

**Observable Practice Activities  
Pediatric Psychology Post-doctoral Fellowship  
Marshfield Clinic**

Fellows will primarily consult to the following 3 units: Pediatrics, the Pediatric Intensive Care Unit (PICU), and the Neonatal Intensive Care Unit (NICU), in addition to other hospital units as requested. The fellow will also work with patients on the Pediatric Rehabilitation Inpatient Team (PRIT) when consulted. The following are expectations common to all units, with some particular items specific to the individual units listed below. It is expected that you will be exposed to a broad range of patient ages and presenting medical concerns. These will likely include patients consulted by endocrinology, hematology/oncology, respiratory diseases and disorders, surgery, orthopedics, neonatology, gastroenterology, nephrology, trauma, and cardiology. Also patients will present with pain (both acute and chronic), issues of death and dying, suspected child abuse, somatization, eating disorders (requiring medical intervention), and conversion disorders, as well as general emotional adjustment to chronic or acute illness or incapacitation.

**A. General Issues in the Pediatric Psychology Inpatient Consultation/Liason service:**

1. Review relevant references in the Reading List for the Ped Psych Postdoctoral Fellow
2. Review other appropriate references, and share with supervisors, colleagues, and medical staff as indicated.
3. Rely on peer-reviewed medical journals for self-medical education. If offering lay information to patients/family, limit information to objectively reputable sources, and read them yourself first to check for accuracy and responsible presentation.
4. Join professional societies (e.g., APA, Section 53 and 54)
5. Read peer reviewed professional journals in child/pediatric psychology and pediatric medicine
6. Respond to pages from the hospital units in a timely manner.
7. While recognizing that most inpatient consultations will not involve psychopathology, be familiar with DSM-5 nosology and criteria when applicable.
8. Facilitate the care and understanding between the health care team and the patient/family.
9. Educate the patient/family about optimal management of the presenting medical issue.
10. Educate the staff about the understanding, uncertainties, fears, and individual proclivities of the patient/family.
11. Learn to distinguish what information should be legally, ethically, and clinically entered into the medical chart, and what should not.
12. Accept feedback from your supervisor, medical or psychological colleagues in a non-defensive manner, but do not take all such input passively. Explain your

- thinking, and outline it to your supervisor in order to come to a consensus of understanding.
13. Understand that your involvement may make the essential difference in whether a patient feels understood, respected, and listened to, is medically adherent (in the hospital and once home), identifies the hospitalization as a personal growth experience, leaves with an enhanced sense of self efficacy, and is able to return home to his/her original (or even enhanced) developmental trajectory.

**B. Issues specific to working with medical patients in the hospital:**

1. Assess, ameliorate, or manage/minimize pre-existing or newer psychological limitations (cognitive, behavioral, emotional, or experiential) that interfere with medical understanding or adherence.
2. Coordinate optimal overall care of the hospitalized patient (and family) with the medical and affiliated care providers.
3. Educate the hospital staff members about relevant psychological principles and conditions, and how they may interact with medical understanding, behavioral adherence, and immediate/long term psychological and developmental adjustment.
4. Teach and promote strategies for relaxation, and the psychological management of pain and stress.

**C. Prior to meeting the patient:**

1. Receive consult request from supervisor, with active participation in determining whether it is consistent with the fellow's clinical ability, training interests, personal comfort, and time availability
2. Actively discuss relevant issues regarding the consult request, and needs of the referral agent before accepting the consult
3. Familiarize oneself with the relevant medical diagnosis, treatments, medications, and terminology
4. Review the CMR for relevant background to the presenting condition(s), including past behavioral health records.
5. Consult with previous behavioral health clinicians where appropriate.
6. Speak to the referring physician to clarify concerns and needs from the consult.
7. Review the medical chart, speak with appropriate members of the treatment team as available.

**D. Meeting the patient and/or family:**

1. Determine who (patient, parents, extended family, medical staff) is appropriate to sit in on the interview.
2. Clearly communicate that you are a Post-doctoral Fellow in Pediatric Psychology, working under the supervision of Dr. \_\_\_\_\_, the role of a pediatric

- psychologist generally, and your role in this instance (as you understand it at the outset).
3. Further clarify your role on the Pediatric Treatment team by focusing more on the immediate medical issues, and less on any accompanying prior psychological issues, at least initially.
  4. Recall that regardless of the patient's presenting medical issues, your chief task is to maintain and develop a relationship that conveys trust, respect, empathy, and a sincere willingness to be of practical assistance regarding their hospital stay and medical recovery.
  5. Conduct a thorough assessment of the psychological accompaniments to the medical evaluation, diagnosis, and treatment. Be mindful of the child and family's adjustment to the often confusing and frightening atmosphere of the hospital.
  6. As relevant, after an  
+**Introductory Paragraph** (that succinctly states the medical concern, age of child, current length of stay, and who was interviewed), obtain a  
+**Social History** (family structure, educational status, social relations, recreational interests),  
+brief review of **Medical Status** and hospital course,  
+**Psychiatric History** (dx's, treatments, medication, police contact, AODA, abuse, sexual activity),  
+**Patient/family Presentation** (intelligence, mental status, cooperation, relationships/interactions with others in the room),  
+**Psychological Issues** (acknowledged fears, resentments, prior medical experiences [direct or indirect]), related family issues or conflicts, misunderstandings with staff or with the current assessment/treatment course),  
+**Impressions** (answering the consultation question, case formulation, relevant contributing factors, and suggested interventions),  
+**Diagnosis** (per DSM-5), and  
+**Plan** (including estimated timing and frequency of your follow-up).
  7. Conduct your interview with respect for diversity of individual, developmental, racial, ethnic, cultural, religious, and familial differences, remaining always mindful of the child's developmental understanding.
  8. Conclude your interview with a sincere respect for the challenge to the child and family for tolerating this medical experience, for being willing to share it with you, and an appreciation for the difficulty in such, mindful of the threatened interruption to the child's developmental trajectory. Find strengths in the child and family's coping and cite them specifically. Announce your plan going forth, whether that is who you will speak to about what, recommendations for what you wish the child/family to do (relaxation, pain management, logging sleep or feedings, etc), and if/when you plan to return.
  9. Enter your Initial Evaluation note into the medical chart; convey your impressions and plan verbally to relevant members of the medical team in person, by phone, or by email as appropriate.
  10. Notes should be clear, concise, but mindful of the different levels of confidentiality in a medical note, compared to an outpatient psychological note.

- Objective data should be non-judgmental. Conclusions and beliefs should be conveyed only in the Impressions section, and they need to be well tempered.
11. Recognize that a hospital note is much more time sensitive than an outpatient document. Notes should be completed immediately after completion of the evaluation/ session. In rare instances where such is not clinically feasible, the note must be completed and entered into the chart prior to the end of the clinician's day. A short note indicating such, with necessary impressions and plan should be entered before leaving the unit.
  12. If supervision is at a level that allows for the fellow to conduct such interviews without a supervisor present, then the supervisor should be contacted (by page if necessary) in order to discuss the findings, diagnosis, and plan. The supervisor will similarly review the chart/CMR as needed, question the fellow for additional information or impressions, and then meet personally with the patient/family. The supervisor is allowed to use the fellow's background information, but will enter an individual note reflecting a summary, agreement with the fellow's note, and his/her own Impression, Diagnosis, and Plan.

#### **E. Follow-up sessions in the hospital:**

1. Maintain follow-up with patients/family on a schedule/frequency that is *clinically indicated*.
2. Interventions are best rooted in empirically supported methodology, with the recognizable value of an accompanying supportive relationship.
3. Keep your supervisor current on changes or relevant factors in the course of the child's hospitalization. Always consult if any questions or concerns arise, either by you, or by medical staff.
4. All notes need to be reviewed and countersigned by your supervisor.
5. Assess need for psychological follow-up post discharge, and facilitate as needed.

#### **F. PICU:**

1. Suicide assessments must be done on the day of consultation unless the patient condition renders such moot until the following day.
2. The fellow will conduct a standard interview, with emphasis on assessment for safety immediately in the hospital, and with principal consideration for disposition after medical discharge.
3. The fellow will place orders in the medical chart (CPOE) directing specific limitations consistent with the hospital suicide precautions policy.
4. The fellow will determine whether the patient is to be (1) discharged home with family (or foster home), (2) voluntarily placed in a child/adolescent psychiatric hospital, or (3) request the county to evaluate for an emergency order of detention.
5. The Impression section will summarize the patient/family risk factors and protective factors that coalesce into the disposition after discharge.

6. If discharged home, the fellow will take action to pursue necessary psychological outpatient treatment, and assess and arrange for patient safety upon discharge.
7. If discharged to a voluntary psychiatric unit, the fellow will work in conjunction with the hospital pediatric social worker to find an appropriate placement.
8. If referred for an EOD, the fellow will work in conjunction with the hospital pediatric social worker, and/or speak with the County Crisis Worker and/or law enforcement personnel to effect the necessary evaluation.
9. If the patient is transferred to the Pediatric Unit, the fellow will continue follow-up.

**G. NICU:**

1. Judgment regarding what material is entered into the chart is even more delicate here, since the patient is the baby. So certain family information should not be entered, yet part of the fellow's responsibility is the safety of the baby's environment post discharge, which could be directly impacted by salient parent/family psychosocial issues. Hence a lot of discretion is necessitated by chart entry on the NICU, and needs to be a frequent topic of discussion in supervision.
2. The fellow is required to attend weekly discharge planning/psychosocial rounds attended by representatives of all other NICU disciplines.

**H. PRIT:**

1. When a child/adolescent is admitted to the hospital for trauma or recovery from a surgical procedure and then requires a longer period for physical rehabilitation, that patient may stay on the PICU or Peds unit, or may be transferred to the adult rehab unit. The patient will be followed by the fellow as ordered by the Rehabilitation physician.
2. If there is a PRIT patient, the fellow will meet every Thursday at 8am with the other members of the PRIT and the patient/family.

### *Integrated Primary Care Observable Practice Activities*

Primary Care Behavioral Health is an integrated primary care service model that embeds a behavioral health professional into the primary care setting. The provider is integrated within the primary care rather than being simply a referral source or having an office co-located nearby. Goals of integrated primary care include:

- Improving the overall health of the patient population
- Behavioral health services seen as a routine part of medical care
- Prevention services, early identification of concerns, and decreasing delays to mental health treatment

The fellow will have the opportunity to work within the Department of Pediatrics as part of an integrated primary care service. The fellow will work closely with pediatricians, pediatric residents, and support staff. It is expected that the fellow will be exposed to a broad range of presenting concerns from a diverse age range. Pediatrics provides care to newborns through early twenties.

The fellow will provide:

- Curbside consults to pediatricians regarding behavioral health questions
- Warm handoffs for patients identified as needing same-day, problem focused behavioral health interventions
- Short-term problem focused treatment for patients
- Annual screening of behavioral health concerns
- Assistance with referral to Department of Behavioral Health for higher level of care
- Education regarding behavioral health issues for residents, staff, and providers

Some common consults and specific interventions include:

- Problem-solving techniques
- Stress reduction skills, such as deep breathing and progressive muscle relaxation
- Parenting skills
- Coping strategies to assist with the diagnosis and subsequent treatment of a chronic medical condition
- Sleep hygiene skills
- Skills training to improve family/parent-child interactions
- Toilet training techniques
- Weight management
- Help with school related issues, including academics, behavioral issues, and social concerns
- ADHD assessment and strategies
- Tips to prepare for medical procedures
- Behavior management strategies
- Brief cognitive-behavioral treatment for mild mood and behavioral issues
- Psychological and behavioral diagnostics
- Pain management

**A. Integrating services into Department of Pediatrics**

- a. Read select material regarding the Primary Care Behavioral Health (PCBH) model of integrated primary care from *Behavioral Consultation & Primary Care* by Robinson & Reiter (2007).
- b. Review select integrated primary care training materials.
- c. Familiarize yourself with layout of Pediatrics. Your supervisor will introduce you to PCPs and staff.

**B. Receiving consults**

- a. Be available with supervisor within Pediatrics. Being visible and making sure that PCPs know how to reach you is critical in order to receive consults.
- b. PCP identifies patient with mental health concerns. PCP introduces integrated services to patient and/or family. If pt/family agrees to meet with psychologist, PCP completes a warm hand-off to integrated service. PCP may call to reach IPC service through a dedicated phone for the service or come to speak with service in our office.
  - i. Receive consult with supervisor. Briefly review with PCP specific concerns and determine if they have a specific goal for pt (e.g. review sleep hygiene techniques). This will be done quickly in a few minutes.
  - ii. Actively discuss relevant issues regarding the consult request.
  - iii. Briefly review CMR to see whether pt has any previous psych contact or is a current pt.
  - iv. Actively participate with supervisor in determining whether consult is consistent with fellow's clinical ability, training interests, personal comfort, time availability and patient eligibility to be seen by a fellow.

**C. Meeting with patient**

- a. Walk with PCP to their exam room for PCP to introduce you to pt and family (warm hand-off).
  - i. PCP may briefly review the presenting concern again and then will step out of the room.
- b. Introduce yourself as a postdoctoral fellow in Integrated Primary Care psychology, working under the supervision of Dr. \_\_\_\_\_. Introduce your role in meeting with them today as discussed with PCP and supervisor.
- c. Determine who is in the room and whether those present are appropriate to stay for the brief assessment/intervention.
- d. During the initial 15 minute visit, remain focused on the concern identified by the patient and PCP. Your chief tasks are to:
  - i. Introduce the IPC service and PCBH model.
  - ii. Clarify the presenting concern by gathering the most essential details.
  - iii. Offer 1-2 brief interventions.

iv. Determine level and type of follow-up needed.

**D. Providing recommendations for follow-up services**

- a. During the brief visit, determine the severity of the presenting concerns.
  - i. Consider the number of concerns identified, chronicity of concern, motivation of pt and family, and level of distress experienced.
  - ii. Discuss with supervisor and offer your recommendations for follow-up.
- b. If concerns are significant, longstanding, and/or distressing, consider referral to outpatient behavioral health for a higher level of care for the patient. Explain to family what services are offered in Department of Psychiatry and Behavioral Health and that this would begin with a complete diagnostic evaluation.
  - i. If pt agrees to recommendation, assist with the referral and provide relevant paperwork to family for them to complete (e.g. History questionnaire). Advise them to return to the Department for the referral to be completed.
- c. If you determine the concerns would likely be improved by the patient meeting with a psychologist for approximately five 30 minute visits, offer to the pt integrated visits within Department of Pediatrics.
  - i. If pt agrees to recommendation, schedule an integrated visit. If pt declines a follow-up appt in Pediatrics, include this in your documentation.
- d. If you identify only minor concerns, provide relevant psychoeducation/strategies that pt will be able to implement at home.
  - i. Review with family that they may contact you or PCP as needed for any further questions or concerns. They can schedule an integrated visit prn.

**E. Supervision**

- a. If supervision is at a level that allows the fellow to conduct such visits without a supervisor present, the supervisor should be contacted in order to briefly discuss the findings and plan. Discuss with the supervisor the recommended level of follow-up. The supervisor will review the initial consult, question the fellow for additional information/impressions and will briefly meet personally with the patient/family to review plan.

**F. At conclusion of initial visit**

- a. If PCP is available, communicate with PCP either verbally or by email the outcome of the visit (e.g. pt is returning in 1 week to meet with you to review additional interventions, pt declined a referral to Behavioral Health, pt only needs to be followed prn).
- b. Document your brief assessment and interventions to CMR.
  - i. Include:
    1. Reason for consult/presenting concerns
    2. Relevant symptoms and history
    3. Interventions
    4. Mental status examination
    5. Plan

- 6. Diagnoses
- 7. Time spent
  - ii. CC: the PCP your note
- c. Enter any follow-up integrated visits into your schedule if applicable.
- d. Notify Behavioral Health appointment coordinators if referral was recommended/paperwork was provided so they enter this on patient screen

**G. Follow-up integrated visits in Pediatrics**

- a. Schedule follow-up integrated visits with pt/family within a timeframe that fits with clinical interventions/goals (e.g. return in 2 weeks after implementing toileting chart, return in 1 week to discuss mood).
- b. Continue to focus on the most relevant presenting concern and necessary interventions. Visits are brief (30 minutes).
- c. Regularly assess pt's progress and improvement and whether he/she is receiving the most appropriate level of care. If you determine that the presenting concerns are more significant than originally assessed, discuss with pt/family referral to outpatient behavioral health.
- d. Maintain regular contact with the PCP regarding their patient. The PCP consulted you on this patient and they are invested in their care. As appropriate, review progress with PCP verbally, by email or cc'ing your CMR notes.
- e. Keep your supervisor current on changes or relevant factors in the course of the brief integrated visits. Always consult if any questions or concerns arise, either by you or medical staff.
- f. All dictated notes need to be completed within 48 hours, reviewed and signed by your supervisor.

## **Cystic Fibrosis Clinic**

The fellow will have the opportunity to work on the cystic fibrosis multi-disciplinary treatment team, working with providers from genetics, nutrition, social work, nursing, respiratory therapy, and pediatric pulmonology. Patients seen on this service are at every stage of their disease, from initial diagnosis to long term maintenance. Services that the fellow will provide include: (a) initial assessment of the patient and family's strengths and weaknesses, (b) family and individual treatment that focuses on coping and adjusting to a new diagnosis, adherence issues, and other disease-specific issues, (c) individual and family treatment related to general psychological difficulties, and (d) inpatient psychological consults with families and patients during hospitalizations. Skills and knowledge that the fellow can expect to acquire include: (a) medical knowledge of cystic fibrosis and its treatments, (b) how to communicate psychological information to medical professionals, and (c) a greater understanding of psychological issues unique to a diagnosis of cystic fibrosis.

### **CYSTIC FIBROSIS CLINIC OPAs**

1. Receive referral from pediatric pulmonology (nurse, NP, MD)
  - a. Discuss with referral source to clarify concerns
2. Screen referral for relevance to Individual Fellowship Plan, caseload goals, and eligibility to be seen by a fellow.
3. Review EHR and all relevant medical history.
4. Effectively summarize the diagnoses and concerns based on the review in #3. Incorporate new knowledge obtained via consultation with supervisor and literature review.
5. Meet with patient and/or family
  - a. New diagnosis
    - i. Introduce role of integrated behavioral health service
    - ii. Develop rapport
    - iii. Assess current level of coping and adjustment to new diagnosis
    - iv. Provide appropriate interventions consistent with presenting concerns, as indicated
  - b. Current/on-going difficulties or concerns
    - i. Assess adherence and address adherence engagement
    - ii. Assess behavioral/emotional functioning
    - iii. Assess psycho-social functioning
      1. School
      2. Family
      3. Social
  - c. Assess level of intervention needed and make appropriate referral if needed, including:
    - i. PRN in CF clinic
    - ii. Regularly in CF clinic
    - iii. On-going psychotherapy in local community
    - iv. On-going psychotherapy in Psychiatry and Behavioral health
  - d. Conduct Annual screening.

6. Provide timely feedback to referral source
  - a. Verbal (immediate)
  - b. Written (EHR)
    - i. Use integrated behavioral health care macro

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## **Diabetes Clinic**

The fellow will have the opportunity to work on the pediatric diabetes multi-disciplinary treatment team with providers from nutrition services, social work, and pediatric endocrinology. The fellow will provide services in the inpatient and outpatient settings to children and adolescents diagnosed with diabetes and their families. This includes patients newly diagnosed with diabetes to those who have been managing this chronic illness for quite some time. Services that the fellow will provide include: (a) initial assessment of the patient and family's strengths and weaknesses, (b) family and individual treatment that focuses on coping and adjusting to a new diagnosis, adherence issues, and other disease-specific issues, (c) individual and family treatment related to general psychological difficulties that may impact optimal diabetes management, and (d) inpatient psychological consults with families and patients. The outpatient multi-disciplinary diabetes clinic meets weekly, and the fellow can expect to see 8 patients a day. Skills and knowledge that the fellow can expect to acquire include: (a) how to communicate psychological information to medical professionals, (b) medical knowledge of diabetes and its treatment, and (c) a greater understanding of psychological issues unique to a diagnosis of diabetes and its effective management.

### **Diabetes Clinic Observable Professional Activities (OPAs)**

1. Receive referral from pediatric endocrinology (nurse, NP, MD)
  - a. Discuss with referral source to clarify concerns
2. Screen referral for relevance to Individual Fellowship Plan, caseload goals, and eligibility to be seen by fellow.
3. Review EHR and all relevant medical history. Summarize the review.
4. If not familiar with current medical diagnosis or concerns, review with supervisor and consult current references
5. Meet with patient and/or family
  - a. New diagnosis
    - i. Introduce role of integrated behavioral health service
    - ii. Develop rapport
    - iii. Assess current level of coping and adjustment to new diagnosis
    - iv. Provide appropriate interventions consistent with presenting concerns, if needed
  - b. Current/on-going difficulties or concerns
    - i. Assess adherence and address adherence engagement
    - ii. Assess behavioral/emotional functioning
    - iii. Assess/update psycho-social
      1. School
      2. Family
      3. Social
  - c. Assess level of intervention needed and make appropriate referral if needed, including:
    - i. PRN in diabetes clinic
    - ii. Regularly in diabetes clinic
    - iii. On-going psychotherapy in local community
    - iv. On-going psychotherapy in Psychiatry and Behavioral health

6. Provide timely feedback to referral source
  - a. Verbal (immediate)
  - b. Written (EHR)
    - i. Use integrated behavioral health care macro

## **Hematology-Oncology**

The fellow will have the opportunity to work on the pediatric hematology-oncology multi-disciplinary treatment team which includes providers from child life, social work, nutrition, occupational therapy, physical therapy, and pediatric oncology. The fellow will provide inpatient and outpatient psychological services to children and adolescents diagnosed with an oncological disorder and their families. Patients seen on this service are at every phase of treatment, including initial diagnosis, maintenance therapy, off treatment or end of life. Services that the fellow will provide include: (a) initial assessment of the patient and family's strengths and weaknesses, (b) family and individual treatment that focuses on coping and adjusting to a new diagnosis, adherence issues, and other disease-specific issues, (c) individual and family treatment related to general psychological difficulties, and (d) inpatient psychological consults with families and patients during hospitalizations. Typical psychological issues that the fellow may address include: coping and adjusting to initial diagnoses, difficulties with frequent or long hospitalizations, treatment adherence, and death and dying issues. Skills and knowledge that the fellow can expect to acquire include: (a) medical knowledge of oncology diagnoses and their treatments, (b) how to communicate psychological information to medical professionals, and (c) a greater understanding of psychological issues unique to a diagnosis of cancer.

### **Hematology-Oncology Clinic Observable Professional Activities (OPAs)**

1. Receive referral from pediatric oncology (nurse, NP, MD)
  - a. Discuss with referral source to clarify concerns
2. Screen referral for relevance to IFP, caseload goals, and payor source
3. Review EHR and all relevant medical history. Summarize the review.
4. If not familiar with current medical diagnosis or concerns, review with supervisor and consult current references
5. Meet with patient and/or family
  - a. New diagnosis
    - i. Introduce role of integrated behavioral health service
    - ii. Develop rapport
    - iii. Assess current level of coping and adjustment to new diagnosis
    - iv. Provide appropriate interventions consistent with presenting concerns, as indicated
  - b. Current/on-going difficulties or concerns
    - i. Assess adherence and address adherence engagement
    - ii. Assess behavioral/emotional functioning
    - iii. Assess psycho-social functioning
      1. School
      2. Family
      3. Social
  - c. Assess level of intervention needed and make appropriate referral if needed, including:
    - i. PRN in outpatient oncology clinic
    - ii. PRN during inpatient chemotherapy
    - iii. Regularly in outpatient oncology clinic

- iv. Regularly during inpatient chemotherapy
  - v. On-going psychotherapy in local community
  - vi. On-going psychotherapy in Psychiatry and Behavioral health
- 6. Provide timely feedback to referral source
  - a. Verbal (immediate)
  - b. Written (EHR)
    - i. Use integrated behavioral health care macro