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/Liaison 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.

Pediatric Fellowship Outpatient Service

The fellow provides clinical assessment and treatment through the Department of Psychiatry and Behavioral Health. In that setting, the fellow works with children and adolescents exhibiting a wide range of emotional and behavioral problems, including attention deficit hyperactivity disorder, anxiety disorders, depressive disorders, somatization disorders and behavior disorders. Assessment includes interview, collateral contacts with family and other professionals, and psychological tests and behavioral questionnaires. The fellow conducts diagnostic assessments, conceptualizes the cases, devises treatment plans, and implements interventions. Fellows participate in the weekly fellowship seminar, the weekly case consultation staffing, the monthly professionalism/leadership seminar and quarterly patient safety/quality improvement forums.

Outpatient Service Observable Professional Activities (OPAs)

A. Referrals

1. Screens referrals for relevance to Individual Fellowship Plan, caseload goals and eligibility to be seen by a fellow.
2. Provides timely response to the relevant parties to facilitate the referral
3. Manages documentation to support efficient referral processing.

B. Intake Session Preparation

1. Reviews HX form and available medical records to identify context, concerns.
2. Identifies external records that may be needed and sets up plan to get them.
3. Has a format for the intake that has been developed in collaboration with supervisors and is informed by Department . Q.A. and other regulatory body requirements.

C. Intake

1. Effectively engages child and family in waiting room
2. Provides explanation of role/goals of the intake in supportive manner consistent with health literacy of the adults and developmental level of the child.
3. Provides explanation of their role as a fellow, working under the supervision of the assigned supervisor (provide name). Ensures fellowship acknowledgement form is signed.
4. Supportively reviews confidentiality, risks and benefits of session consistent with the health literacy of the adults and developmental level of the child.
5. Effectively engages patient and family in the following:
    - -review of reasons for referral
    - -history of presenting concerns
    - -detailing of the presenting concerns (onset, duration, frequency, impact, etc)
    - -exploration of working theory each person has for the difficulties
    - -assessment of desire/readiness for treatment
    - -completion of relevant risk assessment
    - -assesses medical, psychiatric, academic, family, trauma history
    - -assesses mental status
6. Provides initial impressions and treatment recommendations to child and family in a supportive, encouraging manner that is consistent with health literacy of the adults and developmental level of the child.

-Provides impressions that are consistent with the data available at the completion of the intake
-Provides impressions in a non-judgmental, non-blaming, supportive manner
-Provides specific treatment recommendations directly related to the impressions and the areas of concern.

7. Solicits family feedback on the evaluation experience by providing family the intake patient survey to complete in the waiting room before they depart.

D. Intake Report

1. Effectively pulls together the various sources of data (interview, internal records, external records, HX form, test data) in preparation for dictation.
2. Constructs an impression/conceptualization that incorporates an ecological, holistic, developmental model. This includes genetics, early development, life events, relational, medical, psychosocial, etc.
3. Constructs the report in a manner that is succinct, organized and integrates the data into the impressions and recommendations sections.
4. Dictates the report in an efficient and timely manner.
5. Accepts supervisor feedback on the report in a non-defensive manner.
6. Ensures findings/report are communicated to other professionals involved in the patient's care as needed.

E. Therapy

1. Session preparation

-Efficiently reviews medical record since last session to identity relevant medical events, concerns for the session

-Develops a specific objective for the session that is consistent with the treatment plan, is informed by the last session and addresses tx modality for the session

-Between sessions, reviews research as needed for treatment planning, conceptualization, intervention

2. Session

-Effectively engages child and family in waiting room
-Identifies acute/urgent concerns by child or family and shifts focus to address them in a manner satisfactory to the family
-Generates a supportive, safe environment
-Effectively structures the session as related to the modality, issues and treatment orientation being utilized
-Provides appropriate and timely review of confidentiality and its limitations depending on the modality and issues being addressed
-Effectively engages a closure time prior to end of session to support emotional composure after addressing affect laden topics
-Monitors progress with review of goals and outcomes with child/family

3. Therapy Progress Notes

- Effectively pulls together the various sources of data (interview, internal records, external records obtained since last session) in preparation for dictation

-Constructs an Assessment/Impression of the session that incorporates the initial evaluation impression, the therapist's theoretical orientation and the treatment plan, and the content of the session

-Identifies specific topics, tasks, activities, etc. for the next session

-Constructs a progress note that is succinct, organized and integrates the data into the impressions and recommendations sections.

-Dictates the progress note in an efficient and timely manner.

-Accepts supervisor feedback on progress notes in a non-defensive manner.

4. Treatment Plan

-Develops a treatment plan that includes all data required per Dept. Q.A. policy

-Presents the treatment plan in collaborative manner with child and family, seeking their input, which is used as appropriate

-Obtains signatures on Treatment Plan and submits it within timeline per Dept. Q.A. policy

-Monitors progress of therapy in part via timely completion of 90 Day Tx Reviews which include the child and family

5. Therapy collateral activities

-returns phone calls from family in a timely manner

-returns phone calls from others involved in the child's care only upon first confirming an active release is on file

-appropriately addresses the concerns in the call

-does timely dictation for each phone contact

-supportively sets appropriate boundaries for use of phone contact

Directed Independent Learning Tasks

1. Reviews the Dept Q.A. manual and demonstrates knowledge of the requirements as related to conducting initial evaluations and psychotherapy.
2. Reviews the Supervision Contract and demonstrates knowledge of the requirements for the supervisee as they relate to providing clinical services.
3. Reviews the Fellowship Handbook and demonstrates knowledge of the requirements and resources available as they relate to providing clinical services
4. Demonstrates initiative and self-directed learning when encountering clinical issues for which the fellow has limited experience.

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