious. It's too easy. It's too satisfying. It's too attractive.

So to break the habit, we flip it. So we make activities, make the habit we want to break hidden, difficult, unsatisfying and unattractive. So with technology, as we're using it, we make sure we are over utilizing alarms, like Michael was saying, to make sure that there's no cognitive component stopping them, help preventing them from seeing a cue to take their medications. But then we're also reducing the number of cues that are being sent in. I'll often look at someone's phone during our habit session and outpatient and I'll say, okay, let's look at these notifications. Do we need all of these notifications from Amazon if you're spending 50% of your budget at Amazon. Let's reduce these queues so that you're not overstimulated and then perro provide a queue to be like, hey, I'm actually going to call my friend now. I'm going to use these timers to change my laundry so they don't go days in the wash.

I'm going to use the technology to my benefit while also being aware of what it can do to keep me stuck in my bed, spending hours on TikTok, hours on Instagram, things that we know are not helping, keeping people up at night, finding that balance of using technology as a tool, but not using it so much that it prevents them from living.

Matt Brandenburg

That's such a wonderful approach and it makes so much sense hearing you to describe it in that way. um I imagine it's it's difficult to to incorporate and difficult to learn, but it can be so impactful. um and and I love how you're harnessing ah the potential of smartphones and the potential of of technology. um As you mentioned, there can be you know, some some drawbacks and and some barriers that come with using technology. and But there are also so many benefits and it can be so helpful in in all those ways. um I want to transition now to to talk a little bit about the poster presentations that you've developed ah in conjunction with your team at Catholic Health Initiatives, so ah Lasting Hope Recovery Center and Creighton University, of course. um How did you develop partnerships with with these programs? um and And if you could, give some recommendations to how other practitioners could establish more community partnerships and and programs in their own work. um what What can you tell us about that?

Michael Tambone

So um we've been working with our bosses to allow us time to do some of that research and to build those presentations. But Creighton University is part of that system, part of the hospital we work with. So we've been really lucky with that. We both attended the university as well and have contacts there. um So we've worked with some people through Creighton University, some professors that want to do these poster presentations with us. And we worked very closely with them to keep that partnership alive and also build those things that we were able to present at the Nebraska OT Association Conference as well as the National AODA Conference.

Sam

Yeah, I think taking time to like really reflect and see what partnerships currently exist is a great place to start. If you have an idea, how do you invest your idea, your passions into what is currently existing? For us, it's kind of a weird umbrella where CHI and Lasting Hope are one unit and Creighton their medical center is through Bergen. So it's this beautiful kind of system where the stars were aligned for us.

But yeah, to Michael's point, we had to have the support of our supervisors, of our leadership to give us the freedom and the time to build this program, to take the time to write these posters and build these presentations. um But then it came down to putting yourself out there. Like Michael and I would just cold call people, set up meetings with Creighton, set up meetings with our supervisors, behavioral health supervisors to say, hey, what do you want this to look like? And how can we have a collective vision for occupational therapy's role in mental and behavioral health? And that advocacy is what sparked this degree of, all right, go for it, have at it. We'll give you two hours a week, an hour a week, and then some work on the back end where Michael and I are spent some time at home making this happen, but Just what needs to be done? So best advice I would give is to see what exists and then cold call people if they don't want the Program to be built. Well, and you lose nothing by putting yourself out there But if you put yourself out there, then there's a chance that you can have your voice heard

Matt Brandenburg

Absolutely. That's such great advice. And I love this example of you two, you know, developing an ineffective approach that is seeing good outcomes and then putting yourselves out there to to spread it and grow it and and have it turn into this wonderful program that's impacting, you know, people in in many different systems and and hopefully will continue to grow. um and I'd love to kind of go through the OT process. um while applying your program. um You mentioned that you know from day one, you're asking about what a typical day looks like. um You're incorporating principles of habit formation um and and the habit cycle. um What other kind of dimensions of wellness do you assess for um and how are you kind of implementing those to to analyze performance and and establish goals with your clients?

Michael Tambone

I know in terms of outpatient, initiating the process again starts with that motivational interview. um as well as getting buy-in from the patient, because if they don't see this is beneficial, why would they come back week after week? um So we have to, that's why the goals are established together. And again, through motivational interview and just general assessment. um Really quickly, I wanna go over just what the eight dimensions are, just cause they're also very important. um So we have physical, intellectual, environmental, emotional, financial, social, spiritual, and occupational. hum So we look at those when asking specific questions. It's really just a conversation um as well as using certain assessments like the COPM. And we identify those barriers gaps. We also identify strengths in order to determine a plan of care that will benefit the client and assist in progressing them toward those those goals we had um addressed together. And the goals have to be challenging but not too challenging to where they'll never reach it, but we want to make those short-term goals something feasible in order to get to those longer-term goals. um So I would say, Sam Chaim, if you would like, but I say we see mainly the physical, environmental, social, and spiritual dimensions affected by um severe and persistent mental illness, um as well as those social determinants that we had discussed a little bit at earlier. yeah And so we try to assess how it impacts their day, where they want to grow, where they're already doing well to where they can kind of add to those other dimensions. It's all a balance. um And along with those, evaluations we use. We also have a couple things that we like to use for the eight dimensions specifically where they can reflect on certain questions maybe to see maybe where they're lower in a dimension, maybe where they're really high in a dimension to where we can kind of figure out that balance.

Sam

Yeah, I say I can speak from an inpatient standpoint. We we thrive when we meet people where they're at. So if someone is in a psychotic state, in a manic state, in a depressive state, we're going to meet them there and then pull them back to kind of a baseline level. through the use of specific sensory integration principles, motivational interviewing, um functional activities, identifying yeah like Michael was talking about with the physical wellness element. I'll start a session with, okay, hey, I hear you're upset. Have you had a glass of water today? Have you eaten today? No, have you been outside in the last two weeks? No, okay, let's start there. we When people come in, they're given these green paper scrubs speak for safety reasons. They do a safety check, give them the scrubs and they get downstairs. And oftentimes our population is unhoused. So they'll be upset. They'll be yelling at me and I'll use some specific techniques to get them to build rapport. And then I'll ask them, do you need a shirt? Do you need a pair of pants? And then even if they're in a somewhat psychotic state, 90% of the time they'll ground and they'll get become grounded and look at me and go, Yeah, size 3230 and a large, that'd be great. I'm like, yeah, sure thing. Let me go to our donation center. We'll get you some clothes and we'll come right back. So when we address their physical wellness, that Maslow's hierarchy, we'll make sure that they're safe, they're fed, they have water. We can get them out of their survival state and help them transition into a more emotional state. And then eventually an executive state where we can actually get the work done. But we'll start with, How do we get you into this present moment and then begin building from there?

36:15.11

Michael Tambone

Yeah, and I really like that you said we meet them where they're at. I think that's one of the most important things. We're not going to go into a room of someone who is. crying, unable to unable to get out of their bed and say, hey, you got to do this right now. We're going to do some jumping jacks, right? We're not going to do anything of that sort. We'll meet them where they're at, where we interview them, see exactly who where they're at. And maybe we don't do too much in the session, but maybe we just leave them with a toothbrush and toothpaste in the bathroom. So we just have that little queue. And then we can kind of build that up as we meet them for future sessions. One thing we haven't talked about too much either is It's our groups. um We do a group a day each, at least, and we love doing that. And the groups can focus on any of those dimensions or all of them, where it can be a reflection piece, where it can be um making goals based on areas you feel like you want to grow into. So just want to throw that out there.

Matt Brandenburg

and i I love that you incorporate group approaches and individual approaches. um you know I think we hear a lot in in occupational therapy how important client-centered care is, how important holistic care is, and I just love this program you've developed because it takes Those very key and important principles of one-on-one treatment um but designed to program to facilitate their application um and kind of increase the scope and impact that occupational therapy can have on a system. and on you know ah a group of people receiving a type of of care. um You've mentioned social determinants of health when when providing care, ah specifically with your program. ah What steps or or actions do you take to really consider and address those social determinants of health within your program?

Michael Tambone

um it's a Really good question. um So through utilization of those eight dimensions, we as occupational therapists are able to identify and ah remediate many social determinants of health that prevent those individuals from reaching their full potential. um So we identify how their severe persistent mental illness affects each dimension, and we draw on our expertise as OTs in activity analysis, environmental modification, skill building, habit and routine formation, and health promotion, as well as advocacy to support participation in those meaningful occupations and hopefully aid in mental health recovery. So again, we're a holistic profession. Love that. um So those social determinants should be taken into consideration when evaluating and applying interventions.

Sam

And I think with that, there are certain things that we're looking at as OTs that are often getting missed. I had a gentleman just last week, he came from a different city to Omaha, and he had no idea what the city looked like. He's unhoused, he's battling a substance use disorder. So I showed him, hey, here's how to get around the city. Here's how the city works. Here's how the streets work. and providing the access to, okay, so here's where you can go where I know you can get food outside of the homeless shelter. Here's where you can go for free community-based events that aren't centered around substances. And like Michael's saying, providing that holistic approach, we take these social determinants And we begin to reduce their impact by saying, well, here are the resources that exist. Let's help coordinate. How do you access those resources? How do you use them? You know, an individual can't prepare a meal if they don't have food stamps. They can't get food. How are we supposed to expect them to buy anything? So showing them where to go, how to work the system, how to navigate an unhoused recovery plan. It's a challenge, but it starts with this 1% of, okay, how do I get to my doctor's appointment from the homeless shelter? How do I get a cell phone so that I can contact someone if I'm in in an emergency? When the Affordable Connectivity Program was running, we were able to provide over a hundred phones for individuals who are unhoused so that they could refill their medications, so that they could um get to their doctor's appointments, contact an AA group. and those social determinants were significantly reduced on their impact of recovery.

Michael Tambone

and I just want to reiterate what Sam was saying too. um We show the how a lot of the time. We can give someone a sheet of paper that has every address, every everything in the area they could use, um but we really work on the how. How to use the bus system, how to apply for the things that you need. um and so those That's what our interventions look like. It's not just giving them information. It's working through how to do these things, how to get to your appointments um in order to remain successful once you leave the hospital.

Sam

And isn't that the beauty of OT? I mean, I feel like we are the how of medicine, right? Like how are you going to take your medications? How are you going to get to disappointments? How are you going to live your life after your knee was replaced? Regardless of the diagnosis, it just feels so powerful to be that how in healthcare.

Matt Brandenburg

Absolutely. that's That's so well said. OT really is where the rubber meets the road. um And and it's it's wonderful to hear um about how you're addressing the how um through this program. And it sounds like it's really impactful, really empowering to the people you work with. Can you share with us maybe some case studies or or clinical examples of how you were able to guide a client through this OT process to achieve improved health and well-being outcomes?

Michael Tambone

Okay, I'll share one patient in particular. um Through the outpatient program, we're able to reduce hospitalizations dramatically. So this patient was coming in last year. maybe once every two to three weeks um because of a lot of deficits in those eight dimensions. So we focus on all of them. So this patient came for four months to outpatient um where we addressed how to manage medications, how to build that into a habit. um We worked on how to use the bus so this patient could reach community programming that's really beneficial and we know it's beneficial And then we worked on those social skills that are important as well, because a lot of times this person may not get along with someone they're living with. And so we would address those social factors and how to use your coping skills in order to remain regulated throughout the day. um And again, this person was coming in once every two to three weeks. But since last August, this patient has been back. maybe twice. um And it was for a much needed medication change. um So it wasn't for just anything, but it was really to reduce maybe auditory visual hallucinations because of some outside factors that we can't control. But just seeing that reduced stay and building that rapport with that patient, I would see that patient even in inpatient and see if there's anything we can work on. And this person was like, no, everything's going really well. I just needed This change is kind of an emergency at this point. So I came in, but once I get this change, I think I have everything going very well for me. And so it's really good to see that progress and to be able to, to know that what we're doing has some impact. ah Yeah. Sam, if you want to go.

Sam

Yeah, I think I um want to speak to a client that we truly met him where he was. He was battling alcohol use disorder and was in and out of the hospital. And I worked with him every time and every time he was not at the right stage of change, but it didn't change our approach. So we came in. Met him once his seawalls at an appropriate level and performed a cognitive evaluation and saw that he had some pretty significant cognitive impairments due to his substance use. And he said, I'm i'm just, I'm not ready. Or he'd say, I want to stop, but I don't know how. He was declining, declining, declining. And then through this constant positive presence that the entire lasting hope team provided for this man, We just kept welcoming him in, and welcoming welcoming him in, providing him hope and a roadmap for recovery when he was ready. ready He came in and he looked at me and he's like, Sam, I'm so sick and tired of being so sick and tired. And that's usually a big flag for me to like ramp it up. So I put in a lot of effort with habit formation, with identifying what is treatment going to look like? What are you going to need to be successful in treatment? making sure that, again, the body was taken care of, and this gentleman was a total 180 from previous days. He started going to groups, he started engaging out in the milieu, made it to treatment, and hasn't been back since. So I think that's one example of, it's not always the first time you go in there that it works, but especially in this population, I think the number is the average, individual battling substance abuse requires has about the average is about 17 relapses before it sticks. So being able to give people the grace to say this will come and this gentleman in particular, we looked at all of his social determinants and got him in a place where he was ready to recover and moved forward in a positive way. And yeah, like I said hasn't been back.

Matt Brandenburg

Wow, that that is a powerful example and you know both those examples that youve you shared um really illustrate how recovery is is a journey and and habit formation takes time and sometimes it can take you know, repeated failures before ah that that improvement occurs. um So thank you both for um sharing those examples. Were there were there any more studies or or personal experiences you've had that you wanted to share with our listeners?

Sam

I mean, I think there's there's there's quite a bit regarding our work with sensory and a ga or sensory integration with individuals with substance use disorders.

I think that's been another, or not substance use, excuse me, with psychosis related disorders. So we've had clients that will be actively responding to internal stimuli and we'll go in with a sensory integration approach and be able to get them into a more grounded reality of like, okay, let's stimulate your visual system. Let's stimulate your olfactory system. Let's push you proprioceptively. And as we're having them engaged in the sensory integration, I had one client in particular, she was lying on the floor of her room screaming, screaming, screaming, screaming. And Instead of running away, I felt it was important that I had a student at the time. And I was like, we need to be curious. We need to see what's going on. So we go in there. She's screaming at us. And we just started slow with, hey, here's just like a soft stuffed animal for you to rub. Just rub it. Bring your attention to here. And then we graded it up and it's like, okay, now we're going to add some lights. So we added some lights to her room. And all of a sudden she stopped yelling. She was quieter. She was more grounded. She's able to have a discussion about what the voices were telling her, how they were making her feel. And we were able to provide this positive self-talk, this positive support. And it got her to a stage where we got her to get up, take a shower, walk with us out in the milieu and engage. But it took 45 minutes and they don't always end like that. Um, and Michael, I'm sure you got more as well. I'll give you a second here right after, but I do want to say this is also strongly interdisciplinary. We are constantly in contact with our psychiatry team, with our counseling team, with our nursing team, with our social work team. So we're coming in and throwing out ideas, trying to see what'll work, hearing what they're learning, what medications they're changing. And that's what's leading to this success, as great as Michael and I are. There's no, we we would not be as successful as we are without the support of this team. So that's the other piece I'm gonna throw in there.

Michael Tambone

Yeah, I completely agree. We meet with them daily as well to discuss each patient and see what the best approach is, where they're discharging to, so we can work on our recommendation for discharge too. And they really have allowed us to be critical members of that team. So it's been really, really wonderful. We've been blessed. I don't know, we have a lot of stories. i One that comes to mind has happened a few times, so just a generalized one. but um Along with psychotic disorders, we use sensory integration with major depressive disorder as well. and We see a lot of patients come in. They're at their lowest. They don't want to leave the bed. So we go in, meet them where they're at. We're not going to just say, get up, you know? um So we work with them through that time, add some more sensory, like, hey, we've been talking a while. It was OK if we turn on the light. And maybe it's a yes. And we've seen a lot of successes with patients um getting out of bed and then starting to be more intentional about attending groups or staying out in the main area, meeting other patients. I know we see that quite a bit and and when we see that it's very, it brings joy to our hearts just to be able to show that maybe maybe we are making a difference.

Sam

Well, and I think there's a parallel to the work that, that I saw in inpatient rehab where, and acute care or sometimes it's, if you can get a patient out of bed, if you can get them from a dependent lift to a max assist transfer into a wheelchair, there's almost like a flip that switches in their brain where the momentum begins to churn and they say, Oh, I can do this. I can get out of bed. And. Having that be our job in inpatient psychiatric care, it's like, hey, we're going to be the people that make sure that people are able to get up out of bed on their own volition, utilizing all of these techniques, gets them more invested in their recovery process. And then just as in, you know, we get them out of bed in inpatient rehab and acute care, we got to have that continuum of care, which is why we built this so that the change can be long lasting and sustained.

Matt Brandenburg

Okay, this has been such valuable information ah for myself. I'm sure for our listeners. I want to ask what um recommendations would you give to other OT practitioners to help encourage the use of habits and wellness in their own interventions?

Michael Tambone

So I would encourage other practitioners in every setting to use this, um to use the use of building positive habits, as well as identification of what cues may lead to unhealthy habits in order to promote wellness and interventions. um So I worked at a skilled nursing facility for a while and loved the population. And I learned that I could use that there without even kind of realizing what those steps were. um But I would go in, work with the patient on exercises that would help them recover after a surgery. um But what I would notice is that some patients would come back after a while because um they hadn't been utilizing those exercises at home. So I'd come up with ways to make it easier to kind of build it into a healthy habit and routine, maybe using commercials during a favorite show to do some therapy exercises while also identifying maybe what factors lead to difficulty in um doing those health promotional things. um So again, I think, Knowing what these are and using them can be beneficial in every single area of practice across the continuing continuum of care.

Sam

Thank you. And on my end, I would say it'd be best to do the best of your ability within what you're limited with, productivity standards and patients that need to be met. Really work to slow down. Try to identify where these behaviors are coming from. Where are these, where are these behaviors that are not present? Why are they not coming? Right? Why are they not where we need them to be? What are the cues in your personal environment, that in your personal life, that are leading to things that aren't making you the greatest version of yourself. And if we don't work on ourselves as therapists, it's going to be really hard to show up and show out every day for our clients. So take a look at what your clients need, take a look at what you need, and then just begin to work with them as you build their recovery.

Matt Brandenburg

Those are great recommendations. Those are such good points. You mentioned earlier, um Sam, how OT is really about the “how” of healthcare. And really in order to provide that how, um practitioners need to understand the why. um and And so I think that's that's excellent advice. um What are some you know resources related to what we've discussed today that that you would recommend to listeners and practitioners who want to um you know improve their care?

Sam

So for functional cognitive remediation with individuals with severe and persistent mental illnesses, we really benefited from the work of Alice Medelia out of Columbia University. And she has a website called teachrecovery dot.com. And it's three free educational sessions, online modules. The other one that we've utilized for motivational interviewing, Chris Voss, Never Split the Difference has been very helpful. He's a crisis negotiator. And when I'm working with someone who is in an elevated state, I can use these tools to help identify, okay, what's the root cause of what's happening? And how can we work as a team to keep everyone safe? Like I mentioned earlier, James Clear's book, Atomic Habits, that one I highly recommend. I believe that's something that should be an OT curriculum. It's been so helpful and can transcend so many practice settings. um Matthew Walker on why we sleep. I think sleep is such a core tenant of a any really real recovery, but specifically in mental and behavioral health, there's not a psychiatric disorder that isn't impacted by sleep. That doesn't impact sleep. So when you understand why we sleep, how we sleep and how to make the changes, that's a great, great resource. And then the last one, Peggy Schwarbeck, who literally wrote the book on the eight dimensions of wellness and she's an OT. She's got some great work out there on the eight dimensions of wellness. So it's a quick place to start, but I hope that the listeners and anyone who needs more information can grow from this.

Matt Brandenburg

Absolutely. We've arrived now to our Golden Nugget segment, our concluding question of this interview. If you could share one piece of advice with practitioners, what would it be?

Michael Tambone

So mine's going to be twofold, so I can get two pieces of advice in there, but I think they they really go handin hand in hand. First, always keep learning. We're lifelong learners, and whether that's as practitioners or as people, striving to better ourselves will benefit all parties involved. And with that, in order to better ourselves, we have to take care of ourselves. So make sure you practice self-care because if your cup isn't full, how are you going to be able to fill others' cups?

Sam

And then my little piece is bet on yourself. So I believe that occupational therapy can make systemic global changes in healthcare. And it starts with these individualized holistic approaches. And while we're trying to tackle mental health, this can grow into pediatrics, addressing the teen crisis, the obesity crisis, the overall health and wellness crisis of the country and really of the world, OTs, we don't need someone to pull up a seat for us at the table. We should be speaking up for ourselves to get at this table. Because if each therapist bets on themselves believes on themselves, believes in themselves, then we can stand up and talk to anyone and say, here's what I'm worth. Here's what my value is. And then people will start needing us and seeing our value. And we can end the days of asking the question, do you don't know what OT is? and start the narrative of, hey, we need an OT. We need an OT for this. We need an OT for that. So I believe that all starts with betting on yourself. And if you're listening to this, my hope is that if you're driving to work or driving home from work or listening to it at home, that you see the impact you have in your practice day-to-day with your clients and your community and that you believe that you're worth betting on.

Matt Brandenburg

and Sam Troyer, Michael Tamboni, thank you for your work. Thank you for um and all the information you've shared with us today and ah thank you for your time in this interview. I really appreciate it.

Michael Tambone

Thank you so much for having us.

Sam

But thank you, Matt.