Internship Handbook

Mission, Policies, Guidelines, and Resources

2019-2020
Internship Handbook

Mission, Policies, Guidelines, and Resources

2019-2020
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I. INTRODUCTION

Welcome to the University of Minnesota Medical School Psychology Internship. The information contained in the Internship Handbook outlines the general policies and guidelines of the Psychology Internship of the Department of Pediatrics of the University of Minnesota Medical School. In formulating these policies and guidelines it is impossible to anticipate every nuance of circumstances to which they may apply. Therefore, certain discretion must be left to the Internship Director, various committees and individuals responsible for the conduct and administration of the Internship as a whole, and to the rotations of the Internship.

These policies are designed to conform to those of the University of Minnesota Medical School, the University of Minnesota, the Departments of Pediatrics and Psychiatry, and the University of Minnesota Medical Center/M Health. Where a conflict arises, the policies of the latter institutions will take precedence. These policies shall also be in accord with the American Psychological Association’s Ethical Principles and Code of Conduct (APA, 2002), 2010 Amendments to the 2002 “Ethical principles of psychologists and code of conduct.” American Psychologist, 65, 493. doi: 10.1037/a0020168 and the Standards of Accreditation (APA, 2015). Policies are also in accord with the membership requirements of the Association of Psychology Postdoctoral and Internship Centers (APPIC). All Internship-related policies shall conform to the Rules and Code of Conduct of the Minnesota Board of Psychology and state and federal statutes. All Internship-related activities shall be conducted in accordance with the above policies and regulations. Interns and supervisors are expected to have read, to be aware of, and to follow the internship’s policies and regulations.

The Internship Handbook is an evolving document. It includes information and input from many sources, including interns, graduates of the Internship, and faculty, supervisors and administrators, APA, APPIC, etc. The contents are provided to familiarize psychology interns, faculty, applicants, administrators, and reviewers with information pertinent to the Internship. The Internship Handbook also provides an overview of resources and outlines mechanisms to facilitate training, clinical practice, and the orderly functioning of the Internship. These policies and guidelines are subject to the periodic review and approval by the Internship faculty and supervisors and/or the Head of the Department of Pediatrics or his or her designee(s). Responsibility for development and implementation of these policies and guidelines and initiation of their periodic review rests with the Internship Director, faculty and supervisors and the Department of Pediatrics. The information in the Internship Handbook can be changed during the internship year. Questions, concerns, and other feedback regarding the content of this Handbook should be addressed to the Internship Director and/or the Training Committee. Individuals who have questions about policies within the Internship should seek clarification from the Internship Director and the Training Committee.

As a matter of policy, this Internship Handbook is made available for inspection on site at the time of candidate interviews and is available on request as a pdf to applicants or other interested parties.

II. STATEMENT OF MISSION, OBJECTIVES, AND PHILOSOPHY OF THE INTERNSHIP

The Departments of Pediatrics and Psychiatry of the University of Minnesota Medical School and other departments participating in the Internship have long-standing traditions of excellence in the medical and psychological evaluation and treatment of children and adolescents and in the enhancement of their care through research and education. The faculty of the Internship is committed to the continuation of all elements of this tradition. The mission of the Psychology Internship is derived from the commitment to provide optimal health care primarily for children, adolescents, and


families. An integral part of this mission is to train psychologists to be fully equipped to develop and advance the skills and knowledge necessary for the provision of high quality psychological care to children, adolescents, and families.

Variations are expected and respected in career goal as well as in the specific strengths and limitations among interns. Graduates of the Internship participate in diverse realms within psychology. The mission of the Internship is to train professional psychologists who are equipped to become practitioners, scientists, and educators. This commitment can be met most successfully by structuring the Internship to furnish training to prepare interns for a range of career paths. The focus of this internship’s training is within hospital settings and the health care system. Internship faculty members have broad skills and can provide resources that enrich the training of interns with diverse interests and goals. These resources are encouraged to be used to allow appropriate tailoring, whenever possible, of the flexible portion of the Internship to meet interns' individual needs, while meeting departmental, divisional, institutional, and clinical service teams' requirements. The Internship strives to provide a solid professional foundation and up-to-date scientific information to ensure that interns' clinical skills ultimately advance to levels that are appropriate for independent professional functioning as psychologists and are consistent with the accreditation requirements of the APA and with the objectives of this Internship.

To accomplish these objectives, interns receive comprehensive as well as some relatively specialized training in broad accordance with the "scientist-practitioner" model in clinical psychology. The Internship strives to prepare psychologists who will be skilled in assessment, intervention, consultation, research, evaluation, referral, and other professional activities and who will conduct themselves as competent and ethical psychologists. The Internship seeks to deepen and broaden interns' understanding of normal and maladaptive aspects of psychosocial and developmental characteristics of children, adolescents, and to refine interns' skills in providing clinical services. The Internship strives to imbue in interns the clinical and research skills and best current clinical and evidence-based practices and to equip them to continue in the development of skills throughout their careers. Interns are expected to further their understanding of research and integrate research findings with clinical practices in various ways, including in their interactions with faculty and supervisors, and through their readings, didactics and conference attendance, and research. Interns also may refine research skills by participating with faculty in research during the Internship whenever possible. Research activities, when undertaken, are generally in addition to clinical responsibilities. The Internship also strives to stimulate careful consideration of the ethical, legal, scientific, and other professional aspects of psychological practice and of professional development. Interns also are expected to participate actively in program evaluation and quality assessment and improvement (QAI) activities.

Professional competence and intellectual and professional growth come from being challenged to reach beyond one's present limits. Such stimulation is expected as part of the Internship through clinical, didactic, supervisory, and other activities. The patients to whom interns are exposed are diverse and present a rich resource for learning. Faculty and trainees alike employ their talents, skills, and other resources in providing quality psychological services for patients and in fostering an environment that maximizes training. This requires personal accountability, efficiency, timeliness, teamwork, and promotion of a culture of respect for trainees, staff, and faculty, and the other professionals and disciplines with whom they interact. The Internship strives to provide education and training that is appropriate and sensitive to patient diversity and that promotes interns’ awareness of their own background and its impact on the services they provide, and awareness of practice guidelines pertaining to diverse patients.


The Internship strives to ensure the provision of strong, well-balanced foundations in health services psychology (previously known as professional psychology) for all interns and the flexibility, as possible, to allow for individual differences in needs, interests, and career goals. The Internship strives to provide experiential training opportunities that, to the extent it is possible to direct, are sequential, cumulative and characterized by increasing complexity. Training comprises various modalities, including, but not limited to supervision, role modeling and enactment, co-therapy/co-service, observational learning, and mentoring, as well as didactics, workshops, professional meetings (e.g., rounds). The opportunities for training within each modality vary across rotations. Each rotation provides interns with descriptions of training objectives, methods, and expectations for developing competence in the area of specialization apart from this Handbook. Efforts are made to assist interns in learning from their current experiences to embrace the challenges of the future. Training activities are designed to promote interactions among interns and faculty and are scheduled in a sequence subject to approval by the Training Committee. Appendix 27 delineates the aims associated with the Internship’s model and philosophy. These are critical to success of the internship as a whole as well as to individual interns, so it is essential that interns be familiar with them.

III. STRUCTURE OF THE INTERNSHIP

The Internship is comprised of both sections of the Division of Pediatric Clinical Behavioral Neuroscience (i.e., Pediatric Neuropsychology and Pediatric Psychology) in the Department of Pediatrics and of the Division of Child and Adolescent Psychiatry in the Department of Psychiatry in the Medical School. The administrative home of the Internship is the Department of Pediatrics. The Internship draws upon the resources and opportunities of these divisions and departments, as well as on the Departments of Medicine. Its operations are dependent on the internal structure and policies of each department. Appendix 24 presents an organizational chart of the Internship.

Supervisors from each participating division are involved in the administration of the Internship. Licensed, doctoral-level psychologists with academic appointments in the participating divisions within the sponsoring departments and select University of Minnesota Physicians staff psychologists are invited to be supervisors and may serve as members of the Training Committee. Other supervisors (e.g., psychologists and physicians) within the participating departments are also involved in the training of interns to a lesser extent. They are not members of the Training Committee and usually are involved minimally in the administration of the Internship. Supervisors who are members of the Training Committee communicate with the administrators, department heads, division heads, and other faculty of the sponsoring departments about Internship related issues to facilitate the planning and operation of the Internship.

A. Overview of the Training Committee

The mission of the Training Committee is to plan, coordinate, direct and organize the activities and resources of the Internship. Part-time psychology supervisors and supervising faculty and staff from other disciplines, as well as administrators from sponsoring departments, may also attend Training Committee meetings and contribute to the deliberations and processes of the Training Committee. The Intern Representative also attends those parts of Training Committee meetings dedicated to intern concerns or areas where the Training Committee solicits intern feedback. The Intern Representative serves in a liaison role and does not participate in discussion.
of evaluations of any interns or participate in the executive sessions of the Training Committee. The Training Committee meets monthly. Meetings are generally on the first Tuesday of each month at 8:00 A.M.

All actions of the Training Committee are advisory to the Head of the Department of Pediatrics or his or her designee and to the faculty of the Department of Pediatrics. In general, actions of the Training Committee, other than recommendations for dismissal from the Internship, are by majority vote of those faculty members who are present. Training Committee members are expected to respect the confidentiality, to the extent possible, of interns and other faculty, as related to all Training Committee proceedings and to approach their work with professionalism and integrity. In the rare event of administrative consideration of disciplinary measures or disposition of an intern, all participants in the Internship are afforded due process considerations. Any recommendation for dismissal from the Internship requires a vote of at least 60 percent of the Training Committee members who are present.

The Internship Director organizes the agenda for Training Committee meetings. Agenda items may be suggested to the Internship Director by: Training Committee members; administrative staff of sponsoring departments; other supervisors; or the Intern Representative. Minutes of Training Committee meetings are prepared by the Internship Coordinator and Director and distributed to supervisors and the Intern Representative. The Internship Coordinator maintains a file of Training Committee meeting minutes. Any minutes of Executive Sessions are kept separately and are not circulated.

Faculty Members of the Training Committee include Drs. Boys, Eisengart, Gross, King, Kunin-Batson, Lingras, Pierpont, Pisetsky, Robiner, Semrud-Clikeman, Wozniak, Zagoloff, and Ziegler.

It is the responsibility of Training Committee members to attend Training Committee meetings consistently. Inconsistent attendance of Training Committee meetings undermines the collegiality of the Training Committee and the efficient operation of the Internship, and ultimately has a corrosive impact on training. Therefore, a pattern of poor attendance or non-participation may be grounds for a review of a supervisor's participation and responsibilities in the training activities of the Internship. Faculty members who do not attend Training Committee meetings therefore effectively relinquish their influence on decisions affecting the Internship.

B. Responsibilities of the Training Committee

1. Training, Accreditation, and Quality (TAQ)

   a. To promote training and meet with interns to facilitate a positive learning atmosphere and appropriate training opportunities.

   b. Members of the Training Committee are accessible to interns on an ongoing basis to discuss training concerns and intern recommendations for improving training.

   c. Policy development and modification.

   d. Internship planning, creation of systems for managing specific tasks (e.g., recruitment process, attendance, scheduling seminars).

   e. Curriculum development and training.

   f. Internship Handbook: Revision, expansion, review.

   g. Website development and updating.


   i. Coordinate and review quality assessment and improvement activities (e.g., reviews faculty evaluations, intern evaluations, time analyses, program evaluations; alumni survey, recruitment survey, solicitation of information from interns and other programs).
j. Assists the Internship Director with preparation of correspondence for APA and APPIC (annual reports, self-study, surveys, listings, site-visit planning and implementation).

k. Address issues related to performance of interns and supervisors, and overall quality of the Internship program and can recommend administrative actions to the Internship Director and the Training Committee.

l. The Training Committee may convene meetings with interns and the Internship Director to discuss training and programmatic issues as needed.

m. Arrange for preparation of intern certificates.

n. Engage in problem-solving and addressing individual and systems issues to facilitate interns’ meeting of Internships’ standards for training (i.e., including accruing specified targets for training and clinical experiences).

2. Application and Recruitment (AR)

   a. Application and Description Materials: Preparation, revision, and ensure consistency with the Internship Handbook, APA standards, APPIC policies.

   b. Planning and execution of application process, phone calls with applicants and future interns and their graduate programs, review of applications, ranking of applicants, and other aspects of the recruitment process (e.g., soliciting extra supplemental information when required).

   c. Oversight of recruitment processes to ensure compliance with APPIC Policies on Internship Offers and Acceptance.

   d. Participate in all phases of interviewing, evaluating, and rating and ranking applicants.

   e. Review and updating of Internship website and other publicity materials (e.g., PowerPoint presentation) including faculty descriptions on the website and the Annual Report Online (ARO).

3. Intern Activity (IA)

   a. Review issues related to promoting a hospitable and supportive environment for interns.

   b. Coordinate social activities (e.g., Orientation luncheon and picnic, beginning of year faculty-intern social gathering, mid-year recognition event, graduation[s]).

   c. Facilitate interns' acclimation to Twin Cities.

   d. Coordinate activities for applicants' interviews.

C. Role and Functions of the Internship Director and Associate Director

The Internship Director is responsible for the overall coordination and administration of Internship training and operations including review of QAI information. The Director represents the Internship to the Academic Health Center, Medical School, and departmental heads and their designees, APA, APPIC, external organizations, applicants, interns' training programs, and the Minnesota Association of APA-Accredited Psychology Internship Centers (MAAPIC). The Director chairs the Training Committee, participates in meetings and functions, and facilitates Internship meetings. The Director is responsible for Internship related-correspondence and communications.

The Associate Director of the Internship plays multiple roles in the Internship providing leadership and key input in various internship processes. The Associate Director assumes the duties of the Training Director when the Training Director is not available.

D. Role and Functions of the Intern Representative to the Training Committee

The Intern Representative serves as a liaison to the Training Committee. Interns elect the Intern Representative and inform the Internship Director of their choice by the end of July. The Intern Representative attends parts of the administrative meetings of the Training Committee as a non-voting member of the Committee. The Intern Representative is excluded from executive sessions (e.g., discussion of intern performance and other topics as determined by the Training
Committee). The Intern Representative may serve for the full year or on a rotating basis with one change per year. The Intern Representative brings forward to the Training Committee issues of concern to interns. The Intern Representative also provides interns with information about the Internship and decisions of the Training Committee. The Intern Representative is encouraged to discuss these matters with the other interns.

The Intern Representative also plays a key role in facilitating communication with the Director of the Internship and the Internship Coordinator. If there are any difficulties associated with training activities (e.g., a presenter does not arrive for a topical seminar, forms or calendars are not distributed, audiovisual aids are not available, rooms are locked or changed unexpectedly, or technology problems), the Intern Representative will communicate immediately (e.g., calling the Internship Coordinator and/or paging the Internship Director or other involved individuals) so that appropriate, timely efforts can be initiated to clarify and remedy the situation and promote training. Communication of concerns to the Training Committee and the Internship Director is encouraged for all interns and is not limited to the Intern Representative. The Intern Representative and other interns are aware of how to gain access to rooms where didactics occur and to technological support (LCD projector; laptops).

E. Role and Functions of the Internship Coordinator

The Internship Coordinator serves in multiple critical roles in support of the Internship. The activities include, but are not limited to:
1. Organization of application materials and interview dates
2. Correspondence with applicants, interns, and faculty
3. Planning and execution of Internship events such as interview and orientation
4. Management and maintenance of information, records, and documents related to training, including security of information
5. Scheduling didactics
6. Organization of the monthly calendar
7. Creation of the seminar evaluation spreadsheet, result tally and distribution to speakers
8. Preparation and dissemination of the Internship Handbook and other materials to interns and faculty
9. Maintenance of the Internship’s website, etc.
10. Assists in preparation of APA Annual Report Online (ARO)
11. Assists in preparation of site visit self-study and planning of the site visit
12. Preparation and distribution of Training Committee Meeting minutes

IV. DEPARTMENT OF PEDIATRICS AND OTHER INTERNSHIP PERSONNEL

A. Pediatrics

<table>
<thead>
<tr>
<th>Personnel</th>
<th>MMC</th>
<th>Telephone*</th>
<th>E-mail</th>
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8274 715 624-9865  |acgross@umn.edu  612-708-7003  |
| Meredith Gunlicks-Stoessel, Ph.D.  
8164 95 273-9844  |mgunlick@umn.edu  612-412-6609  |
| Kelly King, Ph.D.  
3437 486 624-9796  |kingx780@umn.edu  713-408-1980  |
| Alicia Kunin-Batson, Ph.D.  
5106 486 624-6931  |kunin003@umn.edu  651-230-9019-c  |
| Matt Kushner, Ph.D.  
393 273-9809  |kushn001@umn.edu  651-280-7556  |
| Katherine Lingras, Ph.D.  
4723 393 273-9720  |klingras@umn.edu  612-619-8611  |
| Richelle Moen, Ph.D.  
8541 393 273-9810  |moenx008@umn.edu  952-944-0942  |
| Jane Nofer, Ph.D.  
486 625-3617  |janen@umn.edu  |
| Carol Peterson, Ph.D.  
393 273-9811  |peter161@umn.edu  |
| Megan Petrik, Ph.D.  
3536 741 301-1751  |mlpetrik@umn.edu  612-290-1480  |
| Rene (Elizabeth) Pierpont, Ph.D.  
486 625-3930  |pier0053@umn.edu  608-772-1980  |
| Emily Pisetsky, Ph.D.  
3535 95 625-1838  |episetsk@umn.edu  919-452-8866  |
<table>
<thead>
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<tr>
<td>William Robiner, Ph.D.</td>
<td>8925</td>
<td>741</td>
<td>624-1479</td>
<td><a href="mailto:robin005@umn.edu">robin005@umn.edu</a></td>
</tr>
<tr>
<td>Robin Rumsey, Ph.D.</td>
<td>2825</td>
<td>486</td>
<td>626-8076</td>
<td><a href="mailto:rumse002@umn.edu">rumse002@umn.edu</a></td>
</tr>
<tr>
<td>Margaret Semrud-Clikeman, Ph.D.</td>
<td>9373</td>
<td>486</td>
<td>625-3255</td>
<td><a href="mailto:semru002@umn.edu">semru002@umn.edu</a></td>
</tr>
<tr>
<td>Danielle Vrieze, Ph.D.</td>
<td></td>
<td></td>
<td>273-9129</td>
<td><a href="mailto:dvrieze@umn.edu">dvrieze@umn.edu</a></td>
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<tr>
<td>Jeff Wozniak, Ph.D.</td>
<td>8941</td>
<td>95</td>
<td>273-9741</td>
<td><a href="mailto:jwozniak@umn.edu">jwozniak@umn.edu</a></td>
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<tr>
<td>Sasha Zagoloff, Ph.D.</td>
<td>1264</td>
<td>95</td>
<td>273-9825</td>
<td><a href="mailto:zagol001@umn.edu">zagol001@umn.edu</a></td>
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<tr>
<td>Richard Ziegler, Ph.D.</td>
<td>7534</td>
<td>486</td>
<td>625-7659</td>
<td><a href="mailto:zieg002@umn.edu">zieg002@umn.edu</a></td>
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<td>Gail Bernstein, M.D.</td>
<td>7596</td>
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<td><a href="mailto:berns001@umn.edu">berns001@umn.edu</a></td>
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<tr>
<td>Anjum, Afshan, M.D.</td>
<td>8355</td>
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<td>273-9711</td>
<td><a href="mailto:anju0001@umn.edu">anju0001@umn.edu</a></td>
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<tr>
<td>Kathryn Cullen, M.D.</td>
<td>8027</td>
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<td><a href="mailto:rega0026@umn.edu">rega0026@umn.edu</a></td>
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<tr>
<td>Suma Jacob, M.D., Ph.D.</td>
<td>95</td>
<td></td>
<td>273-9803</td>
<td><a href="mailto:sjacob@umn.edu">sjacob@umn.edu</a></td>
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<tr>
<td>Jonathan Jensen, M.D.</td>
<td>2836</td>
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<td><a href="mailto:jense002@umn.edu">jense002@umn.edu</a></td>
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<tr>
<td>Sanjiv Kumra, M.D.</td>
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<td>273-9711</td>
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<tr>
<td>George Realmuto, M.D.</td>
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<td>95</td>
<td>273-9726</td>
<td><a href="mailto:realm001@umn.edu">realm001@umn.edu</a></td>
</tr>
<tr>
<td>Amanda Schlesinger, M.D.</td>
<td></td>
<td>95</td>
<td>273-3283</td>
<td><a href="mailto:schle248@umn.edu">schle248@umn.edu</a></td>
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<tr>
<td>Adnan Ahmed</td>
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<td>273-9116</td>
<td><a href="mailto:adnan@umn.edu">adnan@umn.edu</a></td>
</tr>
<tr>
<td>C. Sophia Albott</td>
<td></td>
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<td>273-9041</td>
<td><a href="mailto:albott002@umn.edu">albott002@umn.edu</a></td>
</tr>
<tr>
<td>Deanna Bass, M.D.</td>
<td>5071</td>
<td>393</td>
<td>273-8700</td>
<td><a href="mailto:bassx003@umn.edu">bassx003@umn.edu</a></td>
</tr>
<tr>
<td>David Bond, M.D.</td>
<td>393</td>
<td></td>
<td>626-6773</td>
<td><a href="mailto:djbond@umn.edu">djbond@umn.edu</a></td>
</tr>
<tr>
<td>Scott Crow, M.D.</td>
<td>8315</td>
<td>393</td>
<td>273-9807</td>
<td><a href="mailto:crowx002@umn.edu">crowx002@umn.edu</a></td>
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<tr>
<td>Elke Eckert, M.D.</td>
<td>8445</td>
<td>393</td>
<td>273-9819</td>
<td><a href="mailto:ecker001@umn.edu">ecker001@umn.edu</a></td>
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<tr>
<td>Kelvin O. Lim, M.D.</td>
<td>1585</td>
<td>393</td>
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<td><a href="mailto:kolim@umn.edu">kolim@umn.edu</a></td>
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<tr>
<td>Ziad Nahas, M.D.</td>
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<tr>
<td>Katherine Nelson, M.D.</td>
<td>6391</td>
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<td>273-9848</td>
<td><a href="mailto:knelly@umn.edu">knelly@umn.edu</a></td>
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<tr>
<td>Stephen Olson, M.D.</td>
<td>7512</td>
<td>393</td>
<td>273-9763</td>
<td><a href="mailto:olson403@umn.edu">olson403@umn.edu</a></td>
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<tr>
<td>Barry Rittberg, M.D.</td>
<td></td>
<td>393</td>
<td>273-9813</td>
<td><a href="mailto:rittb001@umn.edu">rittb001@umn.edu</a></td>
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<tr>
<td>Sheila Specker, M.D.</td>
<td>2366</td>
<td>393</td>
<td>273-9806</td>
<td><a href="mailto:speck001@umn.edu">speck001@umn.edu</a></td>
</tr>
<tr>
<td>Vince Vallera, M.D.</td>
<td></td>
<td>393</td>
<td>273-9102</td>
<td><a href="mailto:vallera@umn.edu">vallera@umn.edu</a></td>
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<tr>
<td>Sofia Vinogradov, M.D. (Chair)</td>
<td></td>
<td>393</td>
<td>273-9820</td>
<td><a href="mailto:svinogra@umn.edu">svinogra@umn.edu</a></td>
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<td>Meredith Gunlicks-Stoessel, Ph.D.</td>
<td>8164</td>
<td>95</td>
<td>273-9844</td>
<td><a href="mailto:mgunlick@umn.edu">mgunlick@umn.edu</a></td>
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<tr>
<td>Jennifer Boike Armerding</td>
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<tr>
<td>Fall</td>
<td>PN</td>
<td>1771</td>
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<td>624-8401</td>
<td><a href="mailto:boik0015@umn.edu">boik0015@umn.edu</a></td>
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<td>Spring</td>
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<td></td>
<td>715</td>
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<tr>
<td>Rosalia Costello</td>
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<td>Fall</td>
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<td>1772</td>
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<td>273-9701</td>
<td><a href="mailto:coste225@umn.edu">coste225@umn.edu</a></td>
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<td>PN</td>
<td></td>
<td>486</td>
<td>624-8401</td>
<td></td>
</tr>
<tr>
<td>Ashley Isaia</td>
<td>Fall</td>
<td>1773</td>
<td>486</td>
<td></td>
<td><a href="mailto:isaia007@umn.edu">isaia007@umn.edu</a></td>
</tr>
</tbody>
</table>

| Mauritius       |       |     |       |             |             |
|----------------|-------|-----|-------|-------------|
|                   |       |     |       |             |             |
V. CURRICULUM, TRAINING ACTIVITIES, RESPONSIBILITIES, AND CASELOADS

The Internship consists of the components outlined in the descriptive materials provided in the program's website, the Internship Handbook, and rotation descriptions. Interns participate in the various components in an educational sequence over 12 months (2000+ hours) of training that is designed to meet the American Psychological Association accreditation standards for internships in health service psychology and licensing requirements in all jurisdictions. This includes providing training and supervised experiences that promote refinement of the Profession-Wide Competencies.

The objective of the Internship is to provide interns with supervised clinical experiences with psychological assessment, treatment, and consultation that promote the refinement of their competence, knowledge, skills, and proficiencies within those areas. Other objectives include increasing understanding of the cognitive, social, biological and emotional aspects of behavior and development, and of dysfunctional behavior and psychopathology. All aspects of training are intended to promote understanding and sensitivity to issues of multicultural diversity and to facilitate cultural competence. In addition, the Internship strives to foster the development of clinical practices consistent with professional values, legal, and ethical standards, and to promote competence in research/scholarly inquiry and evaluation. Training is designed to provide exposure to systems issues to prepare interns for professional functioning in medical schools, academic health centers, children’s hospitals and other complex institutions and systems.

The primary training method during the Internship is supervised clinical experiences with a range of patients. These experiences are supplemented with didactic and academic training opportunities. Training modalities include: faculty demonstration and observation of interns; discussion of clinical and professional issues; attendance at Case Conferences, Topical Seminars, Assessment Seminar, Psychotherapy Seminar, Diversity Seminar, Professional Development Conference; within-rotation seminars and rounds; individual and group supervision; review of the professional literature; review of audiovisual materials including recordings of interns’ interactions with patients and families; and other educational approaches. Supervisors provide interns with formative feedback throughout the internship and summative feedback quarterly.

<table>
<thead>
<tr>
<th>Clinic/Departmental Phone Numbers</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics Clinic</td>
<td>626-6777</td>
<td>365-8078</td>
</tr>
<tr>
<td>Division of General Pediatrics</td>
<td>626-2820</td>
<td>624-0997</td>
</tr>
<tr>
<td>Pediatric Clinical Neuroscience Office</td>
<td>625-7466</td>
<td>624-7681</td>
</tr>
<tr>
<td>Autism Spectrum Disorder Center Coordinator</td>
<td>625-3617</td>
<td></td>
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<tr>
<td>Child &amp; Adolescent Psychiatry Division</td>
<td>273-9711</td>
<td>273-9779</td>
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<td>Chemical Dependency Day Hospital</td>
<td>273-3947</td>
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<tr>
<td>Outpatient Psychiatry Clinic</td>
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<tr>
<td>UMP Psychiatry Billing</td>
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</tbody>
</table>

1 Please note that interns are to communicate with the Internship Director and the Internship Coordinator any changes in their office and home telephone numbers throughout the year. Interns’ information presented in this table is for the first rotation.
A. **Training Activities**

Interns receive a schedule of training activities at the beginning of the Internship including topical seminars, conferences, rounds, and rotation-specific activities.

- **Interns are required to attend Internship training activities.**
- **Interns and supervisors are jointly responsible for scheduling all other activities (e.g., patient contacts, supervision, research) so as not to interfere with attendance of training activities.**

Tuesdays are the day with the greatest emphasis on training in terms of didactics and group supervision. This is to enhance the focus on training activities and to give interns of all rotations opportunities to see psychotherapy patients after the didactics. Didactic training generally is comprised of a weekly psychotherapy seminar and topical seminar, and additional monthly conferences. The Assessment Seminar is conducted on Tuesday mornings for approximately the first half of the training year.

The Tuesday Training Schedule is generally as follows. **In addition, beginning in July, 2019 there are quarterly Wellness /Catch up Tuesdays in which didactics are not planned (though interns do participate in the Group Supervision of Psychotherapy). It should be noted that in 2019-2020, we are exploring scheduling additional didactics during unused times. These should appear on the monthly Internship Calendar.**

<table>
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<tr>
<th>Time</th>
<th>Activity</th>
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<tr>
<td>8:00 A.M.</td>
<td>Professional Development Conference <em>(usually 2nd Tuesday/month)</em></td>
<td>F263</td>
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<tr>
<td>8:00 A.M.</td>
<td>Diversity Seminar <em>(4th Tuesday/month)</em></td>
<td>F263</td>
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<tr>
<td>8:00 A.M.</td>
<td>Other/Mixed Seminars</td>
<td></td>
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<tr>
<td>9:00 A.M.</td>
<td>Assessment Seminar <em>(weekly first part of year)</em></td>
<td>F263</td>
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<tr>
<td>10:00 A.M.</td>
<td>Psychotherapy Seminar <em>(weekly)</em></td>
<td>F263</td>
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<tr>
<td>11:00 A.M.</td>
<td>Break/Lunch</td>
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<tr>
<td>12:00 Noon</td>
<td>Group Supervision of Psychotherapy <em>(weekly)</em></td>
<td>F212i</td>
</tr>
<tr>
<td>1:00 P.M.</td>
<td>Case Conference <em>(1st week &amp; some 2nd weeks/month)</em></td>
<td>F212i</td>
</tr>
<tr>
<td>1:00 P.M.</td>
<td>Topical Seminar <em>(all but 1st week &amp; some 2nd weeks/month)</em></td>
<td>F212i</td>
</tr>
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</table>

*Note Case conferences and topical seminars alternate different weeks of the month. Whereass this table presents the general training schedule, there are exceptions to the schedule so interns should attend to the monthly calendar of events.

1. **Didactics**

Didactics are intended as learning elements to promote intern’s preparation for practice across the health service psychology competencies. Interns complete evaluations for all internship-wide didactics. A google sheet format is planned to be initiated for 2019-2020.

a. **Psychotherapy Seminar**

Interns attend a weekly Psychotherapy Seminar led by Emily Pisetsky, Ph.D. and other presenters on **Tuesdays, 10:00 A.M. to 11:00 AM. In F263**. It is a major contributor to interns’ refinement of intervention/psychotherapy competencies. The seminars include review of literature and discussion of therapeutic process, outcome, and other issues. For questions about the Psychotherapy Seminar, contact Dr. Pisetsky. Seminar offerings are presented in the calendar of training events as an appendix. Interns complete evaluation

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forms after each of the Psychotherapy Seminars and return them to the Internship Coordinator to assist with future planning for the Internship.

b. **Assessment Seminar**

Interns attend a weekly Assessment Seminar on **Tuesdays from 9:00 A.M. to 10:00 A.M.** from July into December. It is a major contributor to interns’ refinement of psychological assessment competencies. The seminar is designed to promote refinement of interns' understanding of and skill in using a range of psychological instruments commonly employed in the psychological assessment of children. It emphasizes the translation of assessment skills into clinical practice. The location of the seminar is **F263** in the Psychiatry Department on the Riverside Campus. For questions about the Assessment Seminar, contact the Internship Director or the Internship Coordinator. Seminar offerings are presented in the calendar of training events as an appendix. Interns complete evaluation forms after each of the Assessment Seminars and return them to the Internship Coordinator to assist with future planning for the Internship.

c. **Topical Seminars**

Interns attend the weekly series of topical seminars (which alternate some Tuesdays with the Case Conferences). Seminars will be held on **Tuesdays from 1:00 P.M. to 2:00 P.M.** other than the first Tuesday of each month when Case Conferences are scheduled (and in May when there are two case conferences). The location is **Room F212i** in the Psychiatry Department on the Riverside Campus. The seminar series contributes didactics to promote interns’ knowledge related to multiple clinical and other professional competencies. For questions related to the Topical Seminars contact Dr. Robiner, the Internship Director, or the Internship Coordinator. If there are problems with the scheduled seminar, please contact the Internship Coordinator page Dr. Robiner at 612-899-8925. At the end of the year, the Topical Seminar series is reviewed to plan for the series in the following year. Interns complete evaluation forms after each of the Topical Seminars and return them to the Internship Coordinator to assist with future planning for the Internship. Seminar offerings are presented in the calendar of training events as an appendix.

d. **Professional Development Conference**

Interns attend monthly meetings with the Internship Director to discuss a range of professional, ethical, legal, regulatory, career, and Internship-related issues. This conference is intended to contribute to interns’ professional development and increased awareness of issues related to professional practice. More specifically, it promotes knowledge, understanding, and preparation for practice related to the competencies of: (a) ethical and legal standards; (b) professional values, attitudes and behaviors; (c) communication and interprofessional skills; and issues related to (d) supervision. This is an opportunity for interns to discuss process issues and other areas of interest to them. Interns establish the agenda for this conference along with the Internship Director. Interns **share responsibility** for making the Conference relevant, timely, and useful in addressing a range of professional development issues. Interns are expected to review the readings associated with the conference. The format includes bringing in some outside speakers. Meetings are usually the **second Tuesday** of each month from **8:00-9:00 A.M.** They are sometimes pushed back to the third month. The location is **F263** in the Psychiatry Department on the Riverside Campus. A second faculty member may also attend the meetings. Seminar offerings are presented in the calendar of training events as an appendix. Readings related to professional development are presented in Appendix 42. Interns complete evaluation forms after each of the Professional Development Conferences and return them to the Internship Coordinator to assist with future planning for the Internship.
e. **Diversity Seminar**

Interns attend a series of seminars meetings to discuss a range of diversity issues. This seminar is intended to contribute to interns’ professional development and increased awareness of diversity issues related to professional practice. More specifically, it promotes knowledge and skills in understanding and dealing with patients of diverse backgrounds in terms of age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation, and socioeconomic status. More specifically, this training is based on multicultural conceptual and theoretical frameworks of worldview, identity, and acculturation, rooted in the diverse social, cultural, and political contexts of society, and integrated into the science and practice of psychology. In addition, the training is intended to enhance respect for diversity and to refine competence in addressing diversity in all professional activities, including research, training, supervision consultation, and service. The format includes bringing in some outside speakers. Meetings are the **fourth Tuesday** of each month from **8:00-9:00 A.M.** The location is **F263** in the Psychiatry Department on the Riverside Campus. Interns complete evaluation forms after each of the Diversity Seminars and return them to the Internship Coordinator to assist with future planning for the Internship.

2. **Rounds**

Interns are encouraged to attend several departmental or divisional rounds and should consult with their supervisors about expectations for attending. Interns may be expected to attend some rounds.

a. **Grand Rounds for the Department of Psychiatry**

Grand Rounds for the Department of Psychiatry are held in the Wilf Family Center of UMMC-Riverside Campus on selected **Wednesdays** from **11:00 A.M. - 12:30 P.M.** Topics are announced in advance and posted on the Department of Psychiatry website at [https://www.psychiatry.umn.edu/education/grand-rounds](https://www.psychiatry.umn.edu/education/grand-rounds). The series features a broad range of presentations about current developments in mental health by speakers from the University, the community, and other academic health centers, including professionals with national and international reputations. Interns on the Child and Adolescent Psychiatry rotation may attend Grand Rounds and are encouraged to attend for select topics. They should discuss attendance with their supervisors. For questions about these Rounds, contact Dr. Wozniak. [https://www.psychiatry.umn.edu/education/grand-rounds](https://www.psychiatry.umn.edu/education/grand-rounds)

b. **Grand Rounds for the Department of Pediatrics**

Interns are encouraged to attend Grand Rounds for the Department of Pediatrics on a selective basis. Rounds are **Wednesdays** at **7:30 A.M. - 8:30 P.M.** in the Wilf Family Center (breakfast at 7:00 A.M.). Grand Rounds and the scheduled can be viewed at [https://www.pediatrics.umn.edu/education/grand-rounds](https://www.pediatrics.umn.edu/education/grand-rounds)

c. **Collaborative Office Rounds (COR)**

Collaborative Office Rounds (COR) is an MCHB-funded program that is sponsored by the U of MN the Department of Pediatrics, co-directed by Dr. Barnes in Developmental-Behavioral Pediatrics and Dr. Cullen in Child and Adolescent Psychiatry. The goals of COR are achieved through collaboration between primary care pediatricians, pediatric nurse practitioners, DBP, child psychologists and child psychiatrists. As case-oriented discussions, COR sessions begin with active case dilemmas from participants. Prospective and retrospective analytical approaches to case management promote understanding and foster optimal patient care.
The overarching goal of COR is to improve the socio-emotional well-being of children through prevention, with early identification of those at risk for, and discerning diagnosis of, biobehavioral problems. Goals and objectives focus on common clinical dilemmas encountered by participants, including:

i. Create a common language for ongoing dialogue between child health professionals from multiple disciplines including psychology, medicine, and nursing.
ii. Enhance cultural/linguistic competence
iii. Increase awareness of scope of participants’ competencies; strengthen abilities to consult other professionals.
iv. Promote collaboration between child health clinicians.

Postdoctoral Fellows are given first priority to seek the group’s input for their challenging cases and clinical dilemmas. COR time and location are

i. **2nd Thursday** from 7:45 to 8:45 in Wilf Conference Room 3 (coffee and pastries are provided), and
ii. **4th Thursday** from 12:15-1:15 in Wilf Conference Room 1+2 (lunch or refreshments are provided)

Interns are encouraged to attend COR as their schedules permit. This is most likely to be on the 4th Thursday meetings for interns on the Child and Adolescent Psychiatry rotation. Pediatric Psychology interns are encouraged to attend some of the COR events as their schedule permits. Due to scheduling conflicts it is not expected that interns on the Pediatric Neuropsychology rotation will be able to attend.

3. Case Conferences
   a. **Overview**

Interns participate in a monthly case conference that provides interns with experiences in making formal, professional presentations. Case conferences are intended to be educational for the presenter and the attendees and should result in enhanced clinical knowledge and skill. All attendees have potential contributions to make by participating in the discussion. Due to the limited time available for this and other professional presentations, information should be presented efficiently, succinctly, in a well-organized format, and in a manner that respects the dignity of patients and sustains the interest of the audience. Interns should be well-prepared when presenting at case conferences and should prepare their talk in consultation with their supervisors. Attendance by interns is mandatory. Whenever possible, a faculty member in addition to the supervisor for the case being presented shall attend. The discussant for 2019-2020 is Sasha Zagoloff, Ph.D. Others may also attend (e.g., postdoctoral fellows, other trainees or professionals involved with the case). Each intern presents two case conferences during the Internship. In general, the first conference focuses on assessment and diagnostic issues and the second case focuses on treatment. This is not always possible. Flexibility and creativity in conducting case conference is encouraged. **Presentations always include distribution of a current and informative bibliography. Interns are strongly encouraged to present cases that enrich attendees' understanding of clinically, ethnically, culturally, and demographically diverse groups.**

The case conference meets the **first Tuesday** (and second Tuesday in May) of each month from 1:00 P.M. to 2:00 P.M. in F212i. It is equipped with audio-visual equipment, including an LCD projector that supports PowerPoint presentations.
If interns wish to change the schedule, they may do so by arranging for another intern to substitute for them. Interns are then responsible for discussing schedule changes with their supervisor, ensuring that their supervisor will be able to attend at the rescheduled time, and notifying: (a) the Internship Coordinator; (b) their supervisors, and (c) the Internship Director of changes. **If schedule changes are requested, they must be submitted in writing (e.g., by email) to the Internship Coordinator and the Internship Director at least two weeks in advance of the scheduled conference.**

Interns are responsible for knowing which months and dates they are scheduled to present the case conference according to the following plan:

<table>
<thead>
<tr>
<th>Intern</th>
<th>Case Conference 1</th>
<th>Case Conference 2</th>
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</thead>
<tbody>
<tr>
<td>Jennifer Boike Armerding</td>
<td>January</td>
<td>June</td>
</tr>
<tr>
<td>Rosalia Costello</td>
<td>August</td>
<td>February</td>
</tr>
<tr>
<td>Ashley Isaia</td>
<td>September</td>
<td>March</td>
</tr>
<tr>
<td>Alex Nyquist</td>
<td>October</td>
<td>April</td>
</tr>
<tr>
<td>Jyothi Ramakrishnan</td>
<td>November</td>
<td>May (week 1)</td>
</tr>
<tr>
<td>Brianna Yund</td>
<td>December</td>
<td>May (week 2)</td>
</tr>
</tbody>
</table>

A template for the format for the case conference is provided below to provide a point of departure or basic guide for the case conference. It is not a rigid structure and may be modified at the discretion of the supervisor for the case in consultation with the intern.

b. **Objectives**

The objectives of the Case Conference are to:

1. Provide an overview of a clinical entity, addressing diagnostic issues, etiological factors, developmental course, prognostic, and treatment considerations, as well as review of pertinent literature and clinical and ethical issues.
3. Provide clinical descriptions and explanations of behavior and demonstrate familiarity with current diagnostic nosology.
4. Demonstrate clinical reasoning and judgment and hypothesis formation based on clinical data and familiarity with relevant clinical literature.
5. Demonstrate understanding of the potential contributions of comorbid medical/neurological conditions and/or the effects of treatments on case.
6. Review relevant clinical intervention approaches (e.g., individual, family, group psychotherapy, medication, community intervention, case-management, placebo) including theoretical models and empirical outcomes as available, and considerations in treatment planning.
7. Promote the development of intern's skills related to scholarly inquiry (e.g., computer searches, literature review, analysis and/or criticism of literature, preparation of data bases, enhance expertise related to research interests).
8. Refine skills in making professional presentations, including preparation of outlines, organization of clinical materials, use of PowerPoint and/or visual aids, handouts, and creation of informative up-to-date bibliographies.
9. Enrich presenters' and attendees' understanding of clinically, ethnically, culturally, and demographically diverse groups.
10. Explore relevant ethical, legal, regulatory, systems and societal issues.

c. **Template for Format of the Presentation**

1. Introduction and Rationale (i.e., why the case is being presented and is of interest)
2. Review of Literature
   a. Clinical literature (i.e., psychology, psychiatry, medicine)
   b. Research literature
3. Presentation of Case Data
   a. Demographic Data
   b. Referral Questions/Reasons for Hospital or Clinic Admission
   c. Case History:
      i. Onset, severity, duration and course of presenting complaints, precipitating events.
      ii. Developmental history (e.g., prenatal course, birth, developmental milestones, premorbid functioning).
      iii. Social history (e.g., age, education, occupation of parents and siblings; places of residence; quality of relationships within family; educational, vocational, and avocational functioning; SES, social and sexual functioning; legal history; cultural factors).
      iv. Medical history (e.g., overall health, co-morbid conditions, history of treatment, adherence, hospital course[s]).
      v. Psychiatric history (e.g., previous symptoms, co-morbid conditions, mental health and chemical dependency treatment, substance usage, suicide and self-injurious behavior, hospitalizations, response to treatment, adherence, motivation).
      vi. Family psychiatric, medical history (e.g., of similar symptoms or conditions, genetic loadings).
      vii. Other relevant history (e.g., systems).
   d. Presentation, signs, symptoms, mental status examination, observations, cooperativeness, rapport, etc.
   e. Psychological Data:
      i. Rationale for selection of tests (specificity/sensitivity of tests for condition, cost benefit analysis of testing, expectations or norms for diagnostic groups for measures used).
      ii. Objective test data.
      iii. Projective test data.
      iv. Other behavioral data.
      v. Collateral information.
      vi. Potential influence of multicultural factors on assessment and/or treatment, presentation, course, resources, and related psychosocial matters.
      vii. Summary of data supporting and/or disconfirming clinical hypotheses, limitations of data.
      viii. Recommendations if further testing or other assessment data should be obtained (e.g., how and would repeat testing be justified?).
   f. Treatment course or summary (if appropriate)
g. Formulation (integration of data to derive differential diagnoses, explanations of presentation citing causative agents, events or conditions, natural course of the disorder, prediction of outcome with and without treatment, recommended treatment plan and rationale of treatment, issues to consider in implementation of the treatment plan.)

4. Discussion (e.g., case, clinical issues, ethical, regulatory and legal issues, systems issues, cultural diversity, research issues; broader societal issues).

5. Summary and Conclusions.

d. Roles of Presenter in Case Conference

1. Review plans and materials with supervisor of the case at least two weeks prior to the presentation.

2. Apprise the supervisor (of the case being presented) of the date and time of the conference at least two weeks in advance so as to provide sufficient notice to maximize the likelihood that the supervisor is available to attend the Case Conference.

3. Inform the Internship Director and the Internship Coordinator which supervisor is providing (or provided) supervision for the case being presented and will be attending the case conference. This information must be communicated by the intern to the Internship Coordinator by the 15th day of the month before the Case Conference, so as to allow for orderly scheduling and preparation of the monthly internship calendar.

4. Provide presentation in professional manner, allocating sufficient time to cover major areas within presentation, and ending at one hour.

5. Provide a current bibliography (≥ 1 word-processed page) and handouts (e.g., key articles, DSM criteria of differential diagnoses).

6. Arrange for patient to be available for brief interview or for videotape as part of conference (optional). If a patient is scheduled to come, advance notice to the supervisor is necessary and a release must be signed.

7. Organize audio-visual support for presentation (e.g., PowerPoint, overheads, slides, audiotapes, videotapes). If audio-visual equipment is necessary, presenter should contact the Internship Coordinator and/or the AV coordinator of the Department of Psychiatry.

8. Select a case that will be of interest to the other interns and faculty (e.g., presents a complex differential diagnosis, that ensures that a broad range of clinical and multicultural populations are discussed during the course of the year, that has not been presented at other conferences associated with the Internship, and that has not been presented by the presenter at any other time).

e. Roles of Supervisor of Case in the Case Conference

1. Provide consultation, guidance, and assistance in working up the case. Review information with presenter prior to conference.

2. Attend case conference.

3. Interviews patient during case conference (optional).

4. Provide feedback to the intern privately within one week of the presentation.

f. Expectations of All Case Conference Attendees

1. Participate in collegial, respectful discussion of case and relevant issues.
2. Review handouts and any information provided before the presentation.
3. Be punctual.
4. Maintain confidentiality of all patient-related materials.

4. Rotation-Specific Training

Interns on certain rotations are required to participate in several training activities and interdisciplinary team meetings.

a. Child and Adolescent Psychiatry Conferences, Rounds and Weekly Meetings

Interns on the Child and Adolescent Psychiatry rotation participate in several conferences and case supervision. These experiences are on the UMMC-Riverside Campus and are subject to change during the year.

**Monday:** psychotherapy cases and supervision at the Behavioral Health Clinic for Families (BHCF).

**Tuesday:** Tuesday is reserved for internship didactics along with interns on other rotations.

**Wednesday:** - Case supervision following patient evaluations and prior to providing feedback in Early Childhood Clinic 9:00 A.M.-10:00 A.M.
- Grand Rounds, Department of Psychiatry- 11:00 A.M.-12:00 P.M, Wilf Family Center (see schedule)
- Individual supervision with Dr. Lingras (both interns, 1:00 P.M.-2 P.M.)
- Individual supervision with Dr. Zagoloff (both interns, 2:00 P.M.-3:00 P.M.)

**Thursday:** - Case supervision following patient evaluations and prior to providing feedback in Child and Adolescent Psychiatry Clinic with Dr. Bernstein, (9:00 A.M. to 12:00 noon)
- Anxiety Round Table- 12:00 – 1:00 P.M., Paula Clayton Room/F263
- Collaborative Office Rounds (COR) with Pediatrics Residents and team (Lunch and Learn, lunch is included, case sent ahead of time. Speak with Dr. Lingras if interested in attending). Monthly, usually last Thursday of the month (optional) 12:15-1:15 P.M.

**Friday:** Case supervision following patient evaluations and prior to providing feedback in Child and Adolescent Neuropsychology Clinic or Child and Adolescent Anxiety Disorders Clinic

b. Pediatric Neuropsychology Conferences, Rounds, Seminars, and In-Clinic Supervision

Interns on the Pediatric Neuropsychology rotation attend a variety of conferences and may choose to attend additional elective conferences. Interns clarify expectations for attendance with Pediatric Neuropsychology supervisors. On days the intern is testing, that intern should not schedule therapy patients until later in the afternoon. For the first 2 months of the rotation, therapy cases should only be scheduled at or after 3:30. For the last months of the rotation, therapy cases may be scheduled earlier (i.e., 2:30-3:00), but the intern should – in advance - tell the supervising neuropsychologist for their case that day the time of the therapy appointment.

**Monday:** *If assigned to an evaluation that day:* Case supervision in clinic- 8:30 A.M.-8:45 A.M. in the Discovery Clinic for which interns are to be prepared.
Additional case supervision after evaluations in clinic rooms (generally for a half hour between 11 A.M. and 3 P.M. [before providing feedback]).

Tuesday: Internship didactics until 2 P.M.
Pediatric Neuropsychology Clinical Case Conference - 2:00 P.M.-3:00 P.M. (room varies within the East Building and UMMCH). It is understood that interns will attend immediately after their internship didactics are dismissed (i.e., may be a few minutes late).
Pediatric Neuropsychology Didactics - 3:00 P.M.-4:30 P.M. (room varies within the East Building and UMMCH).

Wednesday: Weekly Pediatric Grand Rounds/Case 7:30 AM-8:30AM in the Wilf Auditorium (attendance is for selected weeks/topics, not weekly).

If assigned to an evaluation that day: Case supervision in clinic- 8:30 AM-8:45 AM in the Discovery Clinic for which interns are to be prepared.
Additional case supervision after evaluations in clinic rooms (generally for a half hour between 11 A.M. and 3 P.M. [before providing feedback]).

Thursday: Therapy supervision with Dr. Boys and Dr. Gross from 7:30AM-8:15 AM in the Discovery Clinic.

If assigned to an evaluation that day: Case supervision in clinic- 8:30 AM-8:45 AM in the Discovery Clinic for which interns are to be prepared.
Additional case supervision after evaluations in clinic rooms (generally for a half hour between 11 A.M. and 3 P.M. [before providing feedback]).

Friday: If assigned to an evaluation that day: Case supervision in clinic- 8:30 AM-8:45 AM in the Discovery Clinic for which interns are to be prepared.
Additional case supervision after evaluations in clinic rooms (generally for a half hour between 11 A.M. and 3 P.M. [before providing feedback]).

c. Pediatric Psychology Rounds and Weekly Activities

Interns on the Pediatric Psychology rotation attend a variety of conferences:

Monday: Topical Seminar/Journal Club - 7:30 A.M.-8:30 A.M., Voyager Clinic – Conference Room. This seminar is comprised of a variety of journal club and topical seminar topics presented by pediatric psychology faculty, interns, and practicum students.

Wednesday: Patient Staffing Conference or Department of Pediatrics’ Grand Rounds - 7:30 A.M. to 8:30 A.M., Voyager Clinic - Conference Room or Wilf Auditorium. Interns attend Grand Rounds when the topic is suitable for interns. Interns will be notified by supervisors about the weeks they are to attend Grand Rounds.

Thursday: Psychotherapy Group Supervision – 7:30AM-8:30AM, Voyager Clinic - Conference Room. This group supervision provides opportunities to discuss inpatient and outpatient psychotherapy/intervention cases.

B. Research and Scholarly Activity
The philosophy of the Internship is that research and clinical activity inform one another. To facilitate interns’ professional development in accord with the Scientist-Practitioner model, interns are encouraged, but not required, to participate in research during the year (e.g., collaboration with Internship faculty). Research involvement can take many forms, e.g.: empirical
studies in which data is collected; analyses of data sets of Internship or University faculty; scholarly literature reviews of areas related to interns' professional interests and the Internship. The objectives and scope of interns' research activities are to be clarified and negotiated with faculty if interns engage in research during the Internship. Issues of authorship are determined in accord with APA Ethical Principles of Psychologists and Code of Conduct. Interns' development of proficiencies in scholarly inquiry is also promoted through case conferences, rounds, and intra-rotation training activities. In general, when interns have engaged in research or professional writing, it has included time beyond the normal work week. Previous interns’ research efforts have resulted in professional publications. Although, the Internship cannot provide release time from other duties to work on research and dissertations, interns may use administrative leave for research/dissertation-related meetings and are generally encouraged to be involved in research and scholarship to the extent that they can. Some interns have participated in faculty reviews of journal article submissions.

Information about the conduct of research with human subjects at the University of Minnesota may be viewed at http://www.irb.umn.edu/ and http://www.research.umn.edu/subjects/index.html - UBaJ592at48. To obtain information about grants management at the University of Minnesota, including application forms, link to the Sponsored Projects Administration website: http://www.ospa.umn.edu/. The Institutional Review Board must approve research activities involving human subjects and all research activities must be compliant with HIPAA.

The University of Minnesota Medical Center Guidelines for Human Subjects in Research are:

"All research involving human subjects conducted at Fairview Health Services shall be performed in full compliance with the laws and regulations governing the protection of human subjects. Individuals conducting research in any Fairview Health Services facility or using any non-public information for the purpose of identifying or contacting prospective human research subjects shall be aware of and comply with all Fairview policies relating to the use of human subjects in research."

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11Examples include:
The Standards of Accreditation emphasize the role of research in the training and practice of health service psychologists.

C. **Intern Group Meetings**

Interns are encouraged to meet with each other on a regular basis to facilitate social interaction, cohesion, support, and enhance communication with the Training Committee. Interns determine the frequency, time, location, format, and content of their meetings. If they wish for additional structure for organizing such meetings, they may contact supervisors, the Internship Director or Internship Coordinator for further assistance in facilitating them.

D. **Multicultural/Diversity**

One of the objectives of the Internship is to provide training to prepare interns to provide appropriate services sensitive to the needs of a diverse range of patients. Attention to issues of multicultural/diversity is woven through all components of the Internship’s didactic and supervised clinical experiences, including the Diversity Seminar and the MAAPIC workshop on Multicultural Diversity. Interns are especially encouraged to address these issues in topical seminars, supervision, and in the case conferences. For example, case conference presentations are an ideal time to explore issues of diversity. **Interns are also strongly encouraged to develop diverse caseloads of patients for assessment and psychotherapy. Interns are also urged to explore how these factors affect the assessment and treatment and to discuss diversity issues in supervision and in didactics.** Selected resources pertaining to multicultural diversity may be accessed at: [http://www.apa.org/pi/oema/](http://www.apa.org/pi/oema/).

E. **Orientation and UMMC Required Learning**

The Internship begins with an orientation to the program and to the hospital. The purpose of the orientation is to welcome interns and to familiarize interns with the hospital and the Internship as well as their rotations. The orientation takes places the first two days and full time and then continues part-time during the first week. Orientation includes discussions of the contents of the Internship Handbook, treatment planning, documentation requirements, mandatory reporting, stress management, time management, an overview of supervision, completion of paperwork (e.g., financial, orientation self-assessment) orientations to rotations, and opportunities to socialize so as to build esprit de corps among interns and facilitate their socialization into the program. It includes welcoming activities and meals.

At the beginning of the year, interns are expected to read the Internship Handbook and be familiar with the policies of the Internship and Hospital. In addition, all learners at the hospital are expected to review the Required Learning e-learning for the hospital, which can be found on the Fairview Internet (see link below). It is estimated to take 45 minutes to complete.


- **Lesson One: Introductions and Instructions**
- **Lesson Two: Protecting our Patients, Clients and Customers**
- **Lesson Three: Emergency Preparedness and Safety**
- **Lesson Four: Employee Right to Know**
- **Lesson Five: Infection Prevention**
- **Lesson Six: Awareness and Maintaining Compliance**

F. **Interprofessional Education**

Interprofessional Education (IPE) is an increasingly important aspect of training for collaborative healthcare practice. The University of Minnesota Academic Health Center is strongly committed to promoting interprofessional education for all health sciences trainees. The National Center for Interprofessional Education and Collaborative Care is at the University of Minnesota. The internship is exploring opportunities for interns to engage in Interprofessional Education, including the **Foundations in Interprofessional Communication and Collaboration Course (FIPCC).**
IPE is intended to prepare students to be ‘collaboration ready’ which requires a shift in training from profession-specific silos to teams. IPE is intended to foster Development of an interprofessional identity and skill-set that builds upon uniprofessional development. According to the World Health Organization (WHO), IPE provides opportunities for students to learn from, with, and about each other. The 2019 Foundations in Interprofessional Communication and Collaboration Course (FIPCC) is open to interns as an elective. Interns who are interested should contact Dr. Robiner. The course series meets Friday afternoons in the Fall from 1:30 to 3:30 P.M.

<table>
<thead>
<tr>
<th>Date</th>
<th>Session</th>
<th>Core Exercises</th>
<th>IPEC Competency Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/21</td>
<td>Session 1: Roles &amp; Responsibilities of Healthcare Professionals</td>
<td>Gain understanding why interprofessional education and practice is important to providing collaborating healthcare</td>
<td>Roles and Responsibilities Teams and Teamwork</td>
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<td></td>
<td>Learn about professional roles and responsibilities of members of the healthcare team</td>
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<td>10/12</td>
<td>Session 2: Health Systems &amp; Interactions Online</td>
<td>Gain understanding of the Triple Aim and Quadruple Aim and the impact</td>
<td>Roles and Responsibilities Teams &amp; Teamwork</td>
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<td></td>
<td>Understand how team effectiveness impacts patient safety and quality of care</td>
<td>Interprofessional Communication</td>
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<tr>
<td>10/26</td>
<td>Session 3: Interprofessional Teams &amp; Teamwork</td>
<td>Gain an understanding of how essential teamwork is in healthcare</td>
<td>Teams and Teamwork</td>
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<td></td>
<td></td>
<td>Small-group teamwork activity</td>
<td>Interprofessional Communication</td>
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<td></td>
<td></td>
<td>Discuss interprofessional team component of case study</td>
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<tr>
<td>11/2</td>
<td>Session 4: Wellbeing &amp; Resilience for Healthcare Professionals</td>
<td>Gain an understanding of what being resilient means and how this can contribute to overall wellbeing</td>
<td>N/A</td>
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<td>Identify and practice individual self-care and resilience strategies</td>
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<tr>
<td>11/16</td>
<td>Session 5: Ethics &amp; Professionalism</td>
<td>Compare and contrast codes of conduct/ ethics between professions</td>
<td>Values and Ethics</td>
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<td>Discuss common ethical violations</td>
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<td>Identify shared values through case study discussion</td>
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<td>E-professionalism</td>
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<tr>
<td>11/30</td>
<td>Session 6: Leadership</td>
<td>Understand the benefits of including the viewpoints of all team members in healthcare practice</td>
<td>Roles and Responsibilities Teams and Teamwork</td>
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<td>Understand the impact of the leader and of the team members in creating a safe environment and in fostering open communication</td>
<td>Interprofessional Communication</td>
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<tr>
<td></td>
<td></td>
<td>Understand the need for leaders to be resilient and courageous in times of crisis and stress</td>
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</table>

The FIPCC course addresses the core competencies identified by the Interprofessional Education Collaborative (2016). Interns may participate as students or as facilitators, taking on additional leadership responsibilities and receiving a certificate from the
National Center. ITC comprises six 2-hour sessions on Friday afternoons in September, October and November with students from other disciplines.

- Domain 1: Values/Ethics for Interprofessional Practice
- Domain 2: Roles/Responsibilities
- Domain 3: Interprofessional Communication
- Domain 4: Teams and Teamwork

Additional IPE activities may be pursued during the year (e.g., palliative care, Phillips Neighborhood Clinic).

VI. SUPERVISION

Supervision is a strongly valued component of the Internship. In general, the internship is a period of major professional development during the education and training of psychologists. Supervision plays a major role in refining interns’ skills while providing oversight to ensure that interns provide patients with high quality care. Interns are encouraged to develop supervision skills as well as being the beneficiaries of supervision during the internship and to read and be familiar with current supervisory standards (APA, 2014). In addition, it is important to note that supervision is getting additional attention through psychology boards so psychologists need to read and be aware of the evolving guidelines, especially in terms of what might be required of them as they prepare for licensure (ASPPB, 2015). The APA supervision guidelines and other practice guidelines are available at: http://www.apa.org/practice/guidelines/

Supervision involves the teaching, coaching, guiding and monitoring of trainees and others in the development of competence and skill in professional practice for health service psychology including the evaluation of trainees’ skills across competencies. Supervisors act as role models and maintain responsibility for the activities they oversee. Supervision is an interactive educational experience between the intern and the supervisor. The supervisory relationship is hierarchical, has the broad purposes of enhancing the professional functioning of trainee(s), monitoring and ensuring the quality of professional services, and evaluating trainees in that supervisors serve as gatekeepers for the profession (Bernard & Goodyear, 2009). It should be noted that whereas supervisors use discretion, there are limits to confidentiality.

For trainees in health service psychology, the internship is an important developmental phase that can present personal and professional challenges as interns make the transition from student status to entering the field as professionals. The developmental stressors associated within internship training have been discussed in the literature and are discussed during supervision and Training Committee meetings. At times, trainees may feel a sense of vulnerability, as they expose their work to the review of their supervisors and fellow interns and receive feedback. This sense can be compounded as interns broaden their skills and take on increasing responsibilities in the provision of psychological services and work with larger numbers of patients, with broader and potentially more acute problems, than they have encountered previously. In addition, interns may be challenged by the pace of clinical work and the time lines and complex processes (e.g., electronic medical record [EMR]; billing and documentation) involved in completing clinical activities as well as the more extensive experiences

(e.g., interacting with schools, medical teams, and Child Protection). As a matter of professional development, it is each intern's responsibility to discuss concerns or problems if they emerge and to develop strategies for dealing with the developmental stressors and training challenges inherent in internship training.

Individual supervision is the predominant training modality in this and other APA-accredited internships. Ideally, supervision involves oversight of supervisees' work incorporating the perspectives of an experienced clinician, sensitive teacher, discriminating professional, and effective manager of clinical services and training. The clinical aspects of supervision focus on the professional development of supervisees' skills. The administrative or managerial aspects of supervision involve directing and evaluating the work of supervisees while ensuring that patients are provided appropriate care. Supervision is a process in which neither supervisors nor supervisees are expected to be perfect or flawless as human beings, psychologists, or psychologists-in-training. It is a process that is fundamentally dedicated to ensuring and improving the quality of professional services that interns can provide and preparing them to develop greater professional autonomy.

Supervisors and interns are expected to strive to use supervision to promote the achievement of the highest level of performance in the services interns provide through collaborative and collegial working relationships that support and nurture progress toward this goal. It should be noted that whereas supervisors and mentors use discretion, there are limits to confidentiality.

Clinical supervision is a complex undertaking. It can be a richly rewarding endeavor for both the supervisee and the supervisor and interns and supervisors are expected to approach it in a collegial, respectful manner. Supervision has multiple purposes and may be subject to diverse potential factors for creating tension. Supervisory objectives typically include:

a. Enhancing interns' competencies;
b. Exposing interns to a range of patients and models of service delivery;
c. Facilitating information-gathering, problem-solving, clinical and ethical reasoning, effective communication, and professional functioning within multiple systems;
d. Promoting access to other professionals;
e. Monitoring and improving the quality of professional services rendered by interns to patients;
f. Assessing interns' strengths and limitations;
g. Furthering interns' career-development; and
h. Addressing other miscellaneous training and professional issues.

Supervisors strive to find a delicate balance among multiple roles, including: advising; directing; teaching; mentoring; listening; editing; providing emotional support (i.e., not therapy) to interns; assigning cases, and monitoring interns' performance to ensure that clinical services meet clinical, training, professional, and administrative objectives.

Supervision deals with specific clinical tasks and also offers interns opportunities to discuss their reactions, questions, reflections or concerns about the clinical work, as well as concerns about their professional development.

Supervisory tasks generally include:

a. Creating an emotional and social context within the supervisory relationship that permits supervisees to feel that they can learn, discuss concerns, needs, and questions safely, expose weaknesses or vulnerabilities, and take risks;
b. Tailoring learning to meet individuals' needs and developmental levels;
c. Promoting professional development;
d. Helping supervisees develop effective strategies in working with patients;
e. Identifying and addressing supervisees' personal issues and limitations to the extent that they affect their professional activities;
f. Providing positive, professional role models;
g. Working with subjective and ambiguous clinical situations, standards, and evaluative criteria; and
h. Meeting the administrative (e.g., documentation, HIPAA, mandatory reporting; financial) and institutional objectives (e.g., pursuit of excellence, needs of referral sources) of their service and department.
i. Providing supervision in accordance with institutional, accreditation, third party contractual arrangements, as well as ethical, legal and regulatory guidelines and standards.

In accordance with APA (2002) Ethical Standard 7, Item 7.04\textsuperscript{16}, the Internship does not require the disclosure of many forms of personal information. Trainees can benefit, however, from sharing some forms of personal information. For example, one’s personal reactions in the therapy dyad may provide valuable information related to the course of therapy. Self-awareness is critical to the development of professional skills. Because personal and professional growth can be concurrent, there are times when personal information may be constructively discussed within the supervisory relationship. At such times, the supervisor’s exploration of personal qualities and history focuses on enhancing the trainee’s effectiveness as a professional. Such discussion is explicitly not therapy and, if undertaken, is to proceed in a manner that is not perceived as coercive by the trainee. Interns retain the right to privacy and to determine when and how much personal information to divulge. Supervisors are expected to respect interns’ preferences not to disclose personal information but may also explore ways in which the supervision might be improved so that requisite personal disclosures can occur effectively and in ways that interns consider to be safe.\textsuperscript{17} Any questions about our supervision policies may be directed to the Training Director or the Training Committee.

If problems emerge in supervision, supervisors and interns are encouraged to address issues forthrightly with each other, endeavor to be constructive in solving problems and finding effective means of achieving training and clinical goal, and seek whatever assistance (e.g., consultation with peers, other supervisors, mentors, the Internship Director, the Intern Advocate, the Training Committee, etc.) may be necessary to achieve resolution.

**Interns and supervisors are expected to discuss goals and expectations during initial supervisory meetings. They are strongly encouraged to create a list of interns' training goals that will be periodically reviewed during the rotation to help ensure that training aims are met.**

It is incumbent on supervisors and interns to identify goals for supervision, discuss expectations for supervised clinical practice on rotations, and find ways of maximizing the learning that occurs in supervision and through interns’ clinical experiences. Interns' needs are likely to vary over time.

Within supervision, it is vital to address: (a) which clinical activities need to be accomplished by whom, when, where, why, and how; (b) how best to prioritize and accomplish clinical objectives; (c) diagnostic and treatment issues; (d) clinical, ethical, legal, systems and cultural issues; (e) professional issues including confidentiality and informed consent; (f) what is being learned; (g) what questions and concerns are being raised in association with clinical activities; (h) issues and problems (e.g., systems, personal, supervisory) in accomplishing tasks; (i) the intern's personal experience of engaging in clinical activities and his or her responses to clinical material; (j) theoretical orientations; (k) emergency procedures; and (l) supervisory evaluation. When dealing with emergences and

\textsuperscript{16}7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

\textsuperscript{17}This policy has been adapted from materials provided by the University of Texas at Austin and University of San Diego, CA.
mandated reports, interns must collaborate closely with supervisors. All emergency or mandated reports must be made in conjunction with the supervisor (i.e., the supervisor is to be present, or electronically part of the process, and to provide the information).

Interns must consult with their supervisor if any of the following occur:

- Disputes with patients or impasses in therapy
- Allegations of unethical behavior by patients, colleagues, or others
- Other ethical concerns
- Threats of a complaint or lawsuit
- Mental health emergencies requiring immediate action
- High-risk situations (potential suicide, threats of violence)
- Contemplated or known departures from standards practice or exceptions to general rules, standards, policies, or practices
- Suspected or known clinical or ethical errors
- Contact with patients outside the context of treatment or other psychological services, including incidental encounters
- Legal issues (e.g., mandated disclosures)

To provide structure and monitoring of clinical activities, the Internship developed systems for tracking interns' clinical activities and progress. The Clinical Assessment Log (CAL), the Clinical Intervention Log (CIL) (or derivatives), the Tracker, Consultation Log, and the Supervision Log are to be discussed routinely (i.e., at least monthly) within supervision meetings and are to be brought to all supervision meetings by interns. The Clinical Supervision Plan and Clinical Supervision Record (addressed later) need to be initiated at the beginning of supervision and maintained throughout supervisory experiences. Very basic information is to be included about the nature of the supervisory contact.

Supervisors are committed to meeting and balancing the diverse needs of patients, interns, their respective departments, and the Internship as a whole. Interns are committed to meeting the diverse needs of patients, supervisors, their respective departments, and the Internship as a whole. Use of the aforementioned forms/spreadsheets to document interns’ clinical activities, helps in managing caseloads and promote diversity of clinical activities. Copies of these forms (CAL, CIL, Tracker, Consultation Log, Supervision Log, Miscellaneous Log) are submitted at the end of each quarter as spreadsheets to the Internship Director via email, including at the end of the internship year. They are expected to be forwarded to the Internship Director more frequently if problems emerge.

Interns are supervised primarily by doctoral-level licensed psychologists whose competencies in supervision and in the areas of service being supervised are listed with the Minnesota Board of Psychology. Interns may also obtain secondary supervision from designated non-doctoral or unlicensed individuals with psychological training, or from physicians credentialed through the UMMC Medical Staff Office in the areas in which they provide clinical services and supervision, or on a limited basis from other mental health professionals (e.g., licensed social workers). Interns are responsible for being aware of and adhering to the supervision requirements related to all of their training and professional activities. These guidelines were established by the Psychology Standards Committee of the University of Minnesota Medical Center and are summarized in Appendix 1 of this document. In addition, Appendix 20 provides a bibliography that addresses multiple aspects of clinical supervision.

**Supervisory Hours.** It is essential that supervisors and interns approach supervision as an important and valued training activity. Interns share with supervisors the responsibility of ensuring that adequate supervision is obtained. In accordance with the APA Standards of Accreditation, interns obtain a **minimum** of (a) **two hours of individual face-to-face supervision per week** and (b) **two**
additional hours of supervision per week. One of these hours is provided in a group supervision format in conjunction with the Psychotherapy Seminar. These minimal requirements may include supervision from supervisors other than interns’ primary supervisors. If there are any problems in meeting the supervisory requirements, interns will discuss this issue immediately with primary supervisors and/or their faculty mentor, with the Internship Director, and/or with the Training Committee, and possibly with the Intern Advocate. Interns and supervisors are expected to make conscientious efforts, as needed, to remedy any problems related to scheduling adequate supervision. Interns are encouraged to seek any additional supervision as necessary for the management of patients, and to seek immediate supervision upon completing initial assessments, especially for patients with emergent problems. Interns are encouraged to obtain more than the minimal hours of supervision per week when desired or needed, and historically have generally been able to do so in the Internship. Interns generally report obtaining more than the APA-mandated minimum levels of supervision.

Interns use the Supervision Log to document the hours of supervision they receive weekly. This spreadsheet, which was developed at the request of interns, provides documentation that interns are obtaining adequate supervision. It also may provide early identification of any problems they may encounter in obtaining adequate supervision. If interns become aware of a pattern of difficulty in obtaining the minimum of four (4) total hours of supervision per week, they must contact the Internship Director immediately. Interns email the Supervision Log to the Internship Director and the Internship Coordinator quarterly and at the end of the internship year.

Beginning in 2011, the Minnesota Department of Human Services issued new regulations for tracking supervision. Interns are now required to create a Clinical Supervision Plan (Appendix 33) for each supervisor. The supervisor and training director are to be forwarded copies and to maintain copies of the plan. In addition, interns need to track supervision with each supervisor on a weekly basis using the Clinical Supervision Record that meets DHS requirements (Appendix 34). Quarterly, interns are to forward (by email) pdf copies of the signed Clinical Supervisory Record to the Training Director. Supervisors are also required to maintain copies of the signed Clinical Supervisory Records. It is noted that unfortunately these are now required by the Minnesota DHS despite the redundancy with other mechanisms for tracking supervision.

Interns attend a one-day workshop under the auspices of MAAPIC along with interns from the other Minnesota APA-Accredited internships, entitled, “Clinical Supervision Ethical, Legal & Practice Issues.” It is conducted by Gary Schoener who is a national authority on supervision and practice issues.

Group Supervision of Psychotherapy/Intervention:
Interns participate weekly in group supervision on psychotherapy every Tuesday 12:00 Noon to 1:00 P.M. Much of the Internship’s didactic and supervisory training dedicated specifically to psychotherapy is provided through the combination of the psychotherapy seminar and group supervision. by Dr. Pisetsky. The location of the group supervision is F212i in the Psychiatry Department on the Riverside Campus.

A. Observed Supervision/Case Consultation & Interprofessional/Interdisciplinary Interactions

So as to develop basic supervisory skills themselves, interns are required to have minimal experiences functioning as a supervisor each rotation. Technically this is case-consultation because interns do not have the ultimate responsibility of the cases they are discussing. Interns provide practicum students with guidance on managing cases in various forums, including within group supervision and case management conferences. In addition, during group psychotherapy, at least once in
the year, each intern has an opportunity to lead the supervision session. This supervisory experience is observed by at least one of each intern’s supervisors at least once per rotation. Evaluation of this observed supervision is part of the quarterly and end of year review.

1. **Observed Supervision/Case Consultation**

   According to the APA (2015) Profession-Wide Competencies (C- 8 D) Implementing Regulation, “CoA views supervision as grounded in science and integral to the activities of health service psychology. Supervision involves the mentoring and monitoring of trainees and others in the development of competence and skill in professional practice and the effective evaluation of those skills. Supervisors act as role models and maintain responsibility for the activities they oversee. Trainees are expected to:

   - Apply this knowledge in direct or simulated practice with psychology trainees, or other health professionals. Examples of direct or simulated practice examples of supervision include, but are not limited to, role-played supervision with others, and peer supervision with other trainees”

During the group supervision of psychotherapy led by Dr. Pisetsky each intern gets at least two opportunities (i.e., one per rotation) to lead the group supervision of psychotherapy. Interns have opportunities to discuss this supervision with Dr. Pisetsky after their leadership of the group supervision.

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Plan for Observed Supervision/Case Consultation Provided by Intern</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child &amp; Adolescent Psychiatry</strong></td>
<td>Interns are directly observed administering neuropsychological tests, child and parent interviews, and feedback sessions by Dr. Wozniak. Dr. Wozniak also observes the interns as they provide supervision to a practicum student (in person and in written reports).</td>
</tr>
<tr>
<td><strong>Pediatric Neuropsychology</strong></td>
<td>Interns on the Pediatric Neuropsychology rotation have the opportunity to work with and provide supervision/case consultation to graduate level practicum students. During the rotation, interns are assigned a specific case for which they provide case consultation to a practicum student for assessment. This involves consulting with (i.e., paralleling supervising but without the full responsibilities of a supervisor) the practicum student in staffing the case, developing case conceptualization, testing, scoring and report writing. This quasi-supervisory experience is observed by one of the rotation supervisors who gives feedback to the intern.</td>
</tr>
<tr>
<td><strong>Pediatric Psychology</strong></td>
<td>Interns on the Pediatric Psychology rotation have the opportunity to work with and provide supervision/case consultation to graduate level practicum students in various ways throughout the rotation (e.g., providing modeling and instruction on test administration). At least one time per year, each intern has opportunity to lead the Case Conceptualization Conference meeting, which includes providing direct supervision to the practicum students who are preparing for upcoming neuropsychological evaluations. This supervisory experience is observed by at least one rotation supervisor.</td>
</tr>
</tbody>
</table>
2. **Observed Consultation/Interprofessional/Interdisciplinary Interaction**

According to the APA (2015) Profession-Wide Competencies (C-8 D) Implementing Regulation,

“CoA views consultation and interprofessional/interdisciplinary interaction as integral to the activities of health service psychology. Consultation and interprofessional/interdisciplinary skills are reflected in the intentional collaboration of professionals in health service psychology with other individuals or groups to address a problem, seek or share knowledge, or promote effectiveness in professional activities. Trainees are expected to:”

- Demonstrate knowledge and respect for the roles and perspectives of other professions
- Apply knowledge of consultation models and practices in direct or simulated consultation with individuals and their families, other health care professionals, interprofessional groups, or systems related to health and behavior

Interns have unique opportunities to interact with trainees and faculty from other health professions through the Academic Health Center Office of Education course Foundations in Interprofessional Communication and Collaboration (FIPCC). Each year, more than 1,000 health professional students participate in FIPCC, which provides an orientation to interprofessional concepts and competencies. Students from across the Academic Health Center, as well as some additional health-related programs participate. FIPCC consists of six online modules each associated with a facilitated face-to-face small group session. The interprofessional small groups of students meet on Friday afternoons during fall semester. Small groups are facilitated by AHC faculty and health care leaders from the community. Advanced students, such as psychology interns, are also facilitators and contribute to the interprofessional discussion.

In addition to FIPCC, interns have ample opportunities to interact with professionals and trainees in other disciplines.

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Plan for Observed Consultation/Interprofessional/Interdisciplinary Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child &amp; Adolescent Psychiatry</strong></td>
<td>Interns regularly interact with psychiatrists, psychiatric residents, child and adolescent psychiatry fellows in clinical settings and in Departmental meetings (e.g., Grand Rounds), and in various treatment teams, especially the anxiety disorders.</td>
</tr>
<tr>
<td><strong>Pediatric Neuropsychology</strong></td>
<td>Pediatric neuropsychology interns participate in interprofessional management responsibilities. Consultation with educators, pediatrics, blood/marrow transplant physicians, psychiatrists, psychologists, and neurologists is common/interdisciplinary on a regular basis as part of their case management.</td>
</tr>
<tr>
<td><strong>Pediatric Psychology</strong></td>
<td>Each intern is assigned to at least one multidisciplinary clinic (e.g., Teen Weight Loss Surgery, Family Weight Management) that is staffed by at least one supervisor and various other medical professionals (e.g., physician, registered dietician, and registered nurse). Under direct supervision of a rotation supervisor, the intern will consult with the other medical professionals during preparatory</td>
</tr>
</tbody>
</table>
VII. MENTORING AND INTERN ADVOCATE PROGRAMS

A. Mentoring Program

Mentoring has been defined as, “a personal relationship in which a more experienced (usually older) faculty member or professional acts as a guide, role model, teacher, and sponsor of a less experienced (usually younger) graduate student or junior professional” (Johnson, 2002, p. 88). Mentors provide “knowledge, advice, challenge, counsel, and support in the...pursuit of becoming a full member of a particular profession.” (Johnson, 2006, p. 20).

The mentor program provides support and guidance to interns on an individual basis. Mentors may include Internship faculty members, psychologists working within the Academic Health Center, and other faculty members within the participating Medical School Departments of the Psychology Internship. If an intern selects one of their supervisors to serve as their mentor, it is recognized that there may be potential conflicts which could result in limitations or changes in the mentoring relationship. Interns and mentors are free to change mentoring arrangements at any time during the year. Mentors serve as a role model, resource person, and advisor in offering support for issues related to interns' experiences during the Internship and professional development. Mentors do not serve in a psychotherapeutic role. The Mentor Program was designed by the Training Committee with input from interns from previous years. Mentors are available to meet with interns monthly, and possibly at times more often as desired by the intern, to discuss a range of issues and concerns. It is recommended that confidentiality issues, roles, and expectations are discussed and agreed to between the intern and mentor at the outset and that these and other matters related to the mentoring relationship be revisited as necessary to enhance the mentoring experience. It should be noted that whereas mentors use discretion, there are limits to confidentiality.

Trainees and professionals at all career stages can benefit from strategies designed to maintain and increase their productivity and joy in their careers, including mentoring. Bland, Taylor, and Shollenberger (2006) the recommended the following strategies:

(a) Establish trust: Trust results when the members of the mentoring relationship are open to learning about each other’s differences.

(b) Communicate openly and often: Open and ongoing discussion of personal and professional opportunities and differences in worldview contribute to a mutually supportive relationship.

(c) See each other as individuals: Gain an understanding of each other's views. Mentoring partners strive to avoid making assumptions about one another and should identify each other as individuals and not as representatives of a category.

(d) Take the initiative: Mentoring relationships are two-way streets. Mentors are expected take the initiative to contact the mentee. Mentee's enhance the relationship when they take a proactive role.

(e) Publicly support mentees and help them expand professional networks: Visibly promote initiatives and scholarship, introduce them to colleagues and

peers inside and outside of the department and institution, and include them in informal social activities.

(f) **Manage power differentials; maintain appropriate boundaries:** Both partners in a mentoring relationship share responsibility for managing personal and professional boundaries. Mentors must be sensitive to avoiding the illegitimate aspects of power based on socialization, stereotypes, and attributions to minimize their potential influence on mentoring relationships.

The sections below describe mentoring processes and activities.

1. **MENTOR IDENTIFICATION**
   - Efforts will be made to ascertain intern preferences for mentors before they arrive
   - Phase I mentors will be identified by the training committee prior to intern arrival
   - Mentors may potentially include faculty who are not internship core faculty
   - Phase I mentors will each meet with their mentee in **July**

2. **ORIENTATION TO MENTORING PROGRAM**
   Dr. Wozniak will meet with the group of interns during orientation week to formally introduce the mentoring program. General points:
   - Mentorship is separate from supervision
   - The focus is on readying mentees for the year(s) following internship rather than focusing on managing/coping with the internship itself (which may also be addressed)
   - Sharing personal experiences, advice, and perspective is a key component to mentoring
   - Regular (i.e., monthly) meetings between mentor and mentee are essential at the beginning of the internship and may decrease in frequency later during the internship
   - Topics can vary and is expected to address preparation for the postdoctoral year and early career issues. This can cover dealing with health issues, integration of family life and career, medical leaves, parental leaves, etc.
   - Paperwork around mentoring will be minimal, possibly absent entirely

3. **MENTOR ACTIVITIES**
   **July**
   - Phase I mentors and mentees will determine whether:
     - Mentor/mentee combination is a good fit OR mentee would benefit from being transitioned to another mentor
     - Additional side-mentoring may be recommended
   - **Essential activity:** Phase I mentors will review the mentee’s C.V and will share her/his own C.V. with the mentee.
     - Identify missing sections on mentee’s C.V.
     - Strategize about filling gaps/strengthening C.V. and/or tailoring C.V. for applications
     - Together, create a description of current internship clinical activities for mentee’s C.V.
     - Review clinical and supervision logs
     - Address wellness/work-life balance/time management
   - **Suggested activity:**
     - Discuss status of mentee’s dissertation/Publication of dissertation work
     - Plans for other research and dissemination, conference participation
     - Review examples of other faculty members’ CVs.

   **August / September**
   - **NOTE:** Some mentees may move to phase II mentors (maintained for the remainder of the year)
   - **Essential activity:** Monthly meetings
● **Essential activity:** Mentor and mentee will discuss plans for post-doc and/or job applications
  o Identify deadlines for participating in postdoctoral fellowship matches
  o Identify formal post-doctoral opportunities (local and national) including discussion of search strategies
  o Outline strategies for seeking non-advertised post-doctoral positions
  o Review clinical and supervision logs
  o Address wellness/work-life balance/time management

● **Suggested activity:**
  o Mentor will share her/his academic/professional “story” with the mentee
  o Discuss pros and cons of different types of postdoctoral positions
    ▪ Formal vs. informal
    ▪ Clinical vs. research vs. combination
    ▪ 1 or 2 years
    ▪ Requirements for postdoctoral training for some types of board certification
  o Discuss clinical/academic positions as alternative to post-doctoral positions

**October—December**
● **Essential activity:** Monthly meetings
● **Essential activity:** Continue to discuss plans for postdoctoral fellowship and/or job applications
  o **Review clinical and supervisory logs, records**

● **Suggested activities:**
  o Role-play interviews
  o Discuss individual concerns about postdoc, employment, such as integration of career and training with family life.
  o Review cover letters for applications
  o Discuss pros and cons of specific positions with mentee
  o Identify deadlines for participating in postdoctoral fellowship matches
  o Address wellness/work-life balance/time management

**January—April**
● Essential activity:
  o Review clinical and supervision logs
  o Address wellness/work-life balance/time management

● **Suggested activities:**
  o Discuss transition to new position and beyond:
    ▪ Establishing professional identity/niche
    ▪ Thinking about work-life balance/integration
    ▪ Preparing to become a supervisor
    ▪ Integrating research into career
  o Maximize networking/collaboration
    ▪ Identify key people at future institution
    ▪ Discuss managing relationships/collaborations
    ▪ Cultivating interprofessional relationships in Medical Schools.
  o Work on practical matters together
    ▪ Specific licensing issues relevant to mentee

**May / June**
● Mentoring may be winding down and, therefore, monthly meetings may not be essential
  o Review clinical and supervision logs
  o Address wellness/work-life balance/time management
● Planning for mentoring relationship beyond the conclusion of the internship
● Preparation of post-internship CV
The following table is provided with interns Phase I mentors. This can be changed if interns desire. If interns change mentors, they are to inform their phase I mentor of the change, and to inform the Internship Coordinator and the Internship Director of the change, including who will be their new mentor.

<table>
<thead>
<tr>
<th>Intern</th>
<th>Mentor – Phase I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennifer Boike Armerding</td>
<td>Kelly King, Ph.D.</td>
</tr>
<tr>
<td>Rosalia Costello</td>
<td>Alicia Kunin-Batxon, Ph.D.</td>
</tr>
<tr>
<td>Ashley Isaia</td>
<td>Julie Eisengart, Ph.D.</td>
</tr>
<tr>
<td>Alex Nyquist</td>
<td>Alexandra Zagoloff, Ph.D.</td>
</tr>
<tr>
<td>Jyothi Ramakrishnan</td>
<td>Emily Pisetsky, Ph.D.</td>
</tr>
<tr>
<td>Brianna Yund</td>
<td>Rene Pierpont, Ph.D.</td>
</tr>
</tbody>
</table>

References on Mentoring:


B. Intern Advocate Program

The intern advocate program is designed to complement the mentor program by providing interns with additional support. Meredith Gunlicks-Stoessel, Ph.D., L.P. serves as the intern advocate. She is a psychologist in the University of Minnesota Department of Psychiatry and is not a member of the Training Committee. She may be reached at 612-273-9844, by pager, 612-899-8164, or by email at mgunlick@umn.edu. During the training year, the Intern Advocate may provide up to 15 hours of service to the Internship. Contact with the Intern Advocate may be initiated at an intern's request if desired by an intern. It is recommended that confidentiality
issues, roles, and expectations are discussed and agreed to between the intern and Intern Advocate at the outset.

1. **Objectives**
   a. To talk with and/or meet with interns who have concerns
   b. Be able to meet with the intern's consent and preferably in his or her presence with faculty if needed
   c. Help facilitate dialogue with intern(s) and faculty oriented toward problem-solving

2. **Intern Advocate Functions in Discussions or Meetings with Intern**
   a. Assist with clarification of issues
   b. Provide intern(s) with broader perspective of the situation
   c. Provide emotional support (but not therapy)
   d. Explore potential resources and strategies for finding solutions and additional support

3. **Intern Advocate Functions in Meetings with Intern and Faculty**
   a. Assist with clarification of issues
   b. Facilitate communication about different viewpoints
   c. Provide emotional support to intern(s)
   d. Explore potential resources and strategies for finding solutions
   e. Contribute to discussion as an objective party
   f. If summary documents are prepared, may assist in review of drafts to ensure accuracy and objectivity

4. **Limitations of Intern Advocate Role**
   The role of the Intern Advocate is limited in scope and responsibility. It is *not*:
   a. In an administrative role
   b. A mediator
   c. Responsible for "solving" issues
   d. Responsible for conducting the meetings with intern(s) or faculty
   e. In a psychotherapeutic role with either intern(s) or faculty

**VIII. ROTATION SCHEDULING AND ACTIVITIES OUTSIDE OF PRIMARY ROTATIONS**

A. **Rotation Assignments**

   The plan for training is to assign Interns to their first and second choice rotations based on the track to which they are matched through the National Match Service. It is a high priority to implement this training plan. Since the implementation of the National Match, all interns have matriculated in their planned rotations according to the track matches. First choice rotations are not necessarily available during the first half of the year. Interns are encouraged at the time of the match to communicate their preferences for sequence for assigned rotations, if they have preferences, when they are contacted on Match Day. Due to the complexities inherent in negotiating specific rotation experiences, including problems related to degrees of freedom (i.e., matching the preferences, interests and preparation of each intern with the availability of openings and needs of each rotation), the Internship reserves the right to review and modify assignments and these procedures to meet the needs of interns, faculty, and the Internship as a whole. The Internship appreciates the flexibility of all parties in arranging rotation assignments and sequences and strives to minimize changes in rotation assignments.

<table>
<thead>
<tr>
<th>Intern</th>
<th>Rotation 1</th>
<th>Rotation 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennifer Boike Armerding</td>
<td>July 1 - December 31</td>
<td>Pediatric Neuropsychology</td>
</tr>
<tr>
<td>Rosalia Costello</td>
<td>Child &amp; Adolescent Psychiatry</td>
<td>Pediatric Psychology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pediatric Neuropsychology</td>
</tr>
</tbody>
</table>
B. Schedule Changes for Rotations

Once the final rotation schedule is published and distributed, changes will not be permitted except under highly unusual circumstances, such as the following:

1. Individual interns may work out trades that are mutually acceptable to all of the interns within the program and to all supervisors directly or indirectly affected by the exchange. These must be approved by the Internship Director and communicated to the faculty at least one month prior to the beginning of a rotation. Such trades must not compromise the educational value of any individual's schedule or patient care for any of the affected rotations.

2. Occasionally, changes in the schedule may become necessary because of sickness, family emergency, pregnancy, unforeseen administrative issues, etc. Such changes will be made with every effort possible to avoid compromising the curriculum of the Internship or intern's learning and clinical responsibilities, but of necessity, may alter the planned rotation assignments.

C. Activities Outside of Primary Rotations

Activities outside of primary rotations may be arranged primarily to meet the training objectives of interns. Interns have limited ability to see patients outside of their primary rotation. The exception to this guiding principle is Pediatric Neuropsychology. Interns are expected to obtain psychotherapy/intervention patients with supervisors in the other two rotations. Most of their intervention/therapy training is through pediatric Psychology. Interns may make arrangements to obtain intervention/therapy experience with supervisors in other rotations, or with other psychologists (e.g., with Drs. Bearman, Fossum, Kushner, Petrik, or Robiner) to ensure that they obtain psychotherapy/intervention experiences that meet their training goals and meet or exceed minimal thresholds established by the internship (i.e., as identified in the tracker).

When interns provide care to patients outside of their primary rotations, it is necessary for case assignments to be approved by primary supervisors as well as by supervisors outside of primary rotations. This is because of the nature of funding of Internship positions, as well as complexities within the health care system (e.g., needs for prior authorization; separate billing departments and inconsistent contracts with third party providers among medical school departments and personnel, adherence to governmental policies that require the supervisor to be “on premises”), and, most importantly, the need for appropriate supervision. Interns may elect to pursue activities outside of primary rotations, but such activities are not required.

Interns must not allow activities outside of primary rotations to interfere with their clinical responsibilities and case assignments within their primary rotations. At times, therefore, it may be more appropriate to refer patients across departments than for interns to provide services outside of their rotations. When interns pursue activities outside of primary rotations, appropriate levels of supervision of those activities is required. If there are any questions about such activities or supervision, interns and supervisors are encouraged to consult with the Training Committee or the Internship Director. Interns requesting to engage in any clinical activities beyond the internship must discuss it with their supervisor and with the Internship Director. For example, supervisory, liability and insurance issues need to be reviewed in advance. Research or educational elective experiences that enhance interns’ professional development are encouraged as long as it does not interfere with interns’ clinical and educational responsibilities on their rotation.

1. Continuing Cases from First to Second Rotations
Continuing cases from first to second rotations is desirable and appropriate both in terms of providing interns with longer experiences with patients and in terms of providing patients with continuity of care. Interns are encouraged to continue to provide service for up to **three** cases from the first rotation to the second rotation under the supervision of first rotation supervisor(s). Other patients may be transferred to clinicians (e.g., supervisors, new interns, or others) within the rotation at the time of departure from the rotation. If interns wish to continue to provide services during the second rotation to more than three cases from their first rotation, they may submit a request in writing to the Internship Director for discussion at the next Training Committee meeting. Continuation of cases from first to second rotations is not to interfere with the assignment of new cases during the second rotation. If the frequency of sessions with these cases is low, more cases will need to be incorporated into the training plan.

2. **Initiating Cases Outside of Rotations**

Throughout the year, interns may get therapy referrals through the Division of Child and Adolescent Psychiatry or Pediatric Psychology or other areas to supplement their intervention and therapy opportunities on rotations. When potential referrals arise outside of interns’ primary rotations, interns must discuss their interest in accepting a referral with both sets of supervisors (i.e., primary supervisor and the potential supervisor outside of the rotation). It is the shared responsibility of the primary supervisor and the extra-rotation supervisor to communicate with each other verbally to clarify expectations and the appropriateness of each referral. Such communication must be completed sufficiently in advance of all scheduled meetings with the involved patient(s) so as to provide all parties, including the intern and patient(s), with adequate clarity about the management of the case and supervisory responsibility for each case. This mechanism is necessary to reduce the risk of misunderstanding and to ensure participating departments in the internship that interns will be able to manage all of their clinical responsibilities. **Interns must be supervised on all cases.**

3. **Pediatric Neuropsychology Rotation Psychotherapy/Intervention Guidelines**

Interns participating in the Pediatric Neuropsychology rotation are expected to maintain a caseload of therapy patients (i.e., a minimum of 2/week). Pediatric Neuropsychology interns may need to make special arrangements to obtain psychotherapy patients outside of the rotation, generally through the Pediatric Psychology supervisors, though historically also in the Department of Psychiatry. They may also seek therapy experiences with other supervisors (e.g., Drs. Bearman, Fossum, Kushner, Petrik, Robiner). If Pediatric Neuropsychology interns encounter difficulties in obtaining adequate numbers of psychotherapy referrals, this should be addressed with the Pediatric Neuropsychology faculty and the Internship Director within six weeks of beginning the rotation and must be reviewed throughout the rotation if problems persist in accruing therapy hours at a sufficient rate to meet the minimum expectations stated earlier. It is noted that the APA office of Accreditation considers the internship to provide a generic experience, rather than one that is too highly specialized.

Accredited internship programs are required to provide adequate levels of intervention/psychotherapy experiences for interns throughout the internship year. Maximizing psychotherapeutic/intervention experiences is consistent with this intent and with a broad professional development trajectory that facilitates and preserves numerous career options.

D. **Training Transitions**

The transitions at both the beginning and end of rotations can pose challenges to interns of respectively learning new skills and processes and of completing projects and tying up loose ends on the rotation. As an ideal and general principle, the Internship supports a partial reduction of clinical responsibilities during these transitions. For example, on rotations that typically have
caseloads of three assessments per week there may be a caseload of two assessments during transitional weeks.

This is part of the Internship’s effort to provide training experiences that conform to the APA Standards of Accreditation (2015) Learning Elements (c) that, “Training for practice is sequential, cumulative, and graded in complexity.” (p. 27).

The expectations across rotations vary and interns are encouraged to discuss expectations with supervisors to ensure that their understandings are consistent with supervisors' and rotations’ expectations. The clinical service demands for which the rotation is responsible may not necessarily be reduced during these transitions. Consequently, it is not always possible to achieve this aspiration.

E. Transition from First to Second Rotation

Interns and supervisors are encouraged to make the transition from the first rotation to the second rotation in as orderly a manner as possible. As part of this, during the second month of the internship (i.e., August), interns are encouraged to meet with at least one supervisor from the second rotation they will be on to acquaint themselves with the faculty members and to begin the process of preparing for the second rotation.

Interns and supervisors from both rotations are encouraged to discuss the transition during November, to facilitate the development of this transfer and to maximize the likelihood of shared expectations. Faculty supervisors are expected to support interns in the transition, including the completion of the evaluation process in a timely manner. Interns also facilitate each other's orientation to the second rotation. Interns will be given approximately one-half day to become oriented to the second rotation by an intern on that rotation during the first half of the year.

Interns commit a minimum of a half-day to orienting another intern to their second rotation before the conclusion of the first rotation. Supervisors support this type of orientation by reducing clinical responsibilities in interns' schedules during this period to accommodate this purpose. Supervisors will not schedule interns to see patients during their scheduled orientation times. Interns must discuss scheduling these orientation meetings with supervisors from both rotations to make sure that they do not interfere with clinical and training activities. It is strongly encouraged that these meetings be scheduled at least one month prior to the end of the first rotation so that they can occur smoothly during December.

The content of the intern-to-intern orientation for the second semester varies based on the rotation. At a minimum, it is recommended that interns address:

1. Operations of the clinic
2. Introductions to clinic personnel
3. Scheduling patients
4. Scheduling supervision and other rotation activities
5. Report preparation and templates to facilitate report writing
6. Testing resources and protocols
7. Training resources
8. Patient populations
9. Billing activities
10. The flow and scheduling of work and educational activities in the rotation

Supervisors with the second rotation, or their staff, may begin scheduling patient contacts in advance of interns' arrival, and are encouraged to inform interns about scheduled patients in advance of interns' arrival. It is entirely up to interns whether they wish to begin clinical contacts with any patients from the second rotation prior to beginning the second rotation. Once on the second rotation, interns will be granted time to become acquainted with the materials and

20 This may be desirable to meet either the clinical needs of patients and families or the training needs of interns.
procedures of the rotation to make an orderly transition and to limit stress associated with the transition. As a general guideline, interns will not be expected to pick up new cases for the last two days of the first rotation so that they have time to complete their clinical responsibilities for the first rotation. However, they may do so on a limited basis (e.g., consultations) based on their schedule and progress toward completing their first-rotation duties (e.g., paperwork/clinical documentation). Interns will not be expected to pick up new cases for the first two days of the second rotation so that they have time to review rotation-specific readings and to prepare to administer rotation-specific assessment modalities. However, it is acceptable, and at times clinically desirable, for interns to continue to see psychotherapy patients and ongoing consultation patients during the four-day transition period (i.e., last 2 days of 1st rotation, first 2 days of 2nd rotation). It is also possible that they may participate in patient care, primarily as observers, during this period, on the second rotation. It is not expected that interns will have full caseloads the first two weeks of the second rotation. The level of clinical activity during the beginning of the second rotation is determined by supervisors for each rotation.

Interns and primary supervisors from the first rotation are to review interns' Record of Illness, Vacation, and Administrative Leave (RIVAL) which documents time away from the Internship, and interns’ Clinical Assessment Log (CAL) and Clinical Intervention Log (CIL) during regularly during supervision and at the end of the first rotation.

Interns and primary supervisors from the second rotation are to review interns' Record of Illness, Vacation, and Administrative Leave (RIVAL) at the beginning of the second rotation. Copies of the RIVAL, CAL, CIL, Tracker, Consultation Log, and Supervision Log are to be submitted to the Internship Director and Internship Coordinator at the end of each quarter along with copies of the Supervisor Evaluations.

Digitally signed MSIs are submitted at end of each quarter as email attachments by supervisors (i.e., not by interns) to the Internship Director and Internship Coordinator.

F. Requirements for Transitioning from First to Second Rotations/Difficulties in Transitioning

Completion of the first rotation is contingent upon: (a) completion of the rotation's minimum number of psychological evaluations (b) submission of all first drafts of psychological reports during that rotation to the supervisor(s) of those cases, and (c) completion of at least the minimum number of psychotherapy hours for their rotation. Interns are responsible for completing the final versions of any reports by December 31 or as soon as possible thereafter and will not be considered to have officially completed the rotation until all final drafts have been completed.

Completion of rotations is also contingent on the completion of all QAI documents. Only after all of the QAI materials have been returned to the Internship Director (which are due December 31), will the mid-year letter be sent by the Internship Director to interns' doctoral programs informing the Director of Training of interns' progress. Mid-year reports to interns' graduate departments will not be sent until all first rotation activities are concluded and the Internship Director has received all QAI materials (MSIs, Supervisor Evaluation; CAL, CIL, Tracker, Consultation Log, Supervision Log, RIVAL, etc.).

Failure to complete first drafts by the end of December may delay the beginning of the second rotation until all first drafts of reports of suitable quality have been submitted to interns' first rotation supervisors. Such postponements of submitting these materials risk delaying the conclusion of the second rotation and consequently of completing the Internship.

Interns who begin the second rotation late due to late completion of the first rotation psychological assessments may choose either to delay the end of the second rotation or use their vacation days (but not sick days or administrative leave) to move up the conclusion of the second rotation to the normally scheduled end, June 30. Insufficient progress in completing reports for
the first or second rotation may result in a range of administrative actions including, but not limited to:

1. Incomplete; provisional pass;
2. Probationary pass;
3. Extension of the Internship (not necessarily with stipend and benefits); or
4. Termination (without graduation) from the Internship.

Costs (e.g., health insurance, and any mandatory student fees for the next semester) associated with any extensions beyond June 30 resulting from inadequate progress in completing reports are the responsibility of the intern. There generally are NOT funds available for stipends to continue beyond June 30.

G. Young Adult Anxiety Psychotherapy Experience Elective

Matt Kushner, Ph.D., is the Director of the Adult Anxiety Disorders Clinic in the Department of Psychiatry's outpatient clinic. Therapy conducted in the clinic is short-term, limited to ten structured evidence-based sessions. Primary treatments involve exposure therapy and cognitive restructuring. Sessions are conducted in the outpatient Psychiatry Clinic weekly and are from 50-60 minutes each. Interns interested in developing their skills using cognitive-behavioral therapy (CBT) in this population are invited to contact Dr. Kushner (273-9809) about the possibility of doing a six-month rotation in the clinic under his supervision. Supervision includes individual, weekly one-hour meetings with Dr. Kushner. Interns working with Dr. Kushner are expected to maintain a target caseload of ≥ four patients at any given time. Interns wishing to pursue this opportunity should speak to the supervisors on their rotation as early as possible. The availability of this elective varies from year to year.

H. Behavioral Emergency Center (BEC)

The Behavioral Emergency Center (BEC) provides emergency care, assessment and referrals for people of all ages, including children and adolescents. It functions as the psychiatric emergency room for UMMC and other hospitals in the Fairview system. People with behavioral crises (e.g., mental health or substance abuse) are assessed in the BEC by a team of physicians, nurses, mental-health providers and psychiatric technicians for triage (e.g., including psychiatric admission) and referral. The phone number is 612-273-5640. BEC is open from noon - midnight daily (phones are answered noon - midnight in the BEC).

The number for Fairview Mental Health Intake is 612-672-6600. Patients check into the BEC through the Emergency Department on the Riverside Campus. Dr. Natasha Carlson (ncarls12@fairview.org) from the BEC is involved in scheduling interns.

Interns pursue training in dealing with psychological/behavioral emergencies in the BEC. This is an evolving program as part of the internship. Interns work at least two 4-6-hour shifts (i.e., 4:00 P.M. to 8:00-10:00 P.M.) shifts primarily to shadow staff and may participate in evaluations and disposition planning. The objectives are to help interns gain a clearer understanding of options for assessing and managing behavioral crises and to gain exposure to patients with acute psychiatric presentations. More specifically, the learning objectives are:

1. Observe crisis assessment during times of acute mental health duress and determine appropriate disposition
2. Develop a sense of what happens when patients are assessed in psychiatric emergency rooms during mental health crises
3. Assist in gathering history from patient/family to ascertain factors relevant in determining treatment/disposition for acute mental health problems.
4. Participate in determining appropriate referral sources for patients who are not admitted for hospitalization.
5. Interact with other mental health professionals in assessing patients and developing clinical plan

Coordination of interns’ schedules at the BEC is principally by the Internship Coordinator, and the BEC staff, with additional help of the intern liaison to the Training Committee. An initial schedule is presented below and needs to be reviewed by interns and supervisors to ensure that interns participate as scheduled. The process for scheduling this training is to inform the Internship Coordinator, Dr. Robiner, and supervisors at the beginning of the year and to schedule an initial shift during the Fall rotation that orients interns to the workings of the BEC. Additional shifts are scheduled in the Spring rotation when interns have refined their diagnostic and therapeutic skills and feel more prepared to participate actively in the BEC experience. The plan is to schedule the shifts with sufficient advance notice that interns can arrange their individual schedule and their rotational responsibilities around it.

Interns have generally found the staff to be accommodating of their schedules and recommend calling the BEC the day or two before their planned arrival to alert/remind staff to facilitate planning for their experience. Interns are encouraged to review the schedule below and enter it into their personal calendars. If they foresee any problems with this schedule, please contact the Internship Coordinator immediately to explore alternative dates.

Schedule of BEC Assignments

<table>
<thead>
<tr>
<th>Intern</th>
<th>First Semester</th>
<th>Second Semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosalia Costello</td>
<td>7/24/19</td>
<td>1/8/20</td>
</tr>
<tr>
<td>Ashley Isaia</td>
<td>8/14/1</td>
<td>2/5/20</td>
</tr>
<tr>
<td>Alex Nyquist</td>
<td>9/4/19</td>
<td>3/4/20</td>
</tr>
<tr>
<td>Jyothi Ramakrishnan</td>
<td>10/2/19</td>
<td>4/1/20</td>
</tr>
<tr>
<td>Brianna Yund</td>
<td>11/6/19</td>
<td>5/6/20</td>
</tr>
</tbody>
</table>

Upon arrival to the BEC interns are to introduce themselves to staff, explain that they are psychology interns (i.e., advanced Psychology graduate students who are there for one of two shifts during the year), the length of their shift (4-6 hours), and to discuss their roles as observers and possible participants. To the extent time permits, interns are encouraged to discuss the role of psychologists and other mental health professionals in emergency psychiatric departments, the referral and triage process, resources for dealing with acute patients, criteria for admission, etc.

Readings related to psychiatric emergency rooms:


IX. LICENSURE, EXAMINATION FOR PROFESSIONAL PRACTICE OF PSYCHOLOGY (EPPP), PROFESSIONAL IDENTIFICATION, AND PROFESSIONAL FUNCTIONING

A. A license to practice psychology as a licensed psychologist (L.P.) or licensed psychological practitioner (L.P.P.) is not required during Internship training. Some interns may be eligible for licensure at the level of psychological practitioner during the Internship. Interns who choose to practice within Minnesota generally seek licensure during the years after the Internship as they accrue the additional supervised experience required by the Board of Psychology and state statute. Further information can be obtained from the Minnesota Board of Psychology, 2829 University Avenue, S.E., #320, Minneapolis, MN 55414. (612) 617-2230.

B. Interns are strongly encouraged to seek licensure as soon after internship as possible in whichever jurisdictions they intend to practice and/or where they may be directly after internship. During the post-internship year, they are encouraged to seek formal supervision that conforms to the most stringent requirements among jurisdictions so that they will ultimately be eligible for practice in all jurisdictions. They are also encouraged to continue to track hours of clinical work and supervision and may use the logs system from internship to record their professional activities until they are licensed.

If interns become licensed during Internship, they will provide license numbers to their primary supervisors and the Internship Director and discuss any changes in their status before identifying themselves as being licensed or as "psychologists." Interns may not identify themselves with the legally protected title of "psychologist" before becoming licensed. Throughout the Internship, interns are to identify themselves as a "Psychology Intern" in all interactions with patients, medical center staff, and the public, and in all written correspondence. Regardless of whether interns become licensed prior to or during the Internship, they are required to fulfill all of the requirements of the Internship, including obtaining supervision at the required levels. Interns must also indicate the degree upon which their license is based in all written documents if they become licensed. Interns will inform departmental business offices if they become licensed to ensure appropriate billing.

Interns may not refer to themselves as “doctor” during the internship because the internship is required for their degree in health service psychology. Even interns who already have a doctoral degree prior to internship still cannot refer to themselves as “doctor” in any internship-related clinical services as these are being offered as part of their training toward their health service psychology degree, so to do so would be misleading to other parties. Interns who defend their dissertations during internship still cannot refer to themselves as “doctor” until they have completed all of the requirements of the degree, including the internship.

It is strongly recommended that interns make arrangements to take the Examination for the Professional Practice of Psychology (EPPP, the national written licensing exam) as soon as is reasonably possible after completing the internship. This increases their eligibility and competitiveness for some professional positions and takes advantage of the relevant preparations they have been making as they have matriculated through their doctoral programs. To sit for the
EPPP immediately following internship (and presumably graduation from one’s doctoral program), applications must be submitted to the Board of Psychology by early July because of the Board's lengthy process and schedule for reviewing applications. However, please be cautioned due to the Boards' process and close scrutiny of applications, it is recommended that materials be submitted even earlier (e.g., as early as March of the Internship) in case any of the materials are not initially accepted by the Board as meeting eligibility criteria. Passage of the EPPP at approximately the 70% correct level is now a requirement for psychology licensure throughout North America. A few months of intensive studying is recommended to prepare for the EPPP. More information about this is available the www.asppb.org and it will be discussed in the Professional Development Conference.

Beginning in January 2020, the EPPP Part-2 is anticipated to be launched to assess clinical skills. Information about Parts 1 and 2 is available on the ASPPB website.

C. According to APA accreditation criteria, completion of the internship is a prerequisite for completing a doctoral program in professional psychology. In other words, APA-accredited doctoral programs are not considered to be completed until the internship is completed. Consequently, it is extremely rare and controversial for interns to be allowed to identify themselves as "doctor" at any time during the Internship. However, because some training programs have varied from this practice in the past (i.e., in terms of whether or not completion of an internship is required as partial fulfillment of the award of the doctoral degree), interns who have defended their dissertations and completed all other course work at those institutions, must clarify with the Director of Clinical Training at their doctoral program whether they may appropriately be identified as "doctor." Interns may not identify themselves as "doctor" in any activities related to the Internship until the Director of their doctoral program has provided written verification to the Director of the Internship that to do so would be appropriate and the Training Committee of the Internship is in agreement. Interns who have already obtained doctorates (e.g., “retreads” from other areas of psychology or other disciplines) may not identify themselves as "doctor" for the purpose of any activities associated with the Internship because the basis of their clinical work is the doctoral degree or other educational equivalent that they are pursuing at the time of the Internship. Similarly, they are not to identify themselves as possessing a doctoral degree (e.g., in signing their reports and other professional correspondence, identification badges) during the internship without the express permission of the Internship Director. Such matters are typically discussed at meetings of the Training Committee.

D. During interns' first clinical interaction with each patient or family, interns must identify the name of their supervisor and provide patients with a telephone number or other means of contacting the supervisor if necessary. Interns provide a business card of the supervisor as well as their own business card with each patient and/or parents.

E. Interns have student status within the University and are recognized as trainees within the UMAHC and UMMC. The intern role is essentially that of a professional junior staff person, though there may be technical differences in how interns are classified for specific purposes. The official job title for interns throughout the year is "Psychology Fellow Specialist" within the Department of Pediatrics. Interns function in training positions in terms of the structure of psychological services within UMMC. All interns' clinical work must be supervised by appropriate faculty supervisors throughout the Internship and during any continuing professional activity at UMMC and the UMAHC until such time that any former trainee may obtain approval for independent practice through the Fairview Credentialing Office as a credentialed psychologist as a member of the allied health staff at UMMC. There may be fees for becoming credentialed in the hospital.

F. All interns' reports and notes must be cosigned by supervisors. This responsibility is shared equally by interns and supervisors. It is a matter of professional responsibility for interns to present clinical materials, including drafts and final versions of clinical reports, to their supervisor
in a timely manner. Supervisors assume professional responsibility and accountability for the services provided by interns and other trainees under their supervision. With regard to the roles, responsibilities, and supervision process for non-licensed persons who provide psychological services, such persons and their supervisors are to follow the *Ethical Principles of Psychologists and Code of Conduct* as well as the *Guidelines for Clinical Supervision in Health Service Psychology* of the American Psychological Association, the rules of the Minnesota Board of Psychology and the statutes governing psychological practice, and the policies and supervision guidelines of UMMC and University of Minnesota Physicians/M Health. This includes meeting documentation requirements, such as treatment plans and submitting prior authorization requests in a timely manner. Progress notes are to be completed and submitted to supervisors within 24 hours of patient contacts.

**Interns and supervisors work out efficient arrangements for accessing the EMR and co-managing all necessary documentation. Problems in timely completion of records is a serious professional matter and must be discussed with supervisors, mentors, and the Training Committee.**

G. Interns are expected to provide supervised services that conform to expectations that consumers, professionals, institutions, and third party payers have for professionals. Interns' levels of autonomy and responsibility vary among rotations and are based, in part, on each supervisor's perception of an intern's clinical preparation, skill, and personal and professional characteristics. In general, interns become increasingly autonomous in their clinical activities over the course of the year. All of interns' clinical work must be supervised. *Failure to obtain timely supervision on any clinical work is a violation of hospital and internship policy and the requirements of third party payers, is de facto inappropriate patient care, and is grounds for disciplinary action.*

H. Whereas supervisors ultimately bear full responsibility for the psychological services provided to each patient, they delegate to interns specific clinical and case management responsibilities. The specific roles of interns and supervisors in the management of each patient (and family) are to be discussed and clarified at the beginning of each case assignment and as often as necessary during the course of the assessment and treatment of each patient. It is essential that if more than one provider (e.g., the intern and the supervisor) are directly involved in a case that the role and full extent of involvement of each provider be clearly delineated so that the care is appropriately coordinated among multiple providers. This may be especially important and complex in the care of families or when supervisors and interns participate in interdisciplinary/interprofessional treatment teams. Interns and supervisors endeavor to develop clear expectations about interns' supervision and about the role of the supervisor in each case throughout the course of the services that are provided.

Boundary issues related to patient care are to be recognized and discussed by supervisors and interns at the earliest possible time if they arise. Efforts should be made by interns and supervisors to avoid violating boundaries or intruding into others' care of or relationships with patients. The professional role of interns is to be respected and supported by supervisors. However, if problems emerge, supervisors have responsibility to provide clear and direct feedback to interns and to ensure patient safety and appropriate management of clinical activities. Supervisors are strongly encouraged to make every effort to give interns as much advance notice of case assignments as is possible to increase the predictability and organization of service provision. It is noted that some referrals, especially for inpatient consultations, require service to be provided within 24 hours, and are therefore inherently unpredictable. Interns are expected to work in a professional manner.

**Interns work as professionals until necessary tasks are completed, rather than consistently ending the workday at a specified time (e.g., 5 P.M.). Interns will be in communication with**
supervisors to ensure that any after-hours activities are safe, reasonable, necessary, and conducted in accordance with supervisory expectations and professional standards.

I. **Board Certification**: It is recommended that interns pursue board certification through the American Board of Professional Psychology following their training when they meet the experience requirements for eligibility. The website for ABPP is: [www.abpp.org](http://www.abpp.org). Board certification is discussed in the Professional Development Conference and is an appropriate topic for discussions with mentors.

X. **POLICY STATEMENT ON INSTITUTIONAL STANDARDS OF BEHAVIOR IN THE LEARNING ENVIRONMENT**

The learning environment is expected to facilitate trainees’ acquisition of the professional and collegial attitudes necessary for effective, caring and compassionate healthcare. The development and nurturing of these attitudes are enhanced by and, indeed, based on the presence of mutual respect between teachers and learners. Characteristic of this respect is the expectation that all participants in the educational program assume their responsibilities in a manner that enriches the quality of the learning process.

While these goals are primary to the educational mission of the University of Minnesota Medical School, it is acknowledged that the social and behavioral diversity of faculty, staff, and interns combined with the intensity of the interactions between them, may at times lead to perceived, alleged, or real incidents of inappropriate behavior or mistreatment of individuals. Examples of mistreatment include discrimination or harassment based on race, religion, ethnicity, gender, sexual orientation, physical handicap or age; humiliation, intimidation, plagiarism, psychological or physical punishment; or the use of grading and other forms of assessment in a punitive manner. The occurrence, either intentional or unintentional, of such incidents results in a disruption of the spirit of learning, a breach in the integrity and trust between teachers and learners, and adversely affects interns, faculty, and the Internship as a whole. The diversity represented by the participants in the learning process requires the University of Minnesota Medical School to identify expectations of faculty, staff, and interns and a process through which concerns can be resolved.

The Educational Policy Committee (EPC) of the Medical School is charged in the Constitution of the Medical School with the responsibility for continuing review of the curriculum. This responsibility is taken to mean a continuing review of the process by which teaching and learning take place. In this regard the EPC provides the ultimate oversight in relation to acceptable standards of behavior of those in the teaching and learning process. Whereas the behavior between faculty, staff, and interns should at all times be governed by collegiality and respect for individual rights, be carried out through exemplary interpersonal behavior, and above all be characterized by adherence to principles which facilitate learning, the Educational Policy Committee endorses the following procedures/principles:

A. Educational activities shall be organized to promote learning in a manner that fosters professional growth.

B. Methods of evaluation shall reflect training aims and objectives and be accompanied by supervisors’ feedback on performance. Evaluations of interns’ and supervisors’ performance shall be provided in a timely manner and communicated with the Internship Director and the Training Committee at the end of each quarter.

C. In cases where trainees may become concerned about the behavior of faculty that they believe is not in accordance with acceptable institutional standards, they shall be encouraged to discuss or submit their concerns to the faculty member as a first step. Alternatively, the trainee may wish to discuss concerns with their mentor, the Internship Director, the Intern Advocate, or a designee of the Head of the Department of Pediatrics. Interns may also consult with the Associate to the Dean for Counseling whose duties in the Office of Student Affairs and Admissions within the Medical School include serving as an ombudsperson. The trainee also may discuss the concerns with the Department Head or with any of the Associate or Assistant Deans in the Medical School. When
problems require additional deliberation, the Department Head and the Internship Director and the Educational Policy Committee may become involved.

D. The University of Minnesota Medical School has a long tradition of providing counseling to trainees, faculty, staff, and interns with appropriate confidentiality. These responsibilities are carried out by the Dean through responsibility delegated to Associate and Assistant Deans.

E. The University of Minnesota has mechanisms currently in operation that provide faculty, staff and trainees with opportunities to pursue grievances through a formal review process.

F. For concerns relating to Sexual Harassment, trainees may contact the University of Minnesota Office of Equal Opportunity (612-624-9547).

*Modified from the University of Minnesota Medical School's Educational Policy Committee.

XI. GUIDELINES FOR PROFESSIONAL CONDUCT, Demeanor and Attire

Guidelines and standards for professional demeanor have been developed to promote the goal of providing the best services possible to patients and their families in accordance with professional standards and consumers' expectations. In interactions with patients and families, in conferences and clinics, on hospital units, and in team meetings, interns function as competent, ethical, and responsible professionals-in-training. Interns should be familiar with guidelines for professional practice in healthcare settings:


Interns conduct themselves in a professional manner when consulting with other individuals, professionals, schools, and agencies within the community. Interns are responsible for the clarity and accuracy of all of their verbal and written communications related to clinical, educational, administrative, research and professional activities. They are also responsible for understanding supervisors' feedback and directives and therefore are to clarify expectations whenever they are uncertain about what is expected of them or unsure of how to approach clinical activities.

Interns and supervisors will discuss the expectations of the consumers, interns, supervisors, and rotations so that clinical work can be completed in accordance with training and service expectations. The supervisory relationship is enhanced and interns’ professional development is maximized when interns are adequately prepared for supervision. To this end, interns are to provide appropriate clinical materials (e.g., tapes, MP3, or DVD of psychotherapy sessions, test data, drafts of reports) and administrative materials (i.e., CAL, CIL, Supervision Logs, Tracker, Supervisory Records, RIVAL, etc.) for supervisory sessions and other training activities. Interns are expected to be prepared to discuss clinical and related information in a manner that enhances their training and the appropriate management of clinical cases.

Interns and supervisors are required to comply fully with the Ethical Principles of Psychologists and Code of Conduct and with the Guidelines for Service Providers delineated by the American Psychological Association (2002, 2010 and later revisions), with Minnesota State Statutes and the Rules and Code of Conduct of the Minnesota Board of Psychology, as well as the policies, guidelines, and standards of the Internship (as delineated in this handbook), and those of UMAHC, University of Minnesota Physicians, and UMMC governing the practice of psychologists. Fairview policies may be accessed through the Fairview Intranet at: [http://intranet.fairview.org/](http://intranet.fairview.org/).

Supervisors' and interns' mature, thoughtful, and respectful demeanor promotes positive interpersonal interactions throughout the Internship. It is important that work habits include proper dress, personal appearance, and demeanor when interacting with patients, families, and other professionals and trainees. In addition, as role models for future professionals, it is expected that supervisors set a good
example when supervising any trainees and that trainees maintain positive interpersonal relations. Interns' and supervisors' behavior and attire should foster the impression of professionalism as they relate with patients of diverse backgrounds and faculty and staff including diverse health professionals. For example, articles of clothing and shoes should be clean, proper, suitable, appropriate for professional presentation, and in good condition, i.e., no shorts, tee shirts, jeans, torn or revealing articles, flip flops, or sneakers. Male supervisors and interns are strongly encouraged to wear ties so as to meet patients' legitimate expectations of receiving professional services. Hospital identification badges are to be worn daily, above the waist, to conform to the requirements of the Joint Commission. These guidelines are applicable for all workdays, regardless of whether individuals have scheduled patients that day in that they still may encounter patients in unplanned ways and because they represent the profession every day. Hospital badges are necessary to provide entry to and exit from secure hospital units and provide a basis for auditing access.

Interns are responsible to their patients, supervisors, and other involved parties to perform clinical duties in a timely manner. The standard goal across rotations is for initial drafts of psychological reports to be submitted to supervisors as soon as reasonably possible and definitely within two weeks of the last date of patient contact related to the evaluation.

It is preferred that reports be submitted sooner than the 2-week time frame because of the legitimate needs of patients, families, collaborating professionals, and referral sources to obtain information and recommendations within time frames that maximize the value and impact of the psychological consultation. Late reports ultimately compromise patient care and can cause patients, colleagues, referral sources, or other consumers to become displeased with services rendered, no matter how much work went into preparing a report, and regardless of the quality of the report. A recurrent pattern of difficulty completing reports within these time frames may reflect a range of problems, including inadequate time management, perfectionism, procrastination, unrealistic caseloads, difficulty prioritizing work, inefficiency, personal problems, supervisory or systems problems, and ultimately may result in ethical quandaries. As a matter of professional development, interns are expected to complete their work efficiently. The faculty and consumers appreciate interns' efforts to meet the stated timeline in completing reports. The current iteration of the CAL tracks the length of time to completion of final reports. Interns are to use the CAL to track their assessments and timelines associated with them. This should take just a few minutes per week.

If the 2-week Internship report standard is not attained, interns must keep their supervisors fully informed of their progress on each report (at a minimum provide weekly updates), and develop alternative, mutually-agreed upon plans that meet the needs of all involved parties. Final drafts of reports and materials pertaining to evaluations are likewise to be submitted in a timely manner. Interns are responsible for addressing with their supervisors factors contributing to potential difficulties in meeting clinical expectations as part of their training, so that they jointly can develop realistic plans in providing clinical services, prioritize workloads, and so that interns may become more efficient over the course of their clinical rotations. Interns are responsible for taking effective measures to remedy any difficulties they might encounter in meeting clinical time frames.

Interns are fundamentally responsible for completing their work within the established time frames. Supervisors may be helpful in exploring with interns ways in which interns may become more successful in meeting time goals. This can include exploring time management, stress management, and related issues, temporary reduction in workloads, simplifying case assignments, or providing a "catch up" time, etc. A pattern of failure to complete reports within the 2-week time frame, or any other time frame which might be negotiated with supervisors, will be discussed with the Training Committee and may include the intern scheduling a meeting with Training Committee.

Interns who do not achieve sufficient clinical contact hours, or who have reduced caseloads, miss out on opportunities to hone clinical skills, and are at risk of developing practice patterns that are unprofessional and fiscally problematic. Significant inequities among interns in terms of productivity, which reflect reductions in clinical contact hours, also may have an adverse impact on the morale of
other interns or create other systems problems. Inadequate fulfillment of these expectations is grounds for a range of administrative actions, including extension of the rotation and the internship (for which additional funding cannot be anticipated) in order for an intern to complete the training objectives of the Internship, or termination from the internship.

It is expected that interns will comport themselves thoughtfully, respectfully, and professionally during all educational, didactic, clinical, research, and supervisory activities and will be active participants. Interns are expected to be fully engaged in discussions in all of educational activities and to contribute to, and at times lead, discussions. Examples of expected professional behaviors during these activities include, but are not limited to:

- Maintain an openness to learning, refining skills, and enhancing knowledge
- Arrive on time for scheduled activities (e.g., to training, clinical, and supervisory activities);
- Obtain timely supervision for all patients in accordance with Internship and institutional policies and APA accreditation standards;
- Arrive prepared (i.e., having reviewed assigned readings, completed documents, with relevant clinical materials, etc.) for internship-related activities and to fulfill responsibilities;
- Approach educational activities in an organized manner (e.g., know where meetings are);
- Complete and submit by email all QAI materials to the Internship Director and Internship Coordinator within expected time frames (i.e., end of each quarter);
- Respond promptly to pages, texts, and to messages and emails that require responses;
- Complete and submit all clinical documentation in a timely manner;
- Avoid scheduling non-emergency personal or clinical activities in conflict with required educational activities;
- Request permission from supervisors in advance if it is necessary to miss a planned training or clinical activity;
- Arrive alert and ready to participate fully (i.e., avoid sleep/napping during work hours). This entails maintaining good health and self-care (e.g., obtaining adequate sleep, exercise, nutrition, etc.).
- Show respect to presenters and colleagues by giving them your undivided attention. Do not divert attention to extraneous tasks (e.g., correcting reports during educational activities, reading, doodling, solving puzzles, text messaging, unrelated laptop use) or attend to technology (e.g., to cell/ smart phones, iPads, iPods, headphones, DVDs, PDAs, Internet, or other devices) during educational, clinical, and other internship-related activities.

Throughout the internship year, interns are expected to communicate effectively and professionally at all times. Interns are expected to develop strong communication skills and are required to be evaluated on their communication competencies according to the APA (2015) Standards of Accreditation. The APA Commission on Accreditation (October, 2015) Implementing Regulations (C-8 D) Profession-Wide Competencies assert:

“The CoA views communication and interpersonal skills as foundational to education, training, and practice in health service psychology. These skills are essential for any service delivery/activity/interaction, and are evident across the program’s expected competencies...Interns are expected to:

- Develop and maintain effective relationships with a wide range of individuals, including colleagues, communities, organizations, supervisors, supervisees, and those receiving professional services
- Produce and comprehend oral, nonverbal, and written communications that are informative and well-integrated, demonstrate a thorough grasp of professional language and concepts
• Demonstrate effective interpersonal skills and the ability to manage difficult communication well.”

Consistent with this competence, interns refrain from interacting with other interns, trainees, faculty, staff, administrators, patients, families, or presenters in a disrespectful, intolerant, obnoxious, self-centered, abusive, aggressive, bullying, intimidating, or ostracizing manner, etc. Such behaviors undermine the educational and clinical enterprises and will not be tolerated. These expectations also are in accord with the APA Ethical Principles of Psychologists and Code of Conduct, Principle E, Respect for People’s Rights and Dignity. Violation of these expectations is unprofessional and may be considered cause for disciplinary action, including dismissal from the internship. Interns are encouraged to report instances of such behaviors to their supervisors and the Internship Director.

The American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct consists of an Introduction, a Preamble, five General Principles, and specific Ethical Standards. The preamble of stipulates that:

“The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.”

Interns’ and supervisors' work is guided by the APA ethical principles of:
A: Beneficence and Nonmaleficence
B: Fidelity and Responsibility
C: Integrity
D: Justice
E: Respect for People's Rights and Dignity

Interns’ activities are also consistent with the APA ethical standards of:
1: Resolving Ethical Issues
2: Competence
3: Human Relations
4: Privacy and Confidentiality
5: Advertising and Other Public Statements
6: Record Keeping and Fees
7: Education and Training
8: Research and Publication
9: Assessment
10: Therapy

Interns attempt to prevent, identify, and resolve ethical issues and concerns about competence directly with any parties about whom they have concerns, and to address unresolved concerns with faculty, including supervisors, members of the Training Committee, and the Internship Director and Associate Director.

XII. REPORT PREPARATION, DICTATION, RECORDS, AND SECURITY

Health professionals, including psychology interns, who provide patient care may make entries into patients' UMMC medical records and the electronic medical record (EMR), currently Epic. Clinical entries are to be dated and signed, either in writing or electronically in the case of the EMR, with

21 Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.
Interns indicating their status as a Psychology Intern on each note. Interns should be familiar with “protected health information” (PHI; https://en.wikipedia.org/wiki/Protected_health_information).

Outpatient records began to accrue in the Allscripts EMR in 2002. It was the main repository of outpatient records, though outpatient migration to Epic began during 2011 and to inpatient in 2010. Interns learn to use the EMRs during their orientation and are responsible for appropriate usage of it. Previous records are available in paper charts. The EMRs are products that may be accessed within the hospital or remotely (Macintosh may need to run translation programs such as Parallels for Allscripts at https://emr.umdocs.com/ahsweb/). It previously could be accessed at https://62.228.250.70/ahsweb. As of 2015, Allscripts was decommissioned. If information is needed from Allscripts, it can be obtained through Health Information Management (HIM). Earlier information (i.e., paper charts) is also available through health Information Management (previously called the Medical Records Department 612-626-3535) or through a special process in Epic.

Epic can be accessed through: https://securegateway.fairview.org/Citrix/XenApp/site/default.aspx. Epic basic information is provided in Appendix 38.

There are extra levels of security for mental health records which may require use of the “Break Glass” function, especially to gain access to providers in other clinics, and which may not be accessed or even visualized by all hospital personnel. Epic is accessed through Epic Hyperspace and may need to identify the context (i.e., location where the service is provided) because it is a combined documentation and billing suite of functions. Note that there are differences between the EPIC inpatient and EPIC outpatient records at this time. It may be necessary to “change context” when seeking to enter notes in appropriate settings (i.e., inpatient/outpatient).

Dictation policies are set by each participating department. Some departments utilize the UMMC Transcription/Dictation/Word Processing service, some provide secretarial support, and some may require interns to prepare their own written or word-processed reports. Interns follow departmental/divisional policies related to dictation and document preparation, including completing drafts and final documents within expected time frames. Records must be up-to-date, timely, and reflect professional quality in the management of each patient. Records must meet APA and Minnesota Board of Psychology criteria, the requirements of third party payers, and standards set by their supervisors, departments, UMP and UMMC. Handwritten notes historically have needed to be written in black ink on the day of patient contact. All patient-related records must be cosigned by supervisors. Entries to medical records are considered legal documents and therefore may not be altered after signing other than to indicate an error by writing “error” and initialing changes on the paper chart. Currently documented may be formally amended in Epic.

Records conform to the format required of their supervisors (e.g., SOAP format, narrative). Expectations for notes, reports, and test materials should be discussed during supervision and interns should understand the mechanisms for obtaining and returning medical records, accessing the EMR, and related materials within each department. Interns complete drafts and final reports for each patient within the time frames specified by their supervisor and within the Internship Handbook. Interns also keep up-to-date, complete records about preparation of reports on the Clinical Assessment Log (CAL).

Interns may obtain the UMMC-University Campus medical records from the Health Information Management Department. Records may be ordered by telephone (626-3535) or make arrangements through HIM on the Riverside campus (273-4370) if that is where the services are provided. In accordance with the Rules and Regulations of UMMC, original medical records are not to be taken from the UMMC premises except in response to a subpoena ducem tecum or court order served on HIM. HIM assumes responsibility for responding to subpoenas. Medical records signed out of HIM that are needed for inpatient or outpatient care must be immediately relinquished by the record holder to the patient care unit, clinic, or HIM. Medical records signed out of the HIM must be readily available to HIM personnel at all times. Records must not be kept in locked desks or file cabinets, or in areas for which the HIM has not been provided a key. Records of patients discharged from UMMC
historically remained on the inpatient care unit for up to 3 days after discharge for the purpose of record completion. Paper records pulled for outpatient visits should be returned to HIM by the end of the clinic day. Records pulled for non-patient care reasons must be returned to HIM within 7 days.

When a record is transferred from one location to another, it is the responsibility of the original record holder to complete an on-line record transfer transaction on the Medical Record Location/Control (LC) system or to call HIM (626-3535) with the transfer information. As a point of information, according to the policies and procedures of UMMC, cases of non-compliance with the above policies are referred to the Clinical Chief, Chief of Staff, Department Head, or Hospital Director for correction and/or punitive action.

Paper charts were organized chronologically, with first to most recent entries. Information was placed within the section of the chart that is most appropriate for it as indicated by the tabs. In accordance with the Rules and Regulations of UMMC, patient progress notes shall be recorded at the time of observation and be sufficient to permit continuity of care and transferability. Supervisors (attending staff) shall countersign or write progress notes at least every three days for inpatients and as often as is necessary (e.g., at weekly supervision sessions) for outpatients to substantiate supervisors' active participation in, and supervision of, patients' care. All patient-related correspondence and medical records must accurately reflect interns' participation in patient care. All records and correspondence regarding work performed by interns, alone or in conjunction with other personnel, must reflect their work and must identify them by name and title. If interns see Medicare or Medicaid patients, the progress note must reflect whether or not the supervisor was present for the entire session and/or what proportion of the session the supervisor attended. Patient charts should be returned to HIM as soon as possible and preferably by the end of the day on which it is used to facilitate appropriate patient care and as a courtesy to other health professionals in the AHC.

Questions about medical records policies may be addressed to the HIM Department at (612) 626-3535 or Medical Legal Correspondence at (612) 626-3238. Patient or family requests for access to patient records should be discussed with supervisors and in many cases will be dealt with by directing written requests to HIM. Statutes, the Minnesota Data Practices Act, and the Hospital policies govern patients' requests to review records, including requests of minors, parents, and surviving relatives. It should be noted that when the responsible licensed health professional has reasonably determined that knowledge of the contents of the medical record could be detrimental to the patient's physical or mental health or is likely to cause the patient to harm himself or another, and has documented that determination and the reason for that determination in the patient's medical record prior to the receipt of the request, the Hospital may refuse to permit viewing or copying of the record. However, patients generally are able to review their records with a representative of HIM and may obtain copies of records at customary costs through HIM. When writing reports, interns should be aware that patients, their legal representatives, or others ultimately might access their records.

As a general principle, patients should be fully apprised of their rights and procedures involved in the release of information before clinicians, trainees, or other UMAHC or UMMC personnel release any information about patients. Forms authorizing UMMC personnel to obtain or release patient information are available in clinics, departments, and patient care units. Patient information is not to be released without written permission from the patient, or their legally authorized parent, guardian, or proxy as indicated by a signed request except in cases where confidentiality requirements are superseded by statute (e.g., mandated reporting of child abuse or neglect) and the supervisor has determined that the information may be released without written permission.

In the case of child patients, vulnerable adults, deceased patients, it is necessary to ascertain which individuals are legally entitled to request or authorize release of information before releasing information. Patients or their proxy have the right to withhold or rescind the release of information at any time. Written releases allowing for the release or exchange of information are valid only for up to one year. When patients authorize treatment at UMMC, they generally also authorize release of information to their third party payers. If a patient or other party contacts Health Information
Management requesting records, the clinician is not necessarily made aware that records have been requested or released.

Consultation reports (e.g., inpatient consultations) shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. Initial consultation notes must be incorporated in the medical record on the day of service. Other reports shall be made part of the patient's UMMC medical record as soon as possible, and no later than 2 working days after patient contact unless approved by the supervisor.

Abbreviations shall be used in medical records only if they have been approved by the Medical Staff and included on the approved listing of abbreviations (see policy 14.9). A listing of common abbreviations is available in some revisions of the House Staff Manual. Books such as *Medical Abbreviations: 5500* also provide guidance about acceptable abbreviations and may be helpful to interns in learning appropriate abbreviations. In recent years, in an effort to reduce the risk of medical errors, the number of accepted abbreviations has decreased. Idiosyncratic abbreviations are not permitted in medical records.

Special mental health treatments at UMMC require specific additional documentation by the attending staff. The use of restraints, seclusion, behavioral modification procedures using aversive conditioning, electroconvulsive therapy, and psychosurgery, must include justification for these procedures.

In accordance with the Rules of the Minnesota Board of Psychology, accurate records must be maintained for each patient including minimally: (a) listing of all visits; (b) copies of all correspondence relevant to the patient; (c) patient personal data; and (d) copies of all patient authorizations for release of information and any other legal forms pertaining to the patient. Separate records do not need to be maintained other than those required by UMMC and by the Department sponsoring the rotation. The UMP/M Health Compliance Department also has documentation requirements (e.g., specifying time in/time out [i.e., length of service]; type of service, diagnosis).

In accordance with Medicare guidelines (see Appendix 22), documentation of therapy progress notes is to indicate: (a) type of therapeutic techniques and approaches used; (b) list of general topics addressed; (c) risk factors; and (D) how the present session relates to therapeutic treatment goals. For Medicaid and PMAP patients, treatment plans are to be reviewed and documented as having been reviewed every 90 days.

Documentation for all clinical activities must be sufficient to provide adequate information for billing and auditing purposes (e.g., each diagnostic interview report and psychotherapy note should specify time as well as diagnosis).

A treatment plan must be completed for each psychotherapy patient per Medicare and UMP requirements. Treatment plans are to be either scanned into the EMR or created and stored within the EMR. Treatment/intervention patients must have a treatment plan completed and scanned into the record after the second session. Billing will be halted if there is not a treatment plan in effect beyond the second session.

Patients' medical records, test protocols, departmental files, and "soft files" (i.e., clinicians' personal notes) are not to be removed from the premises of the Academic Health Center or UMMC for any reason. Clinical materials are to be safeguarded and retained securely at all times. Soft files, but not UMMC Medical Records, may be maintained in intern's offices, and must be returned to supervisors at the conclusion of case management of each patient and prior to the conclusion of each rotation. Test data and patient files are not the property of interns; interns are responsible for safeguarding these materials. Confidentiality of patient materials is to be preserved at all times to the full extent of the law. If interns wish to work on clinical reports off premises, they may photocopy materials expressly for that purpose and must destroy photocopies within two weeks of creating copies. When reports are completed, interns are responsible for ensuring that test data is filed appropriately, based
on the requirements of the rotation and supervising psychologist. Interns must provide test data, departmental patient files, "soft files", and all other patient-related information to supervisors promptly on any work day the supervisor requests such information. Because it is essential that patient's records satisfy legal and other regulatory requirements, as well as the ethical requirements for patients' records to be dealt with carefully, failure to comply with policies within this section may be grounds for administrative actions, including summary dismissal from the Internship. UMMC Medical Records policies are presented in Appendix 12.

Interns are responsible for maintaining the confidentiality and privacy of all patient records for all patients they assess, treat, consult with or about, refer, or engage in research. This includes electronic documents, paper documents, and databases. Electronic medical records and versions of all patient materials are to be safeguarded at all times to protect the privacy and confidentiality of patients and other parties who may be referred to in such materials.

| All electronic documents with protected health information (PHI) are to be password protected and appropriate encryption is to be used. Following use of the medical record in Epic, all users should log out of Epic. |

The security of computers and storage media must be maintained at all times. Supervisees are required to discuss with supervisors how to maintain the security of such information from inappropriate (including inadvertent) disclosure, theft, loss, hacking, and breaches in the transmission of any such files. It is essential that supervisees, supervisors, and staff be aware of current University of Minnesota Medical Center and Academic Health Center health information management policies and of the increasing sophistication needed to safeguard such materials as electronic records become more complex and accessible, and thereby potentially more vulnerable. Electronic versions of case materials are not to be transmitted electronically unless there are secure lines and the security of the intended storage facility meets prevailing standards to assure the privacy of the files. When in doubt, interns are to discuss such matters with their supervisor and when necessary with information systems personnel. In any clinical materials for which hard copy or electronic versions are maintained for any purpose during the Internship or thereafter (e.g., for teaching or as examples of professional work for job searches) names and other data that potentially could identify patients or related parties must be expunged. Failure to comply with the requirements in this section is grounds for disciplinary action, including dismissal.

Interns must complete University of Minnesota HIPAA training. Maintaining the confidentiality and privacy of patient information is a high priority for the University. One facet of the process is to shred all documents when they are no longer needed. There are specially designated bins for shredding documents in all clinics and patient units. When disposing of materials with patient information, always use these bins.

Interns sign the University of Minnesota Medical Center Statement of Confidentiality during their orientation (Appendix 23).

XIII. CASELOADS, RESPONSIBILITIES, AND COMPETENCIES

A. Caseloads

Interns obtain clinical intervention/psychotherapy experiences throughout the year. Caseloads may vary among interns and rotations due to the specific clinical activities of rotations, different expectations within each participating department, fluctuations in referrals, requirements of patients' third party payer for health coverage, and variable patient follow-up with treatment recommendations.

Interns can expect to provide 15 to 20 hours per week of clinical contact (i.e., including assessment, consultation, and intervention). On relatively rare occasions, that number may be exceeded due to fluctuations in referral patterns, consultations, and emergencies for the clinical services associated with each rotation. Typically, such surges are then balanced out with more typical activity levels.
Interns are responsible, along with their supervisors, to make efforts to obtain adequate clinical experiences to meet training objectives (e.g., sufficient hours of clinical experience to prepare them for competitive fellowships/residencies and professional practice following the Internship).

Interns are to use the Therapy Tracker to keep track of their therapy/intervention hours. Whereas this spreadsheet, and the information provided elsewhere in the Handbook about the accrual of therapy hours, is intended to help interns make sure they are seeing sufficient patients to meet minimum goals for their rotations, by its end. It should be noted that it is highly recommended that interns schedule more patients and therapy hours than may appear necessary (i.e., > 100%) due to the fluctuating nature of clinical work (e.g., patients dropping out of treatment, cancelling appointments), especially during the summer months.

a) minimum hours of psychotherapy and clinical intervention and (b) minimum number of clinical reports are indeed just minimum thresholds necessary to pass the rotation. These minimums are derived based on trainees' developmental needs, the institution's service demands, and performance expectations at comparable internships, as well as expectations of the APA Committee on Accreditation. Most interns exceed these minimal expectations and all interns are expected and strongly encouraged to exceed these minimum thresholds to promote their overall professional development and overall competence development. Interns can be required at the discretion of their supervisors, to exceed these minimum criteria.

Time Analyses have consistently revealed that interns report spending more time in report writing than other activities. There is heterogeneity in how much time interns spend preparing reports. The amount of time spent writing reports is a function, in part, of the relative emphasis of the internship on assessment, which rotations interns are in, and individual variation. This also underscores the importance of becoming more efficient in writing throughout the internship year, especially for interns who anticipate careers with strong assessment foci.

Supervisors are expected to determine reasonable and appropriate caseload requirements to meet training objectives while ensuring adequate clinical coverage within their clinical service. Problems related to caseloads (i.e., insufficient caseloads or excessive caseloads) should be addressed directly with supervisors. Persistent problems related to caseloads may also be discussed with intern mentors, the Internship Director, the Training Committee, and the Intern Advocate.

The Accreditation Council for Graduate Medical Education (ACGME) initiated caps on medical residents’ time spent in hospitals, limiting weekly resident activity to 80 hours per week in hospital related to their residency. This expectation within academic medical centers significantly exceeds how much time interns in our program report working weekly. The American Psychological Association has never issued guidelines for psychology interns or fellows in terms of maximum duty hours. Whereas the results of our time analyses vary, historically interns have spent more time at work than do interns at many other internships. Interns are informed of trends revealed on time analyses during the application process when they are provided an overview of the internship.

Although the internship is a busy year, interns are encouraged to seek balance and time away from the internship as consistent with the general thrust of the duty hour caps of medical residents. Even at the upper limit, it is anticipated that interns will spend less than 70 hours per week in internship related activities and usually spend less than 60. Interns are expected to be on campus 8:00 A.M. to 5:00 P.M. weekdays unless ill or on leave, regardless of their activity on preceding or successive days or whether they have patient appointments on a given day. Interns
are not expected to be on campus before 6:00 A.M. or beyond 7:00 P.M. and are explicitly discouraged from spending excessive time on site. If it is necessary to see patients before or after typical working hours (i.e., for appointments or consultation sessions beginning before 8:00 A.M. or after 5:00 P.M.) interns must obtain explicit approval from their supervisor (i.e., for each patient encounter outside of usual time or site parameters). As a safety measure, interns are not to see outpatients or inpatients unless their supervisors or other clinic or hospital staff members are within sufficiently close proximity to respond in the event of an emergency.

Becoming efficient in clinical service delivery is a primary developmental objective of internship training in that interns are being prepared for the realities of clinical practice after the Internship. If interns are having difficulty managing their assigned caseloads, they are encouraged to review how they can meet learning objectives, accomplish their clinical service requirements more efficiently, and to actively seek ways of remedying difficulties. Interns are encouraged to approach writing tasks efficiently. The use of templates, dictation, Dragon speech recognition software, computers, and concise writing styles for written communication may reduce some of the time inherent in report preparation. Clinical reports are expected to be well-written. They are intended primarily to communicate information about patients balancing conciseness and comprehensiveness. They are not expected to be superlative literary works or encyclopedic biographies or summaries of patients. At times, supervisors may negotiate adjustments in caseloads with interns to enable interns to catch up or balance their service delivery expectations with other training, professional or personal concerns.

It is recognized that caseload issues can be a complicated matter. It is incumbent on all interns, supervisors, and faculty to address this issue respectfully and with sufficient flexibility and problem-solving to achieve both the individual intern’s training goals, as well as to fulfill the clinical missions of the rotations and the Internship. This may entail interns proactively seeking intervention/psychotherapy cases outside of the rotation experience (e.g., obtaining cases in the Primary Care Center supervised by Drs. Bearman, Fossum, Petrik, or Robiner; informing physicians, social workers, and other personnel of their availability to pick up additional therapy cases which can be supervised by various Internship faculty.

Meeting the minimal hours for expectations does not in and of itself demonstrate mastery of basic assessment, consultative, or therapeutic skills. However, sufficient experiences in assessment, consultation, and intervention/therapy are necessary to provide the opportunities for learning and are part of the service requirements for the Internship. The internship is the most clinically intense phase in the training of doctoral, health service psychologists. Failure to meet the minimal or reasonable clinical expectations for assessment, consultation, and intervention/therapy may interfere with interns’ preparation for functioning at the post-internship level.

Major inequities among interns’ productivity levels have a demoralizing effect on interns, undermine training, and adversely complicate the learning environment. Caseloads judged by the Training Committee to be inadequate may result in administrative actions, such as extension of training. It is important for interns to seek out and obtain adequate clinical experiences throughout the Internship and for supervisors to facilitate interns' obtaining adequate and diverse clinical experiences. The use of Clinical Intervention Log (CIL) and Clinical Assessment Log (CAL) are intended to help interns manage and document their clinical experience and to discuss it with their supervisors and mentors.

While recognizing that our interns work hard, and that there are systems issues that complicate some referrals and clinical processes, the faculty and previous site visitors consider the workload at the University of Minnesota to be possible for motivated interns and reasonable for a medical-school based internship.

If interns are spending more than 60 hours/week related to internship activities, they are expected to discuss it with their mentors and supervisors to address options and strategies for changing the pattern.
If interns are having difficulty keeping up with clinical responsibilities and other activities, they are encouraged and expected to discuss it with their supervisors and their mentors so that strategies can be developed to help them. For example, timelines for completing reports may be extended if necessary.

1. Psychological Assessments

The APA Commission on Accreditation (October, 2015) Implementing Regulations (C-8 D) Profession-Wide Competencies assert. “Trainees demonstrate competence in conducting evidence-based assessment consistent with the scope of Health Service Psychology … Interns are expected to demonstrate the following competencies:

- “Select and apply assessment methods that draw from the best available empirical literature and that reflect the science of measurement and psychometrics; collect relevant data using multiple sources and methods appropriate to the identified goals and questions of the assessment as well as relevant diversity characteristics of the service recipient.”
- Interpret assessment results, following current research and professional standards and guidelines, to inform case conceptualization, classification, and recommendations, while guarding against decision-making biases, distinguishing the aspects of assessment that are subjective from those that are objective.
- Communicate orally and in written documents the findings and implications of the assessment in an accurate and effective manner sensitive to a range of audiences.

Psychological assessment is a key competence focus of the Internship. Interns are not expected to have a full caseload during the first four weeks of their first rotation or three weeks of their second rotation. It is recommended that during that period, interns provide fewer evaluations, than they will later in the rotations. A recommended guideline is to alternate between two and three evaluations per week during the first month of a rotation, whenever possible, so that interns can have sufficient time to become familiar with the testing and report-writing processes for the rotation and to allow for a developmental sequence in refining their clinical skills.

On the Pediatric Neuropsychology rotation, an expectation of three evaluations per week has been established. For weeks that include holidays or vacation or other variations in the clinic schedule, it is essential that interns check in advance with their supervisors about how many evaluations they may anticipate providing (i.e., it may or may not be pro-rated). If interns have questions or concerns about their schedule of evaluations, they are encouraged to speak directly with their supervisors and with the Internship Director at their earliest convenience.

It is also noted that there can be considerable variability in assessments based on issues such as clinical questions, recency of previous evaluations, patient complexity, number of tests administered, cooperation of patients, participation of psychometrists or other trainees, as well as on supervisors’ practices. This heterogeneity makes it difficult to quantify workload for psychological assessments. As such, the CAL and rotations’ assessment expectations may not fully characterize interns’ experiences. Interns’ individual productivity needs to be understood based on such factors.

At minimum, the total number of written reports summarizing clinical assessments expected of interns by the end each rotation is below.

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Minimum # of reports</th>
<th>Typical # of scheduled evaluations or reports/week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Adolescent</td>
<td>Supervisors’ discretion</td>
<td>Supervisors’ discretion</td>
</tr>
</tbody>
</table>
Psychotherapy/Intervention

The APA Commission on Accreditation (October, 2015) Implementing Regulations (C-8 D) Profession-Wide Competencies assert:

“Trainees are expected to respond professionally in increasingly complex situations with a greater degree of independence across levels of training.

- Trainees demonstrate competence in evidence-based interventions consistent with the scope of Health Service Psychology. Intervention is being defined broadly to include but not be limited to psychotherapy. Interventions may be derived from a variety of theoretical orientations or approaches. The level of intervention includes those directed at an individual, a family, a group, an organization, a community, a population or other systems.”

Psychotherapy is an important and fundamental aspect of the internship experience in professional psychology. Psychology has positioned itself as the doctoral-level mental health profession whose providers have the most extensive psychotherapy training. It is incumbent on internships to provide extensive supervised psychotherapeutic services.

The need for child mental health services has been well documented historically. "The nation is facing a public crisis in mental healthcare for infants, children, and adolescents" according to the Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Many children have mental health problems that interfere with normal development and functioning (U.S. Public Health Service, 2000, p. 13). The Surgeon General estimated that approximately 21% of Americans below age 18 have a diagnosable mental health condition; 11% experiencing impairment. Regrettably, < 10% receive mental health services (U.S. Department of Health and Human Services, 1999). The prevalence and impact of child mental health problems is growing. The World Health Organization predicts that by the year 2020, childhood psychiatric disorders will rise by 50%, and will become one of the five most common causes of morbidity, mortality, and disability among children.

Epidemiological trends for children and adolescents in the US reveal Anxiety disorders are estimated >25% of adolescents and that 2.8 million adolescents experience major depression. To make it worse our mental health system is failing them: 80% of kids with anxiety and 60% of kids with depression are probably not getting adequate or any treatment. Psychology as a profession is committed to addressing these needs by providing interventions that have clinical utility to children and adolescents who need them.

There are substantial needs for patients obtaining care at the University of Minnesota Medical Center to obtain care. The comorbidity of medical and psychiatric problems presents enormous challenges to the delivery of pediatric care. The effects on medical care of clinical conditions, such as depression, and other psychosocial phenomena (e.g., problematic family dynamics, ineffective communication with health professionals), such as adherence to regimens, are critical to the delivery of medical services. Research has documented the importance of including psychologists as interprofessional/interdisciplinary team members in delivering care across a broad range of clinical conditions (e.g., asthma, CF, diabetes, oncology, organ transplants) to address psychosocial issues and optimize management of care. Consequently, the presence of psychology training programs in academic health centers would be justified.

<table>
<thead>
<tr>
<th>Psychiatry</th>
<th>50</th>
<th>32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Neuropsychology</td>
<td>50</td>
<td>32</td>
</tr>
<tr>
<td>Pediatric Psychology</td>
<td>Supervisors’ discretion</td>
<td>2 (full)</td>
</tr>
</tbody>
</table>

1As with psychotherapy, the minimum number of reports in a rotation is likely to be exceeded.

2 One week/month interns may be anticipated to schedule a 4th evaluation. Over the course of the 26-week rotation interns historically provide < 2.5 evaluations per week.
is a means of both improving patient outcomes and of preparing health professional students for interdisciplinary collaborations. Such considerations underscore the clinical importance for interns at the University of Minnesota to obtain rich, broad, and ample therapy experiences. This both allows interns to meet the current needs of patients seeking care at the University of Minnesota, and to be capable of addressing these needs and demands for services in the future.

The Internship is involved in an ongoing process of ensuring minimal standards for clinical activities for interns to obtain sufficient clinical experience during the Internship to prepare them for post-internship activities. Even though the faculty recognizes that this Internship has a particularly strong emphasis on assessment that often attracts interns with such interests, internships are intended to prepare psychologists for entry-level practice. According to the APA accreditation requirements, internships "should be broad and professional in ... orientation rather than narrow and technical." This principle requires that interns receive broad training and obtain sufficient experiences to function as psychologists. Regardless of an intern's level of interest in functioning as a therapist or the extent of their pre-internship intervention experience, interns are required to pursue and obtain satisfactory training and supervised experiences in psychotherapy during the internship. Minimum hours of psychotherapy have been established by each rotation.

Interns are generally expected to accept referrals of therapy patients as assigned by their supervisors or made available in the Psychiatry Clinic and Pediatric Psychology service. Although interns may, on occasion, decline therapy referrals, (i.e., when holding a full caseload determined by that rotation), a pattern of seeking to do so is not acceptable. Interns may not decline therapy referrals if they have not been accruing sufficient therapy hours on their rotation, or if they are only barely meeting the recognized minimums. If interns decline more than three therapy referrals per rotation, they will be required to discuss this pattern at the next meeting of the Training Committee.

When interns have extra-rotation intervention patients, they maintain a reasonable caseload of patients related to their rotation as consistent with the expectations of their supervisors. In other words, their non-rotation activities cannot interfere substantially with their primary rotation clinical assignments.

Interns and supervisors are expected to monitor interns' accrual of psychotherapy/clinical intervention hours throughout the rotation to ensure that interns obtain appropriate referrals and manage caseloads effectively to meet these minimum levels and to facilitate overall professional development.

Interns review their psychotherapy accrual on an ongoing basis (at least every two weeks) with their supervisors and are expected to adjust their caseloads as necessary to ensure that they meet training needs and assist their rotation (i.e., clinical service) in fulfilling its clinical mission. This includes ongoing maintenance of the CIL and routine review of the CIL with supervisors.

Due to the rate of cancellations, "no shows", and "premature terminations" in mental health services, especially around vacations and toward the end of the year when school is busy and then not in session, it is highly recommended that interns schedule considerably more therapy experiences than might appear necessary to meet the minimum training requirements. That is, interns are advised to “front end load” their rotations with

22 Historically, patients do not keep all appointments at UMMC, so it would be risky to expect that all appointments will be kept or that the rate of cancellations is predictable. It is very strongly advised that greater numbers of hours be obtained. More specifically, interns are encouraged to reach 100% on the Tracker as soon as possible and to prudently stay consistently above 100% on the Tracker to ensure meeting or exceeding minimums by the end of the rotation.
psychotherapy experiences so as to ensure that they obtain adequate psychotherapy hours during the rotation.

Interns are encouraged to schedule specific times in their weekly calendar for therapy appointments (e.g., at least one specified afternoon per week) so as to increase the likelihood that patients will keep appointments. Previous interns have recommended this strategy as a means of maximizing the efficiency of their therapy experiences while preserving blocks of time for other professional responsibilities (e.g., report writing).

A minimum number of therapy hours have been established for each rotation. It should be emphasized that this is a bare minimum required to pass the rotation and that interns are both strongly encouraged and expected to exceed it, preferably by significant margins so as to become as competent within this competence area as possible during the internship. The minimum total number of hours of psychotherapy or clinical intervention required of interns by the end of each rotation is identified in the table below.

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Minimum # of Therapy Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Adolescent Psychiatry</td>
<td>200 hours</td>
</tr>
<tr>
<td>Pediatric Neuropsychology</td>
<td>40 hours</td>
</tr>
<tr>
<td>Pediatric Psychology</td>
<td>80 hours</td>
</tr>
</tbody>
</table>

Interns are strongly encouraged and expected to maximize their therapy experiences and to exceed the minimum. If interns are having difficulties obtaining an adequate volume of referrals for therapy/intervention, they are encouraged to consult on a regular basis with their immediate supervisors, the group supervision of psychotherapy supervisor (Dr. Pisetsky), and the clinic staff in the Department of Psychiatry. Interns need to be proactive and may need to apprise other interns, psychiatric fellows, residents, faculty, and their other supervisors that they are looking for additional clinical intervention/psychotherapy cases. Problems developing adequate caseloads should be reported to the Internship Director at the earliest possible time to develop appropriate plans to facilitate interns’ training and to prevent problems in meeting the minimal intervention/therapy requirements.

If interns are not accruing therapy hours consistent with the expectations on the preceding pages of the Internship Handbook, they must report it to the Internship Director and to their supervisor and to the faculty conducting the Group Supervision of Psychotherapy to maximize efforts to obtain minimal therapy hours and provide regular follow-up about their efforts to increase their caseload.

The following chart is provided to help interns keep track of whether they are accruing Intervention/psychotherapy treatment hours at rates commensurate with meeting minimal expectations.

Failure to meet a rotation’s minimal psychotherapy hours will automatically result in at best a Provisional Pass for that rotation even if the rest of their work on that rotation has been satisfactory. In the case of this occurring on a first rotation the intern must make up the deficit in therapy hours during the second semester. Interns’ doctoral programs will be informed of the Provisional Pass in the mid-year letter sent at the end of the first rotation. If this occurs in the second semester, the internship will not be considered completed until the total minimal number of hours required for both rotations is met. Delays in eligibility for completion of the internship due to a failure to meet total minimal therapy hours may, at the discretion of the Training Committee, be remedied by the intern continuing to see patients beyond the June 30 scheduled end of the internship. It may, however, also result in failure of the internship. Such an extension would not be offered with additional stipend or financial support for the intern.
<table>
<thead>
<tr>
<th>Week of Rotation</th>
<th>Weekly Minimal Accrual Goal</th>
<th>Cumulative Weekly Minimal Accrual Goal (Minimum Total = 40)</th>
<th>Cumulative Weekly Minimal Accrual Goal (Minimum Total = 80)</th>
<th>Weekly Minimal Accrual Goal</th>
<th>Cumulative Weekly Minimal Accrual Goal (Minimum Total = 200)</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>0 - 1</td>
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<tr>
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<td>1 - 2</td>
<td>4</td>
<td>3 - 4</td>
<td>13</td>
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<tr>
<td>6</td>
<td>1 - 2</td>
<td>6</td>
<td>3 - 4</td>
<td>17</td>
<td>8</td>
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<tr>
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<td>3 - 4</td>
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<td>3 - 4</td>
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<td>1 - 2</td>
<td>40</td>
<td>1 - 4</td>
<td>80</td>
<td>2</td>
</tr>
</tbody>
</table>

B. Consultation and Interprofessional/Interdisciplinary Skills

The APA Commission on Accreditation (October, 2015) Implementing Regulations (C-8 D) Profession-Wide Competencies assert:

“The CoA views consultation and interprofessional/interdisciplinary interaction as integral to the activities of health service psychology. Consultation and interprofessional/interdisciplinary skills are reflected in the intentional collaboration of professionals in health service psychology with other individuals or groups to address a problem, seek or share knowledge, or promote effectiveness in professional activities. Trainees are expected to:

- Demonstrate knowledge and respect for the roles and perspectives of other professions.
- Apply knowledge of consultation models and practices and respect for the roles and perspectives of other professions in direct or simulated (role played) consultation with individuals and their families, other health care professionals, interprofessional groups, or systems related to health and behavior”
Consultation experiences include a broad range of professional activities with patients and multidisciplinary staff in The University of Minnesota Masonic Children's Hospital and various University settings. Interns are expected to work closely with their supervisors to integrate selected clinical approaches in primary, secondary and/or tertiary care settings. Interns may be involved in consultation with diverse health, mental health, and social service professionals in health care facilities, schools, public institutions (e.g., courts), and community and governmental agencies. Interns may serve as team members to specific medical (e.g., brain tumor, cystic fibrosis, FAS, genetics, oncology, PKU) and interprofessional/interdisciplinary treatment teams (e.g., inpatient psychiatry). The opportunities for consultation vary over time in response to clinical, staffing, and systems factors. As hospitalization lengths have shortened, services that previously would have been provided in the hospital are now provided in the outpatient clinics, including specialty clinics, where psychologists and interns work with interprofessional teams.

Consultation requests within UMMC may indicate whether the type of consult requested is either:

- **Advise Only**: Consultant will not authorize services nor write orders.
- **Advise and Treat**: Consultant may authorize services or write orders in conjunction with the reasons of the consult.

The current protocol is for the attending physician to personally contact the consultant(s) whenever possible. Consultants within UMMC are to inform Telecommunications how they may be reached 24 hours/day, 7 days per week. Consultants' examinations are to be documented appropriately within 24 hours for routine consults and 4 hours for urgent consultations from the time of the consult request. The consultant is to contact the attending physician following the initial consult (whenever possible).

UMMC consultation guidelines are presented in Appendix 11. Consultation documentation in the patient's medical record shall show evidence of:

- A review of the patient's record by the consultant;
- Pertinent findings on examination of the patient (including diagnosis);
- The consultant's opinion and recommendations or plan;
- Time spent with patient, diagnosis, history, services provided;
- Who provided and who supervised the consultation.

Billing for inpatient consultation previously used different CPT codes than for outpatient services. As of 2013, CPT codes for services are identical inpatient and outpatient settings.

### C. Attendance and Tardiness

As a matter of professionalism, it is important for interns and faculty to be punctual for clinical and training activities. Tardiness or absence from these activities is likely to be perceived by interns, faculty, staff, patients, administrators, and others as disrespectful. Ultimately, it has a likelihood of communicating a lack of professionalism and a lack of interest or investment in clinical and training activities. It detracts from patients' appreciation of the clinical services they receive, undermines and distracts from training activities, wastes other people’s time, and creates avoidable frustrations. Interns and supervisors are therefore strongly encouraged to be attentive to time and to act in ways that foster a training environment in which punctuality is valued. **Interns and faculty** are responsible for being aware of where they are expected to be at all times and to be thoroughly familiar with the training calendar and their clinical appointments.

Internship calendars of internship-wide didactics are distributed monthly. Should scheduling conflicts arise in any internship activity, it is essential that interns inform their supervisors or the presenter of a training activity as soon as possible of the conflict. If ongoing scheduling conflicts arise, interns need to discuss them with their supervisors so that issues can be resolved in a manner that supports the training and clinical activities of intern, supervisor, and the Internship. Patterns of recurrent tardiness or absence are to be discussed with supervisors and may be
brought to the Training Committee. Chronic patterns that compromise training for the individual or others, or compromise clinical services may result in administrative and disciplinary action.

D. **On-Site Responsibilities During Work Week**

Interns are to be on site at the University of Minnesota Academic Health Center or University of Minnesota Medical Center from 8:00 A.M. to 5:00 P.M. on all weekdays other than for MAAPIC training activities, holidays and dates of leave. Consultation requiring travel to other organizations is excluded from this requirement. When earlier meetings and later professional activities are scheduled, interns are expected to be on site for longer periods of time. A request for an exception to this policy must be based on circumstances that warrant an exception due to (a) the essential nature of the other activity and (b) the reasonable inability to schedule the alternative activity at a time that does not conflict with internship activities and must be approved in advance of each date by the primary supervisor. Requests to be off campus are not granted automatically. If an intern plans to be off campus, the intern should discuss this (again) the day before with their supervisor. Interns also need to be available to come in for unexpected clinical assignments. Whether or not interns are on site during routine working hours, they are expected to be available by pager and/or cell phone unless they are ill, on vacation, or on administrative leave.

E. **Audio and/or Video Recording**

Internship training is enriched by the use of audio and/or video recording of patient contacts which are then to be reviewed during individual and/or group supervision. Interns are responsible for safeguarding the confidentiality of all recordings and of the identity of all individuals who are recorded. This responsibility continues throughout the Internship and into perpetuity. The consent form in Appendix 9 is to be signed by the patient(s) or his, her, or their legal representative prior to initiating any recording.

F. **Internship Materials**

Interns and faculty are responsible for the safety and integrity of Internship materials, including tests, apparatus, audiovisual equipment, laptop computers, videoconferencing facilities, and other equipment, etc. Removing such materials from the Academic Health Center or UMMC is discouraged because of the possibility of disruption of other clinical or training operations and increased risk of liability. Individuals may be held responsible, including financially responsible, by individual departments for damage, loss, or theft of such equipment. In rare circumstances, interns may remove materials from the UMAHC or UMMC for very brief periods of time. Removal of University or hospital property may occur only: (a) with clear verbal permission from their immediate supervisor; (b) with a clear plan for when the material(s) will be returned; and (c) after checking with all other parties (e.g., other trainees, faculty) who might reasonably be expected to need to use the material(s) during the proposed period.

Interns also are responsible to read and be conversant with the Internship Handbook and all policies herein. They have a responsibility to clarify with supervisors and the Internship Director any policies about which they have questions. Interns are also required to read the Fairview Required Learning documents.

G. **Health Insurance Portability and Accountability Act (HIPAA) and Password Protection**

The University has legal and ethical obligations to ensure that everyone who has access to individuals’ health information has been trained in how to properly protect that information from disclosure or unauthorized use. All Univeristy personnel, including psychology interns, are required to complete the two trainings on-line: (1) HIPAA training and (2) University Information Security Awareness Training during the first week of the internship.
Training is to be accessed through the Academic Health Center portal at: http://www.healthprivacy.umn.edu/training. If you have technical problems accessing the courses, please call the University of Minnesota Helpline at 301.HELP for assistance.

**Interns password protect all documents with patient information on them.** The password **Intern2019** will be used on clinically related educational materials, such as draft reports, other clinical documentation, and clinical logs which may have some identifiable information. Other QAI materials which lack patient identifying information, such as end-of-the-year program evaluation materials, do not need to be password protected.

**XIV. INTERN EVALUATION AND PROGRAM QUALITY ASSESSMENT AND IMPROVEMENT**

**A. Principles**

1. Evaluation is an essential component of the educational process and contributes to the professional growth of each intern. Interns receive grades (P/F) each semester from the Internship Director that appear on their Medical School transcripts.

2. The objective of evaluation is to document that interns achieve an appropriate level of professional psychological skills, abilities, proficiencies, competencies, knowledge, and that interns conduct themselves in an appropriate, professional manner. The program is responsible for balancing interns' rights with the rights and needs of the public and the profession (i.e., for trainees to be capable of providing competent services).

3. Problems meeting expected performance standards or making adequate progress on the part of an intern must be discussed verbally with the intern and will be reported to the Training Committee and the Internship Director as early as possible by supervisors so that every effort can be made to assist the intern in remedying the situation.

4. Interns are provided with written evaluations by supervisors on a quarterly basis on the Minnesota Supervision Inventory (MSI). Interns provide quarterly written evaluations of supervisors on the Supervisor Evaluation spreadsheet. Evaluations of interns are discussed by interns and supervisors within scheduled supervision meetings prior to the deadlines for submitting the written evaluations to the Internship Director at the end of each quarter. **Interns and supervisors share the responsibility of making sure that the evaluation process proceeds in a timely manner. Interns forward Supervisor Evaluations to the Internship Director and the Internship Coordinator for all of their supervisors that quarter for which they have had at least 3 supervisory meetings.**

5. Evaluations of individuals are to be objective and to demonstrate respect for and understanding of cultural and individual diversity.

6. The Intern Advocate may become involved in the review process if there are disagreements between interns and supervisors, at the discretion of the intern.

7. Evaluation shall include sufficient information that is pertinent to the evaluation to provide interns and supervisors with clear understanding of strengths and areas of desired development. Evaluation may include documentation of critical incidents if necessary. Interns and faculty share responsibility for taking sufficient time to communicate feedback and to address any and all concerns of interns and supervisors.

8. At the end of the year, interns need to be favorably assessed as meeting all Profession-Wide Competencies (See APA Implementing Regulation C-8 I) in order to confirm that they meet Minimal Learning Achievements to graduate from the internship and be ready to go on to postdoctoral fellowships, or the equivalent, and be adequately prepared for entry level practice. Minimal Learning Achievements

**B. Steps in the Evaluation Process**
1. Supervisors provide verbal (formative) and written (formative and summative) evaluations of all interns they supervise. Verbal feedback about interns' performance is an ongoing function of supervision throughout each rotation and supervised experience. Discussion of supervisory feedback should be included in a scheduled supervisory session by the end of each quarter. Evaluation materials (MSI and Supervisor Evaluation: Summary by Intern) are to be completed and returned to the Internship Director quarterly - no later than the last working day of September (First Quarter), December (Second Quarter), March (Third Quarter), and June (Fourth Quarter) for review and entry into interns' files. Supervisors and interns sign the MSI.

2. Interns complete written evaluations (Supervisor Evaluation: Summary by Intern) of each supervisor on a quarterly basis. Interns are responsible for completing their evaluations of supervisors within the following evaluation deadlines and returning them to the Internship Director and Internship Coordinator with electronic signatures (/First Name Last Name/). Feedback can be shared verbally with supervisors to provide a feedback loop to them for enhancing supervision and the rotation. Supervisor evaluations will be shared following the internship to provide feedback, as part of faculty portfolios, and as a matter of due process.

3. The supervisor is responsible for returning evaluation forms of interns (MSI) to the Internship Director and Internship Coordinator with electronic signatures (/First Name Last Name/). Supervisors and interns are both responsible for complying with the evaluation schedule. Interns and supervisors are required to discuss any potential or actual delays in completing quarterly evaluation materials with the Internship Director. If necessary, interns may be evaluated more frequently than quarterly. Interns and supervisors are encouraged to retain copies of all evaluations for their own records before returning evaluations to the Internship Director.

4. **Evaluation Deadlines:**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Date Evaluation Materials are Due to the Internship Director and Internship Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Quarter</td>
<td>September 30</td>
</tr>
<tr>
<td>Second Quarter</td>
<td>December 31</td>
</tr>
<tr>
<td>Third Quarter</td>
<td>March 31</td>
</tr>
<tr>
<td>Fourth Quarter</td>
<td>June 30</td>
</tr>
</tbody>
</table>

5. Summative evaluations are completed by supervisors, using either the Minnesota Supervisory Inventory (MSI) or the MSI-Neuropsychology Version, using the current Excel spreadsheet version of these materials. Supervisors may also provide additional materials, such as examples of interns’ work or description of critical incidents. A copy of the evaluation instruments shall be shared with all interns at the beginning of the Internship to clarify the basic areas on which interns and supervisors will be evaluated.

6. **Interns are encouraged to complete the MSI about themselves at the beginning of the Internship to establish a baseline and clarify individual training goals.**

7. Supervisors determine and review sources of information pertinent to the evaluation and clearly communicate information pertaining to intern performance and functioning (i.e., strengths and areas of needed improvement; signal events).

8. Written evaluations are retained in interns' files in the Internship Director's office computer and/or on a secure server. Each intern will have access to his or her file in the presence of the Internship Director and will be given the opportunity to make photocopies of any evaluation materials.

9. The Internship Director and the Training Committee routinely review written evaluations. 
   a. If an evaluation is flagged by a supervisor for special attention, it will be reviewed immediately by the Internship Director and the Training Committee.
   b. Ad hoc review by the full Training Committee can also be arranged at the discretion of the Internship Director.
10. If at any time an emergency arises such that a supervisor or the Internship Director determines that patient care or safety is jeopardized by an intern, they may bring that information to the Head of the Department of Pediatrics, or his or her designee, who may remove the intern from patient care responsibilities. This would be an extreme circumstance and other remedies should be explored fully prior to relieving an intern of patient care responsibilities.

11. Mentors may meet with interns at a mutually agreed frequency and may review interns' progress and concerns at the discretion of interns.

12. If evaluation materials are not completed in a timely manner interns are encouraged to discuss the delay with their mentor and with the Internship Director and the Training Committee. Supervisors encountering difficulty complying with any aspect of the evaluation process outlined in this section, including submitting evaluation materials to the Internship Director in a timely manner, are required to address this issue with the Training Committee and the Internship Director to facilitate resolution of the difficulty.

13. In addition to completing evaluations of supervisors, interns submit copies of their logs, RIVAL, Supervision Records at the end of each quarter.

14. **Failure to complete and submit QAI materials to the Training Director and Internship Coordinator within the stipulated time frames is a violation of Internship policy and an issue of professionalism that undermines the Internship. Professionalism matters, including these, may result in actions including appearing before the Training Committee, interruption of clinical duties, delayed graduation, assignment of additional remedial and/or reflective tasks, and/or dismissal from the Internship.**

C. **Training Committee Responsibilities in Evaluation**

1. All actions of the Training Committee are advisory to the Head of the Department of Pediatrics or his or her designee and to the faculty of the Department of Pediatrics.

2. All actions of the Training Committee, other than recommendations for dismissal from the Internship, are by simple majority vote with a quorum present. A quorum consists of one-half or more of the members of the Training Committee. A recommendation for dismissal requires a vote in favor of this action by 60 percent or more of Training Committee members.

3. Any recommendation of the Training Committee for dismissal regarding a specific intern will be made in writing, with copies given to the Head of the Department or his or her designee, to the Internship Director, and to the intern's mentor if the intern wishes for the mentor to be informed. A copy will also be placed in the intern's file.

4. Interns who are subject to Training Committee actions are informed of their status and any actions taken both verbally and in writing.

D. **Possible Outcomes of Review by the Training Committee**

The Training Committee may recommend one or more of the following as courses of action or other actions consistent with educational standards, professionalism, adherence to ethical standards and meeting expectations based on other practice guidelines, etc.:

1. Pass: Normal advancement within the training program.

2. A plan of action(s) to solve problems and/or provide support, intensified supervision, with reassessment of impact of proposed remedies, or extension of training. This includes documentation with an Individual Training Plan.

3. Probation with continuation of normal rotations, but with *intensified supervision*, and more detailed and frequent evaluation. The intern is invited to appear before the Training Committee before an individual is placed on probation. The intern's mentor may be invited to this meeting at the discretion of the intern. The Intern advocate may be invited to this meeting at the discretion of the intern.

4. Probation without academic credit for a specified rotation or rotations deemed unsatisfactory by the Training Committee. The Training Committee may recommend that such non-credited
rotations be satisfactorily repeated or that the intern be assigned to a remedial program or alternate rotation.

5. Immediate suspension without or with pay. Interns may be relieved temporarily of all duties relative to the Internship until one of the following is implemented:
   a. Probation with certain rotations or services to be repeated.
   b. Modification of the intern's assigned program to provide remedial training in a designated setting with designated tutoring and/or supervision.
   c. Extension of training.
   d. Dismissal from the program.

6. Medical and/or psychiatric appraisal as to suitability for continuation of Internship training. Such a step would be coordinated with other personal of the Medical School and General Counsel to ensure proper and legal procedures are followed.

7. Final written summary review on completion of, or departure from, the Internship to be entered into interns' permanent file.

E. Minimal Levels of Achievement, Intern Retention, Completion of Rotations, Graduation, and Termination

1. Interns must comply with all Minnesota and federal statutes, Rules and Code of Conduct of the Minnesota Board of Psychology, the APA Ethical Principles and Code of Conduct, and APA Standards of Providers of Psychological Services, and all of the policies and standards of the Internship (as described in the Handbook and elsewhere), the Department of Pediatrics, UMAHC, the University of Minnesota, and University of Minnesota Physicians.

2. Interns are to complete their work in a timely manner and in accordance with the requirements of their supervisors and rotations. Interns are required to provide timely and appropriate clinical materials (e.g., DVDs or mp3s of psychotherapy sessions, test data, and draft and completed reports, collateral information, case management materials, relevant medical records) for supervisory sessions and other training activities.

3. Interns are required to conduct themselves in a professional manner when providing clinical services and participating in Internship training activities, including in demonstrating respect, sensitivity, and competence in interactions with patients of diverse backgrounds, trainees, staff and faculty, and in interacting with professionals from other disciplines. As part of this, interns are expected to have read the most current versions of the following APA documents:
   a. Ethical Principles and Code of Conduct
   b. Guidelines for Psychological Practice in Health Care Delivery Systems
   c. Guidelines for Clinical Supervision in Health Service Psychology

4. Interns are required to demonstrate consistent, professional management of clinical work and appropriate case management of each patient, including follow-up and appropriate referrals, while maintaining an adequate caseload as defined by each rotation. All clinical work is to be provided ethically, and in a manner consistent with professional standards and the requirements of patients' third party payers. For example, interns are to submit all reports, progress notes, and prior authorization documentation consistently and punctually as required by managed care organizations, or governmental entities, to provide care in accordance with patients' needs and applicable regulations. Interns are expected to complete progress notes within 24 hours of each patient contact. They are to submit all progress note documentation to their supervisors within 24 hours of each patient contact.

5. Satisfactory performance by interns results in completion of rotations and satisfactory grades on the University of Minnesota academic transcript. Satisfactory performance in both rotations, including adherence to the policies outlined in the Internship Handbook, conducting oneself consistently with expectations for professional behavior and judgment, and meeting expectations for clinical functioning and productivity is required for successful completion of the program.
The APA (2015) *Standards of Accreditation* stipulate that:

1. “Certain competencies are required for all interns who graduate from programs accredited in health service psychology. Programs must provide opportunities for all of their interns to demonstrate they have satisfactorily met the standard for each required Profession-Wide Competency of achieving “broad and general preparation for entry level independent practice and licensure” (Implementing Regulation C – 8D).

2. The role of the internship is to build upon a trainee’s competencies in all the competence areas. Because science is at the core of health service psychology, programs must demonstrate they rely on the current evidence base when training and assessing interns in the competency areas. Interns must demonstrate competence in:
   a. Research
   b. Ethical and legal standards
   c. Individual and cultural diversity
   d. Professional values, attitudes, and behaviors
   e. Communication and interpersonal skills
   f. Assessment
   g. Intervention
   h. Supervision
   i. Consultation and interprofessional/interdisciplinary skills

In accordance with a competency-based evaluation approach, **Minimal Levels of Achievement required for** interns to satisfactorily progress through and complete the program include the following levels of performance documented on the Minnesota Supervisory Inventory (MSI):

<table>
<thead>
<tr>
<th>Competence Area</th>
<th>Minimal Levels of Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Research</td>
<td>≥ 70% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>b. Ethical and legal standards</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>c. Individual and cultural diversity</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>d. Professional values, attitudes, &amp; behaviors</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>e. Communication and interpersonal skills</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>f. Assessment</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>g. Intervention</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>h. Supervision</td>
<td>≥ 70% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>i. Consultation and interprofessional/interdisciplinary skills</td>
<td>≥ 70% of ratings meet or exceed expectations</td>
</tr>
</tbody>
</table>

1These percentages refer to individual ratings within each competence domain. In addition, the summary score for ≥ 8 of the 9 domains must meet or exceed expectations. The varying levels of achievement reflect, in part, the relative priorities of the internship that are considered to be primarily clinical in nature.

In addition, by the end of the internship year, interns need to be rated satisfactorily by the Training Committee on the Profession-Wide Competencies Assessment (PWCA). See Appendix 40 for the PWCA. Ratings are made at the meeting of the Training
Committee in May. If problems are noted, interns may be rated again at the June Training Committee meeting. Interns who do not meet the PWCA will need to develop a plan to address deficiencies so that they can complete the Internship: the plan may include extending the Internship.

A convergent method for assessing readiness to complete the internship involves the MSI. By the end of the year, interns are required to be meeting or exceeding expectations on all of the Essential Competence Elements of the MSI. This subset of MSI items were derived empirically by the faculty based on ratings of the most essential competence elements for completing the internship. See Appendix 39 for ECEs.

6. Interns engage in evaluation projects during the internship including reviewing therapy outcomes and program evaluation. This began as a required part of the internship as consistent with the former APA (1996) Guidelines and Principles of Accreditation, which stipulated that interns demonstrate skills in evaluation.
   a. Interns meet as a group for a Program Evaluation session with the Training Director and possibly other faculty in which the previous year’s QAI materials related to the Program Evaluation are collated and then discussed as a means of exploring how the training program could be improved.
   b. Interns meet a few times during the year to discuss therapy outcomes with Dr. Zagoloff.

7. If interns are experiencing significant problems in undertaking their clinical responsibilities, participating in didactics, or in dealing with personal issues, early identification of the problems and contributing factors is strongly advised. Reasonable, appropriate efforts to communicate about and remediate the problem(s) are indicated. Whenever possible, it is advantageous to document the nature of problems in writing, so that appropriate individualized training plans can be developed and implemented, and so that progress in meeting the conditions of the plan can be reassessed at a later date. Specific and detailed description of the nature of problems is most helpful in clarifying the circumstances. For example, information from the CAL, CIL, Supervision Log, or information provided by patients or other supervisors may be helpful in pinpointing areas of concern and providing information that potentially affects remedies. The objective of individualized training plans is to enhance the intern's capacity to contend more effectively with whatever factors may be impeding their functioning and progress, and to promote faculty involvement in assisting the intern. The initial plan is reviewed by the Training Committee during executive session and is to specify when reassessment of the problematic areas and general progress will occur. Written acknowledgement of the intern’s progress in remediating problems, including the extent to which any corrective actions have or have not been successful in addressing issues of concern, will be provided at an appropriate juncture based on the nature of the problem and plan of remediation.

8. Failure to meet standards of supervisors or rotations in terms of the quality, quantity, professionalism, or timeliness of clinical work or management of training or other professional responsibilities can result in the imposition of remedial or disciplinary action or termination by the Internship Director and the Training Committee. Problems in meeting performance expectations, after reasonable attempts by supervisors to offer support and assistance in problem solving and priority-setting, can result in further remediation, further development of an individualized training plan, probation, academic incomplete, suspension, termination from the Internship, extension of the Internship, or other actions as judged as appropriate and consistent with academic and professional standards by the Training Committee. The arrangements for remedial training and extensions of training are determined on a case-by-case basis. The Internship does not assume responsibility to provide additional funding, stipends, benefits, on-site clinical experiences, on-site supervision, or allocation of
other resources, or to provide arrangements for alternative training at other sites, as part of requiring remedial or extended training.

The Training Committee is charged with reviewing and addressing issues related to the performance of all interns. It can recommend administrative actions to the Internship Director and the Department of Pediatrics. Identification of concerns about intern functioning, including any intern evaluation other than a full pass, shall be communicated by supervisors to the Training Committee as early as possible. It evaluates concerns about intern performance and makes recommendations about administrative actions. The Training Committee may meet with interns, supervisors, the Intern Advocate, mentors, faculty from interns' doctoral programs, and other appropriate parties to discuss performance issues.

9. In the event of a remedial or disciplinary action, including termination, interns will be informed in writing of the Training Committee's determination by campus or U.S. mail. If interns are not readily accessible, determinations shall be forwarded by first class registered mail and possibly with return receipt requested.

10. Interns are entitled to appeal a remedial or disciplinary decision to the Internship Director or to the Chair of Pediatrics within one week of being informed of the remedial or disciplinary action. Appeals must be made in writing and must address the substance of the issues raised. Remedial or disciplinary actions will also be communicated to the Director of Training of the intern's program and/or their advisor as well as with the intern’s mentor in the Internship.

F. Communication with Graduate Programs

At the beginning of the Internship, interns sign releases authorizing communication between the Internship and interns' degree-granting programs. In accordance with APA accreditation criteria, the Internship Director communicates with interns' degree-granting programs. Written communication shall occur at the end of each rotation after all QAI materials have been returned to the Internship Director, at the conclusion of the Internship after QAI materials have been returned, and at other times as necessary. The content of the communication may include, but is not limited to interns': preparation for the Internship; pre-internship functioning; experiences within the Internship; professional development and progress in training; achievements and significant difficulties encountered; supervisory experiences; documentation related to training; status within the doctoral program and Internship; recommendations for additional training; plans for the future; and other information pertaining to the intern, the doctoral program, and the Internship. In the event that an intern has not satisfactorily completed the Internship by June 30, the Internship Director will provide the Director of Training of the interns' degree-granting program with a progress report and disposition.

G. Quality Assessment and Improvement (QAI) Within the Internship

The Internship is committed to ongoing quality assessment and improvement. The Training Committee reviews quality assessment and improvement information and quality issues to ensure that appropriate modifications to the program are made to improve the quality of training. Interns' feedback is valued and vital to the QAI process. Interns are required to provide input to the Training Committee and to meet all deadlines for returning materials related to the quality assessment and improvement process. Interns provide feedback during and at the end of the year about the Topical Seminar series and other aspects of training. Interns may provide feedback related to QAI efforts at any time during the Internship by contacting their supervisors, the Training Committee, or the Internship Director. Interns may also communicate quality concerns during intern-faculty meetings or to the Training Committee via the Intern Representative.

Interns are required to submit to the Internship Director and Internship Coordinator completed quarterly logs, supervision records, and evaluations of supervisors with whom they have worked sufficiently to provide feedback. Supervisory Plans and Supervision Records are to be completed for each supervisor.
Interns are not considered to have completed the Internship until they have completed and returned all of the completed QAI materials required at the end of the year. Official certificates signifying successful completion of the Internship will not be issued until all QAI materials have been completed and submitted. Final letters will not be sent to the doctoral programs until all materials have been completed and submitted.

H. Quality Assessment and Improvement (QAI) Processes and Forms

A quality assessment and improvement (QAI) infrastructure has been created through the development of a family of forms, spreadsheets, and processes for addressing administrative and quality concerns. Interns are required to provide all of the data accurately on all of the elements of the Internship’s QAI logs (e.g., CAL, CIL, Supervision Log, RIVAL) and materials (e.g., evaluations) as a matter of policy and professional ethics. Falsification or misrepresentation of experiences is unethical and is not acceptable. Materials are to be submitted in a timely manner at the end of each quarter.

The materials were primarily developed by Dr. Robiner23,24 with contributions of other faculty and trainees. In developing the MSI, directors at all clinical psychology hospital-based internship centers were invited to participate in research about the instrument (e.g., psychometric characteristics25,26). Other programs’ forms also were obtained and reviewed as was data from the ASPPB job analysis for psychologists. The current anchors of the MSI are: Development Needed, Meets Expectations, and Exceeds Expectations. The 3-point scale below is used to rate knowledge, skills, behavior, and competence during the training experience. The NA response should be used as often as necessary to designate areas that were either not applicable or not observed sufficiently. Hence, the MSI is used to document areas of functioning in which supervisees had supervised training experiences. The level of expectation at any time takes into consideration when during the training experience (i.e., the internship) the intern is evaluated. Narrative comments are recommended to provide further feedback about interns’ development during the course of training, which may not be captured fully by the ratings.

The feedback obtained is used to monitor performance, assure that training is achieving desired objectives, and improve the program in an ongoing manner. Interns are given access to of all QAI materials used during the orientation so that they are aware of QAI dimensions and processes and can approach the QAI activities systematically. They are also given the materials on a CD or through Box. These quality enhancement materials are licensed at a nominal charge to other psychology training programs by Quality Assessment and Improvement Systems (QAI Systems) through the University of Minnesota. The QAI methods are updated as needed to reflect developments within the field or in the APA accreditation process. Most recent revisions occurred to many QAI materials in 2016 to bring them in line with the APA (2015) Standards of Accreditation and the APA (2014) Guidelines for Clinical Supervision in Health Service

Interns complete a series of spreadsheets and forms throughout the Internship. Prior to arrival, interns complete Mental Health Reference and Verification forms for all employers within the past five years to complete. At the beginning of the Internship, interns complete the Orientation Self-Assessment, which provides a preliminary assessment of their skills at the beginning of the Internship, a baseline copy of the MSI, and an authorization to exchange information with the interns’ doctoral program.

Throughout the year, interns maintain records of their effort with the Clinical Assessment Log (CAL), Clinical Intervention Log (CIL), Consultation Log, that are reviewed with supervisors twice per month and forwarded to the Internship Director at the end of each quarter. Interns also maintain a Record of Illness, Vacation, and Administrative Leave (RIVAL) that is reviewed with supervisors at the time of illness, in advance of leaves, and throughout rotations, including at the beginning and end of rotations. The RIVAL is forwarded to the Internship Director at the end of each quarter. Interns complete the Minnesota Supervisory Inventory (MSI) at the beginning of the year as a self-assessment.

Interns maintain the Supervision Log and Supervision Records throughout the internship.

Supervisors rate interns quarterly with the MSI or the Neuropsychology version of the MSI. Interns complete the Supervisor Evaluation: Summary by Intern for all supervisors quarterly. They also use the Supervision Log to keep track of their supervision throughout the year. During the last few weeks of the Internship, interns complete the Annual Program Evaluation, the MSI Self-Assessment to assess change in multiple skills areas during the Internship, and the End of Year Summary of Intern's Experiences and Accomplishments. All of these items are returned to the Internship Director and Internship Coordinator at the conclusion of the Internship.

Completion and return of the materials are a requirement for graduation from the program. Evaluations are forwarded by the Internship Director to supervisors at the end of the year. Interns are encouraged to retain a copy of all relevant records at the end of the year, including each evaluation of themselves and their supervisors, as well as logs. Supervisors are also to retain copies of all evaluation and supervisory documents.

**First, Second and Third Quarter QAI Materials.** Please forward the following materials to the Internship Director and Internship Coordinator quarterly. These are also submitted the 4th quarter along with the other QAI materials (Program Evaluation, End of Training Summary).

<table>
<thead>
<tr>
<th></th>
<th><strong>Logs- CIL, CAL, Tracker, Supervision (password protected)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td><strong>UMP Supervision Plan</strong> (for each supervisor you have been supervised by. Only 1 plan per supervisor for the year is required. Only submit new supervisor plans for that quarter if the supervisor started supervising that quarter.</td>
</tr>
<tr>
<td>3</td>
<td><strong>UMP Supervision Record</strong> - initialed weekly and signed. Send as a pdf or electronically sign.</td>
</tr>
<tr>
<td>4</td>
<td><strong>Supervisor Evaluation</strong> (for all supervisors except those who have supervised fewer than 3 neuro psychological evaluations that quarter)</td>
</tr>
<tr>
<td>5</td>
<td><strong>RIVAL</strong></td>
</tr>
</tbody>
</table>

Quality Assessment and Improvement Processes, Spreadsheets and Forms

1. Mental Health Reference and Verification Form

   This form is required by State of Minnesota for all persons who will be providing mental health services. Interns are sent this after the match date and are to complete some parts themselves and have former employers complete parts.

2. Authorization to Exchange Information

   During orientation, interns complete a form authorizing exchange of information with their degree-granting programs.

Completing and Submitting QAI Materials.

Signing Documents: QAI documents are signed electronically on the document using a S-signature formatted with a forward slash before the person’s name and a forward slash after their name, and with the name repeated below. More information about s-signatures is available at: http://www.uspto.gov/web/offices/pac/dapp/opla/documents/e_sig_examiners_05152007.pdf

For example, Supervisor John Doe’s electronic signature would be: /John Doe/

Naming QAI Files: QAI documents are to be labeled with the intern’s last name and the quarter for which it is submitted. MSIs, Supervisor Evaluations, and Supervisory contracts and records are also to include in the document name last name of the supervisor. Examples are below:

MSI for intern Jane Doe completed by supervisor B.F. Freud for the first quarter would be labeled: MSI.Doe.Freud.q.1

Supervisor Evaluation by intern Jane Doe completed for supervisor B.F. Freud for the second quarter would be labeled: SupervisorEval.Doe.Freud.q.2

Logs for Jane Doe for the third quarter would be: Logs.Doe.q.3

RIVAL for Jane Doe for the 4th quarter would be: Rival.Doe.q.4. (it is to be scanned and emailed).

The Supervision Plan and Supervision Records are similarly to include the intern’s and supervisor’s last names. The Supervision Records are to be initialed for each week, signed and submitted quarterly. Each record should be sent as a separate document (signed, scanned as an individual pdf rather than as an aggregate containing all of the interns’ supervisors that quarter).

Submitting QAI Materials: Documents are sent by email attachment to both the Internship Director and to the Internship Coordinator. Supervisors are responsible for submitting MSIs. Interns are responsible for submitting all other materials.

Logs and any materials with Protected Health Information (PHI) are to be password-protected. The password for internship materials is Intern2019.

All QAI spreadsheets, including the Supervisor Evaluations, are to be submitted as spreadsheets rather than as pdfs.

When submitting Supervisory Records and Supervision Plans, please scan each item separately. They are to be scanned and sent as separate pdfs with faculty signatures. They may be sent together in a single email with multiple attachments.
3. **Clinical Assessment Log (CAL)**

   This Excel-based spreadsheet provides a record of supervisees’ assessment activities. It includes descriptions of evaluations, and timelines for completing aspects of the evaluations. It provides a record of how clinical material is being managed by the supervisee. Supervisees use it throughout the year to document their assessment experiences and regularly bring it to supervisory sessions. The CAL provides a running tally of the assessments that interns conduct, dates that drafts of the reports are due, and dates that initial and final copies are completed. This serves as a tickler system for keeping interns apprised of their workflow and success in meeting the objectives of supervisors and of the rotation. It provides a clear record, reducing the potential for ambiguity in clinical assignments and facilitates providing timely feedback to patients and referral sources. **Interns keep it up to date throughout the year and have ongoing reviews of it throughout the year with supervisors, at least twice per month during supervision.** Interns may adapt the form to meet their needs and preferences. Interns are encouraged to retain a copy of it for their records at the end of the year. **Separate logs are kept for each rotation.** The log is returned to the Director of Training quarterly via email, including at the end of the training experience.

4. **Clinical Intervention Log (CIL)**

   This Excel-based spreadsheet provides a record of supervisees’ intervention experiences. It includes descriptions of clinical populations served, the number of sessions provided. Supervisees use it throughout the year and regularly bring it to supervisory sessions. The CIL identifies the breadth and quantity of intervention experiences interns undertake. These logs ensure that interns are obtaining sufficient clinical experiences to meet minimal training aims. **Interns keep it up to date throughout the year and have ongoing reviews of it throughout the year with supervisors, at least twice per month during supervision.** Interns may adapt the form to meet their needs and preferences. Interns are encouraged to retain a copy of it for their records at the end of the year. **Separate logs are kept for each rotation.** The log is returned to the Director of Training quarterly via email, including at the end of the training experience.

5. **Record of Illness, Vacation, and Administrative Leave (RIVAL)***

   Interns maintain a record of their illness, vacation, and administrative leave (RIVAL) that is reviewed with supervisors in anticipation of time away and throughout the year. It is essential that it be kept up to date and that planning for predictable times away are discussed sufficiently in advance to allow for adequate planning to meet interns' and rotations' needs. Interns are required to obtain supervisors’ initials or signatures associated with each day away. Vacation time must be approved by supervisors in advance. The RIVAL is reviewed regularly during supervision on each rotation and copies are returned to the Director of Training at the end of each quarter. Interns are encouraged to retain a copy of it for their records at the end of the year.

6. **Supervision Log, Supervision Plan, Supervision Record***

   The Excel-based Supervision Log is used to track interns' supervision and ensure that they are obtaining adequate supervision to meet their training needs as well as the APA accreditation requirements of a total of 4 hours of individual and group supervision per week. Interns are encouraged to retain a copy of it for their records at the end of the year. The supervision log is one of the tabs on the Logs spreadsheet and covers both semesters. The log is returned to the Director of Training quarterly via email, including at the end of the training experience.

   In addition, interns complete a **Supervision Plan (Appendix 33)** for each supervisor and maintain **Supervision Record (Appendix 34)** for each supervisor. These materials are required by the Department of Human Services of the State of Minnesota and serve a
different reporting purpose so there unfortunately is some redundancy. One Supervisor Plan per supervisor is required to be submitted for the year. If there are significant changes over the course of time updated versions are submitted.

The **Supervision Record** is to be initialed by the supervisor and signed quarterly. A scanned copy is to be submitted at the end of each quarter to the Internship Director and the Internship Coordinator. Separate Supervision Records are submitted as unique documents for each supervisor and labelled with the interns’ and supervisors name and quarter.

7. **Consultation Log**

The Excel-based Consultation Log is used to track interns’ consultation experiences including direct patient care and time spent in consultative activities (e.g., team meetings). Interns are encouraged to retain a copy of it for their records at the end of the year. The log is returned to the Director of Training quarterly via email, including at the end of the training experience.

8 **Minnesota Supervisory Inventory (MSI)**

Interns and supervisors are evaluated quarterly by each other by completing the MSI or neuropsychology version (or MSI-N). This evaluation form was previously in Microsoft Word and is now a spreadsheet. It was updated to meet the *Standards of Accreditation* (APA, 2015) addresses nine domains fundamental to psychologists’ activities and characteristics plus providing feedback about presentations and other site-specific activities:

1. Research and Scholarly Inquiry
2. Ethical and Legal Standards
3. Individual and Cultural Diversity
4. Professional Values, Attitudes, and Behaviors
5. Communication and Interpersonal Skills
6. Assessment
7. Intervention/Therapy
8. Supervision
9. Consultation and Interprofessional/Interdisciplinary Skills

The MSI provides sections for narrative comments and overall assessments within each area. The MSI was developed to provide assessments about multiple relatively narrow bands of functioning. This approach permits supervisors to provide specific information that may be obscured in forms composed of broad general items. It uses a 3-point scale (i.e., development required, meets expectations, or exceeds expectations). Due to the limitations inherent in any supervised training experience, supervisors rarely complete each item. Instead, they provide ratings only on those items relevant to the supervised experiences for which they have sufficient basis to provide an assessment.

When reviewing the MSI, supervisors and supervisees are expected to discuss their respective ratings in a constructive, respectful manner to promote learning and refinement of clinical and supervisory knowledge, skills and proficiencies. It is returned to the Director of Training by the supervisor after being discussed within supervision at the end of each quarter.

MSIs will be collated for each intern as part of the QAI process for the internship. Consequently, it is essentially the Excel versions be used and that care be taken to ensure that data is entered correctly (e.g., the cells that are programmed area not overwritten with new entries). Interns are expected to have MSIs completed by all supervisors who have sufficient knowledge of the intern’s work (i.e., typically at least 3 cases with them).

Faculty are encouraged to provide narrative to document interns status and progress. Their expectations for interns are informed by where interns are in the rotation and the year (i.e., Q1, Q2, Q3, Q4) such that expectations rise over time but may not be reflected in changes in I consecutive MSIs because of taking into consideration where interns are over the course of
the year. The Essential Competence Elements of the MSI for each competence are listed in Appendix 39. Interns sign the MSI (/Intern Name/) and return it to the supervisor.

9. Minnesota Supervisory Inventory-Neuropsychology Version (MSI-N)

The version also is a spreadsheet. It includes a section specific to Neuropsychology training in addition to the other MSI items.

10. Supervisor Evaluation: Summary by Intern

On the Supervisor Evaluation spreadsheet revised in 2016 to reflect the APA (2014) Guidelines for Clinical Supervision in Health Service Psychology, and ASPPB (2015) Supervision Guidelines for Education and Training Leading to Licensure as a Health Service Provider, supervisees rate supervisors and their training experience. It is completed quarterly at the University of Minnesota. Supervisors and supervisees, may are expected to discuss the supervisory experience. When so doing, it is to be in a constructive, respectful manner to promote learning and refinement of clinical and supervisory knowledge, skills and proficiencies and to enhance the training experiences at the University. Interns return the Supervisor Evaluation to the Director of Training at the end of each quarter. Interns complete a Supervisee Evaluation for each supervisor with whom they have worked for at least two patients and for each supervisor who has completed an MSI about them. Interns are not required to discuss these ratings and the form. This spreadsheet is signed electronically and then returned as outlined elsewhere in the Handbook. Supervisors obtain feedback about their supervision from the Supervisor Evaluation and will have access to these evaluations. There may be a delay in obtaining the forms from when they are completed. Interns are encouraged to discuss their training experiences with supervisors quarterly to ensure that supervision is being provided in a manner that meets interns’ training needs.

11. MSI Self-Assessment Version

This spreadsheet completed at the end of the year. Interns rate their professional development in two ways. It incorporates items from the MSI using scaling estimating the extent of their professional development during their training experience. The second part includes items from the Orientation Self-Assessment. The MSI-SA documentation of supervisees’ professional development is a training outcome relevant to the current accreditation emphasis on documenting outcomes. Supervisees complete the MSI-SA only at the end of the Internship. It was revised in 2018.

12. Program Evaluation

This form solicits trainees’ impressions of the program on diverse dimensions, including specific aspects of training programs (e.g., didactic training, rounds), quality of training in broad areas of professional functioning, and assessments of specific rotations. It is completed at the end of the training experience and returned to the Director of Training and Internship Coordinator. It may be completed anonymously.

13. End-of-Training Summary of Intern’s Experience and Accomplishments

On this form, supervisees summarize their assessment, intervention, consultation, research, and other professional activities. It also includes a section about future plans and contacts. It is returned to the Director of Training and Internship Coordinator at the end of the training experience. It provides information that can be readily incorporated into Director of Training correspondence with other training programs (e.g., degree-granting programs) or parties
inquiring about individuals’ training experiences (e.g., licensing boards). Interns are encouraged to retain a copy of it for their records at the end of the year.

14. Recruitment Survey

This survey provides data to assess aspects of the recruitment process. It is currently a SurveyMonkey survey. It is anonymous and is completed after the conclusion of the matching process by all invitees for interviews so as not to interfere with the recruitment process or violate APPIC policies. The information is used to redesign descriptive materials, assess the impact and effectiveness of interview strategies, identify problems within recruitment, curriculum, and systems issues, along with how well they are resolved from year to year.

15. Alumni Survey

This survey solicits information from graduates of programs about their activities, accomplishments, and potential challenges they have faced after the training experience. It previously incorporated items based on the APA (1996) Guidelines and Principles of Accreditation, but now reflects the Standards of Accreditation, so that information can be presented within self-studies as required by APA. Interns are sent the Alumni Survey electronically via SurveyMonkey as part of the Internship’s ongoing self-assessment process. Aggregate data is incorporated into the self-study as part of APA accreditation reviews. It is critical that interns respond to the Alumni Survey and maintain contact with the Internship to allow for post-internship communication and collection of the distal outcomes required by CoA. It is now collected three years after interns complete the program and at the time of the preparation of the next self-study.

16. Miscellaneous Log

Additional activities may be records on the miscellaneous logs page on the same spreadsheet document as other logs. Dates of additional activities are recorded covering times in the Behavioral Emergency Center, Interprofessional Education, and MAAPIC Workshops for the year do document participation in these aspects of the program.

17. Profession-Wide Competencies Assessment

The Profession-Wide Competencies Assessment (PWCA) is completed by the supervisors of interns at the end of the internship during the May Training Committee meeting in Executive Session. It is based on the Profession-Wide Competencies that interns are required to attain according to the APA SoA and Implementing Regulations.

I. Records Retention and Access to Quality Assessment and Improvement Information

Records pertaining to the Internship are maintained by the Internship Coordinator and the Internship Director in secure files on serves and password-protected hard drives. Older paper records are also stored at a secure University storage site. These archival materials are kept for future references, verifications, and credentialing purposes.

As a matter of policy, access to Quality Assessment and Improvement and clinical information may be permitted to third parties for regulatory, accreditation, promotion, and auditing purposes. Interns' and faculty members' participation in the Internship implicitly provides authorization for QAI information to be available to third parties (e.g., APA site visitors, representatives of the APA Commission on Accreditation, the Minnesota Board of Psychology, the Joint Commission on the Accreditation of Healthcare Organizations, and to University, University of Minnesota Physicians, and UMMC administrators) on a need to know basis. It is the reviewers' responsibility to maintain the privacy and confidentiality of this information.

XV. CONCLUSION OF THE INTERNSHIP
The Internship ends on June 30. There are a number of matters to be settled at the end of the Internship year. Interns are expected to have completed all of their clinical responsibilities by June 30. By March 31, interns are to discuss and develop, with their supervisors, plans and timelines for concluding the Internship, including any remaining vacation plans. Interns need to allocate their vacation days carefully during the year so as to have flexibility at the end of the year in the event they wish to begin a postdoctoral fellowship or job immediately following the internship. The Internship is not required to grant additional time off, beyond the policies described elsewhere in the Internship Handbook, to meet the expectations, wishes, or demands of other entities related to interns' post-internship activities (e.g., early start dates or early moves). Interns are expected to have completed all of the requirements for both rotations to be eligible for finishing the Internship including to meet the minimal competencies for completing training.

Exceptions to policies stated in this section must be discussed with primary supervisors, the Training Committee, and the Internship Director. It is highly unlikely that requests to graduate before June 30 will be accommodated. It is recognized that employers, including postdoctoral fellowships generally have some latitude in establishing of modifying start dates. Approval of such a request would require unanimous determination by all of the second rotation supervisors, members of the Training Committee, and the Internship Director following a mandatory meeting of all of the above to discuss the request. Interns must make such requests in writing to the supervisors and to the Internship Director no later than March 31 and requests must specify the actual dates being requested. Individual supervisors and rotations are not authorized to provide approval of such requests.

Similarly, it is highly unlikely that requests to leave the University of Minnesota more than 5 work days before June 30 will be accommodated even if interns have sufficient vacation days left to cover the period. Approval of such a request would require unanimous determination by all of the second rotation supervisors, members of the Training Committee, and the Internship Director following a mandatory meeting of all of the above to discuss the request. Interns must make such requests in writing to the supervisors and to the Internship Director no later than March 31 and requests must specify the actual dates being requested. Individual supervisors and rotations are not authorized to provide approval of such requests.

A. **Award of Certificate**

Interns are provided with a certificate documenting their completion of the Internship at the end of the Internship signed by the Medical School Dean, Chair of the Department of Pediatrics, and Internship Director. Under some circumstances, arrangements may be made for certificates to be mailed. Interns are to inform the Internship Coordinator and Internship Director in writing how they would like to be identified on the certificate (e.g., full name? middle initial?) by the end of May. Certificates do not designate interns’ degree because of variability in when the degree is technically awarded by the degree-granting institution. Identification of the degree is not necessary for any credentialing or authentication purposes. Certificates (i.e., original signed copies) are not provided until all work is completed and all materials, including QAI materials (and other materials listed elsewhere) are returned. Interns make arrangements to obtain the final copy from the Internship Coordinator when all materials have been submitted.

B. **Work Load for Last Two Weeks of the Internship**

During the last two weeks of the Internship, interns gradually decrease patient contacts, including the number of psychological evaluations undertaken per week, to allow for an orderly completion of the Internship. The reduction in clinical load is designed to provide interns with time to complete their clinical responsibilities, including completion of all paperwork. It is expected that interns will continue to provide services during this period. However, during the last two or three business days of the second rotation (i.e., June 28, 29 and 30, or if they are on weekends, the respective day or two preceding them), interns’ participation in the care of new cases may be reduced, with primary responsibility for case management (e.g., referral). Although generally there are reduced expectations for interns (i.e., to be primarily responsible for conducting new...
evaluations and writing reports on new patients) during the last two or three days of the rotation, interns are expected to continue to participate in the general, ongoing, emergency, or inpatient consultation clinical services of the rotation. Interns make efforts to provide appropriate disposition of cases (e.g., termination or transfer to incoming interns, fellows, staff, or faculty).

All clinical and educational responsibilities must be completed to conclude the Internship. All clinical and administrative paperwork (i.e., reports, QAI materials) must be completed before interns leave the Internship. Failure to complete and turn in the materials is unprofessional and nullifies any plans for concluding the Internship, including vacation.

Supervisors may assist interns in whatever ways they deem appropriate and feasible to facilitate a timely conclusion of the Internship. If interns elect to take vacation days at the end of the Internship, they must obtain approval from their supervisors, and the Internship Director in writing no later than three months before the end of the internship (i.e., March 31) to allow for the orderly provision of clinical services on that clinical service and for an orderly exit from the Internship. It is essential that interns and supervisors discuss this issue to ensure that workload expectations are clear and explicitly stated.

No more than five (5) consecutive work/business days of vacation may be taken at the end of the Internship. This includes for the purpose of starting a new position or leaving early in preparation for starting a new position. If interns choose to use vacation during the last week of the internship (i.e., at the end of the year), they are expected to continue to provide services and attend didactics in a manner that meets the expectations of their supervisors and may be expected to provide services during the last days before their terminal vacation.

Didactics may continue until the end of the internship on individual rotations and for the Internship as a whole.

C. End of Internship Materials

Interns are responsible for returning keys, etc. to the appropriate personnel within the participating departments prior to their departure and will be responsible for returning all library materials. If security deposits have been made, they will be returned in accordance with institutional policies. Interns will be responsible for costs associated with failure to return materials as consistent with institutional and departmental policies. Interns are to return their pager and ID badge to the Internship Coordinator at the end of the year so that the pager will be available as assigned to interns the following year. Interns must return final evaluation forms (signed intern evaluations and supervisor evaluations) and the Record of Illness, Vacation, and Administrative Leave (RIVAL) to the Internship Coordinator and Internship Director before departing. Returning these materials directly to the Internship Coordinator is the responsibility of each intern and is required to complete the Internship. Delays in returning these materials will delay the awarding of final certificates and will delay the Internship Director contacting degree-granting programs to affirm that the Internship was completed. It will also result in delays in providing confirmation of completion of the Internship to potential employers and licensing boards.

Please use the checklist below assist with this conclusion process:

<table>
<thead>
<tr>
<th>Materials</th>
<th>Return/Send to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical files and departmental materials (e.g., tests)</td>
<td>Department or Supervisor(s)</td>
</tr>
<tr>
<td>Keys</td>
<td></td>
</tr>
<tr>
<td>ID tag-hospital badge</td>
<td>Internship Coordinator</td>
</tr>
<tr>
<td>Pager</td>
<td></td>
</tr>
<tr>
<td>End-of-Training Summary of Intern's Experiences and Accomplishments</td>
<td>Internship Director and Internship Coordinator</td>
</tr>
<tr>
<td>MSI-SA</td>
<td></td>
</tr>
</tbody>
</table>
D. **Use of Confidential Materials After the Internship**

If interns maintain copies of case-related materials, they are responsible for maintaining the confidentiality of those materials into perpetuity in accordance with the guidelines of the APA and state and federal laws, including HIPAA. At no time may such PHI or related materials be used in any way that would identify patients by name or reveal sufficient personal information to compromise their confidentiality and privacy. Questions about post-internship use of materials should be addressed with supervisors. Documents must be maintained securely and be password-protected.

E. **Forwarding Addresses, Telephone Numbers, and Further Contact with the Internship**

Interns are to provide the Internship Coordinator and Internship Director with all known forwarding addresses and telephone numbers and emails prior to their departure. This will facilitate forwarding of interns' mail, Internship correspondence with graduates of the Internship, and potentially continuity of care for patients. **Interns are requested to kindly provide timely updates to this information for a minimum of 10 years per current APA accreditation requirements, and to keep the Internship Director informed of their professional activities for that period.**

F. **Quality Assessment and Improvement Materials**

Interns are expected to complete all self-evaluations and evaluations of the Internship according to the quarterly schedule throughout the internship (i.e., MSI/supervisor evaluations quarterly; didactics evaluations weekly). End of year materials are to be completed prior to their departure and to be returned to the Internship Coordinator. Interns may, but are not required to, provide their names on the Program Evaluation materials. Interns are to provide their names on self-assessments, End of Year Summary of Intern's Experiences and Accomplishments and supervisory materials. Interns are to complete evaluations of their supervisors and to sign MSIs and have the supervisor forward them to the Internship Coordinator and Internship Director.

G. **Confirmation of Completion of the Internship**

The Internship Director will confirm interns' conclusion of the Internship by mail to interns' degree-granting programs. In the event that an intern has not satisfactorily completed the Internship by June 30, the Internship Director will provide the Director of Training of the interns' degree-granting program with a progress report. Interns authorize communication with interns' degree-granting programs when they apply for the Internship and/or during the Internship orientation.

Periodically, intern alumni will need documentation of their completion of the internship (e.g., for employers, psychology boards, hospitals, third party payers, etc.). Interns forward requests to the Internship Director and may forward some materials to individual supervisors. These requests are considered a priority and every effort is made to respond to requests in a timely manner.
However, because the volume of requests can be considerable, it is recommended that interns follow up with internship personnel to confirm that the materials were completed and submitted efficiently.

H. Internship Maintenance of Records

The Internship Director maintains a permanent list of graduates of the program, currently as an Excel and word file. Electronic records are maintained to the degree possible. This information is important to retain for auditing, legal, licensing, credentialing, and certification purposes.

I. Intern Retention of Supervision Information

Interns are advised to retain copies of their logs and evaluations. They are also encouraged to obtain and keep contact information for all of their supervisors and to keep a list of their supervisors, including the supervisors’ license numbers, and start and end dates of the supervision for each supervisor, hours/week of supervision throughout their supervision with each supervisor, as well as supervisors’ contract information.

Interns are also strongly encouraged to continue to maintain complete, detailed (i.e., weekly) records of supervision throughout their postdoctoral/post-internship training. They are granted permission and encouraged to continue to use the Internship’s materials (i.e., supervision log, supervision contracts) for that purpose and are encouraged to give a copy of those materials to their supervisors at the end of supervisory experiences or when applying for licensure. Such information is required by some licensing boards. It is important that both supervisors and supervisees maintain these records and that the records are consistent and provide confirmatory documentation of statements made in the licensing process.

Interns may also take advantage of credential archiving services through the National Register of Health Service Psychologists or the Association of state and provincial Psychology Boards.

XVI. SAFETY ISSUES AND CODES

Within the hospital, a set of codes has been developed to address a variety of emergencies. In the event of Emergencies call (612) 626-4005 or 888. Fire, theft, and accidents, etc. requiring emergencies responses should use this number. Make sure to identify the location of the emergency. Interns do not have assigned roles for these emergencies. In case of police emergency call the Campus Police at 911. Text messages may be forwarded by the University to intern, staff, and faculty cell phones in case of emergencies on campus and significant weather warnings.
### Emergency Codes

| Code Blue                       | "Adult Team" and "Pediatric Team" are codes for a person with a medical emergency. Designated personnel are to respond immediately to the announced location. |
| Code Red                        | Fire Code: In the event of fire announcements stay on the hospital floor and await directions. Do not use elevators during these emergencies. Actions are to rescue, confine, and alert. It may be possible to exit through an adjacent building. |
| Code Yellow                     | Unauthorized takeover of hospital unit by patients. Designated personnel report stat (i.e., emergency) to announced area to assist with intervention. |
| Code Green                      | Potential Behavioral Crisis Code. Designated personnel report stat to announced area to assist with intervention, if needed. |
| Code 21                         | Stat behavioral crisis: Requires that designated personnel report stat to the announced area to assist with the intervention. |
| Code Search                     | Bomb Threat: Requires a search. Suspicious objects should be reported to security at 626-4005 or 1-2-3. |
| Code A                          | Infant or child abduction. Report anyone carrying or leading an infant or child to security at 626-4005 or 1-2-3. |
| Code Evacuation                 | Evacuation from the announced area to a designated safe area. |
| Orange Alert                    | Internal or External Disaster. Designated departments prepare for a large number of casualties to be treated at the medical center. |
| Stat/Triple Page                | Immediate response of designated personnel to respond to the announced area. |
| T-Alert, Stage 1                | A tornado has been sighted, not in the immediate area, and personnel should be prepared to take cover. |
| T-Alert, Stage 2                | A tornado has been sighted in our immediate area and personnel should move to safety and take cover. |

Interns are encouraged to consider their personal safety and the security of their belongings, and clinical materials (e.g., medical records) at all times. In case of emergency, dial 123 or 911. The UMMC Security Monitor Program (624-WALK) is available to assist with any emergency, including observation or restraint. The escort service is available to patients, employees, and trainees for after hour escorts to parking facilities. After hours outpatient clinical activities should be cleared with supervisors. It is strongly recommended that other staff or trainees be nearby during any after hour contact with patients or families.

The telephone number for the Campus Police is 624-COPS. Many outside doors are locked at 6 P.M. Access to the Academic Health Center after hours and on weekends may be limited to main entrances and increasingly require appropriate ID (badge/University ID). The U of M Police website is http://police.umn.edu/. It offers information about crime prevention, campus alerts and statistics, how to report a crime, and other useful information. Crime statistics are made available to all current and prospective students, and to staff and faculty. Statistics are compiled by the University Police Department in consultation with the St. Paul and Minneapolis Police Departments and a wide range of University personnel in accordance with the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act *(informally known as the "Clery Act"). Crime alerts are posted for your information and safety via email. Further information is available at: http://police.umn.edu/statistics/cleryact
BASIC CAMPUS SAFETY TIPS

Be mindful of your surroundings.

Lock your work and living areas every time you leave.

Report any suspicious persons or activities to the University Police Department: 624-COPS

Report lost access cards or compromised passwords immediately.

Report all maintenance problems to Facilities Management. 624-2900; http://www.facm.umn.edu

Use the escort service rather than walk alone at night.

Do not prop open entrances to buildings.

Emergency/Campus telephones are located near attendant booths in parking areas or exits of various facilities for your safety convenience. Improved lighting in parking facilities is an ongoing project. Security systems using closed circuit television, alarm buttons, microphones, and motion detectors are being upgraded in many facilities. In addition, Parking and Transportation Services' Safety Personnel frequently patrol parking facilities and now provide increased coverage on weekends, overnights, and holidays.

Interns are encouraged to lock offices when they are not in use to deter theft and to avoid leaving personal possessions or sensitive clinical materials in public areas.

Incident reports for on-the-job accidents should be reported immediately to the Employee Health Service (Mayo A297 or on the Riverside Campus) during normal working hours or the Emergency Room after hours.

Interns, supervisors, patients, and visitors are prohibited from possessing firearms or other weapons while on the premises of the University of Minnesota and University of Minnesota Medical Center.

Interns and faculty home telephone numbers are provided on the Roster. This information is considered private and is not to be released. Interns are encouraged to not list their home address in public telephone directories.

Think Green: Interns and staff are encouraged to minimize their environmental footprint by turning off lights when they expect to be out of their offices > 30 minutes. Please discuss policies for turning off computers in divisional computers. Recycling is encouraged of plastics, bottles, and paper by using the properly designated containers.

XVII. ILLNESS, VACATION, LEAVE, AND HOLIDAYS

A. Illness, Vacation, Leave and Holidays

Interns have three (3) weeks (i.e., total of 15 working days) of paid vacation. Interns are to schedule up to seven (7) or eight (8) days of vacation during the first rotation and the remaining up to seven (7) or eight (8) days of vacation during the second rotation. The division of vacation time between rotations ensures that interns are able to take advantage of as many training opportunities on each rotation as possible and that no rotation is placed at a disadvantage in terms of clinical coverage. Vacation times also is divided to promote interns' personal wellness throughout the Internship, so it is important that vacation not saved up to all be used up at the end of the year. Failure to use vacation in this manner results in forfeiture of unused vacation time with either rotation. During the second rotation, interns may not use more than one week (i.e., five business days) at the end of the Internship to allow for leaving the Internship early.

Interns are allowed up to five (5) days of paid sick leave to meet legitimate needs due only to personal illness or illness of their child. Routine health care is to be scheduled so as not to interfere with any clinical activities or scheduled training activities.
The following procedures have been established to assure that interns meet the training requirements of the Internship. Interns are to keep track of their vacation, sick leave, and administrative leave on the Record of Illness, Vacation, and Administrative Leave (RIVAL) to record time away from the Internship. Interns and supervisors should review this form at minimum quarterly and at the beginning and end of each rotation. **If interns require additional sick leave after using up the allotted vacation time, their Internship will most probably be extended accordingly without pay.** It is each intern's responsibility to obtain their primary supervisor's signatures on the RIVAL each time paid vacation, sick leave, and administrative leave are taken. To keep the RIVAL up to date, it is generally expected that interns will present the RIVAL within two days of each absence. The RIVAL is to be returned to the Internship Director and Internship Coordinator at the end of each rotation of the Internship. The Internship is not considered to be completed until the RIVAL is returned to the Internship Director or Internship Coordinator.

Interns are also expected to communicate their time away from the Internship to all relevant personnel associated with the Internship (e.g., clinic and/or departmental support staff as outlined within each rotation, Internship Coordinator, all supervisors who would reasonably be expected to be involved in their work or who might be anticipated to be contacting them [e.g., about potential referrals] during the absence) to reduce the potential impact of their absence on clinical and training operations. Such communication should be as far in advance of time away as possible. Unless interns are legitimately ill, on vacation or on leave, they are expected to be punctual in attending required training events and in providing clinical services.

Interns are to allocate their vacation days carefully during the year so as to have flexibility at the end of the year in the event they wish to begin a postdoctoral fellowship or job immediately following the internship. Similarly, if interns wish to leave before the official end of the internship for other reasons, they may only do so if they have available vacation days left for that purpose and may not leave more than 5 working days before the end of the internship.

### B. Scheduling Vacation Time

Interns schedule their time away from the Internship **equally between their two rotations** (e.g., not to schedule it all at one time or for just the second rotation, or significantly more for one rotation than the other). In other words, 7 days for one rotation and 8 days for the other. Failure to take vacation in this manner will result in a net loss of vacation days.

Interns are required to discuss plans with their primary supervisors to ensure that adequate coverage is available to meet clinical service responsibilities during their absence and to assure that vacation does not interfere with their other roles within the Internship (e.g., presentations). **Supervisors are to sign the RIVAL one month in advance** of vacation to reflect their approval of vacation plans. Once a supervisor has approved vacation, interns are also to **inform the Internship Coordinator** of the vacation so that training operations are coordinated appropriately. Requests for vacation without sufficient notice will not necessarily be authorized by supervisors. **It is interns’ responsibility to present the RIVAL to their primary supervisor in accordance with this policy and to follow the other procedures within the policies delineated in the Internship Handbook.**

### C. General Comments

**Sick leave is allowed to fill legitimate needs due to illness.** It is understood that sickness may occur on a date during which an intern has been scheduled to perform intakes and testing. Given the significant lead time necessary for these patient appointments, the difficulty in rescheduling patients due to inadequate coverage, and the amount of work necessary in writing-up an evaluation, another trainee may be asked to cover a scheduled assessment visit that another intern
is unable to perform. In return, interns may be asked to "make up" the assessment times for a colleague at a later date.

It is essential that interns communicate effectively with their supervisors and appropriate clinic personnel when they are sick at the beginning of any time away from the Internship to ensure appropriate management of clinical responsibilities. It is interns’ responsibility to assure that supervisors are actually aware when they will not be present in clinic on sick days. Because of the many avenues of communication available (e.g., pager [e.g., text page], cell phone, voice mail, email, leaving messages), interns must be sure that communications go through in a timely manner and that supervisors receive the message. It is recommended that multiple channels of communication be employed to ensure that supervisors are informed in a timely manner that allows for clinical operations to proceed as smoothly as possible. Interns should confirm that supervisors have been apprised of absences and should make every effort to be available themselves by telephone or email to allow for coordination of activities related to their absence.

Misuse of sick leave, as judged by the Training Committee, will result in administrative actions, such as extension of the training period required for the Internship, etc. Interns must communicate with the Internship Director and Brett Steger of the Department of Pediatrics Payroll Office (624-1911) if it appears that an illness will be long-term. Illnesses requiring more than 3 days of absence must be documented with a letter from a physician or other treating health care provider, describing the medical condition and, if necessary, the need for an extended absence. The Pediatric Payroll Office, Internship Director, Training Committee, and supervisors will make reasonable efforts to work with interns to develop appropriate and realistic plans for dealing with major illness. Supervisors sign the RIVAL preferably within two days of when interns return from sick leave, and certainly within one week of any day of sick leave. It is interns' responsibility to present the RIVAL to their primary supervisor in accordance with this policy and to follow the other procedures within this policy.

Resources for students with disabilities may be accessed at:


University of Minnesota: [Disability Resource Center of the Office for Equity and Diversity at 626-1333 and](https://diversity.umn.edu/disability/home)

D. Holiday Schedule for Academic Year 2019-2020

The following holiday schedule has been established for the University.

<table>
<thead>
<tr>
<th>Date</th>
<th>Day</th>
<th>Holiday</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 July 4</td>
<td>Thursday</td>
<td>Independence Day</td>
</tr>
<tr>
<td>2 September 2</td>
<td>Monday</td>
<td>Labor Day</td>
</tr>
<tr>
<td>3 November 28</td>
<td>Thursday</td>
<td>Thanksgiving Day</td>
</tr>
<tr>
<td>4 November 29</td>
<td>Friday</td>
<td>Floating Holiday</td>
</tr>
<tr>
<td>5 December 23</td>
<td>Monday</td>
<td>Floating Holiday</td>
</tr>
<tr>
<td>6 December 24</td>
<td>Tuesday</td>
<td>Floating Holiday</td>
</tr>
<tr>
<td>7 December 25</td>
<td>Wednesday</td>
<td>Christmas Day Holiday</td>
</tr>
<tr>
<td>8 January 1</td>
<td>Wednesday</td>
<td>New Year’s Day Holiday</td>
</tr>
<tr>
<td>9 January 20</td>
<td>Monday</td>
<td>Martin Luther King, Jr. Day</td>
</tr>
<tr>
<td>10 May 25</td>
<td>Monday</td>
<td>Memorial Day Holiday</td>
</tr>
<tr>
<td>11 (unassigned)</td>
<td>-</td>
<td>One Personal Floating Holiday</td>
</tr>
</tbody>
</table>

The 11th holiday has been designated as a "personal floating holiday." This holiday shall be taken at a time approved by the intern's primary supervisor and is not to interfere with clinical or
training operational needs. Interns should check with their primary supervisor about when the personal holiday may be taken and must do it in accordance with University policies. **Personal floating holidays are to be recorded on the RIVAL.**

### XVIII. OTHER LEAVES OF ABSENCE

#### A. General Comments

Extended leaves of absence (LOA), as a general rule, are not allowed except in unusual circumstances as outlined below. Requests for LOA should be considered carefully because it will invariably create difficulties for patients, other interns, faculty, and the training program. Interns may also risk experiencing certain inconveniences, including delays in completing the Internship, possibly delaying the granting of doctoral degrees, and postponing eligibility for licensure. All leaves **must** be applied for in writing to the rotation supervisor and the Internship Director and must be approved by the Internship Director in writing. Exceptions may be made if the request falls within the definition of the Family Medical Leave Act (FMLA). Should an intern qualify for such a leave, the Internship will continue to make contributions toward the intern's health insurance during the leave. Further details are available through the Department of Pediatrics Payroll Office. Potential expenses to cover periods of extensions may be the responsibility of the intern.

Individuals are not to assume that LOA will be granted automatically. It is essential to obtain approval before making any firm plans. All interns must meet the training requirements (i.e., one-year full-time Internship or equivalent) established by the American Psychological Association and the Internship. Due to variability in licensing requirements across jurisdictions (i.e., states or provinces may have rigid requirements delineating hours or weeks of training at the internship level), it is strongly advised that interns consider fully any potential implications of LOAs in terms of their candidacy for licensure or readiness to pursue post-internship employment opportunities.

#### B. Family Medical Leave Act (FMLA)

FMLA allows employees to take up to twelve weeks of leave **without** pay during a year **provided** that the employee has been employed **a minimum of 1,250 hours** in the preceding 12 months (i.e., more than half of the Internship has been completed). This leave is provided upon request for one of the following reasons:

1. Parental leave: childbirth and/or care of the newborn; placement of an adopted or foster child (leave must be completed within 12 months following the event).
2. Family medical leave: care of a close family member (spouse/child/parent) with a serious health condition.
3. Personal medical leave: A serious health condition that prevents an intern from performing professional responsibilities. Medical leave may be part-time or taken intermittently. Arrangements must be approved by the Internship Director and supervisors. **Documentation from a treating health professional is required to support requests for leave.**

#### C. Parental Leave of Absence (Parental LOA)

Interns are entitled, upon request, to two weeks of parental leave with pay starting on the day of delivery or adoption. An additional leave of absence without salary may be requested. Any time lost due to sickness during the pregnancy is treated as standard sick leave. Parental LOA will be determined in consultation with primary supervisors and the Internship Director and the Training Committee. Any additional time will need to be made up after the intended conclusion date of the internship. See APPIC document regarding pregnancy (Appendix 26).

#### D. Personal Leave of Absence (Personal LOA)
Only under unusual circumstances, such as a personal or family emergency, will a Personal LOA be considered. LOA will be subject to the general conditions noted above.

E. **Administrative Leave of Absence (Administrative LOA)**

Interns may be granted up to **four (4)** days administrative leave to attend professional conferences or conventions, or for other professional purposes, such as to defend their dissertation, or interview for post-internship positions. Administrative LOA time needs to be approved in advance by interns’ supervisors. Interns should avoid making plans without discussing the administrative leave in advance because it is subject to the approval of the supervisors AND the Training Committee. Administrative leave will be granted on a discretionary basis. Interns are responsible for ensuring that administrative leave does not interfere with the provision of clinical services of their rotation or with their other roles within the Internship (e.g., presentations). Interns are to inform the Internship Coordinator in advance of each day of leave, once the intern’s supervisor has approved it, so that training operations can be coordinated appropriately. LOA time away from the Internship must be documented on the RIVAL and must be signed in advance by the intern's primary supervisor. It is interns' responsibility to present the RIVAL to their primary supervisor in accordance with this policy and to follow the other procedures within this policy.

F. **Insurance Coverage During a Leave of Absence (LOA) and Following Internship**

The insurance benefits noted previously may be continued at an intern's own expense during a LOA. Consultation with the Payroll Office of the Department of Pediatrics is necessary to arrange for extended coverage. Interns are not able to purchase COBRA to continue their insurance following internship. If their postdoctoral fellowship or job does not begin immediately after the internship, they are encouraged to obtain policies through the exchange or other source.

G. **Extension of Training**

The Internship and the American Psychological Association require twelve months of internship training. Absences in excess of three weeks, whether for vacation, sick leave, maternity leave, etc., must be made up in a timely manner to fulfill the training requirements of the Internship. The Training Committee may grant extensions for remedial purposes as part of a training plan. Extensions of training, when granted, are at the discretion of the Training Committee and Internship Director.

Arrangements for an extension of training, whether requested by an intern, or based on a determination of need by the Training Committee, are at the discretion of the Training Committee. The Internship will determine on a case-by-case basis whether or not to provide additional training on-site and the objectives and elements of extensions. The Internship is not required to provide additional funding for extensions of training or any other benefits during that period. Consequently, there may be costs (e.g., tuition, health insurance) borne by the intern if an extension is required.

XIX. **STIPEND/PAYROLL**

A. **Salary Levels**

Estimated salary for interns as of July 1, 2017 is **$26,500**. Stipend levels are reviewed for adjustment at the beginning of the Internship year. The Internship covers (and then the University payroll system automatically deducts) related University fees. Consequently, for tax purposes gross income exceeds net income. Interns are responsible for paying FICA through payroll deductions in accordance with IRS rulings. It is noted that University policies and IRS rulings regarding FICA withholding have varied at times and are subject to change. The University makes a FICA contribution on behalf of interns comparable to the withholding. All interns receive the same stipend.
B. **Paydays**

Paydays are biweekly on Wednesdays throughout the Internship year. For questions regarding paydays, contact Brett Steger (612-626-6910). Payment histories may be accessed through [http://onestop.umn.edu/](http://onestop.umn.edu/)

C. **Payment Methods**

Payment will be made by only one of the following methods:

1. **Direct deposit**
   
   Payments may be deposited directly into your checking or savings account if your banking institution accepts direct deposit transactions. Most financial institutions in the area accept direct deposit. Brett Steger, or other staff in the Department of Pediatrics Payroll Office, will assist you with arrangements for direct deposit. Your direct deposit record may be reviewed through the Internet at: [http://hrss.umn.edu/](http://hrss.umn.edu/)

2. **Payroll checks**
   
   If you choose to be paid by check, your check will be mailed to your home address unless you make prior arrangements with the Pediatrics Payroll Office.

D. **Lost Checks**

Report lost checks immediately and in person to the Department of Pediatrics Payroll Office. Issuance of a duplicate check may take up to two months. Therefore, always handle your paycheck with care and deposit it promptly. It is strongly recommended that interns arrange for direct deposit to avoid the possibility of lost checks.

E. **Tax Matters**

Other than providing the standard W-4 deduction claim forms, the Department of Pediatrics Payroll Office does not provide information or advice on tax matters. FICA and other legally mandated amounts are withheld from interns' checks.

XX. **FRINGE BENEFITS AND MISCELLANEOUS ISSUES**

A. **Insurance**

1. **Health Insurance**
   
   Individual health insurance coverage is currently provided through Boynton Health Service (general information at (612) 625-8400. Dental coverage is also provided on a limited basis through Boynton Health Services via a discount on services.

2. **Extending Health Insurance Beyond Internship**

   There are options to extend health insurance beyond June 30 of the internship year. Interns can contact Brett Steger [(612) 626-6910; stege015@umn.edu] and personnel at Boynton Health Service.

3. **Malpractice Insurance**

   Professional liability (malpractice) insurance is provided to interns through RUMINCO, a blanket insurance policy purchased by the Regents of the University of Minnesota. This policy covers trainees in the health professions who are registered for courses in the Medical School Graduate School. Interns are registered for courses each quarter. Interns are not covered by the malpractice insurance policy when they are providing services that are not part of the formal rotations of the Internship (i.e., trainees are not covered if they are moonlighting). Interns may, but are not required to, obtain their own professional liability insurance (e.g., through the American Psychological Association Insurance Trust).
4. Injury While on Duty

If an injury is sustained related to an intern's duties, interns are to complete forms and follow specific procedures. Interns must contact the Department of Pediatrics Payroll Office for assistance. Reports must be filed immediately to ensure Workers Compensation coverage. Interns are to contact Brett Steger ([612] 626-6910) when dealing with these matters.

B. Graduate Trainee Status

1. Registration/Transcripts

The Internship is a professional graduate program leading to professional qualification, but not to an advanced degree other than through their degree-granting institution. Interns are enrolled as "Psychology Fellow Specialists" in the Medical School Graduate School of the University of Minnesota and are registered each quarter for courses through the Department of Pediatrics. A transcript provides a permanent record of matriculation through the Internship.

The Department of Pediatrics Medical Education Office in conjunction with the Payroll Office accomplishes registration of all interns each quarter. Interns are not involved in their quarterly registration for classes. Once registration has been completed, paid fee statements are mailed to interns. As trainees, interns are granted several student privileges.

2. Tuition and Fees

Tuition and all ordinary fees for registration in the Medical School Graduate School are paid by the Department of Pediatrics with contributions from all participating divisions. This is likely to be considered as taxable income by the IRS.

   a. Late Fees
      Any late fees incurred due to holds on registration because of library fines, nonpayment of student loans, etc. are the responsibility of the intern incurring the fees.

   b. In-State Tuition for Spouses
      Spouses of interns are eligible for in-state (intern) tuition rates. A form verifying appointment for intern tuition must be filled out and certified by the Department and is available through the Department of Pediatrics Payroll Office.

3. Student Identification

At entrance to the Internship, interns are provided with an authorization card to receive a University I.D. card called a "U Card." I.D. cards are issued in Room 40 of Coffman Memorial must bring picture identification card with them to this desk. Interns go to Room 40 on the first day of the internship with the Internship Director. Identification as a student of the University of Minnesota may be made by presenting a current U Card. To take advantage of University privileges (e.g., to check out books from the library, get discounts), interns may be required to present it.

4. University Recreation Center

Interns with current fee statement may participate in recreational programs and use the facilities of the University Recreation Center. The U Card must be presented for identification each time to access the facilities. For most current information call 625-6800. Lockers may be rented for a nominal fee per academic quarter.

C. Photocopying Privileges

Interns are granted photocopying privileges in the offices of the departments through which they rotate. Please ask for assistance when first using the copier, or if experiencing difficulties while using it. This privilege is for documents related to the Internship only and is not to be abused. For
example, Department photocopy resources are not to be used for personal photocopying (e.g., personal correspondence, dissertations). There is a Mayo Digital Print Center in Mayo D-104 (625-8914).

D. Nametags/ID Badges

Patients and families appreciate having ways to identify interns. **Interns are required to wear University of Minnesota Medical Center nametags during all professional activities** while on-site above the waist facing away from the holder’s body per Joint Commission regulations. Stickers, tape, or other objects that alter the appearance of the badge holder must not cover the badges. Badges should be worn when riding the shuttle between the Riverside Campus and the East Bank of the University Campus and CSC and when leaving parking lots or ramps.

Interns arrange to have pictures taken and to procure an official UMMC nametag. On it they are to be identified as "Psychology Intern" and may include highest relevant academic credential (but not a doctorate). Interns seeking to identify themselves as "doctor" must obtain approval first from the Internship Director and must provide a statement from their Director of Training that they have already fulfilled all requirements for the doctoral degree. Nametags may not identify interns as a "Psychologist." If nametags break or are lost, the Department of Pediatrics will provide a single replacement. Interns may be responsible financially for arranging for any additional nametags. Lost nametags require a replacement charge. Please contact the Internship Coordinator and Payroll Office if a new nametag is required. To arrange for nametags to be made contact Protection Services at 626-4005. Photographs are taken as part of the preparation of a nametag. It is necessary to use hospital badges to gain access to certain hospital units and space. Access is subject to auditing. Bring some form of picture ID such as a driver’s license to the Security Office when requesting the University of Minnesota Medical Center photo ID. Individuals who experience a status change, such as name change, must go to the Security Department to receive a new Photo ID Badge and must provide adequate documentation for making changes.

E. Mail/Address

Interns are required to read informational mailings on a timely basis. Since individual intern mailboxes are limited and change mid-year, non-internship-related mail (e.g. journals, etc.) should be sent to interns' home address. Professional correspondence related to internship responsibilities should be addressed to interns in care of the departments through which they rotate. Each intern has two addresses during the internship. Interns therefore must update their address information online in the University Directory mid-year in terms of their address and telephone numbers when they change rotations. The addresses of the rotations are below. Pediatric Psychology and Pediatric Neuropsychology are part of the Division of Clinical Behavioral Neuroscience:

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of Clinical Behavioral Neuroscience</td>
<td>Division of Child &amp; Adolescent Psychiatry</td>
</tr>
<tr>
<td>Department of Pediatrics</td>
<td>F256/2B West</td>
</tr>
<tr>
<td>Mayo Mail Code 486</td>
<td>2450 Riverside Avenue South</td>
</tr>
<tr>
<td>420 Delaware Street, Southeast</td>
<td>Minneapolis, Minnesota 55454</td>
</tr>
<tr>
<td>Minneapolis, MN 55455</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Courier/Shipping Address</th>
<th></th>
</tr>
</thead>
</table>
Interns must report any changes in home address to the Pediatric Payroll Office, Internship Coordinator, and to the Internship Director immediately throughout the Internship. Interns are responsible for arranging for mail to be forwarded at the end of each rotation and at the end of the Internship. Interns are required to provide the Internship Coordinator and the Director of the Internship with a forwarding address and telephone number at the conclusion of the Internship. It is requested that interns continue to provide the Internship with their current addresses and email addresses for at least the 10 years following the Internship for accreditation purposes, and beyond that so that future interns can communicate with them about a range of professional concerns (e.g., job networking).

F. Pagers

UMAHC pagers are supplied by University of Minnesota Medical Center and paid for by the Department of Pediatrics. The Internship Director at the beginning of the Internship assigns pager accounts. Pagers are to be returned at the end of the Internship year to the Internship Coordinator. UMAHC does not have extra pagers so it is essential to be careful with pagers. Interns are responsible for maintaining pagers and ensuring that pagers and batteries are functioning properly. New batteries and loaner pagers can be picked up at the Hospital Information Desk in the main lobby of Unit J. Problems with pagers should be addressed to the Hospital Information Desk. Loaners are available for temporary use at this location. Loaners must be returned within three days. Manuals for SBC/Motorola pagers can be accessed through http://www.sbcmanuals.com/

Interns are financially responsible for lost or broken pagers or for failure to return pagers at the end of training periods at a cost (subject to change). Interns must inform the Communications Center of all changes in their telephone number(s) throughout the Internship year. Interns are responsible for keeping their pager status current daily.

To change pager status, dial 612-626-4433 and use the most appropriate codes. To change pager status from (University campus on the East Bank) phones, dial 19191.

Providers and staff pagers and other contact are available through the Fairview Internet. http://intranet.fairview.org/. The Page Operator at (612) 626-3211 can also identify pager numbers. Interns need to be aware of the range of their pagers in keeping pager status current.

Interns typically are responsible for wearing pagers during normal working hours. Interns may be required to wear pagers on weekends on a selective basis as determined by supervisors. Interns are to return their pager to the Internship Coordinator prior to their departure at the end of the year. The Communication Center that coordinates pagers is now at Fairview Southdale Medical Center. Manuals for pagers are available on the internet.

Outside & Within Hospital Access: To access a UMAHC pager, dial (612) 899- [then last 4 digits]. The last 4 digits often appear as the pager code for individuals who re paging you to page them. The recorded message provides instructions for how to enter the call back number. This system bypasses the hospital.

Within Hospital Access: To access a pager from within the hospital, dial 19393 and then the last 4 digits. Directions of how to contact the individual and what their status is are provided.
Text paging within the system is possible for some pagers. To send a text page, from the American Messaging website link to: http://www.myairmail.com/index.shtml. In the “To” field, enter the 10-digit pager number (i.e., 612899xxxx). In the other fields, enter the information you wish to communicate with the recipient. Page numbers for Internship related individuals are elsewhere in this Handbook and in the Internship Roster.

Typical alphanumeric pages might include:

<table>
<thead>
<tr>
<th>Type of page</th>
<th>Information that may be included</th>
<th>Example (s)</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>To another pager within system</td>
<td>4 digits</td>
<td>8925</td>
<td>Call back pager 612-899-8925</td>
</tr>
<tr>
<td></td>
<td>7 digits</td>
<td>899-8925</td>
<td>Call back pager 612-899-8925</td>
</tr>
<tr>
<td>To a university telephone number</td>
<td>7 digits starting with 624, 625, or 626</td>
<td>624-1479</td>
<td>Call back number 612-624-1479</td>
</tr>
<tr>
<td></td>
<td>5 digits beginning with 4, 5, or 6</td>
<td>41479</td>
<td>Call back number 612-624-1479</td>
</tr>
<tr>
<td></td>
<td></td>
<td>55195</td>
<td>Call back number 612-625-5195</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66910</td>
<td>Call back number 612-626-6910</td>
</tr>
<tr>
<td>To a hospital or psychiatry telephone number</td>
<td>7 digits starting with 273 or 672</td>
<td>273-9741 672-9742</td>
<td>Call back number 612-273-9741 or 612-672-9742</td>
</tr>
<tr>
<td></td>
<td>5 digits starting with 3</td>
<td>39741</td>
<td>Call back number 612-273-9741</td>
</tr>
</tbody>
</table>

Note, callback numbers may also include area codes (e.g., 612) and the 612 area code may be presumed for pages unless otherwise indicated because the hospital is in the 612 area code. If using a Google phone, the area code will need to be entered (i.e., even for local calls).

G. Parking, Transportation, Shuttle and Maps

Parking may be available on the Riverside Campus at a discounted daily rate that is subject to change. Interns are eligible for this discount by showing their University of Minnesota Medical Center badges. Interns may take the shuttle service between the Riverside and the University Campuses of UMMC. Parking records may be subject to review.

If interns wish to purchase parking permits on a semester basis, they can contact Parking Services (626-7275). There is also excellent bus service to the University. Bus schedules are available at Coffman Memorial Union. Information about Route 13 and commuter bus service is available at 625-9000. The Metropolitan Transit Commission number is 373-3333. Discounted bus passes are available at Coffman Memorial Union. The light rail provides transportation to the East Bank station (Green Line) of University campus and to the West Bank station (Green Line) or the Cedar-Riverside station (Blue line). Additional information about bus and light rail service is available at: http://www.minneapolis.org/visitor/map-transportation/lightrail-bus-schedules

Escort service is available to parking facilities ([612] 626-4005). Interns may place their names on waiting lists for parking contracts at the Academic Health Center if they intend to pursue post-internship experiences (e.g., job, fellowship) at the University of Minnesota ([612] 624-5444). This is strongly encouraged given the long waiting lists. Parking arrangements are discussed the first day of the orientation.

Intercampus shuttle service between the Riverside and University campuses is available from 5:20 A.M. to 7:15 P.M. The shuttle runs approximately every 10 minutes until 5:00 pm then runs every 20 minutes until 7:00 pm (West Bank) and 7:15 pm (East Bank). Shuttles also run continuously between Unit J of UMMC and the new Clinics and Surgery Center (CSC) which is at 909 Fulton Street, S.E.
See the shuttle schedule near the boarding locations on each campus. The shuttle picks up and drops off at the front entrance to the Variety Club Research Center connected to the hospital on the University campus and in the Physicians parking lot to the west of the hospital on the Riverside campus. Further information is available at (612) -273-4544.

H. Business Cards

Business cards are prepared for interns for both rotations at the beginning of the Internship year after telephone numbers have been assigned. Interns are identified as Psychology Interns on the cards. Interns are to contact the Internship Coordinator to finalize information to be printed on the cards (e.g., provide their office telephone number, degree, and whether or not they want their email or pager printed). Most do not include email or pager information.

I. Area Codes

There are four area codes covering the Twin Cities.

<table>
<thead>
<tr>
<th>Area Code</th>
<th>Geographic Area</th>
<th>Municipalities (not exhaustive list)</th>
</tr>
</thead>
<tbody>
<tr>
<td>612</td>
<td>Minneapolis</td>
<td></td>
</tr>
<tr>
<td>651</td>
<td>Saint Paul &amp; Eastern</td>
<td>Arden Hills, Eagan, New Brighton, Roseville,</td>
</tr>
<tr>
<td></td>
<td>Suburbs</td>
<td>Shoreview, Stillwater, White Bear Lake, Woodbury</td>
</tr>
<tr>
<td>763</td>
<td>Northwestern suburbs</td>
<td>Anoka, Blaine, Golden Valley, Hopkins, Plymouth,</td>
</tr>
<tr>
<td>952</td>
<td>Southern and</td>
<td>Bloomington, Burnsville, Edina, Minnetonka, St.</td>
</tr>
<tr>
<td></td>
<td>southwestern suburbs</td>
<td>Louis Park</td>
</tr>
</tbody>
</table>

Additional area codes in the area include:

<table>
<thead>
<tr>
<th>Area Code</th>
<th>Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>218</td>
<td>Northern Minnesota, e.g., Duluth</td>
</tr>
<tr>
<td>320</td>
<td>Central Minnesota, e.g., St. Cloud</td>
</tr>
<tr>
<td>507</td>
<td>Southern Minnesota, e.g., Rochester</td>
</tr>
<tr>
<td>715</td>
<td>Wisconsin</td>
</tr>
</tbody>
</table>

J. Telephone, Voicemail and Personal Long-distance Phone Calls

Interns have telephones in their offices. They can check their voicemail by dialing 612-626-0001. Interns phone numbers are in the directory and change mid-year because phones are assigned by rotations. Interns are responsible for setting up their outgoing voicemail messages. **The password for each of the intern office phones is 12345.** Interns are expected to check their voicemails routinely (e.g., daily).

Rotations suggest different scripts for outgoing voicemails to include the following information. If you wish to customize it, please speak with your supervisors.

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Voicemail script</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and Adolescent Psychiatry</td>
<td>Hello, you have reached <em>(Name of Intern)</em> the Child and Adolescent Psychiatry intern at the University of Minnesota Medical School. I am not able to take your call at this time. If this is an emergency please hang up and call 911. Otherwise, please leave a detailed message including, your name, and phone number. I strive to return calls within one business day. Thank you for calling.</td>
</tr>
<tr>
<td>Pediatric Neuropsychology</td>
<td>Hello, you have reached <em>(Name of Intern[s])</em> Pediatric Neuropsychology interns at the University of Minnesota Medical School. We are not able to take your call at this time. If this is an emergency please hang up and</td>
</tr>
</tbody>
</table>
99

| Pediatric Psychology | Hello, you have reached (Name of Intern), Pediatric Psychology intern at the University of Minnesota Medical School. I am not able to take your call at this time. If this is an emergency please hang up and call 911. Otherwise, please leave a detailed message including your name, and phone number. I strive to return calls within one business day. Thank you for calling. |

Personal long distance phone calls are not to be charged to University or UMMC telephones.

K. **Email and Internet Access**

Interns are provided with X.500 email and Internet access accounts from the University of Minnesota, Department of Pediatrics. Interns are expected to activate the X.500 e-mail account and regularly (i.e., at least daily) read messages sent to that account or to forward messages to an account which is regularly used by the intern. Important information related to the internship is sent frequently to interns via this account. Email is not currently considered a secure way of transmitting patient-related information, so encryption of documents is required.

The Epic EMR allows for patient-related messages to be communicated securely as staff messages. Basic information about Epic is available in Appendix 38.

XXI. **BILLING, THIRD PARTY PAYERS, AND MANAGED CARE**

Patients at UMMC are billed independently by (a) the Hospital/Medical Center (i.e., Room or Facilities Fee) and (b) by the Medical School departments (i.e., Professional Fee) which provide services. This is in the process of changing for some clinics. Professional fees are currently processed by UMP/M Health. The Medical School department sponsoring each rotation within the Internship submits bills to patients and third parties for services rendered by interns. Accuracy of billing information entered into Epic is required by UMMC, M Health, federal and state statutes and regulations, third party providers, and APA. Misrepresentation of the nature of services provided for the purposes of billing is illegal, may be fraudulent, and jeopardizes participation in provider programs and licensure eligibility. Billing practices and documentation is subject of audits by UMMC, M Health (e.g., coders), governmental entities, and third party payers.

Interns are to submit billing information in accordance with the requirements of the rotation and of the third party payers. Billing protocols and requirements vary among rotations. Interns **must** complete billing information in a timely manner (clarified by supervisors and compliance personnel), provide diagnostic and procedural codes, and are required to conform to policies of third party payer programs (e.g., Medicaid). Interns are required to be aware of pertinent billing policies (e.g., the need for billing statements to reflect that they provided services directly under supervision). Because some programs (e.g., Medicaid a.k.a. "M.A." not to be confused with Medica [a local private third party payer/HMO]) use modifiers to procedural codes for non-licensed providers, interns must submit information that accurately describes their credential or level of training in all clinical documentation and billing processes. Interns may not need to use modifiers for certain procedures (e.g., psychological tests) or when services are provided conjointly with supervisors for such procedures. Interns must clarify these billing issues with their immediate supervisor and shall obtain clarification from other supervisors, the Internship Director, or from the billing personnel of the rotation or UMMC, if necessary. Interns may seek additional guidance from published Medical Assistance guidelines or those of other third party payers, or through telephone contact with such organizations. Pediatric Psychology and Pediatric Neuropsychology interns can contact the UMP Billing Supervisor.
Interns and all providers of psychological services are expected to develop familiarity with the requirements of third party payers for all patients to whom they provide services. Most Minnesotans currently have health care coverage that includes managed care for mental health services. Policies change episodically and patients can change their health care coverage or primary clinics, so it is increasingly necessary to pay attention to details of health coverage. Interns are encouraged to discuss health care coverage and policies at the beginning of consultations with patients, or preferably in advance of meeting with patients, to clarify that they can meet with them at all. Even though on some rotations, such verification of coverage is completed for the intern prior to scheduling the patient, it is an issue that warrants careful attention. It is essential to keep informed of updated information regarding third party coverage for psychological services. It is also important to recognize that some patients or families may not understand their health care coverage, especially their mental health coverage. Patients should be encouraged to check their coverage, but providers also need to be alert for the possibility that patients may provide them with inaccurate information.

Several health plans, including Aspen, HealthPartners, Med Centers, Metropolitan Health Plan, Mayo Health Plan, and Park-Nicollet, generally require their patients to be seen at designated clinics and do not cover services at UMMC without prior authorization. If they do, they may not permit unlicensed personnel to provide services. Below is a list of some of the local health care organizations that permit mental health coverage at UMMC and a brief summary of pertinent policies. This information is subject to change at any time. There is now a universal treatment plan authorization request form that is accepted by most Minnesota third party payers.

**All therapy patients must have treatment plans completed and scanned into the EMR as well as documentation of the date of the prior treatment plan or review. Government–funded care (MA, and Prepaid Medical Assistance Programs [PMAPs] requires review of the treatment plans quarterly and documentation of that review in Epic. Mental Health treatment Plan completion should be noted in Epic on a flowsheet designed for that purpose.**

### A. Medical Assistance

#### 1. Overview

Minnesota Medical Assistance, (aka “M.A”) or Medicaid, is a governmental program supported by funds from the federal and state governments. It serves the indigent with multiple health programs and is available for families through the Aid for Families with Dependent Children (AFDC). Enrollees get cards monthly which they are supposed to present each time they are seen to verify that they are still covered by the program. MA covers many patients at UMMC and the other teaching hospitals of the Medical School. MA policies are detailed online at [https://mn.gov/dhs/partners-and-providers/policies-procedures/](https://mn.gov/dhs/partners-and-providers/policies-procedures/). It also updates providers approximately quarterly about changes in the program. It is essential that supervisors and interns provide services consistently with MA policies. If interns have doubts about any policies they may contact MA directly, speak with the UMP Billing Office, or with personnel with the Department of Psychiatry. A procedure for submitting prior authorizations and treatment plans must be followed.

#### 2. Medical Assistance Policies and Minnesota Care

a. It is not possible to list all MA policies in this handbook, so interns are advised to review MA policies as available through their supervisor, departmental business office, or the M Health

b. Psychological services should be spaced out by 10 days (i.e., not be weekly unless prior authorization has been sought and granted). Up to 20 hour-long psychotherapy sessions may be provided per year without prior authorization as long as they are spaced far enough apart. Half-hour psychotherapy sessions may be billed weekly.

c. Mental health services provided by multiple providers need to be delivered in accordance with the schedule describe above so coordination of services is essential. If patients have
used their services with another provider, or are receiving concurrent services in excess of the guidelines, a prior authorization needs to be submitted.

d. **Treatment plans are required by M.A. and Prepaid Medical Assistance Programs (PMAPs) be on each patient’s chart and are to be updated or reviewed every 90 days.** PMAP is a health care program that pays for medical services for low-income families, children, pregnant women, and people who have disabilities in Minnesota. PMAP helps members get the care they need to be healthy. PMAPS (e.g., UCare and other companies) are private third parties that are funded by Medicaid. This includes coverage for hospital stays, physician services, rehabilitation services, and preventive care. Information about the PMAP programs are available at: [https://www.ucare.org/HealthPlans/statemedicalassistanceprograms/Pages/PrepaidMedicalAssistanceProgram(PMAP).aspx](https://www.ucare.org/HealthPlans/statemedicalassistanceprograms/Pages/PrepaidMedicalAssistanceProgram(PMAP).aspx)

e. Psychological testing guidelines are different than the therapy guidelines described above. MA patients have limitations in terms of the number of psychological tests they can be administered per year. Neuropsychological testing is governed by special billing policies.

f. Reimbursement for services differs based on the actual provider. It is essential that billing accurately reflects who provided the services. If interns provide interview or therapeutic services alone, this should be clear on the documentation for billing. If they are provided in the presence of a licensed doctoral-level professional, they can be billed at the higher level. For testing, different guidelines should be checked in terms of billing.

g. Preauthorization is possible if the 26 annual visits are clinically indicated or if the frequency of sessions needs to depart from other MA guidelines. A standard format is necessary for a letter seeking prior authorization. In addition, a specific form needs to accompany the letter requesting prior authorization of services.

h. If MA patients are seen for a half hour instead of an hour, they may be seen more frequently without prior authorization.

i. For family therapy, one member of the family is to be billed per session.

j. If somebody has M.A. and Medicare, **they must be seen by a Medicare Provider.** They may not be seen by an intern alone. Billing must use the appropriate procedure code modifiers.


### B. Medicare

1. **Overview**

   Medicare is a federal program, which provides health care coverage for older adults and disabled individuals. There are two types of Medicare Coverage: Part A covers inpatient hospital services and Part B covers outpatient coverage. Drug coverage is provided by Part D. The medical record identifies if individuals have Medicare by indicating a Medicare certification number or ID #. Patients who are disabled or older adults who receive Social Security benefits are likely to have Medicare. Medicare often requests copies of medical records as a surveillance mechanism to ensure that services are provided in accordance with guidelines. Medicare began to provide reimbursement for psychological services around 1990. Medicare reimburses for psychiatrists, doctoral-level psychologists, and social workers. Licensed individuals need to enroll in the Medicare Program.

2. **Medicare Policies**

   a. Interns are **not** to provide psychological services to or bill for Medicare patients unless they provide services conjointly with their supervisor. Our understanding of a possible
exception to this guideline is psychological testing, which trainees and non-licensed providers may administer, but the assessment needs to be provided by the supervisor. Billing must be submitted with the code appropriate to the individual who provided the testing. Interns should check with supervisors and coders about their ability to provide services to Medicare patients, who typically are the elderly or disabled youth.

b. If individuals have Medicare as well as other health coverage through private insurance, the Medicare guidelines take precedence and non-licensed providers may not be able to see them. If patients have dual coverage, care must be provided in accordance with both sets of policies. The additional coverage is likely to cover only services that are provided in accordance with Medicare guidelines and probably will not cover services that the third party payer might normally cover. Interns should clarify coverage before providing services to any patient. Treatment plans must be updated periodically per Medicare requirements.

c. Medicare policies are not detailed here because of the limited extent to which interns will be involved in providing care to Medicare patients. However, documentation guidelines are provided in Appendix 22 and it may be useful to obtain a (free) copy of the following document: American Psychological Association, Practice Directorate. (2000). *Medicare Handbook: A guide for psychologists*. Washington, DC: Author.


C. **Preferred One**

1. **Overview**

   Preferred One is an umbrella organization managing over 100 different payers which became solely owned by Fairview Health Services in 2016.

2. **Preferred One Policies**

   a. Preauthorization must be completed for all patients beyond 10 visits.
   b. For patients seen by interns on the Child and Adolescent Psychiatry rotation, new patients need to be opened by an intake specialist to coordinate logging and distribution.
   c. "Opening a case" means notifying Preferred One of a patient contact by telephone or fax.
   d. Preferred one sends preauthorization forms to be completed.

D. **Blue Cross Blue Shield of Minnesota (BCBSM)**

1. **Overview**

   Patients with other BCBSM coverage may be seen by BCBSM providers, including University providers. However, some BCBSM products may not allow trainees to provide services. This should be clarified with the Department Billing Office.

2. **Blue Cross Blue Shield of Minnesota (BCBSM) Policies**

   a. Services need to conform to BCBSM policies. The most important policies for providers establish number of contacts, preauthorization, and appeals processes. Two group sessions count for one individual session.
   b. Patients may receive the first ten sessions without a referral. All additional sessions require preauthorization from BCBSM.
   c. BCBSM preauthorizations follow a specific format that either uses their form or may be word-processed as long as the format is followed.
   d. BCBSM patients may get up to a total of 40 sessions per calendar year (30 beyond the first 10). The number of sessions is on a per patient basis, not a provider basis. If BCBSM patients have gotten services through another provider, those count toward the first 10 as well as the total 40.
e. Psychological testing counts toward the 40 hours so authorization needs to be obtained in advance, especially if therapeutic services are being obtained concurrently.

f. BCBSM does not cover V codes. BCBSM will cover a single diagnostic session, even if the only diagnosis is a V code.

g. It is appropriate to use the appeal process if any services are denied or if preauthorizations are denied. Whenever submitting preauthorization requests or making an appeal, the provider is a most effective advocate when providing sufficient diagnostic and treatment information to present the reviewer with a thorough understanding of the patient to convince of the "medical necessity" or "therapeutic necessity" of providing care. Documentation should be clear and objective.

E. UCare

1. Overview

UCare is one of several Medical Assistance managed care programs (PMAP) for patients who otherwise would be eligible for the usual M.A. program. It was devised to provide medical services to the indigent less expensively than M.A. UCare has several clinics, most, if not all, of which are associated with the Department of Family Practice and Community Health of the Medical School. It is important to make sure on a monthly basis that patients continue to be covered by UCare. It is not uncommon for patients to change or lose their coverage without informing providers. The phone number for UCare is (763) 525-9919. The address is UCare Minnesota/BHP, 1405 North Lilac Drive, Suite 151, Golden Valley, MN, 55422. The fax number is (763) 525-9918.

2. UCare Policies

a. Some patients need to be referred from their primary clinic (e.g., Community University Health Care Center [CUHCC]). Retroactive authorization from UCare/BHP is rare.

b. All services must be preauthorized prior to providing services. UCare is not likely to provide retroactive authorizations. This policy covers first appointments as well as services provided beyond either the number of authorized sessions or the dates of service. In terms of the latter, it is important to make sure that the authorized period has not expired. This policy makes it critical to check insurance prior to the first meeting, and to monitor the authorization throughout the period in which services are provided.

c. Prior authorizations generally cover a limited number of sessions for a specified period of time (e.g., 90 days or one quarter).

d. Patients seen without up-to-date referrals and authorization may be financially responsible for services. They will be upset about it and may not be able to afford services, so it is essential that providers pay close attention to policies and provide services accordingly. Different departments have their own mechanisms for assisting clinicians to monitor treatment to make sure it conforms to policies and individual patients’ authorized services.

e. Some UCare primary clinics, such as Community University Health Care Center (CUHCC) have their own mental health providers and are unlikely to refer to other providers, including other UCare providers, but may do so on a discretionary basis.

F. Medica/United Behavioral Health

1. Overview

Medica is one of the largest health plans in Minnesota. It is associated with Allina and with United Health Care/Optum. United Behavioral Health (UBH) manages the mental health services and benefits for subscribers. Some of the psychologists within the AHC are in the UBH provider network and others are not. UBH also has clinics within the community to which many patients go for their care. Medica has several types of policies, some of which provide for care in more extended networks. The Provider Express website network can be helpful in
making referrals:
https://provider.liveandworkwell.com/content/laww/cliniciansearch/en/spa.html#/provider-home

2. Medica Policies
   a. Interns are allowed to see Medica patients for psychotherapy/clinical intervention as long as the supervisor is a UBH provider. Their role within intervention and assessments needs to be discussed with supervisors. Some supervisors are UBH providers and others are not. Those that are not may provide "out of network" services at a higher cost to patients than if they were seen "within network."
   b. Patients need to contact UBH prior to being seen for any mental health services to obtain authorization and/or referral to other UBH providers. The phone number is (800) 848-8327.
   c. Some information about services, policies, and referrals is available through http://www.ubhonline.com/index.html.
   d. The required Wellness Assessment for UBH patients is available at: http://www.ubhonline.com/html/alert/index.html

G. HealthPartners

Interns may see HealthPartners patients as inpatients because they are considered part of the treatment team. There is a possibility that they may be able to have outpatient psychotherapy referrals from HealthPartners on a case-by-case basis. This should be clarified before scheduling appointments with a patient. For questions, contact Dr. Robiner.

Some information about the HealthPartners Mental health Network is available at: http://www.healthpartners.com/locator/practitioner/form.do - scroll

XXII. REFERRAL INFORMATION AND COMMUNITY RESOURCES

Interns may have multiple experiences to refer patients and families for assistance with psychological, medical, and social service needs. Consultation with supervisors, faculty, and other health professionals within the Academic Health Center is advised when making referrals. Appropriate referrals take into consideration clinical issues, and systems issues such as requirements of third party providers. Referrals within the Academic Health Center may be facilitated by listings in the House Staff Manual, or UMMC Directory. Health maintenance organizations may require subscribers to obtain services through specific provider groups. The Internship does not take responsibility for any specific referral. Listings do not constitute endorsements for any specific organization. Interns should discuss referrals with supervisors. Listings are subject to change. In using this directory, if you become aware of any changes, please forward the updated information to the Internship Director.

Directories may be accessed via the Internet at:
University of Minnesota People Search:
http://www.umn.edu/lookup?SET_INSTITUTION=UMNTC&type=name&campus=t&role=any&CN=

UMP/M Health: http://source.umphysicians.org/login.cfm?msg=NN&pages=%2FzXXX001.cfm

Fairview Staff: http://intranet.fairview.org/.

A. Emergency Psychiatric Services

The following resources may be used for a range of emergencies (e.g., serious suicidal threats). The psychiatric resident on call for the Department of Psychiatry can be accessed 24 hours per day through the hospital paging system with pager (612) 899-0028. On call psychiatric residents also may be paged through the UMMC Operator at (612) 273-3000. Emergencies may also be assessed in the Psychiatry Clinic (612-273-8700). Patients may be admitted to inpatient
psychiatric units through the psychiatric clinics or via the resident on call for Psychiatry. The inpatient psychiatric units of UMMC are on the Riverside Campus.

**University of Minnesota Medical Center, Referral Numbers**

**Mental Health Intake** (for psychiatric inpatient admissions): (612) 672-6600

**Behavioral Emergency Center (BEC) (associated with the ER):** (612) 273-5640

**Day Hospital/Partial Hospital Programs:** (612) 672-2736

**Chemical Dependency Intake:** (612) 672-2222

Emergency psychiatric services are also available 24 hours per day through:

- **Acute Psychiatric Services** (CIC), Hennepin County Medical Center, MPLS (612) 873-3161
- **Emergency Room, Regions Medical Center**, St. Paul (651) 221-2121
- **Suicide Prevention Center**, Hennepin County Medical Center (612) 873-2222

**B. Psychology and Mental Health Services**

Several directories have been prepared by local and national psychological organizations and may be available from the organizations or through supervisors. These include online directories for the American Psychological Association (APA), the Minnesota Psychological Association (MPA), the American Board of Professional Psychology (ABPP), and the National Register of Health Service Providers in Psychology. Interns may consult with their supervisors and the Internship Director for referral information. Most directories provide information based on geographical areas.

The American Board of Professional Psychology Directory provides information about areas of specialization of board-certified diplomates. It may be accessed at:

http://www.abpp.org/i4a/member_directory/feSearchForm.cfm?directory_id=3&pageid=3292&showTitle=1&showDebugOutput=false&widgetPreview=0&page_version=

The National Register of Health Service Psychologists hosts an online searchable database at:

http://www.nationalregister.org/

The United Way of the Twin Cities 2-1-1 service provides referral information for a wide range of services. It can be accessed by calling (612) 335-5000 or linking to:

https://www.211unitedway.org/

The Hennepin County Human Services and Health Department has an office to assist in accessing outpatient mental health services. It is called the Front Door and can be reached at (612) 348-4111.

Minnesota counties provide case management services for children's mental health. These services include both direct case management as well as dissemination of referral and resource information. For information about greater Minnesota call the local county human services department and ask for the children's mental health case management services.

**Twin Cities**

- **Crisis Connection** …………………………………………………………………………..(612) 379-6363
- **Fraser Child and Family Center** (Multiple locations) ………………………………..(612) 767-7222
- **Hennepin County Chemical Health Assessment/Intervention/Referral** …………. (612) 879-3501
- **Hennepin County Mental Health Center**, MPLS socialservices@hennepin.us …(612) 348-4111
- **Hennepin County Mobile Crisis teams**
  - COPE: Adult…………………………………………………………………………………..(612) 596-1223
  - Child Crisis…………………………………………………………………………………..(612) 348-2233
- **Canvas Health** (Washington County) ……………………..…………..(615) 777-5222
- **Indian Health Board Mental Health Clinic** …………………………………………..(612) 721-9800
- **Lifespan Behavioral Health Services**
  - (formerly Dakota County Mental Health Center) ……………………………………….(952) 562-8500
Chemical Dependency Treatment for Deaf and Hard of Hearing (612) 273-8383
National Alliance on Mental Illness (NAMI Minnesota) (651) 645-2948
Ramsey County Mental Health Center, St. Paul (651) 266-7900
Tuohman Family Crisis and Support Services, MPLS (612) 825-5000
Walk-In Counseling Center (WICC), MPLS (612) 870-0565
Washburn Child Guidance Center, MPLS (612) 871-1454
Amherst H. Wilder Foundation, St. Paul (651) 280-2000

Greater Minnesota:
Central Minnesota Mental Health Center, St. Cloud (320) 252-5010
Hiawatha Valley Mental Health Center, Winona (507) 454-4341
Human Development Center, Inc., Duluth (218) 728-4491
Lakeland Mental Health Center, Fergus Falls (218) 736-6987
Northern Pines Mental Health Center, Brainerd (218) 829-3235
Northern Pines Mental Health Center, Little Falls (320) 632-6647
Northland Counseling Center, Grand Rapids (218) 326-1274
Northwestern Mental Health Center, Crookston, MN (218) 281-3940
Range Mental Health Center, Virginia, MN (218) 749-2881
St. Olaf Mental Health Center, Austin (507) 433-7389
Sioux Trails Mental Health Center, New Ulm (507) 354-3181
South Central Human Relations Center, Owatonna (507) 451-2630
Southwestern Mental Health Center, Luverne (507) 283-9511
Upper Mississippi Mental Health Center, Bemidji (218) 751-3280
Western Mental Health Center, Marshall, MN (507) 532-3236
Zumbro Mental Health Center, Rochester (507) 288-2089

C. Medical Services

Medical referrals within UMMC may be facilitated by reference to the University of Minnesota Health System Directory, the Directory of Outpatient Services, and the House Staff Manual. The UMMC Directory includes a listing of telephone numbers of other health care centers and hospitals. The University of Minnesota Medical Center Emergency Department is 273-2700. Medical emergencies requiring resuscitation are managed by the Adult Team, the Pediatric Team, the Mr. Blue or the Pediatric Mr. Blue Team and may be summoned by dialing 123. (current as of 8/2004). Phone numbers for individuals and departments within the hospital may be found through the Fairview website or for UMP services at: http://source.umphysicians.org/index_ie.cfm

Minnesota Poison Control System 1-800 222-1222
Red Door Clinic (STD/HIV testing & counseling) (Hennepin Co)… (612) 543-5555
St. Paul - Ramsey County Department of Public Health - Clinic 555, (STD/HIV testing & counseling) (Ramsey Co) (651) 266-1255
Sudden Infant Death Syndrome-Children's Hospital and Clinics, Minneapolis (612) 813-6285
Teen Age Medical Services, Children's Hospital and Clinics, Minneapolis (612) 813-6125

D. Social Services

The telephone number of the Social Service Department of UMMC is (612) 273-3366. Hospital units and clinics generally have specific social workers assigned to them. In addition, there are listings of social service agencies in the Minneapolis and St. Paul Yellow Pages. Directories of social services and additional referrals are available through 211 (a United Way organization) at (612) 335-5000. An abbreviated listing of social service agencies in this area follows (current as of 8/2004):

Aliveness Project (HIV-related services) (612) 824-5433
<table>
<thead>
<tr>
<th>Organization</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternatives for People With Autism</td>
<td>(763) 560-5330</td>
</tr>
<tr>
<td>Alzheimer's Association</td>
<td>1-800-229-2872</td>
</tr>
<tr>
<td>American Cancer Society</td>
<td>1-800-ACS-2345</td>
</tr>
<tr>
<td>American Council of the Blind</td>
<td>(612) 332-3242</td>
</tr>
<tr>
<td>American Diabetes Association of Minnesota</td>
<td>(763) 593-5333</td>
</tr>
<tr>
<td>American Heart Association</td>
<td>(952) 835-3300</td>
</tr>
<tr>
<td>American Lung Association</td>
<td>(651) 227-8014</td>
</tr>
<tr>
<td>American Refugee Committee</td>
<td>(612) 872-7060</td>
</tr>
<tr>
<td>Arthritis Foundation</td>
<td>(651) 644-4108</td>
</tr>
<tr>
<td>Autism Society Inc.</td>
<td>(651) 647-1083</td>
</tr>
<tr>
<td>Beth Mensing House (formerly Kidney House)</td>
<td>(612) 337-7300</td>
</tr>
<tr>
<td>Big Brothers and Sisters of Greater Twin Cities</td>
<td>(612) 789-2400</td>
</tr>
<tr>
<td>Bridge for Runaway Youth</td>
<td>(612) 377-8800</td>
</tr>
<tr>
<td>Catholic Charities</td>
<td>(612) 664-8500</td>
</tr>
<tr>
<td>Centro Cultural Chicano</td>
<td>(612) 874-1412</td>
</tr>
<tr>
<td>Children With ADD (CHADD)</td>
<td>(952) 922-5761</td>
</tr>
<tr>
<td>Children's Home Society of Minnesota</td>
<td>(651) 646-6393</td>
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<tr>
<td>CLUES (Chicanos Latinos Unidos En Servicios)</td>
<td>(612) 746-3500 or (651) 379-4200</td>
</tr>
<tr>
<td>Courage Center</td>
<td>(763) 588-0811</td>
</tr>
<tr>
<td>Division for Persons with Developmental Disabilities, Minnesota</td>
<td>(651) 296-6117</td>
</tr>
<tr>
<td>Department of Human Services</td>
<td>(651) 296-0535</td>
</tr>
<tr>
<td>Division of Rehabilitation Services</td>
<td>(612) 874-7063</td>
</tr>
<tr>
<td>Minnesota Vocational Rehabilitation Agency</td>
<td>(763) 223-5130</td>
</tr>
<tr>
<td>Domestic Abuse Project</td>
<td>(651) 603-0720</td>
</tr>
<tr>
<td>Doorways (Previously MN Foundation for Better Hearing and Speech)</td>
<td>(651) 647-9712</td>
</tr>
<tr>
<td>Down Syndrome Association of Minnesota</td>
<td>(651) 287-2300</td>
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<tr>
<td>Emotions Anonymous</td>
<td>(612) 874-8823</td>
</tr>
<tr>
<td>Episcopal Community Services (formerly ParentsAnonymous)</td>
<td>(651) 296-3800</td>
</tr>
<tr>
<td>Family and Children's Service</td>
<td>(612) 861-1688</td>
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<tr>
<td>Fraser Community Services</td>
<td>(612) 827-2841</td>
</tr>
<tr>
<td>Harriet Tubman Women's Shelter (crisis line)</td>
<td>(612) 374-0701</td>
</tr>
<tr>
<td>Head Start-PICA Parents in Community Action</td>
<td>(651) 559-4945</td>
</tr>
<tr>
<td>Home Free Battered Women's Shelter</td>
<td>(952) 546-0616</td>
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<tr>
<td>Jewish Family and Children's Service</td>
<td>(952) 851-0770</td>
</tr>
<tr>
<td>Juvenile Diabetes Research Foundation</td>
<td>(651) 221-0069</td>
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<tr>
<td>Lao Family Community of Minnesota, Inc. Services</td>
<td>(952) 922-8374</td>
</tr>
<tr>
<td>Learning Disabilities Association</td>
<td>(612) 334-5970</td>
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<tr>
<td>Legal Aid Society</td>
<td>(952) 545-3309</td>
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<tr>
<td>Leukemia Society of American, MN Chapter</td>
<td>(612) 379-1199</td>
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<tr>
<td>Love Lines (phone line)</td>
<td>(612) 871-0221, St. Paul: (651) 642-5990</td>
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<tr>
<td>Lutheran Social Service</td>
<td>(651) 215-8960</td>
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<tr>
<td>Maternal and Child Health Section, Minnesota Dept. of Human Services</td>
<td>(612) 331-6840</td>
</tr>
<tr>
<td>Mental Health Association of Minnesota</td>
<td>(612) 332-1441</td>
</tr>
<tr>
<td>Mid-Minnesota Legal Assistance</td>
<td>(763) 591-0100</td>
</tr>
<tr>
<td>Minneapolis Crisis Nursery</td>
<td>(612) 341-2060</td>
</tr>
<tr>
<td>Minnesota AIDS Project</td>
<td>(651) 523-0823</td>
</tr>
<tr>
<td>Minnesota Association for Retarded Citizens (ARC)</td>
<td>(651) 646-8689</td>
</tr>
<tr>
<td>Minnesota Association for the Education of Young Children</td>
<td>(612) 767-4230</td>
</tr>
<tr>
<td>Minnesota Autism Center</td>
<td>(651) 215-8956</td>
</tr>
<tr>
<td>Minnesota Children with Special Health Needs (formerly Services for Children with Handicaps), Department of Health</td>
<td>(651) 215-8956</td>
</tr>
<tr>
<td>Organization</td>
<td>Phone Number</td>
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<tr>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Minnesota Civil Liberties Union</td>
<td>(651) 645-4097</td>
</tr>
<tr>
<td>Minnesota Coalition for the Homeless</td>
<td>(612) 870-7073</td>
</tr>
<tr>
<td>Minnesota Governor's Council on Developmental Disabilities</td>
<td>(651) 296-4018</td>
</tr>
<tr>
<td>Minnesota SIDS Center</td>
<td>(612) 813-6285</td>
</tr>
<tr>
<td>Minnesota Tenants Union</td>
<td>(612) 871-7485</td>
</tr>
<tr>
<td>Mobile Crisis Team (formerly Crosstreets)</td>
<td>(651) 771-0076</td>
</tr>
<tr>
<td>Multiple Sclerosis Society of Minnesota</td>
<td>(612) 335-7900</td>
</tr>
<tr>
<td>Muscular Dystrophy Association, Inc.</td>
<td></td>
</tr>
<tr>
<td>National Alliance on Mental Illness</td>
<td>(651) 645-2948</td>
</tr>
<tr>
<td>National Federation of the Blind of Minnesota</td>
<td>(612) 872-9363</td>
</tr>
<tr>
<td>Neighborhood Involvement Program</td>
<td>(612) 374-4601; (612) 374-3125</td>
</tr>
<tr>
<td>OutFront Minnesota (formerly Gay and Lesbian Community Action Council)</td>
<td>(612) 822-0127</td>
</tr>
<tr>
<td>PACER (Parent Advocacy Coalition for Educational Rights)</td>
<td>(952) 838-9000</td>
</tr>
<tr>
<td>Pathways</td>
<td>(612) 822-9061</td>
</tr>
<tr>
<td>Rape and Sexual Assault Center Help line</td>
<td>(612) 825-4357</td>
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<tr>
<td>Resolve of the Twin Cities</td>
<td>(651) 659-0333</td>
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<tr>
<td>Southeast Asian Community Council</td>
<td>(612) 342-1530</td>
</tr>
<tr>
<td>Spina Bifida Association of Minnesota</td>
<td>(612) 222-6395</td>
</tr>
<tr>
<td>State Services for the Blind and Visually Handicapped, Department of Jobs &amp; Training</td>
<td>(612) 642-0500</td>
</tr>
<tr>
<td>United Cerebral Palsy of Minnesota</td>
<td>(612) 646-7588</td>
</tr>
<tr>
<td>Youth and AIDS Project</td>
<td>(612) 627-6820</td>
</tr>
</tbody>
</table>

**E. Self-Help Groups**

The Internship does not take responsibility for any specific referral. Listings do not constitute endorsements for any specific organization. Interns should discuss referrals with supervisors.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Alternatives (listing of non-AA chemical health support groups)</td>
<td>(952) 922-3392</td>
</tr>
<tr>
<td>Abuse Hot Line (National Domestic Violence Hotline)</td>
<td>1-800-799-SAFE</td>
</tr>
<tr>
<td>Adoptive Families of America (formerly &quot;OURS&quot;)</td>
<td>(763) 535-4829/ (651) 645-9955</td>
</tr>
<tr>
<td>Adult Children of Alcoholic Intergroup (ACA)</td>
<td>(763) 574-0903</td>
</tr>
<tr>
<td>Adult Children of Sexual Dysfunction</td>
<td>(612) 293-9448</td>
</tr>
<tr>
<td>Alcoholics Anonymous Intergroup (MPLS)</td>
<td>(612) 788-4464/ (952) 922-0880</td>
</tr>
<tr>
<td>Alcoholics Anonymous Intergroup (St. Paul)</td>
<td>(651) 227-5502</td>
</tr>
<tr>
<td>Al-Anon (MPLS)</td>
<td>(952) 920-3961</td>
</tr>
<tr>
<td>Al-Anon (St. Paul)</td>
<td>(651) 771-2208</td>
</tr>
<tr>
<td>Cancer Club, The</td>
<td>(952) 944-0639</td>
</tr>
<tr>
<td>Center for Grief</td>
<td>(651) 641-0177</td>
</tr>
<tr>
<td>Centre for Mental Health Solutions (formerly &quot;Minnesota Bio Brain Association&quot;)</td>
<td>(952) 922-6916</td>
</tr>
<tr>
<td>Chemical Injury Resources Association</td>
<td>(651) 647-0944</td>
</tr>
<tr>
<td>Clutterers Anonymous</td>
<td>(612) 821-3934</td>
</tr>
<tr>
<td>Cocaine Anonymous: Coc-Anon</td>
<td>1-800 925-6159 or (763) 323-3350</td>
</tr>
<tr>
<td>Codependents Anonymous</td>
<td>(612) 872-0336</td>
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<tr>
<td>Codependents of Sex Addicts Anonymous (COSA)</td>
<td>(763) 537-6904</td>
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<tr>
<td>Concerned United Birth Parents</td>
<td>(952) 930-9058</td>
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<tr>
<td>Contraceptive Hotline</td>
<td>1-800 584-9911</td>
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<tr>
<td>Crime Victim Services (Citizens council)</td>
<td>(612) 340-5400</td>
</tr>
<tr>
<td>Children of Deaf Adults</td>
<td>(651) 405-0332</td>
</tr>
<tr>
<td>Debtors Anonymous</td>
<td>(952) 953-8438</td>
</tr>
<tr>
<td>Dentists Concerned for Dentists</td>
<td>1-800 364-7646</td>
</tr>
<tr>
<td>Dual Recovery Anonymous MN Area</td>
<td>(651) 776-2212</td>
</tr>
</tbody>
</table>
Emotions Anonymous (651) 647-9712
Families Anonymous (24 hour) 1-800-736-9805
Focus Adolescent Services
Gambling Addiction:
Fairview's Compulsive Gambling Program (612) 672-2222 or 1-800-233-7503
Minnesota Problem Gambling Helpline (formerly the Minnesota Compulsive Gambling Hotline) 1-800-333-HOPE
Minnesota Council Compulsive Gam-Anon (952) 922-3956
Gambler's Alternatives (and others) (612) 929-6115
Incest Survivors
Survivors of Incest Anonymous (612) 332-0150
Adults Recovering from Incest Anonymous (ARIA) (women only) (763) 591-5916
Jewish Recovery Network (952) 545-2672
Lake Harriet Spiritual Community (612) 922-4272
Lawyers Concerned for Lawyers (651) 642-0182
Lesbian Al-Anon (651) 935-9375
1-888-4AL-ANON (1-888-425-2666)
Men's Center (various groups, e.g., anger management/support) (612) 822-5892
Men's Line (24 hour) (612) 397-6367
Mental Illness Anonymous (651) 220-8565
Mental Health Consumer Survivor Network of MN (651) 379-7933
Model Cities (651) 221-4442
Mothers of Multiples (952) 953-7177
Nar-Anon (612) 379-4253
Nicotine Anonymous (952) 939-3939 or 1-877-767-7676
National Domestic Violence Hotline (formerly "Abuse Hotline") 1-800-799-SAFE
Narcotics Anonymous (952) 404-1488
O-Anon Family Group (952) 935-9375
Obsessive Compulsive Disorder Support Groups (651) 646-5615 or 800-NEWS-4OCD
Open Door (Agoraphobia & Panic Disorder Support) (612) 377-2467
Overeaters Anonymous (612) 377-1600 or 1-888-540-1212
P-FLAG (Parents, Families and Friends of Lesbians and Gays) (612) 825-1660
The Queer Student Cultural Center (U of M) (612) 872-6525
REACH (for families of people with mental illness) (612) 331-6840
Recoveries Anonymous (952) 933-7235
Recovering Couples Anonymous (612) 869-3866
Recovery, Inc. (facilitated, self-help mental health groups/nervous symptoms and fears) (612) 824-5773
Resource Center for Fathers & Families (parenting, step-parenting, anger management) (763) 783-4938
Senior Link AGE Line 1-800-333-2433
SAA: Sex Addicts Anonymous
P. O. Box 50286, Minneapolis, MN 55405 (651) 646-1970
Sexaholics Anonymous 1-866-424-8777
Shoplifters Anonymous (612) 273-9800
Spenders Anonymous (651) 649-4573
Stuttering Association, National (800) 397-8888
TOPS-Take Off Pounds Sensibly (612) 789-1774 or (763) 441-7878
TOUGHLOVE Parent Support Group (763) 391-2630
Tubman Family Alliance (formerly Family Violence Network) (groups/shelters; Ramsey/Washington Co) (612) 825-0000
Twelve Steps for Christian Living Groups (763) 593-1791
XXIII. MANDATED REPORTING: CHILD PROTECTION AND ADULT PROTECTION

Licensed health professionals in Minnesota, including psychologists, are mandated to report maltreatment of minors (626.556) and vulnerable adults (626.557). The statutes pertaining to mandated reporting are very specific and are appended to the list of the Minnesota Board of Psychology Statutes and Rules. Interns may be involved in making such reports and are responsible for familiarizing themselves with these responsibilities. **Interns should consult immediately with supervisors about all suspected cases of abuse or neglect.** They may also consult with the child protection and adult protection departments of counties before making reports. **Verbal (telephone) reports must be followed-up with a written report within 72 hours** (exclusive of weekends and holidays) for children and as soon as possible for adults and must be cosigned by supervisors with a copy placed in the medical record. In preparing reports, interns should be aware that the subject of reports may have legal access to reports, including identity of reporter, if reports are false and if there is evidence that the report was not made in good faith. Otherwise, the identity of the reporter is confidential. Interns should inform all new patients (or families) of the limits to confidentiality at the outset of providing services. For UMMC inpatients, reports should also be coordinated with the attending physician and social worker within the Hospital to coordinate the reporting process and to maximize communication. These other professionals can also be consulted to help to determine whether formal reports are indicated and to help with the follow-up process. If necessary, the attending physician or social worker will notify the Hospital's medical child abuse consultant. There are Hospital forms for filing reports available on inpatient units, in the Social Service Department, and in the Emergency Room. Reports for outpatients should be coordinated with the social worker assigned to the clinic or through a rotational system in the Social Services Department (273-3366).

For outpatients seen in the Department of Psychiatry, consult with Dr. Realmuto before making reports and have him cosign the report. When reports are made, they are based on the county of residence. If the physical safety of the individual is at risk at the time of the report or if evidence needs to be preserved, the University Police should be called at 624-3550. Appendix 18 has the Fairview Policy and Procedures regarding child abuse and neglect. Below is a list of the most frequently used numbers.
XXIV. GRIEVANCE PROCEDURES

A. General Comments

The following is an outline of the general scheme proposed for the resolution of grievances that may arise within the Internship. Detail and clarification may be added as the various elements of these proposals are accepted or rejected or replaced with alternatives. These guidelines or policies are confined to the process within the Department of Pediatrics with the assumption that appeal of the final action or decision coming from the intradepartmental process will remain a viable option once the departmental grievance process has been completed. Additional guidance regarding due process may be accessed through the APPIC website at: http://www.appic.org/Problem-Consultation. In addition, the University sponsors a Student Conflict Resolution Center offering informal and formal conflict resolution services to resolve students' campus-based problems and concerns and an ombudsman. These can be accessed through http://www.sos.umn.edu/.

B. Principles

1. Definition of the legitimate areas of disagreement to be covered by these procedures.
2. Provision of ascending levels of recourse with potential for final resolution of the conflict at each of these levels without prejudice to any rights of the involved individuals.
3. Adherence to the principles of due process, academic freedom and fairness.
4. Procedures to be readily available and expeditiously executed.
5. Inclusion of a system of advocacy (i.e., Intern Advocate or intern's mentor).
6. Process to be fully documented.
7. Due process considerations are to be respected and appropriate discretion is to be maintained by all parties involved in this process and should be explicitly agreed to as part of the process.

C. Grievance Committee for the Psychology Internship

1. The committee is ad hoc, appointed by the Internship Director or the Head of the Department of Pediatrics or his or her designee, with representation of faculty and supervisors.
2. All actions of the Grievance Committee are considered advisory to the Head of the Department of Pediatrics.
3. All actions of this committee are by a simple majority vote with a quorum present. A quorum consists of one-half of all the named members of the committee, plus one.

D. Areas of Potential Grievance Covered by these Guidelines

The areas of possible grievance to be resolved by the following procedures include, but are not limited to, the following:

1. Evaluation of intern performance by a faculty member.
2. Assignment or definition of intern duties.
3. Interpretation and implementation of other policies and guidelines, such as those included in this document.
4. Intern-intern conflicts.
5. Intern-fellow conflicts.
6. Intern-faculty conflicts.

E. Potential Parties to the Process

1. Principals in the complaint.
2. Grievance Committee members.
3. Department Head or his/her designee(s).
4. Internship Director
5. Intern Advocate, at the discretion of the intern.

F. Grievance Resolution Process

As defined herein, resolution will be considered an outcome deemed acceptable to the principals to the complaint. When resolution is reached, no further steps in the process will be taken and the matter will be considered closed. This policy assumes that any single principal to the grievance retains the right to carry the process forward by denial of resolution, and to appeal intradepartmental decisions to extra-departmental grievance procedures. At that point, the University processes, policies, and procedures are followed. The Internship and Department Grievance Process is outlined below and in Appendix 28.

Steps in the Process:

1. Attempted resolution of matter by parties involved in conflict prior to implementing additional steps in the formal grievance process.
2. Intern may review complaint with mentor or another ad hoc advisor. **Outcome:** resolved or taken to step 3.
3. Intern may engage in informal discussion with other persons deemed appropriate by parties to the complaint. **Outcome:** resolved or taken to step 4
4. Formulation of a formal written complaint.
5. Forwarding of formal written complaint to the Grievance Committee, with copies to principals to the complaint, to the Internship Director, and to the Head of the Department of Pediatrics or his or her designee.
6. Grievance Committee review of the complaint with consultation and written minutes, but without tape recording. **Outcome:** resolved with report to the Head of the Department or his or her designee or taken to step 7.
7. Department Head or his or her designee reviews the Grievance Committee actions and recommendations and then advises the parties to the complaint of his or her decision as to the dispensation of the complaint action. **Outcome:** resolved or taken to step 8
8. Appeal to the Medical School or the appropriate University Grievance Office (The Office of Conflict Resolution telephone number is [612] 624-1030).

G. Records Regarding Grievances

The Internship Director maintains a written or electronic record of any grievance procedures including statement of the problem, process for addressing it, and resolution. Due to the privacy and confidentiality of these records, they are maintained as a password-protected document and/or in a locked, secure environment.

XXV. SUBSTANCE USE/ABUSE POLICY

It is the policy of the University of Minnesota that University personnel will be free of controlled substances. Chemical abuse affects the health, safety and wellbeing of all members of the University community and restricts the ability of the university to carry out its mission. Similarly, the Department of Pediatrics recognizes that chemical/substance abuse or dependency may adversely affect interns’ ability to perform efficiently, effectively and in a professional manner. The Department believes that early detection and intervention in these cases constitutes the best means for dealing
with this social problem and creates the best environment for providing improved patient care. Accordingly, the following policy has been adopted

A. No intern shall report for assigned duties under the influence of alcohol, marijuana, controlled substances, or other drugs including those prescribed by a physician that affect alertness, coordination, reaction, response, judgment, decision-making abilities, or adversely impact the ability to properly care for patients. If prescribed medications described above are necessary, a written communication from the treating provider may be necessary to assure that the intern is capable of carrying out their professional activities without impairment.

B. Engaging in the use, sale, possession, distribution, dispensation, transfer or manufacture of illegal drugs or controlled substances would have a negative impact on an intern's ability to perform his/her duties and fitness for professional functioning; therefore, no intern shall use, sell, possess, distribute, dispense, transfer or manufacture any illegal drug, including marijuana, nor any prescription drug (except as medically prescribed and directed).

C. Any violation of this policy may subject the intern to discipline, including, but not limited to, suspension and/or termination from the Internship.

D. When there is reasonable cause to believe that an intern may be using, selling, possessing, distributing, dispensing, transferring, or manufacturing any illegal drug, controlled substance, or alcohol, the intern may be required to undergo medical evaluation and mental health assessment. The intern's ability to continue participation will be determined by the Internship Director in consultation with faculty, the Training Committee, and the Head of the Department of Pediatrics and/or his or her designee, as well as Risk Management personnel. Actions may include, but are not limited to, recommendation for treatment and return to duty, suspension from duty with pay, suspension from duty without pay, and/or termination from the Internship.

E. Depending upon the circumstances, the Department may notify appropriate law enforcement agencies and/or licensing boards and/or degree-granting institutions of any violation of this policy. Nothing within this policy limits the Department in cooperating fully with investigations by other organizations (e.g., law enforcement agencies, Medical School committees, University of Minnesota General Counsel), Risk Management, related to violations of this policy.

F. Interns who are convicted of a criminal drug statute violation (including DWI, boating tickets, etc.) are required to inform the Internship Director and Department Head of the conviction (in writing) within five (5) calendar days thereof.

G. Interns who have reasonable cause to believe that a colleague is using a substance that adversely impacts on the intern's performance in the training program must report the factual basis for their concerns to the Internship Director. The Internship Director will communicate this concern with the Department Head or his/her designee and members of the Training Committee and pertinent University personnel.

H. If an intern is taking a medically authorized substance that may impair job performance, the intern must notify his or her supervisor and the Internship Director of any temporary inability to perform assigned duties. The intern will refrain from performing duties that she or he is not capable to perform safely and competently.

I. Interns are encouraged to seek assistance in addressing any problems they might have related to alcohol or substance abuse.

The services of the University of Minnesota Employee Assistance Program are available to all interns and their families. Interns may also be seen through the Mental Health Department of Boynton Health Service ([612] 624-1444) or at the Student Counseling Services ([612] 624-3323).

J. Interns must be aware that there are significant criminal penalties, under state and federal law, for the unlawful possession or distribution of alcohol and illicit drugs. Penalties include prison terms, property forfeiture, fines, and mandatory treatment.
Details of relevant state and federal laws and their penalties are at the University of Minnesota policy Drug Free University which may be accessed at: https://policy.umn.edu/operations/drugfree


SECTION I: DEFINITIONS

Subd. 1. Member of the University Community. "Member of the University Community" or "University member" means any University of Minnesota faculty member, student, or staff member, or other individual engaged in any University activity or program.

Subd. 2. Personal Relationship. "Personal relationship" shall mean marital or other committed relationship, significant familial relationship, or consensual sexual or romantic relationship.

SECTION II: EMPLOYMENT AND ACADEMIC ACTIVITIES

Subd. 1. Prohibited Activities. A member of the university community may not directly influence the university employment or academic progress of a university member with whom he or she has a personal relationship. Prohibited activities include, but are not limited to, hiring, promotion, supervision, evaluation, determination of salary, grading, and advising.

Subd. 2. Non-competitive Appointments. This policy does not prohibit noncompetitive appointments of spouses and partners otherwise authorized by University policy.

Subd. 3. Relationships with Current Students. Personal relationships between faculty members or advisors and their current students are very unwise and may violate other University policies, even when prohibited activities have been avoided, because of the trust accorded to faculty members and advisors by students, the power differential inherent in academic associations, the difficulty of making alternative arrangements for grading and evaluation, and the risk of real or perceived favoritism toward the student in the personal relationship and the potential harm to this student and other students.

SECTION III: ADMINISTRATIVE DIRECTIVES

Subd. 1. Procedures Required. The president shall adopt procedures for the implementation of this policy. The procedures must contain the provisions outlined in subdivisions 2-5.

Subd. 2. Consultation. Consultation shall be mandatory for University members who are or will be in a position to engage in an activity prohibited by section II. A consultation process shall be designed to ensure that:

A. Appropriate steps are taken to avoid the prohibited activity,
B. Steps taken will not unreasonably disadvantage either University member,
C. The consultation is with an appropriate administrator, and
D. Appropriate confidentiality is provided.

Subd. 3. Goal of Consultation. Compliance with this policy may be achieved either by structuring the condition of the employment or academic association of the related parties so as to avoid or eliminate the prohibited activities or by avoiding the personal relationship that may lead to the prohibited activities. The structuring of the association must be done after appropriate consultation and must not unreasonably disadvantage either University member.

Subd. 4. Power Disparity. When a power disparity exists in the employment or academic association of the individuals in the personal relationship, the employment or academic interests of the subordinate must be protected when structuring the association to avoid the prohibited activity.

Subd. 5. Exclusions. In exceptional circumstances an exclusion from section II, subd. 1 may be granted when eliminating the prohibited activities would unreasonably disadvantage one or both the
University members involved in a personal relationship. In the event that exclusion is granted, safeguards must be implemented to help ensure that employment or academic decisions regarding the involved University members are made impartially.

SECTION IV. DISCIPLINARY ACTION

A violation of section II, subd.1 may lead to disciplinary action up to and including termination of employment or academic dismissal. Participation in and adherence to the consultation process may mitigate disciplinary action.

XXVII. POLICY ON SEXUAL HARASSMENT

*Updated: 2014 https://policy.umn.edu/hr/sexualharassment

The University is committed to creating a welcoming and respectful work and educational environment that is free from sexual harassment, and the University provides comprehensive support, education, and reporting mechanisms to all members of the University community.

All members of the University community are prohibited from engaging in sexual harassment and retaliating against individuals based on their participation in a sexual harassment investigation. When they learn about incidents of sexual harassment, University employees who are supervisors must take prompt remedial action to respond to any concerns including referring the matter to relevant internal options.

Reporting
Any individual who believes they have been subjected to sexual harassment or retaliation for reporting sexual harassment can report their concerns to the Office for Equal Opportunity and Affirmative Action (EOAA) or the relevant internal office for investigation, problem solving, dispute resolution and potential disciplinary action, up to and including termination against perpetrators. Victim survivor services are also available to provide additional support.

Retaliation
No one acting on behalf of the University may retaliate against an individual for having made a report in good faith under this policy or participated in a sexual harassment investigation. Any employee who engages in retaliation may be subject to disciplinary action up to and including termination of employment. Reports of retaliation will be reviewed and investigated in the same manner in which other allegations of misconduct are handled. This provision aligns with Board of Regents Policy: Code of Conduct.

REASON FOR POLICY

To implement Board of Regents Policy: Sexual Harassment and Student Conduct Code, as well as to comply with the law in the employment context by Title VII of the 1964 Civil Rights Act, in the education context by Title IX of the Educational Amendments of 1972 and in both the employment and educational contexts by the Minnesota Human Rights Act.

This policy prohibits the conduct covered by this administrative policy and establishes procedures for reporting incidents of sexual harassment and retaliation. The commitment of the entire University to this policy contributes to our goal of creating an inclusive campus climate including the active prevention, awareness of and response to sexual harassment.

Reporting Incidents of Sexual Harassment
The University strongly encourages individuals to report incidents of sexual harassment because it is the only way that responsive action can be taken against perpetrators of sexual harassment. Further, in order to continue to create a safe and welcoming environment for staff, faculty, students and visitors to the University we should all strive to maintain an academic and work environment that is free of sexual harassment.

Sexual harassment violates University policy and is also illegal. It is prohibited by law in the employment context by Title VII of the 1964 Civil Rights Act, in the education context by Title
IX of the Educational Amendments of 1972 and in both the employment and educational contexts by the Minnesota Human Rights Act.

**Reporting: Faculty and Staff**
The following options are available for faculty and staff to report incidents of sexual harassment.

<table>
<thead>
<tr>
<th>Reporting Options</th>
<th>Special Conditions</th>
<th>Action Taken</th>
</tr>
</thead>
</table>
| Office for Equal Opportunity and Affirmative Action (EOAA) | *Note: An individual may not access the Office for Conflict Resolution (OCR) and EOAA simultaneously. Individuals on system campuses can report to Twin Cities EOAA or their local EOAA. | - Interview the target of the sexual harassment, the alleged perpetrator and any other relevant witnesses.  
- Analyze the facts and review any relevant documents.  
- Provide coaching and/or informal problem-solving  
- When informal processes do not resolve the situation investigate and issue a findings letter as to whether or not there has been a violation of the University policy against sexual harassment and make recommendations to the responsible administrator for addressing the potential sexual harassment including, reassignment, organizational change, education and discipline (up to and including termination.) |
| Local Human Resources Representative       |                                                                                                                                                                                                                                                                                                                                                     | - Interview the target of the sexual harassment, the alleged perpetrator and any other relevant witnesses.  
- Analyze the facts and review any relevant documents.  
- When appropriate, refer the reporter to the relevant EOAA Office or recommend action to be taken by the responsible administrator in consultation with the EOAA Office including, reassignment, organizational change, education, and discipline (up to and including termination.) |
| Office for Conflict Resolution (OCR)       | *Note: An individual may not access the Office for Conflict Resolution (OCR) and EOAA simultaneously. Individuals on system campuses can report to Twin Cities EOAA or their local EOAA.                                                                                                                                  | - Conduct a confidential initial meeting with the complainant to discuss the circumstances and identify options, such as EOAA and the Aurora Center  
- Take steps to resolve the situation through the exchange of information, promoting understanding and identifying resolution options  
- Utilize a three-stage, reporter-led formal resolution process, where informal processes have failed and the reporter so chooses |
| UReport (anonymous online reporting system) |                                                                                                                                                                                                                                                                                                                                                     | - Incidents reported through this mechanism will be given to the appropriate office for investigation.  
*Note: It is recommended that you identify yourself as the subject of the harassment to the investigating or reviewing entity. If reporting anonymously, only |
Reporting: Students, including Student Employees
The following options are available for students to report incidents of sexual harassment.

<table>
<thead>
<tr>
<th>Reporting Options</th>
<th>Special Conditions</th>
<th>Action Taken</th>
</tr>
</thead>
</table>
| Office for Equal Opportunity and Affirmative Action (EOAA) on the Twin Cities campus or the campus in which you are enrolled. | • Interview the target of the sexual harassment, the alleged perpetrator and any other relevant witnesses.  
• Analyze the facts and review any relevant documents.  
• Provide coaching and/or informal problem-solving  
• When informal processes do not resolve the situation investigate and issue a findings letter as to whether or not there has been a violation of the University policy against sexual harassment and make recommendations to the responsible administrator or in situations involving students make recommendations to OSCAI for addressing the potential sexual harassment including, reassignment, organizational change, education and discipline (up to and including termination or in the case of a student: suspension, expulsion, probation, class reassignment or counseling.) | |
| Office for Student Conduct and Academic Integrity (OSCAI) or the relevant student conduct office on the campus in which you are enrolled | Reporting related to sexual harassment from another student | I. Meet with the target of sexual harassment and refer to EOAA for complete investigation. Meet with the student against whom the report was made and consider whether or not an informal resolution of the situation is possible. Informal resolutions may include, making amends, compliance with imposed requirements, restitution, disciplinary sanctions and other responses appropriate to the violation.  
II. Refer to EOAA for a formal investigation.  
II. Provide the alleged student perpetrator the opportunity to challenge the complaint in a formal hearing before a University hearing panel. Depending on the circumstances, the hearing panel would be the Campus Committee on Student Behavior or another hearing body with the appropriate college or campus. |
| UReport (Anonymous online reporting system) | | A. Incidents reported through this mechanism will be given to the appropriate office for investigation.  
*Note: It is recommended that you identify yourself as the subject of the harassment to the investigating or reviewing entity. If reporting anonymously, only a limited response and investigation can be conducted. |

XXVIII. EMPLOYEE/STUDENT ASSISTANCE PROGRAMS
The services of the University are available to all interns and their families to respond to a variety of personal concerns and problems (including, but not limited to, chemical/substance abuse and dependency).

A. Resident Assistance Program (RAP)………………………………………………..(651) 430-3383
Resident Assistance Program (RAP). The Resident Assistance Program (RAP) is a confidential counseling service designed to offer University of Minnesota residents and their immediate family members a professional, external resource to address a variety of stressors, at no cost to the client. In many cases, these stressors are affecting personal lives and impacting a resident’s ability to meet professional expectations in the workplace. You can reach them by phone 651-430-3383 (local) OR 1-800-632-7643 (toll free); or the web www.sandcreekeap.com.

B. **Student Legal Service**

University Student Legal Service (USLS) exists to help trainees with legal problems that otherwise might interfere with their academic progress. All trainees who are currently enrolled and who pay the student service fee are eligible to use the service; there is no additional charge for an initial appointment to get advice in an area handled by USLS.

As the service is designed to address the legal problems students most frequently encounter, it offers full service, from consultation to document preparation to court appearance, in such areas as tenants’ problems; consumer matters; family law; employment grievances; wills; criminal and traffic matters; and small claims. (In addition, USLS offers free walk-in notary public service.)

Legal service beyond an initial advice appointment is provided upon payment of a fee according to the USLS Schedule of Benefits. Problems outside USLS expertise may be referred elsewhere.

To find out more about University Student Legal Service, or to set up an appointment with a USLS attorney or legal assistant, call 624-1001. USLS is located at 160 West Bank Union Skyway between Willey and Blegen Halls. Office hours are 8:30 A.M. to 5:00 P.M. Monday through Friday.

C. **Student Conflict Resolution Center (SCRC)**

Trainees can talk to someone outside of their department, by contacting the SCRC. Consultations are confidential - no one will know you contacted SCRC without your permission. SCRC offers information, coaching, and intervention and can be reached by phone 612-624-7272, by email sos@umn.edu, or in person (254 Appleby Hall, 128 Pleasant St. SE).

D. **Office of Minority Affairs and Diversity**

Mary Tate, M.A. is the Director of the Medical School Office of Minority Affairs and Diversity and is the Equal Opportunity and Affirmative Action liaison. For questions or concerns regarding matters of allegations of mistreatment, sexual harassment, or discrimination, the Office of Minority Affairs and Diversity may assist in finding solutions. She can be reached at (612) 625-1494, or by email tatex001@umn.edu, or in person B608 Mayo.

XXIX. **PUBLIC DISCLOSURE POLICIES OF INTERNSHIP**

The Internship provides accurate descriptions of its training opportunities, resources, policies, and accreditation status to prospective and current interns, the Office of Program Consultation and Accreditation of the American Psychological Association, the APA Commission on Accreditation, site visitors, the Association of Psychology Postdoctoral and Internship Centers, faculty and staff associated with the Internship, and other “publics.” Prospective interns are provided with a description of the program through the website of the Internship. When prospective interns interview for the Internship, they have opportunities to review more detailed descriptions of the program in terms of the Internship Handbook as well as rotation-specific overviews. For example, they can review the Internship Handbook and request a pdf copy for later review.

The current accreditation status of the Internship is accurately represented in all Internship descriptive materials and is also available in the APPIC Directory, the *American Psychologist* December issue, and through the Office of Program Consultation and Accreditation of the American Psychological
Association (202-336-6123; www.apa.org/ed/accreditation/). The address of the Office of Program Consultation and Accreditation is:

<table>
<thead>
<tr>
<th>Office of Program Consultation and Accreditation</th>
<th>750 First Street, NE</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Psychological Association</td>
<td>Washington, DC 20002-4242</td>
</tr>
</tbody>
</table>

Additional information regarding accreditation status may be obtained through the Internship Director. In matters of public disclosure, the Internship adheres to local, state and federal statues and rules of the Minnesota Board of Psychology regarding confidentiality and due process as well as to institutional policies.
APPENDIX 1
UMMC SUPERVISION STANDARDS FOR PSYCHOLOGICAL ACTIVITIES

A. Guidelines


2. Supervisor and supervisee review most recent APA standards for providers for clinical settings (APA, Board of Professional Affairs, 1987 and later revisions).

3. Supervisor and supervisee review relevant statutes and Minnesota Board of Psychology rules governing psychological practices including a minimum of mandatory reporting for children and vulnerable adults, licensing laws governing how supervisees can identify themselves, sexual exploitation by therapists.

4. Supervisor and supervisee review emergency procedures in setting including giving supervisee pager number and telephone numbers for contacting supervisor. Discuss with supervisee when it is appropriate to contact supervisor beyond scheduled supervisory times. Supervisee should be given telephone numbers of UMMC main switchboard (273-3000 University Campus; 672-6000 Riverside Campus), UMMC Emergency Room (273-2700 University Campus; 672-6402 Riverside Campus) and of Crisis Intervention Center at Hennepin County Medical Center (873-3161).

5. Supervisee should be given information about the clinic including hours of operation, after-hour policies/practices, policies governing use of UMMC patient medical records, etc.

6. Supervisor must complete relevant evaluation forms and communicate feedback in a timely manner. Discuss supervisee's training and professional development issues and communicate feedback directly to supervisee.

7. Supervisor must cosign supervisee correspondence related to patient care as appropriate.

8. Supervisor and supervisee must discuss "boundary issues" involved with patient care.

9. Supervisor and supervisee must discuss supervisor's therapeutic and supervisory approaches.

10. Group supervision of trainees may have a maximum ratio of one supervisor to six supervisees. Group supervision may fulfill part of supervision requirements but may not exceed 50% of overall supervision for any supervisee, and may not substitute for 1:1 supervision required by APA.

11. Supervision of trainees must include 1:1, face-to-face meetings with an Independent Psychology Staff member (licensed). Supervisees also may obtain additional supervision from other mental health professionals as appropriate.

12. Supervisors must be on-site when cases that they are supervising are being seen by supervisees. If a supervisor is not on-site, arrangements must be made for the supervisee to be able to consult with alternate supervisors. When supervisor is away from UMMC (e.g., on vacation), supervisee must know which alternate supervisor is covering for the supervisor.

13. Supervisor must be identified and named by supervisee to all patients.

14. Supervisors are ultimately responsible for determining how autonomously each supervisee can function. Assignment of cases to supervisees is based on degree of supervision required and on the supervisor's assessment of the supervisee's competence and level of professional development.
APPENDIX 1 (continued)

B. Supervisory Standards for Specific Levels of Training

<table>
<thead>
<tr>
<th>Supervisee Level of Trainees</th>
<th>Diagnostic Interview</th>
<th>Psychological Testing</th>
<th>Psychological Reports</th>
<th>Feedback Sessions</th>
<th>Therapy</th>
<th>Inpatient Consultation</th>
<th>Required Frequency of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicum Student</td>
<td>Minimum of 2 cases directly observed. Case discussed. Supervisor to review chart.</td>
<td>Minimum of 2 of each instrument directly observed. Check scoring for 2 cases. Case discussed. Supervisor to meet patient.</td>
<td>Supervisor to read, edit and cosign. Case discussed.</td>
<td>Supervisor to attend all feedback sessions</td>
<td>Supervisor to meet patient, review tapes, cosign notes. All sessions to be taped with patient consent. Case discussed each session.</td>
<td>Supervisor to attend all sessions. Case discussed each session. Notes cosigned. Diagnosis and recommendations must be approved by supervisor.</td>
<td>Minimum of 1:4-hour ratio of supervision to patient contact. Minimum of 1 hour/week.</td>
</tr>
<tr>
<td>Intern</td>
<td>Minimum of 2 cases directly observed. Case discussed. Supervisor to review chart and meet patient.</td>
<td>Minimum of 2 of each instrument directly observed. Check scoring for 2 cases. Case discussed. Supervisor to meet patient.</td>
<td>Supervisor to read, edit and cosign. Case discussed.</td>
<td>Supervisor to attend all feedback sessions and be available for questions</td>
<td>Supervisor to meet patient, review tapes, cosign notes. Some sessions to be audiotaped or videotaped with patient consent. All sessions discussed.</td>
<td>Supervisor to meet patient. Case discussed before D/C and/or within 24 hours of being seen. Notes cosigned. Diagnosis and treatment plan must be approved by supervisor. Minimum of 6 consults attended by supervisor.</td>
<td>Minimum of 1:10 hour ratio of supervision to patient contact. Minimum of 2 hours of individual supervision per week addressing all psychological services provided.</td>
</tr>
<tr>
<td>Postdoctoral Fellow</td>
<td>Minimum of 2 cases directly observed. Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 1 of each instrument directly observed. Check scoring for 2 cases. Case discussed. Supervisor’s name and phone number given to each patient.</td>
<td>Supervisor to read, edit and cosign. Case discussed.</td>
<td>Minimum of 2 attended by supervisor. Supervisor available for questions.</td>
<td>Case discussed at least every 2 sessions. Optional review of tapes. Notes cosigned for at minimum first 3 months. Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 4 cases observed. Notes cosigned. Meet patient when possible. Case discussed prior to D/C and/or within 24 hours of being seen. Supervisor’s name and phone number given to each patient. Diagnosis and recommendations must be approved by supervisor.</td>
<td>Minimum of 1:10 hour ratio of supervision to patient contact. Minimum of 2 hours of supervision per week addressing all psychological services provided.</td>
</tr>
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(continued)
## APPENDIX 1 (continued)

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<tr>
<th>Supervisee Level of Trainees</th>
<th>Diagnostic Interview</th>
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</tr>
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<tbody>
<tr>
<td><strong>Non-Trainees</strong></td>
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<tr>
<td><strong>Therapist with Master’s Degree in Psychology</strong>&lt;br&gt;(Associate Psychology Staff)</td>
<td>Minimum of 1 case directly observed.&lt;br&gt;Case discussed.&lt;br&gt;Chart review through 1st year of service at UMMC.&lt;br&gt;Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 2 of each instrument directly observed if trained in testing.&lt;br&gt;Check scoring for 2 cases.&lt;br&gt;Case discussed. If not formally trained in testing, supervisee can only perform assessments when supervisor judges supervisee to be competent.&lt;br&gt;Supervisor’s name and phone number given to each patient.</td>
<td>Supervisor to read, edit and cosign cases discussed through 1st year of service at UMMC.</td>
<td>Minimum of first 10 attended by supervisor.</td>
<td>Case discussed at least every 3 sessions. Notes cosigned for at minimum first 3 months.&lt;br&gt;Supervision can be group supervision.&lt;br&gt;Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 2 directly observed and notes cosigned.&lt;br&gt;Case discussed prior to D/C and/or within 24 hours of being seen.&lt;br&gt;Therapist can provide therapy. Beyond first 2 patients, diagnosis, treatment and recommendatio ns must be discussed as necessary with supervisor.</td>
<td>Minimum of 1/2 hour of supervision per month when providing services to UMMC patients.</td>
</tr>
<tr>
<td><strong>Therapist with Master’s Degree in Psychology</strong>&lt;br&gt;(Assistant Psychology Staff)</td>
<td>Minimum of 4 cases directly observed.&lt;br&gt;Case discussed.&lt;br&gt;Chart review through 1st year of service at UMMC.&lt;br&gt;Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 2 of each instrument directly observed if trained in testing.&lt;br&gt;Check scoring for 2 cases.&lt;br&gt;Case discussed. If not formally trained in testing, supervisee can only perform assessments when supervisor judges supervisee to be competent.&lt;br&gt;Supervisor’s name and phone number given to each patient.</td>
<td>Supervisor to read, edit and cosign each report. All cases discussed.</td>
<td>All attended by supervisor.</td>
<td>Case discussed at least every 2 sessions. Notes cosigned.&lt;br&gt;Supervision can be group supervision.&lt;br&gt;Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 2 directly observed and notes cosigned.&lt;br&gt;Case discussed prior to D/C and/or within 24 hours of being seen.&lt;br&gt;Therapist can provide therapy. Beyond first 2 patients, diagnosis, treatment and recommendatio ns must be discussed as necessary with supervisor.</td>
<td>Minimum of 1/2 hour of supervision per month when providing services to UMMC patients.</td>
</tr>
<tr>
<td><strong>Subdoctoral Psychometrist</strong>&lt;br&gt;(Assistant Psychology Staff)</td>
<td>Minimum of 2 of each instrument directly observed.&lt;br&gt;Check scoring for 3 cases.&lt;br&gt;Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 2 of each instrument directly observed.&lt;br&gt;Check scoring for 3 cases.&lt;br&gt;Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 10 attended by supervisor.</td>
<td>Semi-annual review of testing procedures and scoring</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(continued)
# APPENDIX 1 (continued)

<table>
<thead>
<tr>
<th>Supervisee Level of Trainees</th>
<th>Diagnostic Interview</th>
<th>Psychological Testing</th>
<th>Psychological Reports</th>
<th>Feedback Sessions</th>
<th>Therapy</th>
<th>Inpatient Consultation</th>
<th>Required Frequency of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlicensed Doctoral Psychology Clinician (Assistant Psychology Staff)</td>
<td>Minimum of 2 cases directly observed. Case discussed. Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 1 of each instrument directly observed. Check scoring for 2 cases. Case discussed. Supervisor’s name and phone number given to each patient.</td>
<td>Supervisor to read and cosign. Case discussed.</td>
<td>Minimum of 2 attended by supervisor. Supervisor available for questions. Case discussed.</td>
<td>Case discussed at least every 2 sessions. Optional review of tapes. Notes cosigned. Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 4 cases directly observed. Notes cosigned. Meet patient when possible. Case discussed prior to D/C and/or within 24 hours of being seen. Supervisor’s name and phone number given to each patient.</td>
<td>Minimum of 1 hour of supervision per week. If &gt; 20 hours of patient contact per week, 2 hours of supervision per week.</td>
</tr>
<tr>
<td>Research Assistant (who has patient contacts) (Assistant Psychology Staff)</td>
<td>see closest training level.</td>
<td>see closest training level.</td>
<td>see closest training level.</td>
<td>see closest training level.</td>
<td>see closest training level.</td>
<td>see closest training level.</td>
<td>see closest training level.</td>
</tr>
</tbody>
</table>
APPENDIX 2

SUPERVISION AND PSYCHOLOGICAL RECORDS POLICIES OF THE PSYCHOLOGY STANDARDS COMMITTEE FOR PROVIDING PSYCHOLOGICAL SERVICES IN UNIVERSITY OF MINNESOTA MEDICAL CENTER

A. The Psychology Staff supervisor is identified as the responsible agent in all advertising, public announcements, and billing for supervised psychological services.

B. The Psychology Staff supervisor reviews and is responsible for all reports prepared by the supervisee, including inpatient and outpatient chart entries, as appropriate and indicated in Appendix 1.

C. All entries in a patient's medical record shall be accurately dated and signed with the title and/or qualifications of the person making the entry.

D. Medical records shall not be permanently filed until completed and signed by the responsible Psychology Staff member.

E. Pertinent evaluation summaries and progress notes shall be recorded at the time of observation, sufficient to permit continuity and/or transfer of care. Supervisors shall countersign or write progress notes as often as is necessary to substantiate their active participation in and supervision of the patient's care and as indicated in Appendix 1.

F. Outpatient psychological evaluations will include typed/word-processed summaries including reason for referral, history of presenting complaint, pertinent history, mental status, and a summary of psychological test data and interpretation. Reports are to be made a part of patients' medical records within 20 days of the completion of the evaluation, and within 20 days of the patient's second appointment. Under rare circumstances, initial contacts with patients may not require evaluations (e.g., if patient had a recent evaluation [past 30 days] and is referred for psychotherapy rather than evaluation).

G. Inpatient consultation requests are responded to within 24 hours weekdays. Consultations have handwritten note and/or typed report within 24 hours of when patient is seen.

H. Psychological test data is to be retained by the psychologist for a minimum of 7 years. A summary of that data is to be incorporated within patients' medical records. Screening psychological measures such as the MMPI and MMPI-2 may be incorporated within patients' medical records at the discretion of the Psychology Staff.

I. Standardized psychological test data may be released by UMP Psychology Staff to other UMP Faculty and Staff at the verbal request of the patient. Other release of information requires written authorization in accordance with data privacy laws and UMMC Health Information policies.

J. All billing information provided by psychological staff accurately reflects the nature of psychological services rendered in terms of date of service, diagnosis, procedural code, length of services provided, and service provider.
APPENDIX 3

MINNESOTA DEPARTMENT OF HEALTH GUIDELINES FOR ACCESS TO HEALTH RECORDS PRACTICES AND RIGHTS

A health care provider or a person who gets health records from a provider may not release a patient's health records without a signed and dated consent from the patient. Sometimes the law makes exceptions.

RELEASE OF HEALTH RECORDS AND CONFIDENTIALITY:

Certain federal and state laws protect patients' rights to confidentiality of their health records.

Under Minnesota law, a patient may review any information in his or her health records, regarding any diagnosis, treatment and prognosis. If a patient asks in writing, a provider must give the patient copies of either the records or copies of a summary of the information in the records unless the provider has determined that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self-harm, or to harm another. If such a determination had been made, then the information can be given to another provider or appropriate third party. Minnesota statute sets a maximum charge for finding and copying records.

RELEASE OF HEALTH RECORDS WITHOUT PATIENT CONSENT:

In circumstances specified in statute, health record information may or must be released without the patient's consent. The following are some, but not all, examples:

A. In a medical emergency.
B. When a federal law requires it.
C. When someone receives a court order or a federal grand jury subpoena requiring release of health information.
D. Under Minnesota law to the following persons or organizations for specific purposes.

<table>
<thead>
<tr>
<th>Department of Health</th>
<th>Public or private post-secondary education institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Human Services</td>
<td>Local welfare agencies</td>
</tr>
<tr>
<td>Department of Public Safety</td>
<td>Medical examiners or coroners</td>
</tr>
<tr>
<td>Department of Commerce</td>
<td>Medical or scientific researchers</td>
</tr>
<tr>
<td>Department of Employee Relations</td>
<td>Minnesota Health Date Institute</td>
</tr>
<tr>
<td>Department of Labor and Industry, insurers and employers in worker's compensation cases</td>
<td>Potential victims of serious threats of physical violence</td>
</tr>
<tr>
<td>Office of Mental Health Practices</td>
<td>Guardians or conservators of incompetent persons</td>
</tr>
<tr>
<td>Ombudsman for Mental Health and Mental Retardation</td>
<td>Parents/legal guardians of a minor who is being treated where failure to inform could create serious health problems</td>
</tr>
<tr>
<td>State Fire Marshall</td>
<td>Insurance companies and other payers paying for independent medical examinations</td>
</tr>
<tr>
<td>Health Boards</td>
<td>Proxies, ombudsmen, attorneys-in-fac</td>
</tr>
<tr>
<td>Community Action Agencies</td>
<td></td>
</tr>
<tr>
<td>Health professional licensing boards of agencies</td>
<td></td>
</tr>
<tr>
<td>Schools and childcare facilities may transfer immunization records without consent</td>
<td></td>
</tr>
<tr>
<td>Law enforcement agencies</td>
<td></td>
</tr>
</tbody>
</table>

If you have any questions or require additional information, call the Minnesota Department of Health at (651) 282-6314.
APPENDIX 4

AFFIRMATION OF INFORMED CONSENT FOR NEUROLEPTIC MEDICATION

UMMC Policy and Procedure:

Purpose: To facilitate the provision of treatment for patients who are in need of neuroleptic medications.

Policy:

I. Definitions:

A. Capacity to Consent (also referred to as "Decisional Capacity"): A physician's medical assessment of the patient's ability to understand and consent to their treatment.

B. Neuroleptic Medication: A drug that by its characteristic actions and effects is useful in the treatment of mental disorders, especially psychosis, and whose possible side effects may include tardive dyskinesia. See attachment B.

C. Routinely Scheduled Medication: A medication that is prescribed by the attending physician to be given on a routine basis at regularly scheduled times of the day.

D. Emergency: A situation caused by an exacerbation of a patient's medical or psychiatric disorder in which the patient's behavior poses a serious, immediate threat of physical harm to self or others. The information used to make the assessment of the situation as an emergent one may be based on the patient's illness, history and presenting symptomatology.

1. Emergency Scheduled Medication: Medication that is prescribed by a physician to be given at regularly scheduled times of the day to intervene when the patient's behavior or exacerbation of symptoms has been deemed a psychiatric emergency.

2. PRN Medication: Medication that is prescribed by a physician to be administered on a PRN basis to intervene when the patient's behavior or exacerbation of symptoms poses a serious, immediate threat of physical harm to self or others.

E. Affirmation of Informed Consent: The verification by the patient or a person representing the patient that the proposed treatment has been discussed with the physician and that the patient or the patient's representative understands the proposed treatment, how it will be administered, its possible consequences, the possible consequences if it is not administered, and the available alternatives to the treatment.

F. Substitute Decision Maker: An individual designated by the local mental health authority and appointed by the court with authority to consent to the administration of neuroleptic medication.

Refusal: A patient's verbal or nonverbal behavior demonstrating a clear rejection of the neuroleptic medication. Occasionally declining medication is not to be considered refusal unless the patient declines so often or in such a way that effective treatment is not possible.

If you have any questions or require additional information, call the Minnesota Department of Health at (651) 282-6314.

II. Policy

A. This policy applies to all patients except in some cases of short-term use. Short term use (within medically accepted guidelines) of some neuroleptic medications as part of normal medical intervention for the management of symptoms such as nausea, hiccups, or delirium, that are not due to mental illness is excluded from the scope of this policy.

B. Neuroleptic medication may be given only with a standard, documented informed consent discussion, in emergent situations, or per court order.
C. If a newly admitted patient is currently on physician prescribed neuroleptic medication and is not refusing the medication, that patient may continue to receive medication per physician order for a period of up to 24 hours after admission. The administration of the medication may continue past the initial 24 hours if consent is obtained via other means described in this policy.

D. Who may give consent:

1. Affirmation of informed consent may be obtained from the patient by the physician or a hospital staff member when the patient is:
   a. Not subject to petition for early intervention or commitment;
   b. Has the capacity to consent and is 16 years of age or older; and
   c. Is accepting (acquiescing) of the medication.

2. Court intervention is required prior to administration (excluding emergency administration) of neuroleptic medication to a patient who lacks the capacity to consent when the patient is:
   a. The patient is subject to intervention or commitment;
   b. The patient is refusing medication; or
   c. The substitute decision maker refuses to consent.

3. A person other than the patient may give consent for a patient who lacks the capacity to consent when the patient is:
   a. Not subject to petition for early intervention or commitment (except if awaiting appointment of guardianship/conservator of person) and
   b. Accepting of medication (acquiescing).

4. For the patient who is fifteen years of age or younger, parents may give consent.

5. Persons other than the patient may give consent when the court has authorized them to do so.

6. For those patients with an advance directive or health care directive, the patient’s wishes as expressed in the directive will be followed per clinical indications.

7. Consent may be obtained via a previously signed consent for neuroleptic medication form when:
   a. The patient is not subject to petition for commitment or early intervention (except if awaiting appointment of guardianship/conservator of person) and
   b. The patient lacks capacity to consent, and
   c. The patient is accepting of medication (acquiescing).

E. The physician is responsible for documenting:

1. The patient’s capacity to consent; and
2. That the informed discussion has taken place.

F. In an emergent situation, a physician may order emergency neuroleptic medication to be given consistent with the above definition of emergency medication. Even if the patient refuses the medication, the medication may be given for as long as the emergency exists up to 14 days if the physician documents the emergency. If a petition for a Jarvis hearing is filed within 14 days, then the physician may continue the medications up through the date of the first court hearing, if the emergency continues to exist and there is ongoing documentation (by the physician or per physician direction) in the record that supports the assessment. The need for emergency scheduled medication shall be evaluated on a daily basis, and the physician order for emergency medication renewed every 24 hours.
APPENDIX 4 (continued)

III. Procedure

A. The physician assesses the patient's capacity to consent to neuroleptic medications.

B. The physician has the informed discussion with the patient or the person permitted to give consent.

C. The physician or RN gives the patient or person permitted to give consent the opportunity to review and sign the affirmation of consent form and places it in the patient's medical record.

D. Photocopies or fax copies of advance directives and health care directives are places in the patient's medical record.

E. If the patient lacks the capacity to consent and refuses medication,
   1. The physician may initiate a Commitment Petition and request for a substitute decision maker (or county alternative) and a Jarvis Petition, if necessary.
   2. For patients whom the physician determines do not have the capacity to consent, staff persons with case management functions will request, in conjunction with the Commitment Petition and at the direction of the physician, that a substitute decision maker (or county alternative) be appointment.

F. For the patient whom the physician assesses as in an emergent situation and in need of emergency scheduled medication, the physician documents the existence of an emergent situation, orders emergency scheduled medication, and maintains documentation (consistent with the above policy section F) for the duration of the emergent situation.
APPENDIX 5

SUSPECTED MUNCHAUSEN SYNDROME BY PROXY OR OTHER ABUSIVE BEHAVIOR: COVERT MONITORING

UMMC Policy and Procedure:

Purpose: The primary purpose of such testing is to aid in the diagnosis of the child's condition and ultimately protect the child. The materials obtained during monitoring may have secondary uses by others investigating possible child abuse.

Policy: Continuous covert monitoring may be carried out when there are no other reasonable means of establishing the suspected Munchausen Syndrome by Proxy or other abusive behavior.

Procedure: On the basis of standard suspected Child Abuse/Neglect indicators, referral to the Pediatric ward of UMMC is required for review of the case and initiation of covert videotaping. An order by the attending physician on the ward is required. To safeguard the diagnostic purpose of covert videotaping, minimal staff involvement and strict confidentiality is required.

Indications: All of the following indications must be met before continuous video monitoring can be carried out:

1. There is a history consistent with the child exhibiting symptoms which are of unknown origin.
2. Reasonable efforts have been made to rule out natural causes for the symptoms.
3. Consultation has been obtained from one or more medical consultants who have training appropriate to the situation and those consultants are unable to establish a medical diagnosis to explain the signs and symptoms.
4. It must be determined that the possible benefit to the child from obtaining further information regarding the cause of the child's illness outweighs the burdens placed on the parents during continuous video monitoring.
5. The pediatric attending physician, in consultation with an UMMC social worker, will coordinate the case with community resources: child protection, law enforcement, and district attorney's office as needed.

Confidentiality: To promote confidentiality, the following protocol is desired:

1. Limited number of professional staff caring for child.
2. Limited conversation about availability of procedure.
3. Shadow chart be maintained separate from patient's chart.
4. Specific diagnostic discussion held away from patient care area.

Documentation:

1. The attending physician will enter an order into the patient's chart which will indicate that continuous video monitoring will be carried out in the patient's room.
2. The video recording documentation, or shadow chart, shall be maintained at the site of the VCR and video monitor. The shadow chart will become part of the permanent medical record at the time of the patient's discharge from the hospital.
3. No other notations of the covert monitoring or discussion of the possibility of Munchausen Syndrome by Proxy should be entered into the patient's medical record during this admission since this may compromise the effectiveness of the procedure.
4. The attending physician's orders in the shadow chart should list the criteria to be applied when intervention is being considered.

Patient Safety: Continuous video monitoring should be carried out in a way which will potentially provide data to determine causality of the child's symptoms. Based on case review and immediate risk to the child, real-time video surveillance may be indicated. An order from the attending physician is required to initiate real-time video surveillance. During real-time monitoring, a registered nurse will monitor the patient via the video surveillance equipment. Videotapes will be reviewed by the attending physician at appropriate intervals or times as determined by the patient's condition.

Event During Real-Time Video Surveillance: If an abusive event occurs during either real-time monitoring or surveillance, the attending physician will be notified immediately. Child Protection and law enforcement will then be notified by the attending physician/designee.

Storage and Security of Videotapes: The equipment for operating the monitoring devices in the room as well as making videotapes shall be located in a room which is secured by lock and key, and to which there is limited access. Videotapes which are deemed relevant to the diagnosis are a part of the permanent medical records and should be securely stored in the Medical
Record department after it is determined that they are relevant to the chart. The tapes needed for legal action will be the responsibility of UMMC and copies will be made, to be distributed to Child Protection, law enforcement or court personnel as legally appropriate.
APPENDIX 6

DISCHARGE OF A MINOR PATIENT

UMMC Policy and Procedure:

Purpose: The University of Minnesota Medical Center, Fairview has a legal responsibility to protect the children accepted for medical care. In order to discharge that responsibility, the following policy/procedure applies.

Policy: Discharge of patients under 18 years of age, unless an emancipated adult, will be to the legal guardian. Discharge to any person other than the legal guardian shall be according to the following procedure.

Procedure:

1. No minor shall be released to any person other than the legal guardian without written consent or monitored telephone consent of the legal guardian. Such permission must be obtained prior to the time of the discharge and should include the name of the person to whom the minor is to be released.

2. The written consent or monitored telephone consent report must be attached to the minor's medical record before or at the time of discharge.

3. The person authorized by the legal guardian to take the minor out of the hospital must provide appropriate identification to the charge nurse.

4. The responsibility for obtaining the written consent or monitored telephone consent from the legal guardian will be assumed by the Social Work Department, Nursing, or Family/Child Therapist.

5. When a minor is to be released to a social agency or foster parent, the Social Work Department or Child/Family Therapist will be responsible for coordinating the discharge plan and will notify the charge nurse of the name of the person coming to take the minor and make notation in the medical record.

6. When discharging the minor to separated or divorced parents, custodial rights should be determined.

7. Maternal Child Health, Child Adolescent, and Adolescent Chemical Dependency Program, department specific policy will guide special situation of adoption, and minors 16 and older.
APPENDIX 7

CONTROL OF INFECTION HAZARD TO PREGNANT EMPLOYEES

UMMC Policy and Procedure

Policy: Pregnant employees will be protected from infection hazards which may be harmful to the fetus.

Procedure: Employees who are pregnant or who are trying to become pregnant will report to the Employee Health Services for assistance in determining susceptibility to infectious agents. Information and instruction relative to infection control risks and precautions will then be provided. As determined by the employee's susceptibility status, the infection hazard to her will be managed according to the table on the following pages.

Management of Infection Hazard to Pregnant Hospital Personnel

Immune status of Pregnant Employee

<table>
<thead>
<tr>
<th>Immune status of Pregnant Employee</th>
<th>Fetal Damage Common</th>
<th>Fetal Damage Rare</th>
<th>Fetal Damage Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Susceptible or Unknown Exclude Employee From Room of Isolated Patient</td>
<td>If Immune Exclude Employee From Room of Isolated Patient</td>
<td>Non-Serological Criteria</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>Yes</td>
<td>Yes</td>
<td>Vaccination:</td>
</tr>
<tr>
<td>VZV</td>
<td>Yes</td>
<td>No</td>
<td>Prior Chickenpox Zoster</td>
</tr>
<tr>
<td>CMV</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>HIV</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fetal Damage Rare</th>
<th>HBV</th>
<th>Mumps</th>
<th>VZV (1st, 2nd Trimester)</th>
<th>Parvovirus</th>
<th>Other Acute Viral Illness Especially Infections &amp; Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Measles</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Presume Susceptibility</td>
<td>Moot</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Prior Measles, Vaccination After 1980 or born before 1957</td>
<td>Prior Mumps, Vaccination or born before 1957</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Prior Chickenpox or Zoster</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Presume Susceptibility</td>
<td>None</td>
</tr>
</tbody>
</table>

1. Employees who are trying to become or have an unconfirmed early pregnancy will be excluded from the rooms of patients for rubella. The remaining exclusions will not be undertaken until the employee has visited the Employee Health Service for a determination of susceptibilities. Thereafter the employee will be managed as if she were pregnant.
2. Serology should be obtained if there is no non-serological basis establishing immunity.
3. Transmission of CMV from patient to personnel either is very rare or does not occur. Transmission could only occur as a result of improper technique. With proper application of technique specified in Policy 33.21 there is no need for additional precautions for pregnant employees to prevent CMV transmission.
4. HIV or HBV can be transmitted to the fetus. However, these viruses represent a significant hazard to all personnel. Therefore, hospital transmission of these illnesses is unlikely and no personnel exclusions are recommended.
5. Fetal damage commonly occurs from toxoplasmosis and syphilis and rarely occurs from HSV, types 1 and 2. However, hospital transmission of these illnesses is unlikely and no personnel exclusions are recommended.
6. If a significant exposure to HBV infectious blood occurs, in addition to following the needlestick protocol, the pregnant employee should have HbsAg determination done in the eighth or ninth month of pregnancy.
APPENDIX 8

UNIVERSITY OF MINNESOTA PHYSICIANS POLICIES TO PROMOTE QUALITY OF CLINICAL SERVICES

UMP has adopted resolutions and policies developed by its Clinical Services and Quality Assurance Committee in conjunction with the Ambulatory Care Committee and Compliance Committee. These policies reflect what are already practiced in patient care in this highly competitive market.

Consultation Services Policy: All patients will be seen by consulting staff physicians within UMP within 24 hours of a consultation request by the requesting staff physician and more rapidly (2-4 hours) for emergent consultations.

Clinic Appointment Cancellation Policy: Clinic should be canceled only when absolutely necessary and only then, more than four weeks before scheduled clinics except for unforeseen commitments, illnesses, or emergencies.

Clinic Patient Waiting Time: Patients will be seen by their primary physician or provider within 30 minutes of their scheduled clinic appointment.

Evaluating Providers Who Are Not in Compliance with Patient-Care Related Policies/Guidelines/Standards: A process involving the clinical service unit chief/department head and the Clinical Services and Quality Assurance Committee of UMP is outlined to evaluate physicians who allegedly are not in compliance with patient-care related policies/guideline/standards.

Response Time to Referring Physicians: Physicians within UMP will strive to respond to calls from referring physicians within a maximum of 20 minutes (sooner if possible) if indicated. Each physician should have a beeper to ensure availability. The policy asks that physicians (staff and residents) be helpful to those seeking consultation on patients and respond to calling physicians in a friendly, courteous, and helpful manner.
CONSENT FOR AUDIO AND/OR VIDEO RECORDING

This training institution has a mission to provide service, education, and research. In fulfilling this mission, it is important to provide close review of patient care and research activities. This form is to obtain your permission for recording clinical or research activities involving you, your child, or somebody for whom you have legal responsibility. The recordings will be used only for the purposes indicated below. They will be kept confidential in accordance with the Ethical Principles and Code of Conduct of the American Psychological Association as well as relevant federal and state statutes, rules and regulations. They will be maintained in a secure place until erased when the purposes for which they are being made have been completed. This form does not allow the use of recordings outside of this institution unless specifically indicated below.

I, ________________________________, understand that my signature below constitutes permission to permit recording for the following specific purpose(s):

Place an "X" next to the type of recording(s) to be made: ☐ Audio ☐ Video

Place an "X" next to the purpose(s) for which recordings will be made:

☐ Training/Supervision within University of Minnesota Medical School which may involve review by faculty supervisors, interns, postdoctoral fellows, or graduate students

☐ Research

☐ Training/Supervision within and outside of University of Minnesota as specified:

________________________________________________________

________________________________________________________

☐ Clinical activity (specify): __________________________________

________________________________________________________

I understand that my decision to permit or deny permission for recording is voluntary and will not affect my current or future relationships or care within the institution named above. I recognize that I am free to withdraw permission at any time. I understand that I may request a copy of this form for my records. I have read the above information. I have received answers to questions I might have regarding how recordings will be used. I also understand that I will be given the name of supervising person to contact if I have further questions about this recording. By signing below, I consent to permit the recording(s) as specified above.

Name of Patient or Research Subject

Signature of Person Providing Consent

Relationship to Patient: ☐ self ☐ parent ☐ legal guardian 

☐ Other specify: ____________________________________________

Signature of Witness

Name of Clinician or Researcher

Date

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# APPENDIX 10
## TELEPHONE SYSTEM INFORMATION

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
<th>Dialing from a U of M telephone with 624, 625, or 626</th>
<th>Dialing from a UMMC telephone beginning with 273</th>
</tr>
</thead>
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<td>8-273-30 # #</td>
<td>3-30 # #</td>
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<td>3-95 # #-immediate connection, say hello</td>
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APPENDIX 11
UMMC CONSULTATION GUIDELINES

1. Consultation Request
   a) The attending physician/dentist/podiatrist is responsible for requesting consultation. Consultation requests may be written or verbal orders and should include the following:
      i. Name of consultant, practice group and/or specialty,
      ii. Reason for consult request,
      iii. Time frame for consultation response particularly if urgent,
      iv. Type of consult should be specified:
         Advised only: consultant will not authorize services nor write orders.
         Advise and treat: consultant may authorize services/write orders in conjunction with the reason for the consult.
   b) The attending physician is encouraged to contact the consulting physician when appropriate and possible to make certain that the consultant has appropriate information prior to doing the consult.
   c) The consulting physician will not request an additional consult without conferring with the attending, except in an emergency situation.

2. Consultation Services
   a) Consultation services shall be brought to the patient (for the initial visit at a minimum) especially in case of emergency. Some necessary services may require transfer of the patient to another site, but this determination should be made jointly by the attending and consulting physicians.
   b) Medically necessary consultation services must be available from a staff physician/dentist or a group/service/department 24 hours/day, 7 days/week.
   c) Admitting, attending and consulting staff or a designee will provide to Telecommunications reliable information and a method for reaching them 24 hours/day, 7 days/week.
   d) The consulting physician examines the patient and personally documents appropriate consultation notes in the medical record within 24 hours from time of consult request for routine consults. Consultant examines the patient and documents within a time frame consistent with the urgency of the situation for urgent consults as determined jointly by the consultant and the requesting physician.
   e) The consulting physician will contact the attending physician following the initial consult if there are urgent recommendations. Otherwise, written communication in the medical record is appropriate, and should be augmented by a dictated report.
   f) The dictated and/or written consultation documentation in the patient's medical record shall show:
      i. Evidence of a review of the patient's record by the consultant,
      ii. Pertinent findings on examination of the patient
      iii. Consultant's opinion and recommendations. When operative procedures are involved, the consultation note shall be recorded prior to the procedure.
   g) When teaching services are involved, the attending staff consultant must fulfill and document the essential elements of the service/consult with the time frame outlined in d) above.
APPENDIX 12
UMMC MEDICAL RECORDS GUIDELINES

1. A complete medical record shall be maintained for each patient at University of Minnesota Medical Center. The attending physician and/or designee has responsibility to document the following:
   a) Admission Order  
   b) History and physical examination/patient assessment  
   c) The goals of treatment and the treatment plan  
   d) Health care directives  
   e) Informed consent for procedures and treatments when required by UMMC policy  
   f) Special reports such as consultations  
   g) Diagnostic and therapeutic procedures  
   h) Operative and delivery procedures  
   i) Pathological findings  
   j) Progress notes  
   k) Diagnostic, therapeutic and resuscitative orders  
   l) Final diagnoses  
   m) Condition on discharge  
   n) Discharge order and summary  
   o) Autopsy report when performed

Reference: Specific documentation and timeliness requirements for each record component can be found in 
Hospital Policy: Medical Record Content and Completion.

2. Medical record entries may be made by Medical Staff, Allied Health Staff, residents, fellows, students, and 
employed health care practitioners within UMMC who provide patient care.

3. Health care practitioners who need to communicate information to physicians and other caregivers regarding 
treatment or discharge planning may write a progress note.

4. Clinical entries shall be dated and signed including the title, degree, and/or credentials of the person making 
the entry.

5. Electronic and rubber stamp entries may be used in accord with the hospital policy. See hospital policy: 
Electronic and Rubber Stamp Medical Record Authorization.

6. A medical record that remains incomplete for more than 30 days after discharge shall be considered 
delinquent. Reference: Hospital Policy: Delinquent Medical Record.

7. A physician's admitting and scheduling privileges may be suspended for delinquent records in accordance with 
the Delinquent Medical Record Policy. Failure to complete delinquent records within 60 days from the date of 
privilege suspension shall constitute voluntary relinquishment of all clinical privileges and resignation from 
the Medical Staff.

8. A medical record shall not be permanently filed until it is completed by the responsible medical Staff member, 
Allied Health Staff member, or designee or approved for filing by the director of Health Information 
Management.
   a) A Medical staff member who is planning to terminate privileges at UMMC shall complete all medical 
records for which he/she is responsible prior to termination.
   b) No Medical Staff member shall be permitted to complete a medical record on a patient unfamiliar to 
him/her in order to retire a record that was the responsibility of another staff member who is deceased or 
permanently unavailable for other reasons. The HIM director may declare the record complete for 
purposes of filing. The reasons for such action shall be document and included in the record. A report of 
such action will be forwarded to the HIM Committee.
1. It is the practitioner's duty to:
   a) Obtain informed consent for treatment and procedures when, in the practitioner's judgment, there are foreseeable risks.
   b) Determine that the patient has the capacity to give or withhold consent.
   c) Disclose the patient's condition, and clearly explain to the patient, and family when appropriate, the recommended treatment or procedures along with alternative treatment options, potential risks, benefits and drawbacks, and likelihood of success.
   d) Disclose foreseeable risks of a contemplated treatment or procedure, including:
      i. The possibility of serious bodily harm or death
      ii. Potential problems related to recuperation
      iii. Risks which a reasonable person might consider significant in deciding whether or not to consent.
      iv. Risks which the practitioner knows or should know to be significantly to the particular patient.
   e) Disclose the possible results of non-treatment.
   f) Write an order for the wording on the consent.

Reference: Hospital policies on consents: *Patient Consent, Consent of Minors for Health Services*
APPENDIX 14

UMMC GUIDELINES: HOLDS, SECLUSIONS, AND RESTRAINTS

1. Involuntary Holds:

Retention of a patient who is in imminent danger of causing injury to himself/herself or others. A patient may be detained under authority of state law if that patient is believed to be potentially dangerous and the patient may cause injury or harm. Reference Hospital Policy: Involuntary Holds.

2. Pediatric Holds:

When medical judgment indicates that a child's health and welfare would be endangered if the child is discharged to the person to whose lawful custody she or he would ordinarily be released, a physician may implement a 72-hour police health and welfare hold under provisions of Minnesota Statutes Section 260.165, subd. 1(c) (2). To implement this hold, the attending physician or assignee should contact the police authorities and proceed in accord with hospital policy "Police Custody for the Health and Welfare of Children." The police officer will take legal custody of the child and transfer the physical custody of the child to a relative or a facility. (If a peace officer comes to the Hospital to place a hold on a pediatric patient, the officer should be directed first to the Security Department.)

3. Seclusion and Restraint:

The treatment procedures of seclusion and restraint shall be used only for the benefit of the patient and/or the safety of the staff and other patients and in accordance with the hospital policy: Restraint and Seclusion. In any instance where restraint or seclusion is used, a physician order shall be obtained within one hour of initiation of seclusion to include:

a. A time limited restraint or seclusion order.

b. The start and end times.

c. A description of the behavior that necessitated the intervention.
APPENDIX 15

UMMC GUIDELINES: SPECIAL TREATMENT PROCEDURES FOR BEHAVIORAL SERVICES

1. A qualified child psychiatrist shall examine all children and adolescents in Behavioral Services prior to initiating special treatment procedures. Before initiating electroconvulsive therapy to a child or adolescent, two qualified child psychiatrists, not directly involved in the treatment of the patient, shall examine the patient, consult with the attending child psychiatrist responsible for the patient, and document in the patient's medical record their concurrence with the decision to administer ECT.

Reference Behavioral Services Policy: *Electro Convulsive Therapy (ECT) for Child/Adolescent Services Patients.*

2. Medications may be administered without judicial review and without consent of the patient in an emergency situation if the treating physician determines that the medication is necessary to prevent serious, immediate harm to the patient or others.

Reference Behavioral Services Policy: *Emergency Medication Administration*

3. Involuntary intrusive therapy may be administered. Such therapy must be administered in compliance with MN statute 253B.03 Subd 6b and the *Price Hearing.*

Reference Behavioral Services Policy: *Price Hearing.*
APPENDIX 16
UMMC GUIDELINES: REPORTING REQUIREMENTS

The Medical Staff member in collaboration with the appropriate hospital staff and in accordance with State of Minnesota statutes and Hospital policies will report the following:

*Note: The UMMC hospital and Behavioral Services department policies are listed in italics as references.*

1. Suspected maltreatment of vulnerable adults.  
   *Vulnerable Adults: Reporting Suspected Maltreatment*

2. Known or suspected maternal and/or newborn exposure to a controlled substance.  
   *Substance Abuse: Reporting of Maternal and/or Newborn Exposure*

3. Suspected abuse of a child, an adolescent, or an adult  
   *Victims of Abuse (Adolescent and Adult), Child Abuse and Neglect, Police Custody for the Health and Welfare of Children, Suspected Abuse of an Adult*

4. Sexual assault if the patient signs a waiver  
   *Suspected Sexual Assault, Sexual Assault Protocol*

5. A serious and specific threat of harm against a specific individual, public official, or structure made by a patient of Fairview  
   *Reporting Patient Threats*

6. Injuries caused by firearms and/or knife wounds inflicted by another person or under suspicious conditions.  
   *Abuse and Violence-Domestic*

7. Animal Bites  
   *Animal Bites*

8. Abortion and complication from an abortion  
   *Termination of Pregnancy/Selective Reduction Prior to Viability*

9. Communicable Diseases  
   *Infection Control Communicable Disease Reporting*

10. Births

11. Deaths and Serious Injury  
    *Deaths Reportable to the Medical Examiner, Reporting of Death and Serious Injuries to the Office of the Ombudsman for Mental Health and Mental Retardation*

12. Conduct by a Medical or Allied Health Staff member indicating possible impairment by reason of alcohol, drug abuse, physical or mental illness, medical incompetence, or unprofessional conduct  
    *Reporting Obligations under the Minnesota Medical Practices Act, MN Statutes 147.01 through 147.33.*
The Medical and Allied Health Staff recognize the importance of adhering to laws and regulations applicable to the Hospital and the practice of medicine and related health professions shall adhere to such laws and regulations. Members of the medical and Allied Health Staff shall participate in and cooperate with the Compliance Program established by the Hospital, including training and internal reviews, as may be required in accordance with the Compliance Program.

Medical Staff leaders and Hospital staff will work collaboratively to develop training and other compliance initiatives that related to members of the medical and Allied Health Staff. The Hospital recognizes the importance and necessity of the Medical and Allied Health Staff’s input and assistance with respect to the Compliance Program.

Nothing herein shall require a member of the Medical or Allied Health Staff to compromise their medical or professional judgment or ethical obligations to act in the best interests of their patients.
APPENDIX 18
UMMC GUIDELINES: CHILD ABUSE AND NEGLECT

Purpose: To assist staff in meeting statutory obligations for the protection of children whose health and welfare may be jeopardized through physical abuse, neglect, or sexual abuse. To strengthen the family, and to make the home, school and community safe for children.

Policy: It is the policy of University of Minnesota Medical Center to require the reporting of neglect, physical or sexual abuse of children in the home, school or community setting.

Legal Requirement
The Reporting of Maltreatment of Minors Act was passed in 1975. This law requires that any professional or his/her delegate, who is engaged in the practice of the healing arts, psychological or psychiatric treatment, social services, education, law enforcement, hospital administration or child care who:

A. Knows or has reason to believe a child is being neglected or physically or sexually abused or

B. Has been neglected or physically or sexually abused within the preceding three years shall immediately (as soon as possible but no longer than 24 hours) report the information to the local welfare agency, police department or the county sheriff.

Definitions:
Physical Abuse: Any physical or mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries.

Mental Injury: An injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

Sexual abuse of a child includes:

A. Any act which constitutes a violation of any Minnesota criminal statutes (i.e., physical or sexual assault) or

B. Any sexual contact between a facility staff person and a resident or patient of that facility or

C. Threatened sexual abuse

Neglect of a child includes:

A. Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter or medical care when reasonably able to do so.

B. Failure to protect a child from conditions or actions which imminently and seriously endanger the child's physical or mental health when reasonably able to do so. Or

C. Failure to take steps to ensure that a child is educated in accordance with state law.

Note: Nothing in this statute shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care unless a lack of medical care may cause serious danger to the child's health.

(continued)
APPENDIX 18 (continued)

D. Any act by the parent or person responsible for the care of the child including:

1. Engaging in violent behavior that "demonstrates a disregard for the well-being of the child is indicated by action that could reasonably result in serious physical, mental, or threatened injury, or emotional damage to the child";

2. Engaging in repeated domestic assault;

3. Intentionally inflicting or attempting to inflict bodily harm against a family or household member within the sight or sound of the child;

4. Subjecting the child to ongoing domestic violence by the abuser in the home environment "that is likely to have a detrimental effect on the well-being of the child."

5. Chronic and severe use of alcohol or controlled substance that adversely affects the child's basic needs and safety; or

6. Emotional harm from a pattern of behavior that "contributes to the impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development with due regard to the child's culture."

Procedure: Minnesota law requires that certain individuals, including those in health care, who know or have reason to believe a child is being neglected or physical or sexually abused within the preceding three years, to immediately report the information to the local welfare agency, police department or county sheriff. Failure to report is a misdemeanor. To ensure compliance with the law and the reporting of appropriate cases, the following procedure should be followed.

I. Any person who is concerned that either abuse or neglect has occurred shall immediately notify both the responsible staff physician or family therapist/case manager/psychologist/psychiatrist and the UMMC social worker for any patient seen in a clinic or on a patient care unit as University of Minnesota Medical Center, for the purpose of discussing whether or not there is reason to believe that abuse or neglect has occurred. The responsible staff physician or family therapist/case manager/psychologist/psychiatrist shall report the alleged maltreatment to the appropriate welfare or law enforcement authorities, document the facts on the Reporting Form for Suspected Maltreatment of Neonate or Minor and place a note in the patient's medical record. The physician or identified internal expert making the report will provide the authorities with the names of all staff who may have knowledge of the alleged abuse or neglect.

If there is disagreement at the staffing level as to whether or not there is reason to believe that maltreatment has occurred, the physician or family therapist/case manager/psychologist/psychiatrist has the final say, but if another mandated reporter disagrees, that individual is still required to report under the law.
APPENDIX 18 (continued)

II. To assist professionals’ mandates to report and to facilitate appropriate patient and staff education, the following procedures have been developed:

A. Acute Care Medical-Surgical

1. If a multi-disciplinary team discussion is deemed necessary, the responsible physician shall participate in the meeting to discuss abuse or neglect. The meeting shall be coordinated by the social worker, shall occur within 24 hours of identification and shall include the responsible staff physician, house staff, social worker, nurse, and the professional identifying the abuse or neglect if that person is not one of the above. If the Child Abuse and Neglect Consultative Committee physician member on call was consulted, that consultant shall also be included in the meeting.

2. Discussion whether to have communication with the parent or guardian regarding abuse or neglect concerns should be a therapeutic decision based on the clinical implications of the situation. In cases of physical or sexual abuse, consult with Child Protection before discussion with parent/guardian.

3. Either the social worker or the responsible staff physician shall immediately make a telephone report to the local Child Protection unit (county of residence). This should be followed by completion of a written report within 72 hours exclusive of weekends and holidays. This report must be signed by the staff physician.

B. Behavioral Health

1. The responsible internal expert, (clinic therapist/child adolescent social worker or therapist) shall immediately comply with all procedures and decide the need for a multidisciplinary team discussion prior to reporting the event to the county Child Protection unit. If further consultation is needed, the internal expert shall contact the Child Abuse and Neglect Consultative Committee physician on call.

2. If a multidisciplinary team discussion is deemed necessary, the responsible psychiatrist/medical director shall participate in the meeting to discuss abuse or neglect. The meeting shall be coordinated by the identified internal expert and shall occur within 24 hours of identification.

3. Discussion whether to have communication with the parent or guardian regarding abuse or neglect concerns should be a therapeutic decision based on the clinical implications of the situation. In cases of physical or sexual abuse, consult with Child Protection before discussion with the parent/guardian.

4. The identified internal expert shall immediately make a telephone report to the local Child Protection unit (county of residence). This should be followed by completion of a written report within 72 hours exclusive of weekends and holidays. This report must be signed by the identified internal expert.

*Note: Interns may participate in mandatory reports in conjunction with a supervisor and must speak with a supervisor about potentially reportable concerns. They are not to make reports alone. If the supervisor for the case is not available, they are to manage the case along with another supervisor.

(continued)
APPENDIX 18 (continued)

C. Emergency Services Department

1. The Emergency Department (E.D.) Staff Physician shall contact Child Protection with all cases where there is reason to believe that a child is being neglected or physically or sexually abused. The E.D. Staff Physician with assistance from the social worker will complete the reporting form that will be forwarded to Child Protection and archived by Social Work Services.

2. When Alternative placement to the child's usual place of residence is needed to assure the child's safety, Social Work Services will facilitate the placement.

3. The E.D. Staff Physician may consult with the on call physician for the UMMC Child Abuse and Neglect Consultative Committee to discuss reporting concerns or questions.

III. If the reportable situation is serious and requires immediate attention to protect the well-being of the patient and/or the gathering of evidence, the Minneapolis Police Department (Downtown Precinct)-Riverside campus or the University Police-University campus should be contacted. (See Emergency Services policy on Peace or Heath Officer Holds).

IV. The responsible staff physician/family therapist/case manager/psychologist/psychiatrist shall document a care plan in the medical record within 72 hours of having identified abuse or neglect.

V. Documentation in the medical record should include a note indicting that a report was made to the appropriate authorities (name, date and time of agency notification). Details related to the report should not be documented unless important for the patient's treatment. The original copy of the Reporting Form for Suspected Maltreatment of a Neonate or Minor will be maintained in the correspondence section of the medical record and a copy of the form will be maintained in the Department of Social Work Services (Acute Care) and Behavioral Health Administration (Behavioral Services) for statistical reporting purposes.

OTHER CONSIDERATIONS

I. A person making a voluntary or mandated report or assisting in an assessment is immune from any civil or criminal liability that otherwise might result from the person's action, if the person is acting in good faith.

A. A mandated reporter may be guilty of a misdemeanor if:

1. The reporter intentionally fails to make a report,

2. Knowingly provided information that is false, deceptive, or misleading, or

3. Intentionally fails to provide all of the material circumstances surrounding the incident that are known to the reporter when the report is made.

B. An employer of any person required to make reports shall not retaliate against the person for reporting in good faith suspected abuse or neglect because of the report.

C. If the situation requires sexual assault evidentiary examination, consult with the primary physician and refer to Suspected Sexual Assault Protocol (Hospital Policy). Do not let the patient take a bath or shower, change clothes, or alter the scene in any way.

For special reporting obligations regarding exposure to controlled substances, see Prenatal Exposure to Controlled Substances (Hospital Policy)
APPENDIX 19

USEFUL WEBSITES

American Academy of Child and Adolescent Psychiatry http://www.aacap.org/
American Academy of Clinical Neuropsychology https://theaacn.org/-gsc.tab=0
American Board of Professional Psychology (A.B.P.P.) http://www.abpp.org/
American Psychological Association http://www.apa.org/
APA Division 12 Clinical Psychology http://www.apa.org/about/division/div12.html
APA Division 16 School Psychology http://www.indiana.edu/~div16/
APA Division 38 Health Psychology http://www.health-psych.org/
APA Division 53 Clinical Child & Adolescent Psychology http://www.apa.org/about/division/div53.html
APA Division 54 Pediatric Psychology http://www.societyofpediatricpsychology.org/new.shtml
American Psychiatric Association http://www.psych.org/
Association of Psychology Postdoctoral and Internship Centers http://www.appic.org/
Association of State and Provincial Psychology Boards http://www.asppb.org/
Autism Society of America http://www.autism-society.org/site/PageServer
Blue Cross Blue Shield Minnesota http://www.bcbsm.com
Bazelon Center for Mental Health Law http://www.bazelon.org/
Brain Tumor Society http://www.bts.org/
Children & Adults with Attention-Deficit Hyperactivity Disorder http://www.chadd.org/
Depression and Bipolar Support Alliance http://www.dbsalliance.org/site/PageServer?pagename=home
Federation of Families for Children's Mental Health http://www.ffcmh.org/
Health Partners Find a Provider http://www.healthpartners.com/portal/1103.html
International Neuropsychological Society http://www.the-ins.org/
MedlinePlus Mental Health medlineplus.gov/mentalhealth.html
Mental Health Licensure Resources http://www.tarleton.edu/~counseling
Minnesota Medical Assistance http://www.ma.gov
Minnesota Psychological Association http://www.mnpsych.org/
Minnesota Psychiatric Society http://www.mmpsychsoc.org/
National Academy of Neuropsychology http://nanonline.org/
National Alliance on Mental Illness http://www.nami.org/
National Autism Association http://www.nationalautismassociation.org/
National Institute of Mental Health nimh.nih.gov/index.shtml
National Register of Health Service Providers in Psychology http://www.nationalregister.org/
Optum Provider Express https://www.providerexpress.com/content/ope-provexp/us/en.html
PreferredOne Provider Directory http://providerguide.preferredone.com/
Refdesk.com Mental Health http://refdesk.com/mental.html
United Way Twin Cities 2-1-1 http://www.firstcallnet.org/
University & College Counselor Resources http://www.tarleton.edu/~counseling/
University of Minnesota Academic Health Center http://www.ahc.umn.edu/
University of Minnesota Medical School Psychology Internship http://www.med.umn.edu/peds/psych/
University of Minnesota web mail http://www.mail.umn.edu/
United Behavioral Health online https://www.ubhonline.com/
Yale Child Study Center http://childstudycenter.yale.edu/
APPENDIX 20
SUPERVISION BIBLIOGRAPHY

This bibliography is divided into the following categories:

I. BOOKS
II. ETHICAL ISSUES/ETHICS
III. REVIEWS
IV. THEORY
V. SEXUAL ATTRACTION
VI. SEXUAL ORIENTATION
VII. GENDER
VIII. SUBSTANCE ABUSE AND SUPERVISION
IX. MULTICULTURAL DIVERSITY
X. GROUP SUPERVISION
XI. SUPERVISION TRAINING
XII. SUPERVISOR SUPERVISION
XIII. SUPERVISION TECHNIQUES
XIV. SELECTED RESEARCH ON SUPERVISION
XV. EVALUATION IN SUPERVISION
XVI. MISCELLANEOUS

I. BOOKS


APPENDIX 20 (continued)


II. ETHICAL ISSUES/ETHICS

APPENDIX 20 (continued)


APPENDIX 20 (continued)


III. REVIEWS


APPENDIX 20 (continued)


IV. THEORY


APPENDIX 20 (continued)


V. SEXUAL ATTRACTION


APPENDIX 20 (continued)


VI. SEXUAL ORIENTATION


VII. GENDER


VIII. SUBSTANCE ABUSE AND SUPERVISION


APPENDIX 20 (continued)
IX. MULTICULTURAL DIVERSITY
APPENDIX 20 (continued)


X. GROUP SUPERVISION


XI. SUPERVISION TRAINING


APPENDIX 20 (continued)


XII. SUPERVISOR SUPERVISION


XIII. SUPERVISION TECHNIQUES


APPENDIX 20 (continued)


XIV. SELECTED RESEARCH ON SUPERVISION


APPENDIX 20 (continued)


XV. EVALUATION IN SUPERVISION


APPENDIX 20 (continued)


XVI. MISCELLANEOUS

Ammirati, R. J., & Kaslow, N. J. (2017). All supervisors have the potential to be harmful. The Clinical Supervisor, 36, 116-123.

APPENDIX 20 (continued)


Adapted from: [http://www.lehigh.edu/~nil3/stsig/booksandarticles.htm](http://www.lehigh.edu/~nil3/stsig/booksandarticles.htm)
APPENDIX 21

APA RECORD KEEPING GUIDELINES

Approved as APA Policy by the APA Council of Representatives February 2007

Correspondence may be addressed to the Practice Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242

Introduction

These guidelines are designed to educate psychologists and provide a framework for making decisions regarding professional recordkeeping. State and federal laws, as well as the American Psychological Association’s (APA, 2002) “Ethical Principles and Psychologist’s Code of Conduct” (hereafter referred to as the Ethics Code), generally require maintenance of appropriate records of psychological services. The nature and extent of the record will vary depending upon the purpose, setting, and context of psychological services. Psychologists should be familiar with legal and ethical requirements for record-keeping in their specific professional contexts and jurisdictions. These guidelines are not intended to describe these requirements fully or to provide legal advice.

Records benefit both the client and the psychologist through documentation of treatment plans, services provided, and client progress. Record keeping documents the psychologist’s planning and implementation of an appropriate course of services, allowing the psychologist to monitor his or her work. Records may be especially important when there are significant periods of time between contacts or when the client seeks services from another professional. Appropriate records can also help protect both the client and psychologist in the event of legal or ethical proceedings. Adequate records are generally a requirement for third-party reimbursement for psychological services.

The process of keeping records involves consideration of legal requirements, ethical standards, and other external constraints, as well as the demands of the particular professional context. In some situations, one set of considerations may suggest a different course of action than another and it is up to the psychologist to balance them appropriately. These guidelines are intended to assist psychologists in making such decisions.

Guidelines and Use of Language

Psychological practice entails applications in a wide range of settings, for a variety of potential service recipients. This document was written to provide broad guidance to providers of services (e.g., assessment, diagnosis, prevention, treatment, psychotherapy, consultation). Extension of the guideline to some areas of practice (e.g., industrial organizational, consulting psychology) may likely call for modifications, although some of the same general principles may be useful.

The term guidelines refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help facilitate a high level of practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists.

These guidelines are intended to provide psychologists with a general framework for considering appropriate courses of action or practice in relation to record keeping. Record keeping procedures are directed, to some extent, by the Ethics Code and legal and regulatory requirements. Within these guidelines, more directive language has been used when a particular guideline is based specifically on mandatory provisions of the Ethics Code or law. However, some areas are not addressed in those enforceable standards and regulations. In these areas, more aspirational language has been used. This document aims to elaborate and provide assistance to psychologists as they attempt to establish their own record keeping policies and procedures.

It should also be noted that APA policy generally requires substantial review of the relevant empirical literature as a basis for establishing the need for guidelines and for providing justification for the guidelines statements themselves (APA, 2005). There is relatively little empirical literature, however, that bears specifically on record-keeping. Therefore, these guidelines are based

30 This revision of the 1993 Record Keeping Guidelines was completed by the Board of Professional Affairs’ Committee on Professional Practice and Standards (COPPS). Members of COPPS during the development of this document were Eric Y. Drogin (Chair, 2007), Mary A. Connell (Chair, 2006), William E. Foote (Chair, 2005), Cynthia A. Sturm (Chair, 2004), Michele Galietta, Larry C. James (BPA liaison, 2004-2006), Sara J. Knight, Stephen Lally, Gary Lovejoy, Bonnie J. Spring, Carolyn M. West and Philip H. Witt. COPPS is grateful for the support and guidance of BPA, particularly to BPA Chairs Kristin A. Hancock (2006), Rosie Phillips Bingham (2005), and Julie A. Tucker (2004). COPPS also acknowledges the consultation of Lisa R. Grossman, Stephen Behnke, Lindsay Childress-Beatty, Billie Hinnefeld and Alan Nessman. COPPS extends its appreciation to the APA staff members who facilitated the work of COPPS: Lynn F. Bufka, Mary G. Hardiman, Laura Kay-Roth, Ernestine Penniman, Geoffrey M. Reed and Omar Rehman. The records may be accessed at: http://www.apa.org/practice/recordkeeping.pdf

31 The term client is used throughout this document to refer to the child, adolescent, adult, older adult, family, group, organization, community, or other population receiving psychological services. Although it is recognized that the client and the recipient of services may not necessarily be the same entity (APA Ethics Code, Standard 3.07), for economy the term “client” will be used in place of “service recipient.”
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primarily on previous APA policy, professional consensus as determined by the APA Board of Professional Affairs Committee on Professional Practice and Standards (COPPS), the review and comment process used in developing this document, and, where possible, existing ethical and legal requirements.

Interaction with State and Federal Laws

Specific state and federal laws and regulations govern psychological record keeping. To the extent possible, the document has attempted to provide guidelines that are generally consistent with these laws and regulations. In the event of a conflict between these guidelines and any state or federal law or regulation, the law or regulation in question supersedes these guidelines. It is anticipated that psychologists will use their education, skills, and training to identify the relevant issues and attempt to resolve conflicts in a way that conforms to both law and to ethical practice.

HIPAA. Psychologists who are subject to the Health Information Portability and Accountability Act of 1996 (HIPAA) should be aware of certain record keeping requirements and considerations under HIPAA’s Security Rule and Privacy Rule (HIPAA Administrative Simplification Regulation Text, 45 CFR Parts 160, 162 and 164). These guidelines indicate some key areas in which HIPAA requirements or considerations impact record keeping. However, detailed coverage of the requirements for HIPAA compliance is beyond the scope of this document, and the rules related to HIPAA and their interpretation may change over the lifetime of these guidelines. Accordingly, consultation with other sources of information regarding the implications of HIPAA for psychologists is recommended.32

Expiration

These guidelines are scheduled to expire 10 years from February 16, 2007 [the date of adoption by APA Council of Representatives]. After this date, users are encouraged to contact the APA Practice Directorate to determine whether this document remains in effect.

Background

In 1988, APA’s Board of Professional Affairs (BPA) requested that its Committee on Professional Practice and Standards (COPPS) examine the possible usefulness of guidelines on record keeping for psychologists. Interviews with psychologists indicated that such guidance would indeed be useful. COPPS also surveyed state laws and regulations related to record keeping by psychologists and found them to be vague and to vary substantially across jurisdictions. Based on these findings, BPA directed COPPS to undertake the development of “Record Keeping Guidelines” (APA, 1993), which were subsequently adopted as APA policy.

As part of a process of reviewing guidelines over time to ensure their continued relevance and applicability, BPA noted that the guidelines did not account for new questions raised by rapidly changing technology, particularly electronic communications and electronic media. Further, it was clear that the Health Information Portability and Accountability Act of 1996 (HIPAA) had important implications for record keeping by psychologists. In particular, HIPAA’s Privacy Rule and Security Rule, have implications for the development, maintenance, retention, and security of medical and mental health records. In light of these developments, BPA directed COPPS to revise the “Record Keeping Guidelines.”

COPPS began with an assessment of member experience with the current guidelines. The 1993 “Record Keeping Guidelines” were posted on the APA website for member and public comment in the light of a possible revision. A call for comments was published in the APA Monitor and circulated to state, provincial, and territorial psychological associations and to APA divisions. COPPS also surveyed current professional literature on record keeping. Relevant provisions of the, 2010 Code (APA, 2002, 2010), that had been extensively revised since the development of the 1993 Record Keeping Guidelines, were examined in detail, as were the ethics codes and relevant policies of several other mental health professions. COPPS also considered the implications of current federal and state laws and regulations, including HIPAA. COPPS reviewed the questions received from members by the APA Practice Directorate Legal and Regulatory Affairs Office and the APA Ethics Office about record keeping practices. Most commonly, these questions concerned the content of records, management and maintenance of records, electronic records, retention of records, and compliance with rapidly changing state and federal requirements for record keeping. Finally, other APA practice guidelines were examined to ensure internal consistency of APA policies.

After drafting a proposed revision, COPPS sought feedback and incorporated suggestions from APA Ethics and Legal Offices. BPA reviewed and approved the draft for release for a Call for Comments. In the Call for Comments, input was sought from all APA Divisions and individual members. COPPS presented the draft at APA Conventions on July 30, 2004 and August 11, 2006, seeking input from APA members. Comments and recommendations were incorporated by COPPS and a draft was submitted to BPA November 9, 2006. BPA approved the draft in principle and placed it on the agenda for Board of Directors approval in principle during its December 8-9, 2006 meeting. The Board of Directors approved the draft in principle December 9, 2006 and COPPS further revised the draft, incorporating BPA’s recommended changes, during its December 8-9, 2006 meeting and

32 Resources regarding HIPAA, and HIPAA compliance for psychologists, are available at the Health Human Services website (www.hhs.gov/ocr/hipaa/) and in documents prepared by the APA Practice Organization (APAPO), solely or in collaboration with the APA Insurance Trust (APAIT; APAPO, 2006a, 2006b, APAPO & APAIT, 2006).
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throughout the end of 2006. The final draft was forwarded to Council for its approval at its February, 2007 meeting and was approved on February 16, 2007.

Guidelines

1. Responsibility for records. Psychologists generally have responsibility for the and retention of their records.

Rationale. Psychologists have a professional and ethical responsibility to develop and maintain records (Ethics Code 6.01). The psychologist’s records document and reflect his or her professional work. In some circumstances, the records are the only way that the psychologist or others may know what the psychologist did and the psychologist’s rationale for those actions. As a consequence, the psychologist aspires to create records that are consistent with high quality professional work. If the psychologist is later questioned about services or billing, the availability of accurate records facilitates explanation and accountability.

Application. A psychologist makes efforts to see that legible and accurate entries are made in client records as soon as is practicable after a service is rendered. Psychologists are urged to organize their records in a manner that facilitates their use by the psychologist and other authorized persons. Psychologists ensure that supervisees, office staff, and billing personnel who handle records are appropriately trained regarding awareness of and compliance with ethical and legal standards related to managing confidential client information (Ethics Code 2.05; 6.02). Where appropriate, a psychologist maintains control over clients’ records, in accordance with the policies of the institution in which psychological services are provided and consistent with the (Ethics Code 6.01). To the degree there are conflicts between the institutional policies and procedures and the Ethics Code, psychologists appropriately address these issues as outlined in the Ethics Code (1.03), clarifying the nature of the conflict, making known their commitment to the Ethics Code, and to the extent feasible, resolving the conflict in a way that permits adherence to the Ethics Code.

2. Content of records. A psychologist strives to maintain accurate, current, and pertinent records of professional services as appropriate to the circumstances and as may be required by the psychologist’s jurisdiction. Records include information such as the nature, delivery, progress, and results of psychological services, and related fees.

Rationale. The Ethics Code (6.01) sets forth reasons why psychologists create and maintain records. Based on various provisions in the Ethics Code, in decision-making about content of records, a psychologist may determine what is necessary in order to (a) provide good care; (b) assist collaborating professionals in delivery of care; (c) ensure continuity of professional services in case of the psychologist’s injury, disability, or death or with a change of provider; (d) provide for supervision or training if relevant; (e) provide documentation required for reimbursement or required administratively under contracts or laws; (f) effectively document any decision-making, especially in high risk situations; and (g) allow the psychologist to effectively answer a legal or regulatory complaint.

Application. In making decisions about the content of records, the psychologist takes into account factors such as the nature of the psychological services, the source of the information recorded, the intended use of the records, and his or her professional obligations. Some hospitals, clinics, prisons, or research organizations mandate record format, specific data to be gathered and recorded, and time frames within which the records are to be created. A psychologist endeavors to include only information germane to the purposes for the service provided (Ethics Code 4.04). Additionally, consistent with the Ethics Code (Principle A), psychologists are sensitive to the potential impact of the language used in the record (e.g., derogatory terms, pathologizing language) on the client.

Considerations regarding the level of detail of the record: A psychologist makes choices about the level of detail in which the case is documented. Psychologists balance client care with legal and ethical requirements and risks. Information written in vague or broad terms may not be sufficient if more documentation is needed (e.g., for continuity of care, mounting an adequate defense against criminal, malpractice, or state licensing board complaints). However, some clients may express a desire for the psychologist to keep a minimal record in order to provide maximum protection and privacy. Although there may be advantages to keeping minimal records, for example in light of risk management concerns or concerns about unintended disclosure, there are alternately legitimate arguments for keeping a highly detailed record. Those may include such factors as improved opportunities for the treatment provider to identify trends or patterns in the therapeutic interaction, enhanced capacity to reconstruct the details of treatment for litigation purposes, and more effective opportunities to use supervision and consultation. The following issues may provide a guide to assist the psychologist in wrestling with these tensions:

The client’s wishes. For a variety of reasons, clients may express a wish that limited records of treatment be maintained. In some situations, the client may require limited record keeping as a condition of treatment. The psychologist then considers whether treatment can be provided under this condition.

Emergency or disaster relief settings. When psychologists provide crisis intervention services to people on emergency relief basis, the records that are created may be less substantial because of the situational demands. The psychologist may be guided by the oversight agency regarding necessary elements for the record. For example, disaster relief agencies may require only cursory identifying information, the date of service, a brief summary of the service provided, and the provider’s name. There may be limited opportunity to keep as detailed records as would be kept in a less urgent situation, particularly in the short-term or immediate crisis. In some situations, such as disaster relief following an airplane crash or a hurricane, no further intervention
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beyond the on-site contact may occur and, given the brevity and sheer number of services provided, highly detailed records may be impossible to construct even after the crisis.

**Alteration or destruction of records.** Many statutes, regulations, and rules of evidence prohibit the alteration or removal of information once a record has been made. In the context of litigation, addition or removal of information from a record that has been subpoenaed or requested by court order may create liability for the psychologist. Psychologists may wish to seek consultation regarding relevant state and federal law before changing an existing record. It is recommended that later additions made to a record be documented as such.

**Legal/regulatory.** Some statutes and regulations mandate inclusion or prohibit exclusion of particular information. For example, an institutional rule for record-keeping may prohibit reference to sealed juvenile records or to HIV test results, or a statute may govern disclosure of information about treatment for chemical dependency. The psychologist takes into account the statutes and regulations that govern practice and heeds mandates in making decisions about record detail.

**Agency/setting.** Psychologists providing psychological services within an institution consider institutional policies and procedures in making decisions about the level of detail in the record (See Guideline 10).

**Third-party contracts.** The psychologist considers whether the decision to maintain less detailed records deviates from contracts between the psychologist and third-party payors. Many third party payors contracts require specific information to be included within the record. Psychologists who sign but do not abide by contracts with such payors will potentially experience a number of adverse consequences (e.g., required reimbursement of previously received funds, legal actions).

**The record of psychological services may include information of three kinds.**

**Information in the client's file:**
- identifying data (e.g., name, client ID number);
- contact information (e.g., phone number, address, next of kin);
- fees and billing information;
- where appropriate, guardianship or conservatorship status;
- documentation of informed consent or assent for treatment (Ethics Code 3.10);
- documentation of waivers of confidentiality and authorization or consent for release of information (Ethics Code 4.05);
- documentation of any mandated disclosure of confidential information (e.g., report of child abuse, release secondary to a court order);
- presenting complaint, diagnosis, or basis for request for services;
- plan for services, updated as appropriate (e.g., treatment plan, supervision plan, intervention schedule, community interventions, consultation contracts).
- health and developmental history.

**For each substantive contact with a client:**
- date of service and duration of session;
- types of services (e.g., consultation, assessment, treatment, training);
- nature of professional intervention or contact (e.g., treatment modalities, referral, letters, e-mail, phone contacts);
- formal or informal assessment of client status;

**The record may also include other specific information, depending upon circumstances:**
- client responses or reactions to professional interventions;
- current risk factors in relation to dangerousness to self or others;
- other treatment modalities employed such as medication or biofeedback treatment;
- emergency interventions (e.g., specially scheduled sessions, hospitalizations);
- plans for future interventions;
- information describing the qualitative aspects of the professional/client interaction;
- prognosis;
- assessment or summary data (e.g., psychological testing, structured interviews, behavioral ratings, client behavior logs);
- consultations with or referrals to other professionals;
- case-related telephone, mail, and e-mail contacts;
- relevant cultural and sociopolitical factors.

3. **Confidentiality of records.** The psychologist takes reasonable steps to establish and maintain the confidentiality of information arising from service delivery.

**Rationale.** Confidentiality of records is mandated by law, regulation, and ethical standards (Ethics Code 4.01;6.02). The assurance of confidentiality is critical for the provision of many psychological services. Maintenance of confidentiality preserves the privacy of clients and promotes trust in the profession of psychology.

**Application.** The psychologist maintains records in such a way as to preserve their confidentiality. The psychologist develops procedures to protect the physical and electronic record from inadvertent or unauthorized disclosure (see Guideline 5). Psychologists are familiar with the ethical standards regarding confidentiality, as well as state and federal regulations and statutes.
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(e.g., HIPAA, licensing laws, mandated reporting of abuse). Psychologists strive to be aware of the legal and regulatory requirements governing the release of information (e.g., some jurisdictions prohibit the re-release of mental health, sexually transmitted diseases, or chemical dependency treatment records). When the psychologist employs clerical or testing personnel, he or she is required by the Ethics Code (2.05) to take reasonable steps to ensure that the employee’s work is done competently. Therefore, the psychologist strives to educate employees about confidentiality requirements and to implement processes that support the protection of records and the disclosure of confidential information only with proper consent or under other required circumstances (e.g., mandated reporting, court order).

Psychologists may encounter situations in which it is not immediately apparent who should have access to records. For example, children in treatment following marital dissolution may be brought for services by one parent who wishes the record to be kept confidential from the other parent, or an adolescent who is near but has not quite reached the age of majority may request that records be kept confidential from the parent/guardian. A minor may have the legal prerogative to consent to treatment (e.g., for reproductive matters), but the parent may nevertheless press for access to the record. The psychologist is guided by the Ethics Code (providing that psychologists may disclose information to a legally authorized person on behalf of the client/patient unless prohibited by law; Ethics Code 4.05) as well as by state and federal regulations in these matters. Following marital dissolution a psychologist may be unclear whether to release records to one of the parents, particularly when the release is not wanted by the other parent. In such a situation the psychologist recognizes that the relevant court overseeing the marital dissolution may have already specified who has access to the child’s treatment records.

4. Disclosure of record keeping procedures. When appropriate, psychologists inform clients of the nature and extent of record keeping procedures (including a statement on the limitations of confidentiality of the records; Ethics Code 4.02).

Rationale. Informed consent is part of the ethical and legal basis of professional psychology procedures (Ethics Code 3.10, 8.02, 9.03, & 10.01) and disclosure of record keeping procedures may be a part of this process.

Application. Consistent with the APA’s Ethics Code psychologists obtain and document informed consent appropriate to the circumstances at the beginning of the professional relationship. In some circumstances, when it is anticipated that the service recipient might want or need to know how records will be maintained, this process may include the disclosure of record keeping procedures. This may be especially relevant when record keeping procedures are likely to have an impact upon confidentiality or when the client’s expressed expectations regarding record keeping differ from the required procedures.

The manner in which records are maintained may potentially affect the client in ways that may be unanticipated by the client. Psychologists are encouraged to inform the client about these situations. For example, in some medical settings client records may become part of an electronic file that is accessible by a broad range of institutional staff (see Guideline 10). In some educational settings, institutional, state, and federal regulations dictate record keeping procedures that may expand the range of individuals who have access to the records of a school psychologist.

When a psychologist releases client records, with proper authorization to release information, they may be further distributed without the psychologist’s or the client’s consent. The psychologist may wish to alert the client of this potential at the outset of services or before consent for release is given. For example, after release in a litigation context, records may be placed in the public domain and accessible to any member of the public. Another example of unwanted re-release may occur when records are sent, at the client’s request, to another treating professional, whose handling of those records is then beyond the control of the psychologist who sent them.

5. Maintenance of records. The psychologist strives to organize and maintain records to ensure their accuracy and to facilitate their use by the psychologist and others with legitimate access to them.

Rationale. The usefulness of psychological service records often depends on the record being systematically updated and logically organized. Organization of client records in a manner that allows for thoroughness and accuracy of records, as well as efficient retrieval, both benefits the client and permits the psychologist to monitor ongoing care and interventions. In the case of the death or disability of the psychologist or of an unexpected transfer of the client’s care to another professional, current, accurate, and organized records allow for continuity of care (see Guideline 13).

Application. The psychologist is encouraged to update active records to reflect professional services delivered to the client and changes in the client’s status. The psychologist may use various methods to organize records to assist in storage and retrieval. Methods reflecting consistency and logic are likely to be most useful. For example, a logical file labeling system facilitates the search and recovery of records. The psychologist may consider dividing client files into two or more sections. Psychotherapy notes, as defined by HIPAA, are necessarily kept apart from other parts of the record. Additionally, client information that may be considered useful to others and that is intended to be shared with them may constitute a section. A psychologist may also consider, for purposes of convenience and organization, an additional section to include material generated by the client or by third parties, such as the client’s family members, or from prior treatment providers. This might include, among other things, behavioral ratings or logs, diaries, journals, letters from client’s children, pictures or videos, or greeting cards. Psychological test data, because it may bear more careful consideration before being released, may be clustered and designated, within the file, to ensure that its release is appropriately considered.
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A specific area of concern is the re-release of data that has been included in the client’s record. When the psychologist is releasing the client’s record, upon request and with consent, the psychologist is faced with the question of whether the client’s previous therapist’s records, for example, constitute a part of the record and should be released. The psychologist considers HIPAA regulations regarding psychotherapy notes,33 the breadth of the records requested, and the client’s wishes, along with the situational demands. For instance, when a psychologist is responding to a subpoena34 for “any and all records” upon which the psychologist relied in forming opinions, it is generally necessary to re-release any third party information included in the record. The psychologist may nevertheless provide advance notification to the client and allow sufficient time for objection to be raised before responding to such request for records.

6. Security. The psychologist takes appropriate steps to protect records from unauthorized access, damage, and destruction.

Rationale. Psychologists proceed with respect for the rights of individuals to privacy and confidentiality (Ethics Code, Principle E). Appropriate security procedures protect against the loss of or unauthorized access to the record, which could have serious consequences for both the client and psychologist.35 Access to the records is limited in order to safeguard against physical and electronic breaches of the confidentiality of the information. Advances in technology, especially in electronic record keeping, may create new challenges for psychologists in their efforts to maintain the security of their records (see Guideline 9).

Application. The psychologist strives to protect the security of the paper and electronic records he or she keeps and is encouraged to develop a plan to ensure that these materials are secure.36 In the security plan, two elements to be considered are the medium on which the records are stored and access to the records.

Maintenance. Psychologists are encouraged to keep paper records in a secure manner in safe locations where they may be protected from damage and destruction (e.g., fire, water, mold, insects). Condensed records may be copied and kept in separate locations so as to preserve a copy from natural or other disasters. Similarly, electronic records stored on magnetic and other electronic media may require protection from damage (e.g., electric fields or mechanical insult; power surges or outage; and attack from viruses, worms, or other destructive programs). Psychologists may plan for archiving of electronic data including file and system backups and off-site storage of data (See Guideline 9).

Access. Control of access to paper records may be accomplished by storing files in locked cabinets or other containers housed in locked offices or storage rooms. Psychologists protect electronic records from unauthorized access through security procedures (e.g., passwords, firewalls, data encryption and authentication). Consistent with legal and regulatory requirements and ethical standards (e.g., Ethics Code 6.02; HIPAA Privacy Rule and Security Rule), psychologists employ procedures to limit access of records to appropriately trained professionals and others with legitimate need to see the records.

7. Retention of records. The psychologist strives to be aware of applicable laws and regulations and to retain records for the period required by legal, regulatory, institutional, and ethical requirements.

Rationale. A variety of circumstances (e.g., requests from clients or treatment providers, legal proceedings) may require release of client records after the psychologist’s termination of contact with the client. Additionally, it is beneficial for the psychologist to retain information concerning the specific nature, quality, and rationale for services provided. In addition to the interests of the client and psychologist, the retention of records may serve not only the interests of the client and the psychologist, but also society’s interests in a fair and effective legal dispute resolution and administration of justice, when those records are sought to illuminate some legal issue such as the nature of the treatment provided, or the psychological condition of the service recipient at the time of services.

Application. In the absence of a superseding requirement, psychologists may consider retaining full records until 7 years after the last date of service delivery for adults or until 3 years after a minor reaches the age of majority, whichever is later. In some circumstances, the psychologist may wish to keep records for a longer period, weighing the risks associated with obsolete or outdated information, or privacy loss, versus potential benefits associated with preserving the records (See Guideline 8). There are inherent tensions associated with decisions to retain or dispose of records. Associated with these decisions are both costs and benefits for the recipient of psychological services and for the psychologist. A variety of circumstances can trigger requests for records even beyond 7 years after the psychologist’s last contact with the client. For example, an earlier record of

33 See HIPAA Privacy Rule.
35 For psychologists who are subject to HIPAA and keep electronic records, the Security Rule requires a detailed analysis of the risk of loss of, or unauthorized access to, electronic records and detailed policies and procedures to address those risks (for more details regarding the Security Rule, see referenced resources).
36 If the psychologist is subject to HIPAA and maintains electronic records, the HIPAA Security Rule will generally require the development of security policies and procedures for those records (for more details regarding the Security Rule see referenced resources).
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symptoms of a mental disorder might be useful in later diagnosis and treatment. In contrast, the client may be served by the
disposal of the record as soon as allowed. For example, the client may have engaged in behavior as a minor that, if later
disclosed, might prove demeaning or embarrassing. Also, retaining records over long intervals can be logistically challenging and
expensive for the psychologist. The psychologist is encouraged to carefully weigh these matters in making decisions to retain or
dispose of records.37
8. Preserving the context of records. The psychologist strives to be attentive to the situational context in which records are
created and how that context may influence the content of those records.
Rationale. Records may have a significant impact on the lives of clients (and prior clients). At times, information in a client’s
record is specific to a given temporal or situational context (e.g., the time frame and situation in which the services were
delivered and the record was created). When that context changes over time, the relevance and meaning of the information may
also change. Preserving the context of the record protects the client from the misuse or misinterpretation of that data in a way that
could prejudice or harm the client.
Application. When documenting treatment or evaluation, the psychologist is attentive to situational factors that may affect the
client’s psychological status. The psychologist is often asked to assess or treat individuals who are in crisis or under great
external stress. Those stresses may affect the client’s functioning in that setting, so that the client’s behavior in that situation may
not represent the client’s enduring psychological characteristics. For example, a child subjected to severe physical abuse may
produce low scores in a cognitive assessment that may not accurately predict the child’s future functioning. Or, a psychologist
writing a case summary regarding a client who had only been violent in the midst of a psychotic episode is careful to record the
context in which the behavior occurred. The psychologist strives to create and maintain records in such a way as to preserve
relevant information about the context in which the records were created.
9. Electronic records. Electronic records, like paper records, should be created and maintained in a way that is designed to
protect their security, integrity, confidentiality, and appropriate access, as well as their compliance with applicable legal and
ethical requirements.
Rationale. The use of electronic methods and media compels psychologists to become aware of the unique aspects of electronic
record keeping in their particular practice settings. These aspects include limitations to the confidentiality of these records,
methods to keep these records secure, measures necessary to maintain the integrity of the records, and the unique challenges to
disposing of these records. In many cases, psychologists who maintain electronic records will be subject to the HIPAA Security
Rule, which requires a detailed analysis of the risks associated with electronic records. Conducting that risk analysis may be
advisable even for psychologists who are not technically subject to HIPAA. The HIPAA Privacy Rules and Security Standards
provide assistance to the practitioner in scrutinizing office practices such as: assuring that PHI is handled in a way designed to
protect the privacy of recipients; defining proper deidentification of case information for research or other purposes when
deidentification is in order; and clearly defining the elements required in an authorization to release information. The discussion
in this section addresses considerations beyond the requirements of the Security Rule.
Whether or not the Security Rule applies, rapid changes in the technology of service delivery, billing, and media storage, have
prompted psychologists to consider how to apply existing standards of psychological record keeping using these methods and
media. Psychologists struggle with questions such as whether to communicate with clients through e-mail and how to allow for the
secure transmission, storage, and destruction of electronic records. The ease of creating, transmitting, and sharing electronic
records may expose psychologists to risks of unintended disclosure of confidential information.
Application. Psychologists may develop secure procedures that fit the specific circumstances in which they work. Psychologists
using online test administration and scoring systems may consider using a case identification number rather than the client’s Social Security number as the record identifier. Psychologists using computers, or other digital or electronic storage
devices, to maintain client treatment records may consider using passwords or encryption to protect confidential material.38 The
psychologist strives to become aware of special issues associated with using electronic methods and media and seeks training and
consultation when necessary.39
10. Record keeping in organizational settings. Psychologists working in organizational settings (e.g., hospitals, schools,
community agencies, prisons) strive to follow the record-keeping policies and procedures of the organization, as well as the
Ethics Code.
Rationale. Organizational settings may present unique challenges in record keeping. Organizational record keeping requirements
may differ substantially from procedures in other settings. Psychologists working in organizational settings may encounter

37 The HIPAA Security Rule, if applicable, sets forth specific requirements and considerations for the disposal of electronic patient information and
computers and devices that contain such information (for more details regarding the Security Rule see referenced resources).

38 The reader may wish to consult the Security Rule for further guidance on this issue.

39 See Security Rule information in referenced resources.
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conflicts between the practices of their organization and established professional guidelines, ethical standards, or legal and regulatory requirements. Additionally, record ownership and responsibility is not always clearly defined. Often, multiple service providers access and contribute to the record. This potentially affects the degree to which the psychologist may exercise control of the record and its confidentiality.

**Application.** Three record keeping issues arise when psychologists provide services in organizational settings: conflicts between organizational and other requirements, ownership of the records, and access to the records.

The psychologist may consult with colleagues in the organization to support record keeping that serves the needs of different disciplines and while meeting acceptable record keeping requirements and guidelines. In addition, the psychologist may review local, state, and federal laws and regulations that pertain to that organization and its record keeping practices. In the event that there are conflicts between an organization’s policies and procedures and the Ethics Code, psychologists clarify the nature of the conflict, make their ethical commitments known, and to the extent feasible, resolve the conflict consistent with those commitments (Ethics Code, 1.03).

Record-keeping practices may depend upon the nature of the psychologist’s legal relationship with the organization. In some settings, the physical record of psychological services is owned by the organization and does not travel with the psychologist upon departure. However, in consultative relationships, record ownership and responsibility may be maintained by the psychologist. It is therefore helpful for psychologists to clarify these issues at the beginning of the relationship in order to minimize the likelihood of misunderstandings.

Often, rules for record creation and maintenance reflect requirements of all relevant disciplines, not only those related to psychological services. Treatment team involvement in service delivery may occasion wider access to records than usually exists in independent practice settings. Because others (e.g., physicians, nurses, paraprofessionals, and other service providers) may have access to and make entries into the client’s record, the psychologist has less direct control over the record. Psychologists are encouraged to participate in development and refinement of organizational policies involving record keeping.

It is important to note that multidisciplinary records may not enjoy the same level of confidentiality generally afforded psychological records. The psychologist working in these settings is encouraged to be sensitive to this wider access to the information and to record only information congruent with organizational requirements and necessary to accurately portray the services provided. In this situation, if permitted by institutional rules and legal and regulatory requirements, the psychologist may keep more sensitive information, such as therapy notes, in a separate and confidential file.

11. **Multiple client records.** The psychologist carefully considers documentation procedures when conducting couple, family, or group therapy in order to respect the privacy and confidentiality of all parties.

**Rationale.** In providing services to multiple clients, issues of record keeping may become very complex. Because records may include information about more than one individual service recipient, legitimate disclosure of information regarding one client may compromise the confidentiality of other service recipients.

**Application.** The psychologist strives to keep records in ways that facilitate authorized disclosures while protecting the privacy of clients. In services involving multiple individuals, it may be important to specify the identified client(s) (Ethics Code 10.02; 10.03). There are a number of further concerns regarding record keeping with multiple clients. First, the information provided to clients as part of the informed consent process at the onset of the professional relationship (Ethics Code 10.02) may include information about how the record is kept (e.g., jointly or separately) and who can authorize its release. In considering the creation of records for couple, family, or group therapy, the psychologist may first seek to clarify the identified service recipient(s). In some situations, such as group therapy, it may make sense to create and maintain a complete and separate record for all identified clients. On the other hand, if a couple or family is the identified client, then one might keep a single record. This will vary depending upon practical concerns, ethical guidelines, and third party reporting requirements. Upon later requests for release of records, it will be necessary to release only the portions relevant to the party covered by the release. Given this possibility, the psychologist may choose to keep separate records on each participant from the outset. The psychologist endeavors to become familiar with legal and regulatory requirements regarding the release of a record containing information about multiple service recipients.

12. **Financial records.** The psychologist strives to ensure accuracy of financial records.

**Rationale.** Accurate and complete financial record-keeping helps to assure accuracy in billing (Ethics Code 6.04; 6.06). A fee agreement or policy, although not explicitly required for many kinds of psychological services such as pre-employment screening under agency contract or emergency counseling services at a disaster site, provides a useful starting point in most service delivery contexts for documenting reimbursement of services. Accurate financial records not only assist payers in assessing the nature of the payment obligation, but also provide a basis for understanding exactly which services have been billed and paid. Up-to-date

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40 In order for therapy notes to have heightened protection as “psychotherapy notes” as defined by the HIPAA Privacy Rule, the notes must be kept separate from the rest of the record. If they are psychotherapy notes, only the psychologist who took the notes can access them, absent a HIPAA-complaint authorization from the client (for more details regarding the Privacy Rule see referenced resources).
APPENDIX 21 (continued)

record-keeping can alert the psychologist and the service recipient to accumulating balances that, left unaddressed, may adversely affect the professional relationship.

**Application.** Financial records may include, as appropriate, the type and duration of the service rendered, the name of the service recipient, fees paid for the service, and agreements concerning fees, along with date, amount, and source of payment received.

Special consideration may be given to: fee agreements and policies, barter agreements, issues relating to adjusting balances, issues concerning co-payments, and concerns about collection.

*Fee agreement or fee policy.* The financial record for services may begin with a fee agreement or fee policy statement that identifies: the amount to be charged for service and the terms of any agreement for payment. The record may potentially include who is responsible for payment, how “missed appointments” will be handled, acknowledgement of any third-party payer pre-authorization requirements, any agreement regarding co-pay and adjustments to be made, payment schedule, interest to accrue on unpaid balance, suspension of confidentiality when collection procedures are employed, and the methods by which financial disputes may be resolved (Ethics Code 6.04).

*Barter agreements and transactions.* Accurately recording bartering agreements and transactions helps ensure that the record clearly reflects how the psychologist was compensated. Designation of the source, nature, and date of each financial or barter transaction facilitates clarification when needed, regarding the exchange of goods for service. Because of the potential for the psychologist to have greater power in the negotiation of bartering agreements, careful documentation protects both the psychologist and the client. Such documentation may reflect the psychologist’s basis for concluding, at the onset, that the arrangement is neither exploitative nor clinically contraindicated (Ethics Code 6.05).

*Adjustments to balance.* It is helpful to designate the rationale for, description of, and date of any adjustments to the balance that are made as a result of agreement with a third-party payer or service recipient. This may reduce potential misunderstanding or perceived obligations that might affect the relationship.

*Collection.* Psychologists may consider including in the record information about collection efforts, including documentation of notification of the intention to use a collection service.

13. **Disposition of Records.** The psychologist plans for transfer of records to ensure continuity of treatment and appropriate access to records when the psychologist is no longer in direct control and, in planning for record disposal, the psychologist endeavors to employ methods that preserve confidentiality and prevent recovery. 41

**Rationale.** Client records are accorded special treatment in times of transition (e.g., separation from work, relocation, death). A record transfer plan is required by both the Ethics Code (6.02), and by laws and regulations governing health care practice in many jurisdictions. Such a plan provides for continuity of treatment and preservation of confidentiality. Additionally, the Ethics Code (6.01; 6.02) requires psychologists to dispose of records in a way that preserves their confidentiality.

**Application.** The psychologist has two responsibilities in relation to the transfer and disposal of records. In anticipation of unexpected events, such as disability, death, or involuntary withdrawal from practice, the psychologist may wish to develop a disposition plan in which provisions are made for the control and management of the records by a trained individual or agency. In other circumstances, when the psychologist plans in advance to leave employment, close a practice, or retire, similar arrangements may be made or the psychologist may wish to retain custody and control of client records.

In some circumstances, the psychologist may consider a method for notifying clients about changes in the custody of their records. This may be especially important for those clients whose cases are open or who have recently terminated services. The psychologist may consider including in the disposition plan, in accordance with legal and regulatory requirements, a provision for providing public notice about changes in the custody of the records, such as placing notice in the local newspaper.

Considerations of record confidentiality are critical when planning for disposal of records. For example, in transporting records to be shredded, the psychologist may take care that confidentiality of the records is maintained. Some examples of this effort might be accompanying the records through the disposal process or establishing a confidentiality agreement with those responsible for records disposal. When considering methods of record destruction, the psychologist seeks methods, such as shredding, that prevent recovery. Disposal of electronic records poses unique challenges because the psychologist may not have the technical expertise to fully delete or erase records, for example, before disposing of a computer hard drive, external back-up storage device, or other repository for electronic records. Even though efforts to delete or erase records may be undertaken, the records may nevertheless remain accessible by those with specialized expertise. The psychologist may seek consultation from technical consultants regarding adequate methods for destruction of electronic records, such as physically destroying the entire medium or wiping clean (demagnetizing) the storage device. 42

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41 See Security Rule information in referenced resources.

42 See referenced resources regarding HIPAA Security Rule requirements for the disposal of electronic records.
APPENDIX 21 (continued)

Conclusion

These “Record Keeping Guidelines” provide a framework for keeping, maintaining, and providing for the disposition of records and what is contained in them. They discuss special situations: electronic records, organizational settings, and multiple clients. They are intended to benefit both the psychologist and the client by facilitating continuity and evaluation of services, preserving the client’s privacy, and protecting the psychologist and client in legal and ethical proceedings.

These guidelines do not establish rules for practice, but rather provide an overall conceptual model and strategies for resolving divergent considerations. The demands of professional settings are varied and complex. It would not be feasible to establish detailed guidelines for record creation, maintenance, and disposition that would be relevant for each setting. The current document may provide useful guidance for various professional applications. Where standards and legal and regulatory codes exist, they take precedence over these guidelines.

RECORD KEEPING GUIDELINE BIBLIOGRAPHY

The authors considered the following reference materials and relied upon those with obvious authority (for example, the Ethics Code and HIPAA) while also consulting those that provided relevant guidance (APA guidelines; professional publications). This is not an exhaustive list of sources that psychologists may find useful in determining the best course of action in record keeping, and is not intended to be representative of the entire body of knowledge that can guide decision-making. It does represent, however, a solid basis for consideration that, in combination with state and federal regulations, may provide an adequate framework for record keeping.

General References:

APPENDIX 21 (continued)

Content


Disposition of Records


Informed Consent


Multiple Client Records


Technology


Privacy and Confidentiality


HIPAA Resources


APPENDIX 22

APA MEDICARE DOCUMENTATION REQUIREMENTS

As a general rule, it is necessary to keep careful records on Medicare beneficiaries. Post-payment audits are common and psychologists must be prepared to document that they followed Medicare rules and that the services were "reasonable and necessary." Medicare does not pay for routine services (preventive or screening) so documenting presenting symptoms is important. As mentioned in other sections, documentation of circumstances surrounding non-collection of copayments and documentation regarding consultation are also very important.

Basic Requirements

There are no national policies regarding documentation guidelines for psychological services. In light of this, several Medicare carriers have outlined specific documentation requirements through their respective local medical review policies (LMRPs). The following list of elements is a sample of such requirements as they appear in various LMRPs. These are not exhaustive lists and do not guarantee that you will not be audited! Your best strategy is to locate a comprehensive policy for the carrier with jurisdiction in your area.

The most basic element for all documentation is that it must be LEGIBLE. You must also be sure to have the appropriate patient and provider identifiers, the date, diagnoses, and service provided (CPT code). In addition, listed below are elements for two specific types of services.

Psychiatric Diagnostic Interview Examination CPT 90791
Presenting complaint
Background information and history of present illness
Social and Family History
Present evaluation
Clinical observations and detailed mental status examination
Assessment and recommendations including plan for future follow-up

Individual Psychotherapy
CPT 90832- 30 minutes, i.e., 17-36 minutes)
CPT 90834- 45 minutes, i.e., 34-52 minutes)
CPT 90837- 60 minutes, i.e., 53 or more minutes)
Type of therapeutic techniques and approaches used
List of general topics addressed
Risk factors
Briefly, how present session relates to therapeutic treatment goals

The American Psychological Association (APA) has also developed Record Keeping Guidelines that can be found on our website at: [http://www.apa.org/practice/recordkeeping.html](http://www.apa.org/practice/recordkeeping.html), although these are generic in nature rather than specific to Medicare.

APPENDIX 23
UNIVERSITY OF MINNESOTA MEDICAL CENTER

STATEMENT OF CONFIDENTIALITY

By my execution of this Statement of Confidentiality, I hereby acknowledge my responsibility under applicable state and federal law and this Master Clinical Student Affiliation Agreement to keep confidential any information regarding FACILITY patients, clients and any other confidential information that I may encounter while participating in the Clinical Experience program offered at the FACILITY. I agree, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any FACILITY patient or patient except as required or permitted by law.

INDEMNITY

I agree that I shall defend, indemnify, and hold the FACILITY harmless from any and all claims, actions, liabilities, and expenses (including costs of judgments, settlements, court costs, and reasonable attorneys' fees) regardless of the outcome of such claim or action, caused by, resulting from, or based upon my intentional or unintentional violation of this Statement of Confidentiality. Upon notice from the indemnified party or parties, I shall defend against, at my expense, any such claim or action, provided that my selection of counsel shall be subject to the indemnified party or party's approval, and the indemnified party or parties shall have the right to participate in the defense and to approve my settlement.

This Statement of Confidentiality shall survive termination or expiration of the Master Clinical Student Affiliation Agreement.

Dated this _____ day of __________, 201__.

By: __________________________________________________________
    Signature

Printed Name: __________________________________________________

Witness Name: __________________________________________________

Witness Signature: ______________________________________________
Organizational Chart

Jakub Tolar, M.D.
Dean

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Joe Neglia, M.D.
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Dr. Bill Robiner
Internship Director

Drs. Lingras, Pisetsky, Wozniak, & Zagoloff

Pediatric Psychology
Drs. Boys & Gross

Pediatric Neuropsychology
Drs. Eisengart, King, Kunin-Batson, Pierpont, Ziegler

Kayla Kranitz
Internship Coordinator

Emily Gray, Rob Super, Brett Steger, Suzanne Timm
# APPENDIX 25

## QUICK REFERENCE TO PSYCHIATRIC MEDICATIONS

**DEVELOPED BY JOHN PRESTON, P.S.I.B., ABPP AND BRENT A. MOORE, P.S.I.B., ABPP**

To the best of our knowledge, recommended doses and side effects listed below are accurate. However, this is meant as a general reference only and should not serve as a guideline for prescribing of medications. Please check the manufacturer's product information sheet or the PDR for any changes in dosage schedule or contraindications. (Brand names are registered trademarks.)

### ANTIDEPRESSANTS

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### PSYCHO-STIMULANTS

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### PSYCHO-STIMULANTS

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<td>methylphenidate</td>
<td>Daypro (patch)</td>
<td>15-30 mg</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>methylphenidate</td>
<td>Quillivant XR (liquid)</td>
<td>10-60 mg</td>
<td></td>
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</tr>
<tr>
<td>dextroamphetamine</td>
<td>Focalin</td>
<td>4-50 mg</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Notes

1. Sustained release
2. Available in 625, 650, 1250, and 1500mg formulations

### Author's Note

The information provided in this appendix is intended for educational purposes only and should not be used as a substitute for professional medical advice. Always consult a qualified healthcare professional for diagnosis and treatment of mental health conditions. The dosages and side effects listed may vary depending on the specific formulation and patient factors. Always read the product information provided by the manufacturer and consider the potential for interactions with other medications. This appendix is updated regularly to reflect the latest information available, but it is not a substitute for ongoing professional care. Seek the advice of your healthcare provider before making any changes to your medication regimen.
### ANTIPSYCHOTICS

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Dosage Range</th>
<th>Sedation</th>
<th>Ortho</th>
<th>EPS</th>
<th>ACH Effects</th>
<th>Equivalence</th>
</tr>
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<tbody>
<tr>
<td><strong>LOW POTENCY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>chlorpromazine</td>
<td>Thorazine</td>
<td>50-800 mg</td>
<td>high</td>
<td>high</td>
<td>+</td>
<td>+++</td>
<td>100 mg</td>
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<td>thioridazine</td>
<td>Mellaril</td>
<td>150-500 mg</td>
<td>high</td>
<td>+</td>
<td>+</td>
<td>+++</td>
<td>100 mg</td>
</tr>
<tr>
<td>clozapine</td>
<td>Clozaril</td>
<td>300-900 mg</td>
<td>high</td>
<td>0</td>
<td>+</td>
<td>+++</td>
<td>50 mg</td>
</tr>
<tr>
<td>quetiapine</td>
<td>Seroquel</td>
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<td>mid</td>
<td>mid</td>
<td>+</td>
<td>/0</td>
<td>50 mg</td>
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<td><strong>HIGH POTENCY</strong></td>
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<td></td>
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<td></td>
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<td>perphenazine</td>
<td>Trilafon</td>
<td>8-60 mg</td>
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<td>mid</td>
<td>+</td>
<td>+++</td>
<td>10 mg</td>
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<tr>
<td>loxapine</td>
<td>Loxtane</td>
<td>50-250 mg</td>
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<td>high</td>
<td>+</td>
<td>+++</td>
<td>10 mg</td>
</tr>
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<td>trifluoperazine</td>
<td>Stelazine</td>
<td>2-40 mg</td>
<td>low</td>
<td>mid</td>
<td>+</td>
<td>+++</td>
<td>5 mg</td>
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<td>fluphenazine</td>
<td>Prolixin</td>
<td>3-45 mg</td>
<td>low</td>
<td>mid</td>
<td>+</td>
<td>+++</td>
<td>2 mg</td>
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<tr>
<td>thiothixene</td>
<td>Navane</td>
<td>10-60 mg</td>
<td>low</td>
<td>mid</td>
<td>+</td>
<td>+++</td>
<td>5 mg</td>
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<tr>
<td>haloperidol</td>
<td>Haldol</td>
<td>2-40 mg</td>
<td>mid</td>
<td>low</td>
<td>+</td>
<td>+++</td>
<td>2 mg</td>
</tr>
<tr>
<td>pimozide</td>
<td>Orap</td>
<td>1-10 mg</td>
<td>mid</td>
<td>low</td>
<td>+</td>
<td>+++</td>
<td>2 mg</td>
</tr>
<tr>
<td>risperidone</td>
<td>Risperdal</td>
<td>4-16 mg</td>
<td>low</td>
<td>mid</td>
<td>+</td>
<td>+++</td>
<td>1-2 mg</td>
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<tr>
<td>paliperidone</td>
<td>Invega</td>
<td>3-12 mg</td>
<td>low</td>
<td>low</td>
<td>+</td>
<td>+++</td>
<td>1-2 mg</td>
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<tr>
<td>olanzapine</td>
<td>Zyprexa</td>
<td>5-20 mg</td>
<td>low</td>
<td>low</td>
<td>+</td>
<td>++</td>
<td>1-2 mg</td>
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<td>ziprasidone</td>
<td>Geodon</td>
<td>60-160 mg</td>
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<td>/0</td>
<td>10 mg</td>
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<td>iloperidone</td>
<td>Fanapt</td>
<td>12-24 mg</td>
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<td>low</td>
<td>+</td>
<td>++</td>
<td>1-2 mg</td>
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<tr>
<td>aripiprazole</td>
<td>Ability</td>
<td>15-30 mg</td>
<td>low</td>
<td>low</td>
<td>+</td>
<td>++</td>
<td>2 mg</td>
</tr>
</tbody>
</table>

1. Used daily oral dosage
2. Orthostatic Hypotension: Dizziness and falls
3. Acute Parkinson’s-like symptoms, akathisia. Does not reflect risk for tardive dyskinesia. All neuroleptics may cause tardive dyskinesia, except clozapine.
4. Dose required to achieve efficacy of 100 mg chlorpromazine.
5. Available in time-release 24-hour format.

### ANTI-ANXIETY

<table>
<thead>
<tr>
<th>Name</th>
<th>Brand</th>
<th>Single Dose</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BENZODIAZEPINES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diazepam</td>
<td>Valium</td>
<td>2-10 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>chlordiazepoxide</td>
<td>Librium</td>
<td>10-50 mg</td>
<td>25 mg</td>
</tr>
<tr>
<td>lorazepam</td>
<td>Tranxene</td>
<td>3.75-15 mg</td>
<td>10 mg</td>
</tr>
<tr>
<td>clonazepam</td>
<td>Klonopin</td>
<td>0.5-2.0 mg</td>
<td>0.25 mg</td>
</tr>
<tr>
<td>alprazolam</td>
<td>Alivan</td>
<td>0.5-2.0 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>oxazepam</td>
<td>Xanax, XR</td>
<td>0.25-2.0 mg</td>
<td>0.5 mg</td>
</tr>
<tr>
<td><strong>OTHER ANTI-ANXIETY AGENTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>buspirone</td>
<td>BuSpar</td>
<td>5-20 mg</td>
<td></td>
</tr>
<tr>
<td>gabapentin</td>
<td>Neurontin</td>
<td>200-600 mg</td>
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<tr>
<td>hydroxyzine</td>
<td>Atarax, Vistaril</td>
<td>10-50 mg</td>
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<tr>
<td>propranolol</td>
<td>Inderal</td>
<td>10-80 mg</td>
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<td>atenolol</td>
<td>Tenormin</td>
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<tr>
<td>guanfacine</td>
<td>Tenex, Intuniv</td>
<td>0.5-3 mg</td>
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<tr>
<td>clonidine</td>
<td>Catapress, Kapry</td>
<td>0.1-0.3 mg</td>
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<tr>
<td>prazosin</td>
<td>Minipress</td>
<td>5-20 mg</td>
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</table>

1. Doses required to achieve efficacy of 5 mg of diazepam
2. For treatment of nightmares only

### HYPNOTICS

<table>
<thead>
<tr>
<th>Name</th>
<th>Brand</th>
<th>Single Dose</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BENZODIAZEPINES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>temazepam</td>
<td>Restoril</td>
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<td>triazolam</td>
<td>Halcion</td>
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<td>zolpidem</td>
<td>Ambien</td>
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<td>zolpidem</td>
<td>Intermezzo</td>
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<td>zaleplon</td>
<td>Sonota</td>
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<td>eszopiclone</td>
<td>Lunesta</td>
<td>1-3 mg</td>
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<tr>
<td>ramelteon</td>
<td>Rozerem</td>
<td>4-16 mg</td>
<td></td>
</tr>
<tr>
<td>diphenhydramine</td>
<td>Benadryl</td>
<td>25-100 mg</td>
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### OVER THE COUNTER

<table>
<thead>
<tr>
<th>Name</th>
<th>Daily Dose</th>
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<tr>
<td>St. John’s Wort</td>
<td>600-1800 mg</td>
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<tr>
<td>SAM-e</td>
<td>400-1600 mg</td>
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<tr>
<td>Omega-3-6-EPA</td>
<td>1-2 g</td>
</tr>
<tr>
<td>Folic acid</td>
<td>500 mg</td>
</tr>
<tr>
<td>N-acetylcysteine</td>
<td>1200-2400 mg</td>
</tr>
<tr>
<td>Chamomile</td>
<td>200-600 mg</td>
</tr>
<tr>
<td>5-HTP</td>
<td>300-600 mg</td>
</tr>
</tbody>
</table>

1. Treats depression and anxiety
2. May cause significant drug-drug interactions
3. Treats depression
4. Treats depression and bipolar disorder
5. For relaxation/insomnia
6. Treats anxiety-equivalent
7. Treats depression

### REFERENCES and RECOMMENDED BOOKS

Quick Reference • Free Downloads
Website: www.PsyD-fx.com

- **Handbook of Clinical Psychopharmacology For Therapists** (2013) Preston, O’Neal and Talaga
- **Clinical Psychopharmacology Made Ridiculously Simple 7th Edition** (2013) Preston and Johnson
- **Consumer’s Guide to Psychiatric Drugs** (2009) Preston, O’Neal, Talaga
- **Child and Adolescent Psychopharmacology Made Simple** (2010) Preston, O’Neal, Talaga
APPENDIX 26

APPIC GUIDANCE FOR PREGNANCY AND FAMILY CARE ISSUES DURING INTERNSHIP AND POSTDOCTORAL RESIDENCY TRAINING

Developed by: Nadine Kaslow, Ph.D. Nancy Garfield, Ph.D., Joyce Illfelder-Kaye, Ph.D. and Mona Mitnick, J.D.

This document does not constitute APPIC policy but, rather, is guidance. We provide this document as a service to our members, subscribers, applicants, and trainees. It is intended only to be for informational purposes and to provide general suggestions and guidance in response to frequently-asked questions from students, staff/faculty, and institutions. This document does not offer an exhaustive discussion of all situations that may arise during the course of the internship or postdoctoral training experience. Therefore, each program and trainee may want to consult their own legal counsel for guidance on specific questions or situations.

If you have questions regarding any of these matters, please contact the person responsible for APPIC’s informal problem resolution process. The name of this individual can be found on the APPIC website, www.appic.org or by contacting APPIC’s Central Office at (202) 589-0600.

Pregnancy and family care issues arise frequently during the internship and postdoctoral training years. In this document, we begin by providing some relevant legal principles and guidelines that may impact trainees and programs as they face issues related to pregnancy and family care. We then offer a framework for considering best practices building upon relevant legal requirements; training experiences in multiple settings; and a commitment to balancing legal rights and responsibilities, institutional demands and climate, and the best interests of the family. Our goals are to help trainees balance their work and family responsibilities by taking reasonable unpaid leave for certain family and medical reasons, promote equal training opportunities for women and men, and accommodate the legitimate interests of the sites.

Legal Issues

In the United States, the Family Medical Leave Act (FMLA) is the legislation most relevant to this discussion. However, this statute applies only to employers with more than 50 employees and only after someone is employed for one year. Thus, FMLA technically would only be relevant to individuals completing their postdoctoral fellowship training at the same sites at which they completed their internship training. Another relevant statute is the Pregnancy Discrimination Act, which amends the Civil Rights Act to make discrimination based on pregnancy a form of sex discrimination. Sites do not have to treat pregnant applicants, interns, or post-docs more favorably than non-pregnant employees, but only as well as they treat non-pregnant employees. Many states have similar prohibitions against pregnancy discrimination. Although some of these pieces of legislation may not technically apply to interns or postdoctoral fellows (e.g., FMLA), they offer useful guiding principles. For example, the FMLA provides that an employee is entitled to a total of 12 weeks unpaid, job-protected leave during a 12-month period for the birth or adoption of a child or to care for a family member with a serious health condition. If an employer provides paid leave, the trainee may be required to substitute all or part of that leave for the FMLA-authorized leave. FMLA requires that group health benefits be maintained during the leave. Also in the United States, specific institutional policies for both the training site and the larger institutional entity regarding parental leave and childcare also may be relevant. In addition, a number of states have also enacted family and medical leave laws, some of which provide greater amounts of leave and benefits than those provided by FMLA, and/or provide benefits to individuals who are not eligible for FMLA leave. In those situations where a person is covered by both federal and state FMLA laws (e.g., has been employed at the same site for > 1 year and the site has > 50 employees), the person is entitled to the greater benefit or more generous rights provided under the different parts of each law.

In Canada, to qualify for maternal or parental benefits, regular weekly earnings must have been decreased by more than 40% and the person must have accumulated 600 insured hours in the last 52 weeks or since his/her last claim. He/she may receive a maximum of 15 weeks maternity benefits; 35 weeks of parental benefits; and 15 weeks of sickness benefits. In some situations, the person may receive a combination of benefits for a maximum of 50 weeks; and in certain limited situations a combination of benefits for a maximum of 65 weeks.

Guiding Framework

We hope that the framework we provide below will be useful in a variety of situations, including but not limited to: pregnancy and childbirth, including a complicated pregnancy; adoption; and caring for a sick family member. We recommend that decisions be negotiated between the site and the trainee, in consultation with institutional human resource personnel. To the extent possible, we encourage these negotiations to take into consideration the “best interests” of the parents/caregivers, the child, and other relevant family members. What is reasonable and good for the family should be considered seriously. Similarly, the needs of the site should be considered including, but not limited to, institutional physical and financial resources (e.g., space, equipment, payment and benefits flexibility), supervisory resources, the nature of the training program (e.g., seminar schedule, supervision), and cohort issues. With regard to the trainee, these negotiations should consider training needs and requirements (e.g., the numbers of hours necessary for licensure), feasibility considerations, family demands and resources, and the emotional demands of the situation. In general, it is important to balance the best interests of the family, the institutional context, and the legal rights and responsibilities of all concerned.
APPENDIX 26 (continued)

A compassionate and creative approach is desirable to create a win-win solution. For example, we encourage programs to work with trainees so that they can take a reasonable amount of time off to facilitate the attachment process with their newborns and in recognition of the physical demands often associated with having young infants.

Sites and trainees are encouraged to work together to develop a flexible plan for leave and return to work. As a rule of thumb, interns and postdoctoral fellows typically are granted up to six weeks of childcare or other family medical leave time, although depending on the work site, they may be able to negotiate up to 12 weeks. For example, some trainees and sites may determine that it would be advantageous for all concerned if the trainee took off four weeks full time and then returned to work half time for the following four weeks. In other situations, having the trainee at home with the child for six weeks full time may be the most appropriate plan. These recommendations are relevant to primary caregivers who may be mothers or fathers, same sex partners, and persons who adopt children (hereafter parents). For secondary caregivers (as defined by the family), the typical guideline is two weeks time off. Once the trainee returns to work, the site and trainee may develop a plan of flexible work hours that allows the trainee to spend key times with her/his child. A similarly flexible approach should be applied in instances in which there is a family member with a serious health condition. These situations may in fact require greater flexibility than pregnancy and childcare due to their inherent unpredictability. Sometimes, in either pregnancy or childcare or caring for a family member with a serious health condition, flexibility means arranging for a part-time training experience of longer duration. Depending on the jurisdiction in which the training occurs and the expectations of the site, some individuals choose to work longer hours to assure they have the requisite number of hours for licensure.

In certain situations, to best meet the needs of the trainee and her/his family, deferral of an internship or postdoctoral fellowship may be the best plan. There are strategies that can be used for interns and intern applicants through the APPIC Match process to work with trainees and sites to facilitate the deferral process, without having either the trainee or the site violate APPIC Match Policies. Consultation should be sought from APPIC in these instances. It should be noted that in certain circumstances (e.g., maternity leave), the deferral process in Canada must comply with Canadian law. Since there is no postdoctoral match, the site and the trainee may negotiate an agreement regarding deferment.

If the trainee uses vacation time and/or sick leave time for pregnancy or family care leave, they should not be required to make that time up. However, the trainee and site must ensure that the trainee works for the requisite number of hours to ensure eligibility for licensure and the completion of the minimum number of hours required for satisfactory completion of the training program. Questions often emerge regarding the compensation of trainees who take time off for the above purposes during their internship or postdoctoral fellowship year. Typically, it is most reasonable for sites, given budget cycles, to pay the trainee for the year she/he was contracted to work, with a written agreement between the site and the trainee about the additional time the trainee will work after the compensation ends. In the case of sites in which it is possible to have compensation parallel the actual dates the trainee is working, this may be the optimal plan. In either case, it is useful to work toward the trainee having benefits (e.g., healthcare) while employed and while putting in the additional hours. In addition, it is essential that sites that normally provide liability coverage continue to provide such coverage during the extension period as well. Issues may arise relating to the structure, content, and process of the training experience for those individuals who miss some of their internship or postdoctoral fellowship for family reasons. These include, but are not limited to: consideration of responsibilities upon their return, didactics, cohort issues, etc. The training staff/faculty should work with the trainee to determine the best course of action for handling each of these challenges. The handling of such matters often depends upon the timing in the training year, the nature of the training program, availability of resources, etc.

APPIC is willing to consult with individual sites and trainees regarding such questions. Many trainees ask when they need to inform sites that they may need time off or other forms of flexibility. This is a complex question, with no clear answer. Ideally, sites should be informed as early as is reasonably possible. If a trainee does not believe that a site will be flexible and understanding, it may not be the optimal site for them. Interns should remember the binding nature of the APPIC Match when submitting their rank order lists. Sites need to remember that it is not acceptable to ask prospective employees about their health, pregnancy status, or family status during the interview process. However, once the prospective trainee raises these issues, they may be open for discussion. Again, APPIC is more than willing to consult with trainees and prospective trainees regarding this issue. Some students have asked if they should inform sites if they plan to get pregnant. There is no need to discuss this ahead of time.

APPENDIX 27

INTERNSHIP AIMS, COMPETENCIES, TRAINING AND OUTCOMES

The program is designed broadly to prepare trainees for the practice of clinical psychology with child and adolescent populations based generally on the scientist-practitioner model. The intention of the educational, supervisory, and clinical activities of the program are to promote students’ professional functioning and acquisition of relevant skill and knowledge to prepare them for professional practice. The table below documents outlining the aims and competencies of the Internship.

In general, the Internship is dedicated to preparing psychologists with the requisite knowledge and skills for entry into the practice of health service psychology. This includes: (a) increasing interns’ proficiency in the understanding of, and ability to use, clinically relevant research in providing psychological services; (b) increasing interns’ understanding of cultural and individual differences as they relate to clinical practice and science; (c) refining interns' understanding of ethical issues as they relate to clinical practice and science and facilitating the development of professional conduct consistent with ethical, legal, regulatory, and administrative standards; and (d) enhancing communication and collaboration skills to prepare them for the evolving healthcare system. More specifically, the Internship has a single aim:

To prepare psychologists with the requisite knowledge and skills for post-internship career activities, entry to the profession, and into the practice of Health Service Psychology. By the conclusion of the internship, interns must demonstrate competence in each of the Profession-Wide Competencies as outlined in the table below.

How Outcomes Are Measured: Outcomes are measured both proximally and distally as part of the Internships comprehensive QAI program. Interns’ Profession-Wide Competencies are assessed proximally on the MSI. In addition, the Alumni Survey provides distal data about former interns’ competencies and activities. Formative assessment is provided informally during supervision throughout the internship year.

A. Interns undergo quarterly evaluations for which supervisors complete the MSI and review it with them. There is formative assessment on an ongoing basis throughout the internship. Interns’ participation in research activities varies.

B. Other proximal measures of Profession-Wide Competences include the Orientation Self-Assessment, which provides a baseline to which interns can compare their functioning at the end of the year when they complete the MSI Self-Assessment Version. On the MSI-SA interns rate how much growth they have undergone on the same dimensions that are sampled in the MSI. The MSI-SA also repeats the items on the Orientation Self-Assessment, allowing for direct comparisons between entry and exit self-perceptions.

C. Distal outcomes are obtained on the Alumni Survey, which is a SurveyMonkey survey. Former interns describe their level of activity related to research on this measure.

In addition, outcomes on the Program Evaluation provide data about training related to the Profession-Wide Competencies.
Minimum Thresholds for Achievement for Competencies are specified below for interns to complete the program. These include the following levels of performance documented on the Minnesota Supervisory Inventory (MSI) for each of the Profession-Wide Competencies:

<table>
<thead>
<tr>
<th>Competence Areas</th>
<th>Minimal Levels of Achievement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Research</td>
<td>≥ 70% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>b. Ethical and legal standards</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>c. Individual and cultural diversity</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>d. Professional values, attitudes, and behaviors</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>e. Communication and interpersonal skills</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>f. Assessment</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>g. Intervention</td>
<td>≥ 80% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>h. Supervision</td>
<td>≥ 70% of ratings meet or exceed expectations</td>
</tr>
<tr>
<td>i. Consultation and interprofessional/interdisciplinary skills</td>
<td>≥ 70% of ratings meet or exceed expectations</td>
</tr>
</tbody>
</table>

These percentages refer to individual ratings within each domain.

Outcomes are measured proximally and distally as part of our comprehensive QAI program. Interns undergo quarterly evaluations in which supervisors complete the Minnesota Supervisory Inventory (MSI) or MSI-Neuropsychology and review it with them. Minimal Levels of Achievement are measured with a subgroup of MSI items known as the “Essential Competence Elements” (ECEs; see Appendix 39) and on the Profession-Wide Competencies Assessment (see Appendix 40). There is formative assessment on an ongoing basis throughout the internship. In addition, interns provide self-assessments during the orientation and at the end of the internship on the MSI-Self-Assessment.

QAI materials are forwarded to the internship Director and the Internship Coordinator who store them on password protected website and hard drives.

<table>
<thead>
<tr>
<th>Competency:</th>
<th>A. Research</th>
</tr>
</thead>
</table>
| Attachment Name for Evaluation Tools Used for each Competency (if applicable) | 1. Orientation Self-Assessment  
2. Minnesota Supervisory Inventory – Self-Assessment (MSI-SA)  
3. Minnesota Supervisory Inventory (MSI)  
4. Profession-Wide Competencies Assessment (PWCA)  
5. Alumni Survey |
| How Outcomes are Measured | Orientation Self-Assessment completed by intern at entry (i.e., pre-test)  
MSI-Self Assessment completed by intern at conclusion of the internship  
MSI - Evaluation by Supervisors quarterly  
PWCA – Evaluation by Training Committee during month 12  
Alumni Survey completed by intern ≈ 3 years after graduation and within 6 months of successive self-study. |
| Minimum Levels for Achievement for this Competency | MSI – Meets or exceeds expectations on ≥ 80 % of items;  
– Meets or exceeds expectations on “essential competency element” items: A1, A7, A9, A12, A15  
PWCA – Meets Expectation on all items |
### APPENDIX 27 (continued)

<table>
<thead>
<tr>
<th>Competency:</th>
<th><strong>B. Ethical and Legal Standards</strong></th>
</tr>
</thead>
</table>
| Attachment Name for Evaluation Tools Used for each Competency (if applicable) | 1. Orientation Self-Assessment  
2. Minnesota Supervisory Inventory – Self-Assessment (MSI-SA)  
3. Minnesota Supervisory Inventory (MSI)  
4. Profession-Wide Competencies Assessment (PWCA)  
5. Alumni Survey |
| How Outcomes are Measured | Orientation Self-Assessment completed by intern at entry (i.e., pre-test)  
MSI-Self Assessment completed by intern at conclusion of the internship  
MSI - Evaluation by Supervisors quarterly  
PWCA – Evaluation by Training Committee during month 12  
Alumni Survey completed by intern ≈ 3 years after graduation and within 6 months of successive self-study. |
| Minimum Levels for Achievement for this Competency | MSI – Meets or exceeds expectations on ≥ 80 % of items;  
– Meets or exceeds expectations on “essential competency element” items: B1, B2, B3, B4, B5, B10  
PWCA – Meets Expectation on all items |

<table>
<thead>
<tr>
<th>Competency:</th>
<th><strong>C. Individual and Cultural Diversity</strong></th>
</tr>
</thead>
</table>
| Attachment Name for Evaluation Tools Used for each Competency (if applicable) | 1. Orientation Self-Assessment  
2. Minnesota Supervisory Inventory – Self-Assessment (MSI-SA)  
3. Minnesota Supervisory Inventory (MSI)  
4. Profession-Wide Competencies Assessment (PWCA)  
5. Alumni Survey |
| How Outcomes are Measured | Orientation Self-Assessment completed by intern at entry (i.e., pre-test)  
MSI-Self Assessment completed by intern at conclusion of the internship  
MSI - Evaluation by Supervisors quarterly  
PWCA – Evaluation by Training Committee during month 12  
Alumni Survey completed by intern ≈ 3 years after graduation and within 6 months of successive self-study. |
| Minimum Levels for Achievement for this Competency | MSI – Meets or exceeds expectations on ≥ 80 % of items;  
– Meets or exceeds expectations on “essential competency element” items: C2, C3, C5, C6, C8, C11, C12  
PWCA – Meets Expectation on all items |

<table>
<thead>
<tr>
<th>Competency:</th>
<th><strong>D. Professional Values, Attitudes, and Behaviors</strong></th>
</tr>
</thead>
</table>
| Attachment Name for Evaluation Tools Used for each Competency (if applicable) | 1. Orientation Self-Assessment  
2. Minnesota Supervisory Inventory – Self-Assessment (MSI-SA)  
3. Minnesota Supervisory Inventory (MSI)  
4. Profession-Wide Competencies Assessment (PWCA)  
5. Alumni Survey |
### APPENDIX 27 (continued)

| How Outcomes are Measured | Orientation Self-Assessment completed by intern at entry (i.e., pre-test)  
|                          | MSI-Self Assessment completed by intern at conclusion of the internship  
|                          | MSI - Evaluation by Supervisors quarterly  
|                          | PWCA – Evaluation by Training Committee during month 12  
|                          | **Alumni Survey completed by intern ≈ 3 years after graduation and within 6 months of successive self-study.** |

| Minimum Levels for Achievement for this Competency | MSI – Meets or exceeds expectations on ≥ 80% of items;  
|                                                   | – Meets or exceeds expectations on “essential competency element” items: D1, D2, D4, D5, D8, D12, D17  
|                                                   | PWCA – Meets Expectation on all items |

<table>
<thead>
<tr>
<th>Competency:</th>
<th><strong>E. Communications and Interpersonal Skills</strong></th>
</tr>
</thead>
</table>

| Attachment Name for Evaluation Tools Used for each Competency (if applicable) | 1. Orientation Self-Assessment  
|                                                                      | 2. Minnesota Supervisory Inventory – Self-Assessment (MSI-SA)  
|                                                                      | 3. Minnesota Supervisory Inventory (MSI)  
|                                                                      | 4. Profession-Wide Competencies Assessment (PWCA)  
|                                                                      | 5. Alumni Survey |

| How Outcomes are Measured | Orientation Self-Assessment completed by intern at entry (i.e., pre-test)  
|                          | MSI-Self Assessment completed by intern at conclusion of the internship  
|                          | MSI -Evaluation by Supervisors quarterly  
|                          | PWCA – Evaluation by Training Committee during month 12  
|                          | **Alumni Survey completed by intern ≈ 3 years after graduation and within 6 months of successive self-study.** |

| Minimum Levels for Achievement for this Competency | MSI – Meets or exceeds expectations on ≥ 70% of items;  
|                                                   | – Meets or exceeds expectations on “essential competency element” items: E1, E2, E6, E7, E12, E13, E14, E15, E16  
|                                                   | PWCA – Meets Expectation on all items |

<table>
<thead>
<tr>
<th>Competency:</th>
<th><strong>F. Assessment</strong></th>
</tr>
</thead>
</table>

| Attachment Name for Evaluation Tools Used for each Competency (if applicable) | 1. Orientation Self-Assessment  
|                                                                      | 2. Minnesota Supervisory Inventory – Self-Assessment (MSI-SA)  
|                                                                      | 3. Minnesota Supervisory Inventory (MSI)  
|                                                                      | 4. Minnesota Supervisory Inventory – Neuropsychology (MSI – Neuropsychology)  
|                                                                      | 5. Profession-Wide Competencies Assessment (PWCA)  
|                                                                      | 6. Alumni Survey |
# APPENDIX 27 (continued)

| How Outcomes are Measured | Orientation Self-Assessment completed by intern at entry (i.e., pre-test)  
|                          | MSI-Self Assessment completed by intern at conclusion of the internship  
|                          | MSI -Evaluation by Supervisors quarterly  
|                          | PWCA – Evaluation by Training Committee during month 12  
|                          | Alumni Survey completed by intern ≈ 3 years after graduation and within 6 months of successive self-study. |

| Minimum Levels for Achievement for this Competency | MSI – Meets or exceeds expectations on ≥ 80% of items;  
|                                                   | – Meets or exceeds expectations on “essential competency element” items: F1, F2, F11, F20, F21, F25, F26, F27, F28, F30, F31, F32, F33  
|                                                   | PWCA – Meets Expectation on all items |

<table>
<thead>
<tr>
<th>Competency:</th>
<th>G. Intervention</th>
</tr>
</thead>
</table>
| Attachment Name for Evaluation Tools Used for each Competency (if applicable) | 1. Orientation Self-Assessment  
|                                                        | 2. Minnesota Supervisory Inventory – Self-Assessment (MSI-SA)  
|                                                        | 3. Minnesota Supervisory Inventory (MSI)  
|                                                        | 4. Profession-Wide Competencies Assessment (PWCA)  
|                                                        | 5. Alumni Survey  
|                                                       | 6. MAAPIC SurveyMonkey Workshop Survey |

| How Outcomes are Measured | Orientation Self-Assessment completed by intern at entry (i.e., pre-test)  
|                          | MSI-Self Assessment completed by intern at conclusion of the internship  
|                          | MSI -Evaluation by Supervisors quarterly  
|                          | PWCA – Evaluation by Training Committee during month 12  
|                          | Alumni Survey completed by intern ≈ 3 years after graduation and within 6 months of successive self-study. |

| Minimum Levels for Achievement for this Competency | MSI – Meets or exceeds expectations on ≥ 80% of items;  
|                                                   | – Meets or exceeds expectations on “essential competency element” items: G1, G2, G4, G7, G8, G9, G11, G12, G13, G15, G20  
|                                                   | PWCA – Meets Expectation on all items |

<table>
<thead>
<tr>
<th>Competency:</th>
<th>H. Supervision</th>
</tr>
</thead>
</table>
| Attachment Name for Evaluation Tools Used for each Competency (if applicable) | 1. Orientation Self-Assessment  
|                                                        | 2. Minnesota Supervisory Inventory – Self-Assessment (MSI-SA)  
|                                                        | 3. Minnesota Supervisory Inventory (MSI)  
|                                                        | 4. Profession-Wide Competencies Assessment (PWCA)  
|                                                        | 5. Alumni Survey  
|                                                       | 6. MAAPIC SurveyMonkey Workshop Survey |
| How Outcomes are Measured | Orientation Self-Assessment completed by intern at entry (i.e., pre-test)  
|                          | MSI-Self Assessment completed by intern at conclusion of the internship  
|                          | MSI - Evaluation by Supervisors quarterly  
|                          | PWCA – Evaluation by Training Committee during month 12  
|                          | Alumni Survey completed by intern ≈ 3 years after graduation and within 6 months of successive self-study.  
|                          | MAAPIC SurveyMonkey Workshop Survey following annual 1-day workshop: Clinical Supervision: Ethical, Legal & Practice Issues hosted by the Minnesota Association of APA-Accredited Psychology Internships (MAAPIC). |
| Minimum Levels for Achievement for this Competency | MSI – Meets or exceeds expectations on ≥ 80 % of items;  
|                                                        | – Meets or exceeds expectations on “essential competency element” items: H1, H2, H3, H4, H8, H11  
|                                                        | PWCA – Meets Expectation on all items |
| Competency: | I. Consultation & Interprofessional/Interdisciplinary Skills |
| Attachment Name for Evaluation Tools Used for each Competency (if applicable) | 1. Orientation Self-Assessment  
|                                                        | 2. Minnesota Supervisory Inventory – Self-Assessment (MSI-SA)  
|                                                        | 3. Minnesota Supervisory Inventory (MSI)  
|                                                        | 4. Profession-Wide Competencies Assessment (PWCA)  
|                                                        | 5. Alumni Survey |
| How Outcomes are Measured | Orientation Self-Assessment completed by intern at entry (i.e., pre-test)  
|                          | MSI-Self Assessment completed by intern at conclusion of the internship  
|                          | MSI - Evaluation by Supervisors quarterly  
|                          | PWCA – Evaluation by Training Committee during month 12  
|                          | Alumni Survey completed by intern ≈ 3 years after graduation and within 6 months of successive self-study. |
| Minimum Levels for Achievement for this Competency | MSI – Meets or exceeds expectations on ≥ 70 % of items;  
|                                                        | – Meets or exceeds expectations on “essential competency element” items: I5, I6, I7, I8, I9, I10, I13, I14, I15, I20, I21  
|                                                        | PWCA – Meets Expectation on all items |
# APPENDIX 28

## PSYCHOLOGY INTERNSHIP GRIEVANCE PROCESS

<table>
<thead>
<tr>
<th>Step</th>
<th>Status</th>
<th>Conflict Identified</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not Resolved</td>
<td>Parties attempt to resolve conflict informally</td>
<td>Conflict is resolved</td>
</tr>
<tr>
<td>2</td>
<td>Not Resolved</td>
<td>Interns review complaint with mentor or other ad hoc advisor.</td>
<td>Conflict is resolved</td>
</tr>
<tr>
<td>3</td>
<td>Not Resolved</td>
<td>Intern may engage in informal discussion with other persons deemed appropriate by parties to the complaint.</td>
<td>Conflict is resolved</td>
</tr>
<tr>
<td>4</td>
<td>Not Resolved</td>
<td>Formulation of a formal written complaint</td>
<td>Conflict is resolved</td>
</tr>
<tr>
<td>5</td>
<td>Not Resolved</td>
<td>Formal written complaint is forwarded to the Grievance Committee, with copies to principals to the complaint, to the Internship Director, and to the Head of the Department of Pediatrics or his or her designee.</td>
<td>Conflict is resolved with report to the Head of the Department or his or her designee</td>
</tr>
<tr>
<td>6</td>
<td>Not Resolved</td>
<td>Grievance Committee reviews the complaint with consultation and written minutes, but without tape recording.</td>
<td>Conflict is resolved</td>
</tr>
<tr>
<td>7</td>
<td>Not Resolved</td>
<td>Department Head or his or her designee reviews the Grievance Committee actions and recommendations and then advises the parties to the complaint of his or her decision as to the dispensation of the complaint action.</td>
<td>Conflict is resolved</td>
</tr>
<tr>
<td>8</td>
<td>Not Resolved</td>
<td>Appeal to the Medical School or the University of Minnesota Office of Conflict Resolution</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 29

PSYCHOLOGY INTERNSHIP-WIDE DIDACTICS CALENDAR AND LEARNING OBJECTIVES

The Psychology Internship Didactic Schedule with Learning Objectives will be shared on The Psychology Internship Google Calendar.
APPENDIX 30

STATEMENT OF NONDISCRIMINATORY PRACTICES

The internship engages in nondiscriminatory practices in all of its operations and activities. Faculty, staff, and interns avoid actions that would restrict program access or participation on grounds that are irrelevant to success in an internship or the profession. Recruitment of interns and admittance to the internship is based on applicants’ overall qualifications and fit with the aims, objectives, competencies, and perceived capability for contributing to the mission of the internship. Policies governing recruitment and selection are outlined on the website of the Internship and herein. Decisions regarding invitations for interviews and final ranking are made by the Training Committee with involvement of supervisors from all participating rotations. The internship complies with all University policies regarding nondiscrimination and equal opportunity. Stipends, benefits and administrative assistance are provided equivalently among interns.

Recruitment to the University of Minnesota Medical School Psychology Internship is competitive, taking into consideration applicants’ unique backgrounds and talents. In reviewing applications, emphasis is placed on the concordance between applicants training interests and background and the training requirements and clinical responsibilities for each rotation as well as the mission, aims, and objectives of the Internship. Selection of applicants from APA-accredited doctoral programs is based on applicants' records of academic achievement, clinical and other professional experiences, research accomplishments, relevant aptitudes, course work, and skills, and supporting letters of recommendation indicating applicants’ preparation for a medical school-based internship. Applications comprise several components, including the Online APPIC Application, a Supplemental application, and other materials, as described later in this document. GRE (combined verbal and quantitative) scores > 50th percentile are strongly preferred (if taken). Each rotation ranks candidates independently and then combined rankings are used to determine overall rank lists for the tracks (i.e., combinations of 2 rotations) in the computer match process. In general, only applicants who are invited for interviews are ranked in the match process. The deadline for filing all application materials with the Internship is November 1. The Internship observes the guidelines regarding timing of Internship offers and acceptances adopted by the Association of Psychology Postdoctoral and Internship Centers (APPIC), the Council of University Directors of Clinical Programs, and National Matching Services, Inc. (NMSI).

Requirements for Internship Training

Applicants must have completed a minimum of 1,000 hours of practicum training and be familiar with the rudiments of patient contact, test administration, test scoring, diagnostic interviewing, psychotherapy, and professional ethics. Applicants are expected to have attained exposure to diverse populations and to have to have demonstrated respect for and understanding of cultural and individual diversity. Applicants interested in the Pediatric Neuropsychology rotation are required to have clinical neuropsychology practicum experience and relevant coursework. Interns are selected primarily from APA-accredited clinical psychology doctoral programs. Strong candidates from APA accredited counseling psychology, health psychology, neuropsychology, or school psychology programs with practica experience in related health settings also are invited to submit applications. Applicants must be recommended for this clinical psychology Internship training by the Director of Training at their doctoral program and must have successfully completed the general written
preliminary examination for the Ph.D. or Psy.D. degree if one is required for the doctoral degree by their program. By Minnesota Statute (144.057), health facilities licensed by the Minnesota Department of Health are required to obtain criminal background studies on individuals who have direct contact with patients as well as to check with previous employers/supervisors about professional activities that may have involved inappropriate sexual conduct. After the match, applicants matched to the Internship then undergo this additional scrutiny. Individuals who do not pass the criminal background study are prohibited from engaging in direct contact with patients, unless their disqualification has been set aside by the Commissioner of Health through a reconsideration process. Similarly, evidence of inappropriate sexual contact with patients at any time precludes internship participation. Consequently, failure to pass the criminal background check or evidence of sexual exploitation of clients nullifies any offer for internship that might be extended in the computer match. Misrepresentation of one’s background and experiences, or falsification of any information related to the application, are also grounds for nullification of any offer for internship.

Equal Opportunity and Affirmative Action
The Regents of the University of Minnesota reaffirm that it is the policy of the University to provide equal educational access and opportunity to persons of every race and ethnic heritage, sex, religion and creed, as well as fairness to the individual in the competition for educational opportunity, and the appropriate administrative officers and faculty are directed to establish and continue any admission policies and guidelines necessary to implement this policy; further, in order to promote ethnic and cultural diversity which will enhance the campus environment and educational programs of the University; in order to increase the representation of members of minority groups at the highest professional levels, providing encouragement to members of such minority groups to seek to attain the highest achievements of which they are capable; in order to alleviate the shortage of training professionals in diverse fields who will serve unmet community needs; and, in order to compensate for the inequalities that have existed in society; the Regents reaffirm and declare that it is the policy of the University of Minnesota to provide equal educational access and opportunity to members of minority groups and the appropriate administrative officers and faculty are directed to develop affirmative action admission programs and to review admission policies to insure that the intent of this policy continues to be implemented.

The internship recognizes the importance of cultural and individual differences in the training of psychologists, including in selection of trainees. It is committed to not discriminating against any candidates for trainee positions or faculty positions based on age, culture, disability, ethnicity, gender, gender identity, language, national origin, race, religion, sexual orientation, socioeconomic status, or spirituality.
APPENDIX 31

HEALTH INSURANCE AND MENTAL HEALTH INFORMATION

Interns are on the University of Minnesota student health care plan, but do not pay student service fees because the internship program pays for their insurance. This can be a source of confusion when interns call Boynton Health Service and are erroneously told that appointments cannot be scheduled. This can come up for various health services, including mental health services. Their insurance is typically the same as that of medical residents. If you do not get your health coverage card within a few weeks of arrival, a systems issue has likely emerged. Health insurance cards are mailed to the home address of interns. It usually takes 10-14 days for the application to be processed and cards to be mailed. Please contact Brett Steger and the Internship Director if you encounter problems accessing care. Please contact them without delay and continue to be in touch with them until health insurance issues are resolved.

Websites:
Boynton Clinics & Services: http://www.bhs.umn.edu/services/
Boynton Mental Health: http://www.bhs.umn.edu/services/mentalhealth.htm
Boynton Mental Health Providers: http://www.bhs.umn.edu/provider/mentalhealth/
Blue Cross Blue Shield of Minnesota: http://www.bcbs.com

In order to be scheduled at Boynton for mental health services, it may be helpful to do the following:

1. Call the Office of Student Health Benefits (612-624-0627)
2. State that you are "on the student health benefit plan" but that your "department (Pediatrics) pays for the insurance through EFS" (i.e., you do not pay the student fees personally).
3. Then call Boynton to schedule an appointment.

With this information, the benefits person can access your information in the system and update your status to reflect that student service fees are, in essence, "paid" by the department because extended coverage was purchased. After you do this, you should be able to call the mental health side of Boynton to schedule an appointment.

The 2012 Boynton mental health services copay is $10 with a maximum of $250. For therapy, it is recommended that you get pre-authorization for greater than 10 sessions/hours.

For prescription information, medications are reimbursed at the negotiated rate at the pharmacy at Boynton Health Services. You may encounter higher copays, or be responsible for the full cost of your medications, if you have prescriptions filled elsewhere.

If you go elsewhere for services, coverage is 80%/20% if the provider is contracted with the BCBS insurance. There are a number of "participating provider" psychologists in the Minneapolis area who theoretically take this insurance. You can also call or look at the BCBS website to find out if a specific individual is listed as a participating provider by linking to http://www.bcbs.com to locate providers. If you have questions regarding providers, please contact BlueCard® Access at 1-800-810-2583.

The direct line for the Urgent Mental Health Consultation at (612) 625-8475. When Boynton is closed, the emergency room at University of Minnesota Medical Center, Fairview Riverside Campus is available 24 hours/day. For life threatening emergencies, call 911.

If you encounter problems accessing health or mental health services, please contact Brett Steger at 626-6910 and the Internship Director.
APPENDIX 32

ADMINISTRATIVE MATTERS

The Internship is housed administratively in the Department of Pediatrics. Interns are provided with administrative support as appropriate to their roles and functions. The Internship Director and Internship Coordinator are available to interns to address administrative matters. Issues related to interns’ employment, benefits, and educational status within the University may be addressed with Internship faculty and the staff of the Department of Pediatrics.

Interns have access to office space, clinic space, computer, Internet, email, telephone, voice mail, pagers, and other resources to permit them to function effectively in their roles in the Medical School and in the hospital. They are responsible to understand the appropriate use and limitations of use of University resources. Interns have access to a broad range of University, hospital, and UMP support services (e.g., computer support, EMR support, librarians, clinic check in, some dictation).

The Internship makes available supplies (e.g., testing materials, paper) so as to enable interns to provide clinical services, including psychological assessments, and participate in educational activities consistent with training aims.

Interns and faculty are expected to approach activities related to the internship in a professional manner as consistent with policies of the University of Minnesota Medical School and the University of Minnesota Medical Center, Fairview and professional standards (i.e., APA Ethical Principles of Psychologists and Code of Conduct and other professional standards).

Each rotation has administrative systems that provide support for the academic and clinical missions within the Medical School. Rotations vary in terms of the specific clinical resources, administrative structures and processes (e.g., for typing, dictation, photocopying, billing, management of clinical functions). For example, administrative assistance is available in the form of two Division of Child and Adolescent Psychiatry secretaries as well as student workers, all of whom assist with basic tasks such as copying, mailing, taking phone messages, arranging equipment for seminars, etc. The Psychiatry Clinic is staffed to support the clinical and educational missions. That is, support is provided to the interns for scheduling patients, handling phone calls, arranging rooms, documenting clinic activities, and processing billing, as it is for faculty and other trainees (e.g., Psychiatry residents).

Interns are expected to obtain guidance from their immediate supervisors about the use of resources related to their role as interns.

Medical records are completed and maintained in compliance with hospital and UMP policies, including standards that safeguard patient privacy and confidentiality and timeliness.
Both interns and supervisors must: a) complete this plan at the beginning of any training experience; b) retain individual copies of the plan; and c) send a copy of each supervision plan/plan revision to the head of the training program. Supervisors are responsible for having clinical supervision plans in place, and for

<table>
<thead>
<tr>
<th>Supervisee</th>
<th>Agency</th>
<th>Rotation Supervisor</th>
</tr>
</thead>
</table>

Name of Supervisee: 

Degree: 
Licensure: 
Date of Supervision Implementation: 

Agency (Organization) Providing Supervision:  
The organization will usually be University of Minnesota Physicians (UMPhysicians)

Name of Rotation Supervisor:  
Supervisee completes a plan with each Supervisor

Degree: 
Licensure: 

The organization will usually be University of Minnesota Physicians (UMPhysicians)

Total Projected Hours of Supervision

<table>
<thead>
<tr>
<th>Total Hours</th>
<th>Logistics - Method(s) of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision Start Date</td>
<td>Individual Supervision</td>
</tr>
<tr>
<td>Supervision End Date</td>
<td>☐ In-Person</td>
</tr>
<tr>
<td>☐ Group Supervision</td>
<td>☐ In-Person</td>
</tr>
<tr>
<td>☐ Telemedicine</td>
<td>☐ Telemedicine</td>
</tr>
<tr>
<td>Frequency:</td>
<td>Frequency:</td>
</tr>
</tbody>
</table>

Procedures for Consulting Supervisor during Service Provision and Emergencies

1. Contact immediate supervisor via phone, pager or in-person.
2. Contact designated back-up supervisor for internship/rotation via phone, pager or in-person.
3. Contact clinic staff and/or clinic security, when necessary.

Supervisee Scope of Practice

<table>
<thead>
<tr>
<th>Treatment Methods and Modalities</th>
<th>Supervisee Client Population(s) Expected to be Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Diagnostic Assessment</td>
<td>☐ Children and Adolescents</td>
</tr>
<tr>
<td>☐ Psychotherapy, Individual</td>
<td>☐ Adults</td>
</tr>
<tr>
<td>☐ Psychotherapy, Group</td>
<td>☐ Families</td>
</tr>
<tr>
<td>☐ Psychotherapy, Family</td>
<td>☐ Other:</td>
</tr>
<tr>
<td>☐ Dialectical Behavior Therapy</td>
<td>Other: sex offenders, detainees, etc.</td>
</tr>
<tr>
<td>☐ Psych Testing and Reporting</td>
<td>☐ Psych Testing and Reporting</td>
</tr>
<tr>
<td>☐ Neuropsych Testing and Reporting</td>
<td>☐ Neuropsych Testing and Reporting</td>
</tr>
</tbody>
</table>

Additional Comments (e.g., Responsibilities, Plan Revisions, etc.)  
This is an unlimited space that will expand to fit electronic content.
The rest of this form is completed after printing.

<table>
<thead>
<tr>
<th>Mutual Agreement</th>
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<tbody>
<tr>
<td><strong>Original Plan</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervisee’s Signature</th>
<th>Date</th>
<th>Supervisor’s Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

| **Revised Plan** | Check here if this is a plan revision. Attach any previous plan version(s) to this one. (If this is not a plan revision, go to the Original Plan section.) Signature below acknowledges that both Supervisor and Supervisee agree with the content of this revised plan, and that any changes to it will be reflected in a new revised and signed document. |

| Supervisee’s Signature | Date | Supervisor’s Signature | Date |
Both interns and rotation supervisors are responsible for initialing and dating accurate clinical supervision records on a weekly basis. The rotation supervisor’s full signature certifies the accuracy of the supervision record on a quarterly basis. Both must retain individual copies of the record, and send a copy of each supervision record to the head of the training program. Supervisors are responsible for having clinical supervision documentation in place, and for ongoing maintenance and archival of accurate clinical supervision records. Supervision documentation must align with the requirements defined by the MN-DHS, Minnesota Rule, parts 9505.0370 to 9505.0372.

**SUPERVISION METHOD KEY**

<table>
<thead>
<tr>
<th>IND / FTF</th>
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<td>GRP / FTF</td>
<td>IND / TELE</td>
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<tr>
<td>IND / FTF</td>
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<td>IND / FTF</td>
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<tr>
<td>IND / FTF</td>
<td>GRP / FTF</td>
<td>IND / TELE</td>
<td>GRP / TELE</td>
</tr>
</tbody>
</table>

**CERTIFICATION**

I certify, to the best of my knowledge, that the information reported herein is complete.

Rotation Supervisor’s Name: ____________________________
APPENDIX 35

BOX: YOUR PERSONAL FILE STORAGE SPACE
https://netfiles.umn.edu

Your University of Minnesota central Internet account provides you with server space to store your files. These files may be papers you have written, photos you have taken, application installers, or anything you may have saved to your computer.

Benefits:

- ability to access your files from any Internet-connected computer with the appropriate SFTP software
- reliable storage, regularly backed up and maintained
- no need to rely on floppy or ZIP disks, or to write to several CD-R discs, as your only means of backup storage

Personal Web site:

Your file storage space also includes a folder named "web-docs" for you to create your own Web site within the UMN system. For more information on your Web space, go to http://www.umn.edu/adcs/help/webpage.html

Software and Guides:

We have tested the following SFTP applications on the most common computing platforms. Several others may exist, but those listed below are widely used and freely downloadable.

<table>
<thead>
<tr>
<th>Operating System</th>
<th>Application</th>
<th>Guides (Click to download)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mac OS 10.2.3 and higher</td>
<td>Fugu</td>
<td>● Using Fugu with Your Personal Web Space <a href="http://www1.umn.edu/adcs/guides/accounts/filetransfer/fugu.html">http://www1.umn.edu/adcs/guides/accounts/filetransfer/fugu.html</a></td>
</tr>
</tbody>
</table>
## 2013 Psychotherapy CPT® Codes for Psychologists

Effective January 1, 2013

### Diagnostic Interview Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
</tbody>
</table>

### Psychotherapy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient and/or family member</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient and/or family member</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient and/or family member</td>
</tr>
<tr>
<td>90845*</td>
<td>Psychoanalysis</td>
</tr>
<tr>
<td>90846*</td>
<td>Family psychotherapy without the patient present</td>
</tr>
<tr>
<td>90847*</td>
<td>Family psychotherapy, conjoint psychotherapy with the patient present</td>
</tr>
<tr>
<td>90849*</td>
<td>Multiple-family group psychotherapy</td>
</tr>
<tr>
<td>90855*</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
</tr>
</tbody>
</table>

### Interactive Complexity Add-on Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90785</td>
<td>Add-on code to be used in conjunction with codes for primary service: psychiatric diagnostic evaluation (90791); psychotherapy (90832, 90834, 90837); and group psychotherapy (90853)</td>
</tr>
</tbody>
</table>

### Psychotherapy for Crisis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis, first 60 minutes</td>
</tr>
<tr>
<td>90840</td>
<td>Add-on for each additional 30 minutes of psychotherapy for crisis, used in conjunction with code 90839</td>
</tr>
</tbody>
</table>

### Pharmacologic Management Add-on Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services; used only as add-on to primary psychotherapy code (90832, 90834, 90837)</td>
</tr>
</tbody>
</table>

* These codes are the same for 2012 and 2013

For complete information on the 2013 psychotherapy codes, visit [www.apapracticecentral.org/codes](http://www.apapracticecentral.org/codes).

For additional questions, email us at praccodes@apa.org.
# APPENDIX 36 (continued)

## Psychiatric Services

### 2012 to 2013 Crosswalk

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic interview examination</td>
<td>90801</td>
<td>DELETED</td>
<td>Diagnostic evaluation (no medical)</td>
<td>90791</td>
<td>When appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Diagnostic evaluation with medical</td>
<td>90792</td>
<td></td>
</tr>
<tr>
<td>Interactive diagnostic interview examination</td>
<td>90802</td>
<td>DELETED</td>
<td>Diagnostic evaluation (no medical)</td>
<td>90791</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Diagnostic evaluation with medical</td>
<td>90792</td>
<td></td>
</tr>
<tr>
<td>Individual psychotherapy 20-30 min</td>
<td>90804, 90816</td>
<td>DELETED</td>
<td>Psychotherapy 30 (16-37*) min</td>
<td>90832</td>
<td>When appropriate</td>
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<tr>
<td></td>
<td>90806, 90818</td>
<td></td>
<td>45 (38-52*) min</td>
<td>90834</td>
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</tr>
<tr>
<td></td>
<td>90808, 90821</td>
<td></td>
<td>60 (53*) min</td>
<td>90837</td>
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<tr>
<td>Interactive individual psychotherapy 20-30 min</td>
<td>90810, 90823</td>
<td>DELETED</td>
<td>30 (16-37*) min</td>
<td>90832</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90812, 90826</td>
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<td>45 (38-52*) min</td>
<td>90834</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90814, 90828</td>
<td></td>
<td>60 (53*) min</td>
<td>90837</td>
<td></td>
</tr>
<tr>
<td>Individual psychotherapy with E/M, 20-30 min</td>
<td>90805, 90817</td>
<td>DELETED</td>
<td>E/M plus psychotherapy add-on</td>
<td>90833</td>
<td>When appropriate</td>
</tr>
<tr>
<td></td>
<td>90807, 90819</td>
<td></td>
<td>30 (16-37*) min</td>
<td>90836</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90809, 90822</td>
<td></td>
<td>45 (38-52*) min</td>
<td>90838</td>
<td></td>
</tr>
<tr>
<td>Interactive individual psychotherapy with E/M 20-30 min</td>
<td>90811, 90824</td>
<td>DELETED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>90813, 90827</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>90815, 90829</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Psychotherapy</td>
<td></td>
<td>RETAINED</td>
<td>Psychotherapy for crisis</td>
<td>90839, 90840</td>
<td>No</td>
</tr>
<tr>
<td>Family psychotherapy</td>
<td>90846, 90847, 90849</td>
<td>RETAINED</td>
<td>Family psychotherapy</td>
<td>90846, 90847, 90849</td>
<td>No</td>
</tr>
<tr>
<td>Group psychotherapy</td>
<td>90853</td>
<td>RETAINED</td>
<td>Group psychotherapy</td>
<td>90853</td>
<td>When appropriate</td>
</tr>
<tr>
<td>Interactive group psychotherapy</td>
<td>90857</td>
<td>DELETED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Psychiatric Services</td>
<td>90862</td>
<td>DELETED</td>
<td>E/M code</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Per CPT Time Rule

CPT® five-digit codes, descriptions, and other data only are copyright 2011 by the American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT®. CPT® is a registered trademark of the American Medical Association (AMA).
If you are interested in obtaining a fellowship in pediatric neuropsychology following your internship, here are a few things that you should know:

Fellowships in clinical neuropsychology are generally 2 years. While you are free to choose any fellowship program that you wish, if you are interested in eventually seeing board certification in clinical neuropsychology and are pediatric focused, you should consider looking into full member programs of the Association of Postdoctoral Programs in Clinical Neuropsychology (APPCN), http://www.appcn.org/. According to the American Board of Professional Psychology – Clinical Neuropsychology Specialty Board (ABPP-CN) website, “ABCN does not currently require applicants to train in accredited postdoctoral programs; however, candidates who complete an APA-accredited specialty program in clinical neuropsychology or a full member program of the Association of Postdoctoral Programs in Clinical Neuropsychology (APPCN) may skip items on the specialty application form and complete the credential review process more quickly.”
http://www.abpp.org/i4a/pages/index.cfm?pageid=3402. APA-accredited Specialty Practice Postdoc Residency Programs may be viewed at:
http://www.apa.org/ed/accreditation/programs/specialty.aspx. Most are adult focused. On the other hand, the APPCN has numerous full member programs with a pediatric focus, including the University of Minnesota Pediatric Neuropsychology Postdoctoral Fellowship.

The Association of Postdoctoral Programs in Clinical Neuropsychology (APPCN) website indicates its mission is to offer the highest quality competency-based residency training in clinical neuropsychology with an emphasis on preparation for future specialty board certification though the American Board of Professional Psychology/American Board of Clinical Neuropsychology (ABPP/ABCN). APPCN embraces the Houston Guidelines as a model for training in clinical neuropsychology. APPCN specifies a unified competency-based curriculum for residency training programs in clinical neuropsychology. APPCN offers unique and specific resources to APPCN member programs and trainees that support professional development, as well as the competent and ethical practice of clinical neuropsychology. APPCN views the American Board of Professional Psychology diploma in Clinical Neuropsychology (ABPP-CN) as the clearest demonstration of peer-reviewed competence to practice clinical neuropsychology. APPCN Member Programs commit to a curriculum, training resources, and training opportunities that support APPCN graduates in their pursuit of ABPP-CN. They should have 2 hours of supervision and be 50% service delivery.

APPCN provides a national match process (APPCN Residency Matching Program) https://natmatch.com/appcnmat/ to facilitate the application and interviewing process for postdoctoral training in clinical neuropsychology. It is similar to the internship match, but easier. Some non-APCCN programs also participate in the match process (these are called non-member or affiliate member programs). The majority of APPCN member programs hold their interviews at the annual meeting of the International Neuropsychological Society (INS) http://www.the-ins.org/. While actual interview dates may be flexible, the vast majority of interviews are held on a pre-determined “Official Interview Day.” Plan your flight accordingly!

A quick note from a recent intern (Andrew Wahlberg): You do not have to complete an APPCN fellowship to become board certified. There are numerous excellent training programs that chose not to join APPCN for a variety of reasons. However, if you are interested in applying, you are in an excellent position to obtain an APPCN fellowship! The University of Minnesota is a highly respected internship program, and many of the faculty with whom I interviewed at INS were well
aware of the program’s rigor and personally knew many of our internship faculty. Additionally, nearly all of the faculty with whom I interviewed were either board certified in clinical neuropsychology or were early career psychologists in the process of becoming board certified. Recent University of Minnesota Medical School psychology interns who applied to APPCN programs obtained a number of interviews at INS. Good Luck!
New Employee Course:
EPIINP812
Provider
Learner guide

Contents

Learner Objectives ..........................................................................................................
Introduction to Epic ........................................................................................................
Module 1: Overview of Hyperspace .................................................................................
Module 2: Patient Lists ...................................................................................................
Module 3: InBasket .........................................................................................................
Module 4: Patient Chart .................................................................................................
Module 5: Patient Summary Activity ..............................................................................
Module 6: Rounding Navigator ......................................................................................
Module 7: Chart Review .................................................................................................

Learner Objectives

At the end of this session the learner will be able to:

- Verbalize how to log into and out of EPIC
- Describe parts of the patient chart
- Identify use of chart to look up in-depth patient information
- Discuss how to use the rounding navigator
- Identify EPIC tools for documentation
- Describe how to compete orders med rec
- Discuss the admission and discharge navigators

(continued)
APPENDIX 38 (continued)

Introduction to Epic

Welcome to Epic for Providers! In this class you will learn about (and practice) how to document the care you do during the course of your work day. Today’s class covers Epic Basics. As you become more familiar with EPIC, you will discover there are additional ways to achieve the same things.

While you are learning today, please feel free to ask your instructor questions.

Today you will be working with practice patients; however it is important to treat those patients as though you are in production. This means making sure that you keep the patient’s chart secure. If you step away from your computer for a break, please be sure to log out. You are encouraged to review Fairview’s policy related to HIPAA [http://intranet.fairview.org/Resources/Regulatory/HIPAAPrivacy/index.htm].

Most learners choose to continue to practice their charting in EPIC after they leave class. You can do this by going into Fairview’s EPIC practice environment. A handout describing how to do this will be given to you at the end of class.

Let’s get started!

Module 1: Overview of Hyperspace

For the purpose of training today you will focus on accessing EPIC from the hospital; at the end of class you will be shown how to log on using the secure gateway.

The first step is to find the EPIC icon via the Fairview Applications Launcher (often called the FAL). This is located in the lower left hand corner of your screen.

In class, you will be using the EPIC Training icon. In the live environment, you will use the EPIC Hyperspace icon. You will use your own login/password in the live environment; today you are going to use an assigned student login. You will find this login on your tent card.

The password is train1.

Once you have entered your tent card login and the train1 password, you will be prompted for a department. EPIC will remember your last log in location. The department you use will typically be your hospital.
APPENDIX 38 (continued)

location's physician standard. Click on the magnifying glass to the right of the currently listed department. This will bring up all departments recently used. If you do not see the department you wish to choose, click on the search tab, enter UU and then click on the magnifying glass again. Scroll through the choices until you see UU Phys Standard. Select that one and Accept.

***IMPORTANT***

Module 2: Patient Lists

There are three ways to find a patient within Epic:

- System Lists
- Patient Station
- Treatment Team

Epic is used throughout all Fairview hospitals in the Twin Cities. To find patients at just your hospital, you will want to look for your facility's system list.

System lists:

- Are grouped within folders according to the different Fairview facilities.
- Are lists of patients currently admitted to the hospital.
- Includes unit census lists and clinical service team lists

Each Fairview facility has its own 2 letter identifier:

- PH = Princeton Hospital
- RH = Ridgway Hospital
- SH = Southdale Hospital
- UU = University of MN East Bank
- UR = Riverside & Amplatz Hospital
- WY = Lakes Hospital (Wyoming)

Take a minute to find your patient using a system list. Today you will be caring for patients on UU GA.

Browse through the patient names on the unit list. Once you have located your patient, double click on the patient's name to open the chart for documentation.

Another way to locate your patient is through something called Patient Station. Patient Station is a directory of all Fairview patients.
APPENDIX 38 (continued)

Patient Station:

- Is a button located at the top of your Epic workspace.
- Allows you to find patient chart whether they are admitted or discharged.

Locate that same patient using Patient Station.

Click it to bring up a pop up window which allows you to find a patient using name, MRN and date of birth.

Enter the patient's last name first, then a comma, then enter the first name.

Treatment Team:

- Adding yourself to the Treatment Team assists other Providers and staff who are caring for the patient.
- For example, adding your name to the Treatment Team will allow your partner to quickly identify that you are taking care of the patient.
- Treatment Team is listed in:
  - Patient List Overview/_snapshot
  - Professional Exchange
  - Southdale Index Report

Module 3: InBasket

The InBasket function of Epic is an administrative feature of the system that notifies you of chart deficiencies, orders that need signing, alerts, and other important communications. Some of these include:

- Unfinished notes
- Unsigned orders
- Unauthenticated transcriptions
- Lab results
- Clinician correspondence
- Estimated time: 15 minutes

Regular checks of the InBasket need to be integrated into your daily use of the system.
Module 4: Patient Chart

Opening and Closing a Chart

Once you have found your patient’s chart, there are 2 ways to open it:

- From a Patient List - Find the desired patient’s name and open it.
- Using Patient Station - Look up the patient using the first and last name (refer to steps in module 2) on the current admission encounter (figure 1).

To close the patient’s chart, click the “X” next to the right of their name in the chart tab at the top of the workspace.

Basic Chart Overview

The patient header is the white space at the top of the chart workspace. It gives basic patient information such as:

- Name & DOB
- Allergies
- Code Status
- Infectious Diseases
APPENDIX 39

ESSENTIAL COMPETENCE ELEMENTS

By the end of the year, interns are required to be meeting or exceeding expectations on all of the Essential Competence Elements of the MSI. This subset of MSI items were derived empirically by the faculty as being the most essential competence elements constituting the Minimal Levels of Achievement for completing the internship. The ECEs on the MSI are delineated below. Interns are expected to meet or exceed expectations on each of the following MSI items by the fourth quarter (Q4). The Internship Director checks each 4th quarter MSI to ensure that if these items are marked, interns meet or exceed expectations on them.

RESEARCH/SCHOLARLY INQUIRY COMPETENCE
A1 Conducts research professionally/ethically (protects subjects' rights/maintains privacy and confidentiality of data, uses proper scientific methods and reporting practices)
A6 Skill in statistical analysis and data interpretation
A7 Integration of research and clinical issues
A8 Skill in preparing written communication related to research (e.g., grants, manuscripts, IRB, summaries of research)
A9 Skill in organizing and presenting oral communication related to research (e.g., oral presentations, case conferences)
A12 Knowledge of the cognitive, affective, behavioral, developmental, social-cultural, and economic components of health and illness
A15 Application of research skills for evaluating practices, interventions, and programs

ETHICAL AND LEGAL STANDARDS COMPETENCE
B1 Knowledge/Understanding of/adherence to professional standards (e.g., APA Ethical Principles and Code of Conduct) and guidelines (e.g., APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists)
B2 Awareness of/adherence to legal (e.g., HIPAA, mandated reporting, commitment, testimony, Tarasoff) and regulatory (e.g., Board of Psychology) standards
B3 Demonstrates high standards of ethical conduct
B4 Places the interests of patients and populations at the center of service delivery and research
B5 Maintains confidentiality and privacy/understands their limits
B10 Acts with honesty and integrity in relationships with patients, families, and other team members

INDIVIDUAL AND CULTURAL DIVERSITY COMPETENCE
C2 Awareness of/sensitivity to individual and cultural diversity issues in assessment
C3 Awareness of/sensitivity to individual and cultural diversity issues in psychotherapy
C5 Awareness of/sensitivity to individual and cultural diversity issues in consultation including interactions with diverse professionals
C6 Knowledge/understanding of/adherence to professional standards (e.g., APA Ethical Principles and Code of Conduct) and guidelines (e.g., APA guidelines on multicultural education, training, research, practice, and organizational change for psychologists) related to individual and cultural diversity
C8 Awareness of own personal background and cultural heritage and its impact on interactions with and delivery of psychological services to diverse patients

APPENDIX 39 (continued)
C11 Adapts psychological services to meet patient needs in light of individual background and cultural heritage with diverse populations
C12 Respects the cultural diversity and individual differences that characterize patients, populations, and the healthcare team

PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS
D1 Exhibits professional values and attitudes (e.g. compassion for others, honesty, respect, humility, trustworthiness)
D2 Maintains expected work load and professionalism in fulfilling responsibilities
D4 Demonstrates punctuality for patient contacts and professional activities
D5 Demonstrates developing identity as a psychologist/socialization into the profession
D8 Demonstrates initiative/motivation/reliability/dependability
D12 Understands/manages professional boundaries/stress with patients
D17 Demonstrates clinical inquisitiveness/self-reflection

COMMUNICATION AND INTERPERSONAL SKILLS
E1 Develops rapport with patients, families, and other professionals (e.g., diverse clinical, age, gender, and cultural groups)
E2 Develops trusting relationships/rapport with patients, families/therapeutic alliance
E6 Communicates at patient's level of comprehension
E7 Demonstrates effective communication/assertiveness skills
E12 Ability to provide confrontation effectively when needed
E13 Provides timely, effective oral/written communication (addresses questions/requests)
E14 Develops trusting relationships with other trainees, professionals, and staff
E15 Works cooperatively with others
E16 Communication with supervisor

ASSESSMENT COMPETENCE
F1 Judgment in selecting assessment approaches
F2 Diagnostic interviewing
F11 Knowledge of the scientific, theoretical, empirical, demographic, and contextual bases of assessment
F20 Intelligence and Psychoeducational Assessment: Skill and accuracy in administering/scoring
F21 Skill in interpreting intelligence and psychoeducational tests
F25 Integrates assessment data/derives appropriate inferences from multiple data sources
F26 Knowledge/understanding of psychiatric phenomena and nosology (DSM-V/ICD 10)
F27 Formulates appropriate diagnoses/identifies problems and intervention goals
F28 Understanding of/sensitivity to cultural diversity issues in assessment
F30 Prepares timely, clear, objective, organized, integrated, useful reports
F31 Formulates appropriate treatment recommendations
F32 Provides understandable, useful feedback to patients and families
F33 Provides understandable, useful feedback to others (professionals, agencies, schools, etc.)

INTERVENTION/THERAPY COMPETENCE
G1 Knowledge/scientific foundation of psychotherapy (e.g., best practices, evidence-based practice, models, outcomes, principles, practice guidelines, research, theory, technique)
G2 Ability to facilitate patient's self-awareness/present therapeutic interpretations

APPENDIX 39 (continued)
G4 Awareness/management of patients' boundaries
G7  Awareness/management of countertransference
G8  Skill and judgment in treatment planning (considers alternatives, necessity, objectives, strategies, frequency, length, expectations, and termination)
G9  Considers patient safety/necessity, efficacy, and cost-effectiveness of services
G11 Uses current evidence-based interventions
G12 Adheres to treatment plan and treatment protocols/prepares for sessions
G13 Flexibility/skill in problem-solving/adapts techniques to meet patients' needs
G15 Monitors patients' progress toward therapeutic goals
G20 Awareness of ethical and legal issues in intervention/psychotherapy (e.g., referrals, hospitalizations, contracts with patients/families, consent to treatment, dual relationships, treatment of minors, privileged communication, mandated reporting)

SUPERVISION
H1  Knowledge of supervision models, theories, modalities, best practices, ethics, legal standards, and research
H2  Openness and responsiveness to supervision
H3  Cooperation with supervisor
H4  Communication with supervisor
H8  Seeks case consultation/supervision as needed
H11 Effectiveness and competence of supervisee as a supervisor

CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS COMPETENCE
I5  Effectively collaborates as a consultant/defines own role/contributions
I6  Demonstrates timely response to consultation requests
I7  Provides timely, effective oral/written communication (addresses questions/requests)
I8  Demonstrates interprofessional professionalism, including establishing effective interdisciplinary collaborations
I9  Establishes/maintains rapport/colllegiality/boundaries with other professionals
I10 Understands/respects other disciplines' contributions/roles/perspectives/ethics
I13 Attends, participates actively, and is punctual for interdisciplinary team meetings
I14 Communicates with team members to clarify each member’s responsibility in executing components of a treatment plan/health intervention/research
I15 Listens actively, and encourages ideas and opinions of other team members
I20 Works collaboratively with those who receive and provide care, and others who contribute to or support the delivery of prevention and health services
I21 Awareness of/sensitivity to cultural diversity issues in consultation
APPENDIX 40

PROFESSION-WIDE COMPETENCE ASSESSMENT

Profession-Wide Competencies Assessment (Internship)

Supervisee:
Supervisor:
Training Program:
Rotation:
Date:

Introduction: The Profession Wide Competencies Assessment (PWCA) is designed to provide verification of trainees’ competencies at the end of their internship. The APA Commission on Accreditation (CoA) requires that trainees who complete accredited training programs develop certain competencies as part of their preparation for practice in health service psychology (HSP). CoA expects that all profession-wide competencies will be grounded, to the greatest extent possible, in the existing empirical literature and in a scientific orientation toward psychological knowledge and methods. CoA expects that training in profession-wide competencies (PWCs) at the internship level will provide broad and general preparation for entry level independent practice and licensure by the end of the internship. CoA expects that programs will require trainee demonstrations of PWCs that differ according to the level of training provided (i.e., doctoral, internship, post-doctoral). In general, trainees are expected to demonstrate each profession-wide competency with increasing levels of independence and complexity as they progress across levels of training. CoA expects that evaluation of trainees’ competence in each required profession-wide competency area will be an integral part of the curriculum, with evaluation methods and minimum levels of performance that are consistent with the SoA (e.g., for clinical competencies, evaluations are based at least in part on direct observation; evaluations are consistent with best practices in student competency evaluation).

Directions: The PWCA is to be completed by the primary supervisor at the end of the internship to verify that graduating interns possess the profession wide competencies required as described above. For each competence element, supervisors mark Yes or No to indicate whether or not the intern meets expectations for completion of the internship, i.e. readiness for postdoctoral fellowship/residency or its equivalent.

<table>
<thead>
<tr>
<th>Intern meets expectations for completion of internship</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>A. RESEARCH/SCHOLARLY INQUIRY COMPETENCE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Research competency is required at the internship level. Science as the foundation of HSP. Individuals who successfully complete accredited programs must demonstrate knowledge, skills, and competence sufficient to produce new knowledge, to critically evaluate and use existing knowledge to solve problems, and to disseminate research. This area of competence requires substantial knowledge of scientific methods, procedures, and practices</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trainee demonstrates the substantially independent ability to critically evaluate and disseminate research or other scholarly activities (e.g., case conference, presentation, publications) at the local (including the host institution), regional, or national level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Skill in preparing written communication related to research (e.g., grants, manuscripts, IRB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Skill in organizing and presenting oral communication related to research (e.g., oral presentations, case conferences)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Knowledge of the cognitive, affective, behavioral, developmental, social, cultural, and economic components of health and illness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A.1.f. 6/4/16 QAI Systems™ © 1998 Regents of the University of Minnesota. All Rights Reserved. Photocopying permitted by law only when user has site license that is in effect.
**APPENDIX 40 (continued)**

<table>
<thead>
<tr>
<th>B</th>
<th>ETHICAL AND LEGAL STANDARDS COMPETENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical and Legal Standards competence is required at the internship level. Trainee demonstrates competence in each of the following areas:</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Is knowledgeable of and acts in accordance with the current version of the APA Ethical Principles of Psychologists and Code of Conduct</td>
</tr>
<tr>
<td>2</td>
<td>Is knowledgeable of and acts in accordance with relevant laws, regulations, rules, and policies governing health service psychology at the organizational, local, state, regional, and federal levels</td>
</tr>
<tr>
<td>3</td>
<td>Is knowledgeable of and acts in accordance with relevant professional standards and guidelines</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>INDIVIDUAL AND CULTURAL DIVERSITY COMPETENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness in health service psychology requires that trainees develop the ability to conduct all professional activities with sensitivity to human diversity, including the ability to deliver high quality services to an increasingly diverse population. Therefore, trainees must demonstrate knowledge, awareness, sensitivity, and skills when working with diverse individuals and communities who embody a variety of cultural and personal background and characteristics. CoA defines cultural and individual differences and diversity as including, but not limited to, age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation, and socioeconomic status. CoA recognizes that development of competence in working with individuals of every variation of cultural or individual difference is not reasonable or feasible. Trainee demonstrates competence in each of the following areas:</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Understanding of how their own personal/cultural history, attitudes, and biases may affect how they understand and interact with people different from themselves;</td>
</tr>
<tr>
<td>2</td>
<td>Knowledge of the current theoretical and empirical knowledge base as it relates to addressing diversity in all professional activities including research, training, supervision/consultation, and service</td>
</tr>
<tr>
<td>3</td>
<td>Ability to integrate awareness and knowledge of individual and cultural differences in the conduct of professional roles (e.g., research, services, and other professional activities). This includes the ability apply a framework for working effectively with areas of individual and cultural diversity not previously encountered over the course of their careers. Also included is the ability to work effectively with individuals whose group membership, demographic characteristics, or worldviews create conflict with their own.</td>
</tr>
<tr>
<td>4</td>
<td>Demonstrate the ability to independently apply their knowledge and approach in working effectively with the range of diverse individuals and groups encountered during internship</td>
</tr>
</tbody>
</table>
**APPENDIX 40 (continued)**

<table>
<thead>
<tr>
<th>D</th>
<th>PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intern meets expectations for completion of internship</td>
</tr>
<tr>
<td>2</td>
<td>Interns are expected to:</td>
</tr>
<tr>
<td>3</td>
<td>Trainees are expected to respond professionally in increasingly complex situations with a greater degree of independence across levels of training. Interns are expected to:</td>
</tr>
<tr>
<td>4</td>
<td>Behave in ways that reflect the values and attitudes of psychology, including integrity, deportment, professional identity, accountability, lifelong learning, and concern for the welfare of others.</td>
</tr>
<tr>
<td>5</td>
<td>Engage in self-reflection regarding one’s personal and professional functioning; engage in activities to maintain and improve performance, well-being, and professional effectiveness.</td>
</tr>
<tr>
<td>6</td>
<td>Actively seek and demonstrate openness and responsiveness to feedback and supervision.</td>
</tr>
<tr>
<td>7</td>
<td>Respond professionally in increasingly complex situations with a greater degree of independence as they progress across levels of training.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>COMMUNICATION AND INTERPERSONAL SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Trainees demonstrate competence in conducting evidence-based assessment. Interns are expected to demonstrate the following competencies:</td>
</tr>
<tr>
<td>2</td>
<td>CoA views communication and interpersonal skills as foundational to education, training, and practice in health service psychology. These skills are essential for any service delivery/activity/interaction, and are evident across the program’s expected competencies. Interns are expected to:</td>
</tr>
<tr>
<td>3</td>
<td>Develop and maintain effective relationships with a wide range of individuals, including colleagues, communities, organizations, supervisors, supervisees, and those receiving professional services.</td>
</tr>
<tr>
<td>4</td>
<td>Produce and comprehend oral, nonverbal, and written communications that are informative and well-integrated; demonstrate a thorough grasp of professional language and concepts.</td>
</tr>
<tr>
<td>5</td>
<td>Demonstrate effective interpersonal skills and the ability to manage difficult communication well.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F</th>
<th>ASSESSMENT COMPETENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Trainees demonstrate competence in conducting evidence-based assessment. Interns are expected to demonstrate the following competencies:</td>
</tr>
<tr>
<td>2</td>
<td>Select and apply assessment methods that draw from the best available empirical literature and that reflect the science of measurement and psychometrics; collect relevant data using multiple sources and methods appropriate to the identified goals and questions of the assessment as well as relevant diversity characteristics of the service recipient.</td>
</tr>
<tr>
<td>3</td>
<td>Interpret assessment results, following current research and professional standards and guidelines, to inform case conceptualization, classification, and recommendations, while guarding against decision-making biases, distinguishing the aspects of assessment that are subjective from those that are objective.</td>
</tr>
<tr>
<td>4</td>
<td>Communicate orally and in written documents the findings and implications of the assessment in an accurate and effective manner sensitive to a range of audiences.</td>
</tr>
</tbody>
</table>
**APPENDIX 40 (continued)**

<table>
<thead>
<tr>
<th>G</th>
<th>INTERVENTION/Therapy Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interns demonstrate competence in evidence-based interventions. Intervention is defined broadly to include but not be limited to psychotherapy. Interventions may be derived from a variety of theoretical orientations. The level of intervention includes those directed at an individual, a family, a group, a community, a population or other systems. Interns are expected to demonstrate the ability to:</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Establish and maintain effective relationships with the recipients of psychological services</td>
</tr>
<tr>
<td>2</td>
<td>Develop evidence-based intervention plans specific to the service delivery goals</td>
</tr>
<tr>
<td>3</td>
<td>Implement interventions informed by the current scientific literature, assessment findings, diversity characteristics, and contextual variables</td>
</tr>
<tr>
<td>4</td>
<td>Apply the relevant research literature to clinical decision making</td>
</tr>
<tr>
<td>5</td>
<td>Modify and adapt evidence-based approaches effectively when a clear evidence-base is lacking</td>
</tr>
<tr>
<td>6</td>
<td>Evaluate intervention effectiveness, and adapt intervention goals and methods consistent with ongoing evaluation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>H</th>
<th>Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoA views supervision as grounded in science and integral to the activities of health service psychology. Supervision involves the mentoring and monitoring of trainees and others in the development of competence and skill in professional practice and the evaluation of those skills. Supervisors act as role models and maintain responsibility for the activities they oversee. Interns are expected to:</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Apply knowledge of supervision models and practices in direct or simulated practice with psychology trainees or other health professionals. Examples of direct or simulated practice examples of supervision include, but are not limited to, role-played supervision with others, and peer supervision with other trainees</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I</th>
<th>Consultation and Interprofessional/Interdisciplinary Skills Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoA views consultation and interprofessional/interdisciplinary interaction as integral to the activities of health service psychology. Consultation and interprofessional/interdisciplinary skills are reflected in the intentional collaboration of professionals in health service psychology with other individuals or groups to address a problem, seek or share knowledge, or promote effectiveness in professional activities. Interns are expected to:</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Demonstrate knowledge and respect for the roles and perspectives of other professions.</td>
</tr>
<tr>
<td>2</td>
<td>Apply this knowledge in direct (e.g. peer consultation, provision of consultation to other trainees) or simulated (e.g., role-play) consultation with individuals and their families, other health care professionals, interprofessional groups, or systems related to health and behavior</td>
</tr>
</tbody>
</table>

**Total for all 30 competence elements:**

Yes No
## APPENDIX 41

### Epic Shortcuts/SmartPhrases

Below is a list of dot phrases that can be adapted. These, including the dog phrases that start with .h1 can be re-labelled.

<table>
<thead>
<tr>
<th>.Phrase</th>
<th>Provides</th>
</tr>
</thead>
<tbody>
<tr>
<td>.pmh</td>
<td><em>Past medical history</em> (pulls from previously entered data)</td>
</tr>
<tr>
<td>.psh</td>
<td><em>Past surgical history</em> (pulls from previously entered data)</td>
</tr>
<tr>
<td>.med</td>
<td><em>Medications</em> (pulls from previously entered data)</td>
</tr>
<tr>
<td>.weight4</td>
<td>Lists last 4 weights entered through vitals (pulls from previously entered data)</td>
</tr>
<tr>
<td>.ccw</td>
<td>copies referring physician and parents on any letter</td>
</tr>
<tr>
<td>.ccwparents</td>
<td><em>Patient address</em></td>
</tr>
</tbody>
</table>

### Tests

<table>
<thead>
<tr>
<th>.Phrase</th>
<th>Provides</th>
</tr>
</thead>
<tbody>
<tr>
<td>.BASC2CHILDSELFREPORT</td>
<td>Table for the BASC2 child self-report</td>
</tr>
<tr>
<td>.WISCIV</td>
<td>Table for the WISC-IV</td>
</tr>
<tr>
<td>.WIATIII</td>
<td>Table for the WIAT-III</td>
</tr>
</tbody>
</table>

Similar dot phrases exist for other common tests providing tables for reporting results.

### Common phrases in documentation

<table>
<thead>
<tr>
<th>.Phrase</th>
<th>Provides</th>
</tr>
</thead>
<tbody>
<tr>
<td>.h1b</td>
<td>Patient participated fully and appeared to derive benefit. Rapport was excellent.</td>
</tr>
<tr>
<td>.h1con</td>
<td>Confirmation of appointment for:</td>
</tr>
<tr>
<td></td>
<td>I look forward to seeing you then.</td>
</tr>
<tr>
<td>.h1EMR</td>
<td>See EMR for additional information regarding patient health history, status and medications.</td>
</tr>
<tr>
<td>.h1ex</td>
<td>Extended session due to complexity of case and length of interval.</td>
</tr>
<tr>
<td>.h1m</td>
<td>Missed you yesterday. Please let me know if you wish to reschedule.</td>
</tr>
<tr>
<td>.h1mmpi</td>
<td>Patient was administered the MMPI-2. Results will be integrated into upcoming evaluation report.</td>
</tr>
<tr>
<td>.h1mmpi2</td>
<td>Approximately 35 minutes was spent administering, scoring, and interpreting the MMPI2.</td>
</tr>
<tr>
<td>.h1msg</td>
<td>I called to schedule appointment with patient. Left message to have patient call me back.</td>
</tr>
<tr>
<td>.h1sleep</td>
<td>Cognitive behavioral strategies to improve sleep, include the following:</td>
</tr>
<tr>
<td></td>
<td>- Limit time spent in bed each night to about 6 hours per night</td>
</tr>
<tr>
<td></td>
<td>- Keep the same sleep-wake schedule every day of the week, including the weekends, e.g. 12 AM to 6 AM</td>
</tr>
<tr>
<td></td>
<td>- Keep busy during the daytime and particularly the evening hours - avoid sedentary situations where you might get drowsy</td>
</tr>
<tr>
<td></td>
<td>- Get into bed 30 minutes before bedtime doing something relaxing, like reading (try several types of books), movies, music, crossword puzzles, etc.</td>
</tr>
<tr>
<td></td>
<td>- Shut off the lights ONLY when you actually feel drowsy (eyes closing) and not just when the clock says it's bedtime</td>
</tr>
<tr>
<td></td>
<td>- Any time that you wake during the night use your relaxation strategies such as deep breathing, prayer, meditation, imagery, etc. To help relax and go to sleep. If this doesn't work, use the radio, audio book, music, etc.</td>
</tr>
<tr>
<td></td>
<td>- If you want, you can get up and move to the living room and try reading (etc.) again until drowsy</td>
</tr>
<tr>
<td></td>
<td>- Don't talk to people about sleep and don't believe all the reports that are out</td>
</tr>
</tbody>
</table>
there as they typically don't apply to you.

- Don't put pressure on yourself to get a good night sleep, it doesn't work. Try to focus ONLY on relaxation and distraction

- Set the alarm clock for the time you want to get up and turn all the clocks from view during the night. Move them out of reach so you don't check

| .h1t | Time in: |
| .h1t | Time out: |

| .h1tel | I left a telephone message for patient offering to schedule an appointment. Patient has my telephone number if wishing to pursue. |

| .h1tr | The treatment plan was reviewed with the patient at today’s visit. The treatment plan remains current based on the patient’s status and progress to date. |

| .h1tx1 | Treatment plan due : |

| .h1tx2 | A treatment plan was completed. |

| .h1tx3 | A treatment plan will be completed at that time. |
APPENDIX 42

References on Professional Development


**Additional Selected Readings from the Professional Development Conference**


Benson, E. S. (September, 2006). Pursuing the perfect research postdoc. *gradPSYCH, 4* (3).


Robiner, W. N. & Yozwiak, J. A. Business of Practice Bibliography.


