# TABLE OF CONTENTS

**CHAPTER 1**  
CLINICAL PERSONNEL (addresses, telephone numbers and beepers)

**CHAPTER 2**  
ORGANIZATIONAL STRUCTURE

**CHAPTER 3**  
APPLICATION PROCEDURES AND BENEFITS

**CHAPTER 4**  
EDUCATIONAL ACTIVITIES

**CHAPTER 5**  
ACGME REQUIREMENTS

**CHAPTER 6**  
CLINICAL PROGRAMS

**CHAPTER 7**  
ADMINISTRATIVE POLICY AND PROCEDURE

**CHAPTER 8**  
EVALUATION

**CHAPTER 9**  
APPENDICES
CHAPTER 1

Clinical Personnel
Shaw, Jon A., M.D. ................................................................. (T) 305-355-7077
Professor of Psychiatry and Pediatrics and Training Director ........................ (B) 888-773-0855
Chief, Division of Child and Adolescent Psychiatry.............................. e-mail: jshaw@med.miami.edu

Illa, Lourdes, M.D. ........................................................................ (T) 305-355-7077
Associate Professor........................................................................... (C) 305-877-4354
Child and Adolescent Psychiatry.......................................................... e-mail: illa@med.miami.edu

Benitez, Evelyn, F. Ph.D. ............................................................... (T) 305-355-7077
Clinical Psychologist ................................................................. (B) 305-738-5705
CAP Outpatient Clinic ................................................................. e-mail: ebenitez@jhsmiami.org

Buford, Ushimbra, M.D. ........................................................................ (T) 305-355-7077
Assistant Professor of Psychiatry .......................................................... (C) 305-496-8062
Director, Crisis Service and Inpatient Unit, JMH .......................... E-mail: ubuford@med.miami.edu

Campo, Ana, M.D. ........................................................................ (305) 243-3075
RMSB Suite #2106 A................................................................. Fax (305) 243-9893
Miami, FL 33136...................................................................... e-mail: acampo@med.miami.edu
Castro, Anthony ...................................................................................................................... e-mail: acastro2@med.miami.edu

(305)355-9121 ......................................................................................................................

Chalfin, Susan, Ph.D. ............................................................................................................ (T) 305-355-7110
Clinical Psychologist ........................................................................................................... (B) 305-277-8094
Child and Adolescent Inpatient Unit.................................................................e-mail: schalfin@jhsmiami.org

Folstein, Susan, M.D. ............................................................................................................ (T) 305-355-7077
Professor of Clinical Psychiatry .......................................................................................... (C) 305-546-2548
Director of the Child Psychiatry Outpatient Services........e-mail: sfolstein@med.miami.edu

Mavrides, Nicole, MD........................................................................................................... (T) 305-355-9135
Assistant Professor............................................................................................................ (C) 954-873-4841
Director, Child & Adolescent Psychiatry Consult/Liaison Service........e-mail: nmavrides@med.miami.edu

Melisa Oliva, Psy.D............................................................................................................. (T) 305-355-7285
Clinical Psychologist ..............................................................................................................
CAP Consultation/ Liaison Service.............................................................................email: moliva2@jhsmiami.org

Neuhut Rachel, MD.......................................................................................................... (T) 305-243-2301
Assistant Professor.......................................................................................................... (C) 305-202-2100
Director, Eating Disorders Program.............................................................. e-mail: rneuhut@med.miami.edu

Vasiliu-Feltes, Ingrid, M.D., MBA....................................................................................... (T) 305-243-3465
Assistant Professor.............................................................................................................(C) 305-903-5586
e-mail: ivfeltes@med.miami.edu
Xantus, Arunditi, M.D.................................................................(T) 305-305-632-4810

Assistant Professor..............................................................(C) 305--632-4810

-mail: axantus@med.miami.edu
VOLUNTARY CLINICAL SERVICE/CLINICAL SUPERVISORS

Aguilera, Maribel, M.D. ........................................................................................................... (305) 932-5500
21110 Biscayne Blvd Ste# 304 ................................................................. Fax (305) 935-0466
Aventura, FL  33180.................................................................e-mail: habibi08@peoplespc.com

Barzaga, Aramys, M.D. ........................................................................................................... (786) 282-4528
5703 NW 7th Street
Miami, FL 33126.................................................................e-mail: jaba0542@hotmail.com

Carreno, Teresa, M.D................................................................. (305) 595-1616
9480 SW 77th Ave.................................................................Fax (305) 595-7272
Miami, FL 33156.................................................................e-mail: tcarreno@mdpc.cc

Castellanos, Daniel, M.D.................................................................(305) 348-4261
11200 SW 8th St, HLS II 693 .................................................................Fax (305) 348-0626
Miami, FL  33199............................................................... e-mail: dcastell@fiu.edu

Castro, Kenia, M.D................................................................. (305) 519-4916
331 NW 32 Ave Miami, FL 33125................................. e-mail: kexied@aol.com

Ericksen, Ana M.D.................................................................(305) 595-1616
9480 SW 77th Ave Miami, FL 33156................................................................. e-mail: aeriksen@mdpc.cc

Feltman, Douglas, M.D. ...................................................................................... (305) 443-8247

2121 Ponce De Leon Blvd Ste# 1000..............................................................Fax (305) 461-4746

Coral Gables, FL33134.............................................................................. e-mail: dsfelmanmd@gmail.com

Frank, Sheldon, M.D. ...................................................................................... (305) 792-0855

19022 North East 29th Avenue

Aventura, FL 33180.............................................................................. e-mail: frenchshel@gmail.com

Grabois, Lori, M.D. ...................................................................................... (305) 932-5500

21110 Biscayne Boulevard, Suite 304.......................................................... Fax (305) 935-0466

Aventura, FL 33180.............................................................................. e-mail: monkie27@aol.com

Geada, Juan Rene, M.D.............................................................................. (305) 595-1616 Ext. 4599

9480 SW 77 Avenue.................................................................................. Fax (305) 595-7272

Miami, FL 33156.................................................................................. e-mail: jrgeada@aol.com

Hernandez, Jorge, M.D. .............................................................................. (786) 256-6785

11627 SW 90th St

Miami, FL 33176.................................................................................. e-mail: johernmd@yahoo.com
VOLUNTARY CLINICAL SERVICE/CLINICAL SUPERVISORS

Hughes, Michael, M.D. ........................................................................................................................................... (305) 858-7810

Hughes Family Psychiatric Center ......................................................................................................................... Fax (305) 569-0017

2701 South Bayshore - Suite 310 ......................................................................................................................... e-mail: hfpc1@bellsouth.net

Miami, FL 33133

Hunter, Tom, M.D. .................................................................................................................................................. (305) 461-4700

2121 Ponce De Leon Blvd Suite #1000 ................................................................................................................ Fax (305) 461-4746

Coral Gables, FL 33134 .......................................................................................................................................... e-mail: thomasahuntermd@dr.com

Leavitt, Carolyn, M.D. ................................................................................................................................................. (305) 662-1610

7800 SW 57th Av ......................................................................................................................................................... Fax (305) 662-1177

South Miami, FL 33143 .......................................................................................................................................... e-mail: cleavittmd@bellsouth.net

Patino, Edgar, M.D. ...................................................................................................................................................(305)669-7363

SouthMiami/CoralGables ........................................................................................................................................ e-mail: epama41@gmail.com

Peters, Juandalyn, M.D. ........................................................................................................................................... (786) 255-0347

3475 Sheridan Street Suite# 310

Hollywood, FL 33021 .......................................................................................................................................... e-mail: juandalynp@yahoo.com

Pomeraniec, Fernando, M.D.

V.A. Medical Center Psychiatry Service ............................................................................................................... 305-324-4455, ext 4828

Miami, FL 33136 ................................................................................................................................................. e-mail: Fernando.Pomeraniec@va.gov
Pravder, Lee, M.D.  ..........................................................(305) 932-5500

21110 Biscayne Blvd- Ste 304  ...............................................Fax (305) 935-0466

Aventura, FL 33180..........................................................e-mail: lpravder@bellsouth.net

Rodriguez, Juan  M.D. ..........................................................(305) 595-6695

South Miami near Dadeland ..............................................e-mail: rodjesif@yahoo.com

Seligman, Fred, M.D ..........................................................(954) 423-9655

12001 Piccadilly Place ......................................................Fax (954) 424-8760

Davie, FL 33325..........................................................e-mail: albertbmw@yahoo.com
DIVISION OF

CHILD AND ADOLESCENT

RESIDENTS DIGITAL BEEPER

<table>
<thead>
<tr>
<th>First Year Residents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lance Amols, MD - 5-2255-7079</td>
</tr>
<tr>
<td>Bryan Ellerson, MD - 5-2255-0262</td>
</tr>
<tr>
<td>Richard Callahan, MD - 5-2255-0295</td>
</tr>
<tr>
<td>Michael Jacobs, MD - 5-2255-0313</td>
</tr>
<tr>
<td>Suraya Kuwadry, MD - 5-2255-0426</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Second Year Residents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ricahard Idell, MD - 5-2255-0441</td>
</tr>
<tr>
<td>Shanti Jampani, MD - 5-2255-0398</td>
</tr>
<tr>
<td>Samuel Neuhut, MD - 5-2255-0313</td>
</tr>
<tr>
<td>Marilyn Peraza, MD - 5-2255-0336</td>
</tr>
<tr>
<td>Mihaela Stoica, MD-5-2255-0321</td>
</tr>
</tbody>
</table>
CHAPTER 2

Organization Structure
SPONSORSHIP AND OVERALL ADMINISTRATIVE ORGANIZATION

The graduate medical education (residency) programs in this center are accredited under the auspices of the University of Miami-Jackson Memorial Medical Center (UM-JMMC) which is comprised of three institutions: The University of Miami School of Medicine, Jackson Memorial Hospital (JMH), and the Veterans Administration Medical Center -- only the first two of which are participants in this training program in Child and Adolescent Psychiatry. Within the organizational and administrative structure of the medical school, the Division of Child and Adolescent Psychiatry is part of the Department of Psychiatry, and its director reports to the Chairman of the Department who, in turn, reports to the Dean of the School of Medicine. The Dean is also the Vice President for Medical Affairs of the University of Miami and reports directly to the President of the University. This university is a private institution and its president reports to its Board of Trustees.

The faculty of the Division of Child and Adolescent Psychiatry staff, the Child and Adolescent Psychiatry (CAP) Service of JMH report to the Director of the Division, who acts as Chief of the CAP Service. The Chief of the CAP Service reports to the Chief of the Psychiatric Service of JMH who, in turn, reports to the hospital's chief operating officer. This hospital, although owned and financed primarily by Dade County, is operated independently of the County government under the direction of the Public Health Trust (PHT). The CEO of the hospital is also President of the PHT. Decisions regarding the training programs are made ultimately by the PHT on the advice of the House Staff Committee and the JMH Medical Staff Executive Committee.

The CAP Service participates fully in the affairs of the Psychiatric Service generally. The Child and Adolescent Psychiatry Training Director and Division Chief sit on the Departmental Executive Training Committee, which consists of the Department Chairman, Training Director and Associate Directors of the (general) Psychiatric Residency Program, the Director of Undergraduate Psychiatric Education, the Directors of Geriatric Psychiatry, Addiction Psychiatry and Psychosomatic Medicine, and the Director of Continuing Psychiatric Education. The Training Director for Child Psychiatry also participates in the Residency Training Committee.

Funding for the CAP programs comes from the following sources:

1. For all psychiatrist (and social scientists and some faculty members of other professions who are not in the CAP Division but who participate actively in the program): From (a) the university budget; (b) the Annual Operating Agreement within which funds are transferred from JMH to the medical school for administration of the clinical services and supervision of the training programs; (c) grants and contracts, and (d) income from private patient fees within the provisions of the faculty's Professional Income Plan;

2. For all psychologists, social workers, nurses, ancillary therapist, paraprofessionals, etc. Directly from the JMH budget;
3. For teachers: From the Dade County School Systems.

INTERNAL ORGANIZATION OF THE
JMH CAP SERVICE

The various components of the CAP Service are organized in a manner assuring that the basic functions of each component are carried out in an effective and efficient manner.

The clinical components of the CAP Service, as they currently exist, are as follows:

1. The CAP Outpatient Service (also designated as the CAP Clinic)
2. The CAAP Inpatient Service
3. The CAP Consultation/Liaison Service
4. The CAP School and Community Consultation Service
5. The Child and Adolescent Crisis Service

Each component is under the overall clinical direction of a child and adolescent psychiatrist designated as Chief, Medical Director, or Director, as appropriate, of that component.

The senior member of each mental health profession or discipline, as a member of the component’s clinical team, is accountable to the Chief Director, or Medical Director charged with overall responsibility for that component. At the same time, he/she is accountable to the staff member next senior within his/her own discipline in the administrative structure of the Psychiatric Service as a whole.
TRAINING PROGRAM IN CHILD AND ADOLESCENT PSYCHIATRY

The residency training programs in psychiatry and child psychiatry are fully integrated. The training responsibilities of the CAP Service include, in addition to the Residency program in child psychiatry, the following:

- A two month, rotation for all PGY-2 Residents in general psychiatry
- A six-week clinical clerkship for third-year medical students throughout the year
- Elective experience for fourth-year medical students
- Elective rotations for PGY 4 residents
- Elective rotations for Pediatric/Adolescent Medicine residents

The Training Director is responsible for developing, directing and coordinating under the supervision of the Chief of Child and Adolescent Psychiatry all educational activities in the child and adolescent psychiatry training program. This position provides oversight for the overall training curriculum and maintains a training manual delineating all aspects of the training program. The Training Director moderates seminars, conducts clinical case conferences, provides case supervision on an individual basis and coordinates all supervisory and teaching responsibilities of the clinical faculty. This position chairs the child and adolescent psychiatry training committee and is an active participant in research and the medical school’s private practice plan.

The role of the Director of Child Psychiatry Education is to assist the Chief of Child and Adolescent Psychiatry in the development, implementation and coordination and training of the Child and Adolescent Psychiatry Fellows and General Psychiatry Residents in accordance with criteria established by "The Essentials of Accredited Residencies in Graduate Medical Education", recommendation of various appropriate clinical and training committees of the American Academy of Child Psychiatry, as well as the medical and sociocultural needs of the community.

The Director of Child Psychiatry Education is responsible in assisting the Chief of Child and Adolescent Psychiatry Service in:

1. Developing and annually reviewing the basic educational requirements for Child and Adolescent Psychiatry Residents, General Psychiatry Residents, and Medical Students rotating through this Service.
2. Planning and coordinating the implementation of schedules for clinical conferences and didactic seminars.
3. Selection of Child Psychiatry Residents, planning their supervision and maintaining records of their progress in aspects of the program.
4. Providing Residents with an understanding of the goals of training and evaluation procedures, as well as the responsibilities of the Residents for their own learning and clinical work.
5. Providing the Residents with an annually updated Child and Adolescent Psychiatry Bibliography.
6. Assisting the faculty members and clinical child psychiatry consultants in their educational activities and assessment of Fellows training development.

Training Logs. Training logs must be kept by each child psychiatry resident. The training logs delineate patient's initial age, sex, diagnosis, length of therapy, type of therapy, etc. and help the trainee and the training office keep an adequate balance of cases. Training logs should be kept for all rotations, including:
Residents must maintain an updated list of their therapy patients on CERNER as a Patient List. The list must be updated on a weekly basis, and access must be granted to the Training Director (Refer to Appendix A.). This information is utilized by the Training Director to ensure that residents are exposed to patients diverse in age, gender, diagnoses and treatment modality.

**Training Committee.** The Training Committee consists of the Division Chief, Training Director, psychiatry, psychology and social work faculty, and the chief resident. The Committee meets on the first Monday of the month and is chaired by the Division Chief. A written record of the meeting includes an attendance record, a review of past minutes, old business, new business, and a continuing updated agenda. The committee is responsible for ongoing review and evaluation of the training curriculum and the clinical training experiences. It also monitors the training progress of child and adolescent residents as well as the general psychiatry residents. Mid-year evaluations include resident critique of clinical rotations, faculty, and seminars, as well as assessments of the residents at six month intervals. The Training Director discusses the results of these evaluations with each individual resident.
QUALITY ASSURANCE PROGRAM

Objectives:

1. To provide ongoing and continuous monitoring of patient care including evaluation, treatment planning, achievement of therapeutic goals, and the documentation of treatment progress.
2. To provide review of any special procedures and/or unusual or experimental drugs.
3. To provide medication usage review, including review of medication records, adverse reactions and errors involving medication.
4. To provide review of unusual incidents involving patient care as well as the general quality and appropriateness of patient care under unusual circumstances.
5. The clinical performance of all individuals with clinical privileges are monitored and evaluated.
6. To provide for the maintenance of the quality and content of medical records.
7. To provide a credentialing record and regular review of all clinically active personnel.
8. To identify opportunities for improving care: Using methods and theories that reflect current knowledge and clinical experience.
10. To interface with other clinical services Department of Psychiatry and coordinate quality assurance concerns.
11. To provide a forum for continuous education and feedback about quality patient care issues within the Child and Adolescent Psychiatry Service.

Organization. The Child and Adolescent Psychiatry Division Quality Assurance Program will be implemented utilizing clinic professional personnel.

Mechanisms. The Child and Adolescent Service Quality Assurance/ Utilization Review Committee will consist of all clinic professional senior staff and the Chief Fellow.

There will be a monthly updated list of active cases in the clinic. This list will be organized by the Chief of the CAP Outpatient clinic. These will be the cases that will be subject to random audit, one case from each therapist on the service and within the Department who is seeing children or families in treatment. All Child and family charts will be kept in Mental Health Medical Records. All resident/fellow/graduate student cases will have an assigned supervisor.

In addition to the random monthly audit, an audit of all active charts will be done yearly during the month of June and additional times as may be determined by the faculty.

The following elements will be audited:

1. All administrative forms are present and appropriately implemented.
2. All clinical forms are present and appropriately implemented.
3. All entries are signed, dated and timed.
4. A complete intake/evaluation that includes: demographic data, a statement of symptoms and problems, their onset, evolution, and duration, a Developmental
History, Pertinent Medical History, Family History, an Objective Examination of the patient, a Summary or Formulation, a Diagnostic Impression and a Treatment or Follow-up Plan.

5. Evidence of appropriate effort to carry out the treatment plan and regular review of the plan.

6. Documentation of supervision.

7. History of previous audits, noted deficiencies and the clinician correction or response (Audit Form plus any Audit Committee note reflecting the monitoring of deficiencies).

8. Ongoing Utilization Review issues will be addressed and updated monthly. Annual Summaries of Psychology, consultation-liaison, outpatient, and training parameters that are identified and monitored are required. New appropriate studies can be introduced at anytime and current studies reviewed monthly.

9. Risk Management problems in clinical care or program management will be reviewed on a monthly basis and reported. On-going monitoring of proposed solutions will be documented.

10. All staff and outside consultant supervisors will be credentialed for the specific work they do on the service assisting in the care of patients, residents, fellows, graduate students or staff on the service. These credentials will be reviewed on a yearly basis.

**Resident Quality Assurance Projects**

The ACGME has increasingly focused on patient safety and quality improvement. Child Psychiatry fellows are expected to participate in patient safety and quality improvement initiatives.
CHAPTER 3

Application Procedures and Benefits
Since child and adolescent psychiatry is a sub-specialty of psychiatry with its own certification procedures by the American Board of Psychiatry and Neurology and its separate training program accreditation by the Accreditation Council for Graduate Medical Education, a new, original application must be submitted by all applicants for appointment to a residency position.

Applicants From Other Residency Programs In Psychiatry

All documents listed at the bottom of page 3 of the application form must be submitted as well as the biographical sketch mentioned on page 4 of the application form. At least three letters of reference are required, and one of these must be from the applicant's general psychiatric residency training program director.

Applicants From UM-JMH Residency Program In Psychiatry

Applicants from our own general residency program need not submit a letter of reference from their medical school dean or transcripts of their medical school scholastic records.

Application Procedure

Inquires and request for application. The CAP training program coordinator will prepare a letter for the CAP Training Director's signature within three working days of receipt of the inquiry. The letter will be mailed with the following enclosures (at the least): Description of the CAP training program; material descriptive of the Medical Center and the community; an application form.

Receipt of Applications. On receipt of an application the training program coordinator will open a file in the applicant's name; all material relevant to the applications (documents, correspondence, etc.) will be maintained in this file under the supervision of the training program secretary.

Application Check-Off form. The training program secretary will maintain a check-off form for each active application and a summary check-off form (q.v.) for all active applications.

Incomplete Applications. On a date specified by the Training Director, the training program coordinator will contact by telephone each applicant whose application lacks any of the required documentation, letters of reference, etc., and explain specifically what is necessary for the application to be considered complete. The content of this call will be recorded and communicated immediately to the Training Director.

If there is any doubt about the validity of the documentation, the candidate's current Training Director will be contacted.

Each interviewer completes the applicant evaluation form within three working days and forwards it to the Training Director in the confidential envelope already provided.

The Selection Procedure. The Training Director will convene the Training Committee to consider all completed applications.
Each member of the Training Committee will be provided with a complete copy of the documentation in each applicant's file.

The Training Director will designate one of each applicant's interviewers to review the application in detail and to be prepared to summarize it appropriately at the Training Committee meeting.

The Committee will discuss each application on its merits. By secret ballot each Committee member will rank all applicants preferentially, beginning with the numeral 1 for the applicant of top priority, two for the next one, etc.

The numerical ranks of each applicant will be totaled and a composite ranking will be determined, the lowest total score ranking, the next lowest score ranking two, etc.
VACATION, EDUCATIONAL LEAVE OF ABSENCE AND SICK LEAVE

Vacations

Your contract with JMH entitles you to four (4) full weeks of (duty-free) vacation per residency year. (Please refer to your Collective Bargaining Contract). The program requires that you take entire week intervals at a time in order to facilitate coverage. Any special requests must be made to the Training Committee.

Vacations must be planned in advance with the needs of our own inpatient or outpatient clinical services and those of our affiliated institutions in mind, but every effort will be made, within these constraints, to schedule such requested absences at the times you desire. We will attempt to develop for all Residents a schedule for the entire year of all vacations. The Chief Resident has the responsibility for developing this master schedule, and you should provide him/her with any information you wish considered in this process. During the month of June, vacations will not be allowed. Residents must schedule vacation time in one week or two week blocks and must schedule 2 full weeks prior to December 31 and 2 full weeks between January 1 and May 31. Special requests for variation as well as vacation requests for weeks that contain holidays will be reviewed by the Residency Training Committee.

Educational Leave of Absence

Naturally we hope to provide an excellent educational experience for you within our own training program, but no program can provide everything. Occasionally a worthwhile educational opportunity occurs in which you may wish to participate and which would require time away from our own program. In considering requests for educational leave, the advantages of taking part in such an extracurricular activity will be balanced against the disadvantages of not participating in part of our own program. The needs of the clinical services to which we are obligated will also be considered.

Procedures For Requesting Vacations or Educational Leave of Absence

CAP Residents will always carry assignments in the CAP Clinic and usually on one of the other clinical services as well. The procedure outlined below is required in the following circumstances: (a) a new request for a vacation (b) a request for change in an already-scheduled vacation, or (c) a request for educational leave.

Complete the JMH Leave Request and the Division Leave Request forms (obtainable from the Program Coordinator) and obtain approval signatures of the following in the order indicated:

- The resident who has agreed to provide clinical coverage.
- From the Chief/Director/Medical Director of each clinical service to which you are assigned;
- From the Chief Resident in CAP;
- From the CAP Program Coordinator, who will then obtain signatures from:
  - Training Director
  - Division Chief

The program coordinator will then submit the completed request to the departmental Office of Psychiatric Education for transmission
the JMH House Staff Office to verify that the resident has sufficient leave time available. For outpatient evaluations to be scheduled according to vacation requests, requests must be submitted two months in advance. If requests are submitted late, it will be the responsibility of the resident to reschedule the evaluations on his/her own time.

**Sick Leave:** Your JMH contract specifies that you are permitted fourteen (14) sick days per academic year. Additional time away from work because of illness is considered sick leave and requires written verification by a physician. If you become ill while on the job, you should immediately inform the Chief of the clinical service component on which you are then working and the Training Director for Child and Adolescent Psychiatry, who will take responsibility for notifying other faculty as appropriate. *If you become ill at home and are unable to report for your regularly scheduled activities, you should call or email:*

1) Program Coordinator  
2) Training Director for Child and Adolescent Psychiatry  
3) Attending of Clinical Rotation  
4) Chief Fellow

*You must call or email the above persons as soon as possible, preferably before the time at which you would ordinarily be expected to appear for duty.* If you become ill during an approved vacation period, you should call the Training Director for Child and Adolescent Psychiatry on the first day of illness and request that your vacation be canceled. You must call again each day thereafter on which you continue to be ill. When you return to work you must present written verification from your physician that illness necessitated your absence. Otherwise the days on which you were absent for reasons unverified as illness will be counted as vacation.
### SALARY AND BENEFITS

**Cash Stipend**  
**July 2012**

<table>
<thead>
<tr>
<th>Post Graduate Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$46,716.92</td>
</tr>
<tr>
<td>2</td>
<td>$48,682.49</td>
</tr>
<tr>
<td>3</td>
<td>$50,796.31</td>
</tr>
<tr>
<td>4</td>
<td>$53,256.92</td>
</tr>
<tr>
<td>5</td>
<td>$56,131.12</td>
</tr>
<tr>
<td>6</td>
<td>$57,815.06</td>
</tr>
<tr>
<td>7</td>
<td>$60,440.74</td>
</tr>
</tbody>
</table>

**Pay Supplement**  
$50.00 bi-weekly

*Please refer to Article 2; Section 1 of the Collective Bargaining Agreement when assigning PGY levels.*

**Benefits**

I. Medical Insurance for the resident and dependents  
Choice of medical plans offered

(1) Jackson Quality Care
(2) Opt Out Insurance  
- 100% coverage  
- Deductibles
- no deductibles  
  Single coverage $750.00
II. Dental Insurance provided by Oral Health Services for the resident and dependents

III. Mental Health Insurance provided by University of Miami Behavioral Health for the resident and dependents

IV. Disability Insurance provided free to the resident while in training

V. $50,000 term Life Insurance provided free to the resident while in training
   - Supplemental Insurance of $50,000 available for $72.00/year

VI. $1250 Professional Educational Allowance

VII. Discounted parking

VIII. Three new lab coats provided at the beginning of each academic year

IX. Physician Dining Card allocated for On-call Meals ($1,375)

X. Free prescription drugs to be filled at the hospital’s facilities

XI. Vacation - 28 days, inclusive of weekends (20 working days)

XII. Sick Leave - 14 days/year

HEALTH BENEFITS AND MEDICAL INSURANCE

You are automatically covered under the JMH House Staff Health Benefit Plan as of the date you are placed on the JMH payroll. Detailed descriptions of the following are contained in a brochure prepared by the JMH administration: Eligibility and enrollment; extent of coverage; dependent coverage; benefits (including those for maternity); child health supervisory services; benefits for mental disorders, alcoholism, and drug addiction; expenses not covered; how to file a claim, etc.
You should have been given a copy of all your insurance plans at the general orientation provided by JMH.
CHAPTER 4

Education and Training Activities
THE DIDACTIC ACTIVITIES

General Description

The didactic activities offered by the CAP training program include lectures, seminars, CAP Clinical Case Conferences, psychopharmacology conferences, CAP Child Rounds, the Departmental Grand Rounds, the CAP Journal Club, and formal clinical demonstrations and supervised evaluations of children, adolescents and their families. Given the time constraints of a reasonable work week over a two-year period, it is impossible to schedule a formal didactic exercise for every possible aspect of child and adolescent psychiatry. It is assumed that many, if not most, of the issues important in acquiring an adequate knowledge base for the practice of child and adolescent psychiatry will arise in the context of clinical work with child and adolescent patients during the two-year span of the training period and that they will be discussed with the designated supervisor (and other faculty members if desirable or necessary) in appropriate breadth and depth. For example, four 1-hour seminars in the first year of training are devoted specifically to ethics, but ethical issues are discussed regularly as an integral part of patient-care oriented working as well as being a regular part of the discussion in the Clinical Case Conference and in the seminars.

Individual supervisory sessions are considered part of the didactic activities (2 per week for psychotherapy cases, one for consultation-liaison, one for school consultation, and at least one per week for residents on the inpatient service). Residents are expected to contact their psychotherapy supervisors by the 2nd week of the academic year and to attend supervision regularly. An 80% attendance at supervision is required for graduation. Any problems encountered should be directed to the Training Director.

Additionally, residents are expected to conduct self-learning activities, including several required web conferences, on topics such as sleep deprivation, teaching residents to teach, professionalism, systems-based care and trauma focused cognitive behavioral therapy. Residents must complete and notify the training office of successful completion of these conferences.

Seminar Attendance Policy

The goal of each resident is to develop the skills and medical knowledge necessary for the evaluation and treatment of children, adolescents and families. Although this will be obtained via a number of experiences including clinical experiences, supervision and self-learning, seminars are a critical component of the learning process. Seminar attendance and active participation are therefore considered mandatory and your attendance is required for successful completion of the training program. Attendance records are maintained for each activity. In the event of an anticipated excused absence (vacation, educational leave, etc.), it is your responsibility to so inform the staff member in charge of each didactic activity you will miss. Please refer to Appendix B for the complete seminar attendance policy.

Access to Reading Materials

Residents have access to electronic format of specialty specific and other reference materials needed for training. All readings, seminar schedules, and the program’s training manual, are available on the program’s shared drive, located on googledrive.
also expected to purchase the Lewis Textbook, Fourth Edition (2007) and Dulcan Textbook, 2010. If an article cannot be found, it is the responsibility of the resident to contact the faculty member.

Clinical Skills Verification (CSV's)

The American Board of Psychiatry and Neurology (ABPN) requires that Child and Adolescent Psychiatry residents demonstrate mastery of the following three components of the core competencies to apply for certification in the subspecialty of child and adolescent psychiatry. They are:

- Physician-patient relationship
- A developmentally appropriate psychiatric interview, including mental status examination
- Case presentation

All three competency components are to be assessed in the context of a patient evaluation that is conducted in the presence of an ABPN-certified psychiatrist. (Videotaped interactions cannot be used as the basis for the evaluation.) Three child and adolescent psychiatry evaluations with three different CAP patients conducted during CAP training are required.

Patients: At least two of the patients must come from different age groups (preschool, school-aged, and adolescence). Ideally, patients from all three age groups should be used. Information should also be obtained from a family member/guardian, when appropriate. The patients should be unknown to the resident.

Evaluators: Each of the three required evaluations must be conducted by an ABPN-certified child and adolescent psychiatrist. At least two of the evaluations must be conducted by different ABPN-certified child and adolescent psychiatrists.

Duration of Each Evaluation: Each evaluation session should last at least 45 minutes. The resident should be given a minimum of 30 minutes to conduct the psychiatric interview and a minimum of 10-15 minutes to present the case. If appropriate, the evaluator may give feedback to the resident.

For more detailed information, please refer to [http://abpn.com/cap.htm](http://abpn.com/cap.htm).

Mock Boards

Residents participate in a yearly Mock Board examination, which can count towards the three Clinical Skills Verification exams required for Board Certification. Feedback on performance is given to the resident using the same format that is used by Board examiners. Residents are encouraged to utilize the results as part of their own self-assessment. Results are also utilized by the program during the annual program evaluation.

PRITE Examinations

Residents participate in the National Child PRITE, a standardized self-assessment test. PG4 residents also take part in the National Psychiatry Resident-In-Training-Examinations (PRITE), which is designed to prepare residents for the written portion of the Psychiatry and Neurology Boards. Residents receive their individual test scores and are encouraged to utilize the results as part of their own self-assessment. Questions from previous years are available to residents through the training office for preparation of the PRITE. Results are also utilized by the program during the annual program evaluation.

MONITORING RESIDENT DUTY HOURS

Duty Hours
Duty Hours must be logged into New Innovations at www.new-innov.com at the end of each day. The Program Coordinator, Program Director and the GME office monitor duty hours regularly. 100% compliance is expected from each fellow. No exceptions are allowed.
SUMMER LECTURE SERIES

Child and Adolescent Psychiatry faculty, July – August, 2 hours per week.

These seminars highlight the fundamental techniques and background knowledge needed to begin child and adolescent specialty training. Some seminars are specifically designed for first or second year residents, while some are provided for both classes combined.

First Year Residents

- History of Child Psychiatry
- History Taking
- Assessing Children in Crisis/Suicidal Youth
- Parent Management Training
- Core Competencies & Sleep Deprivation
- Psychological Testing
- Diagnostic Interview of a Child
- Meet the Research Faculty
- Meet our Ombudsman

Second Year Residents

- Forensics – 6 sessions
- Life After Residency – 4 sessions
- Psychological Testing
- Meet the Research Faculty
- Meet our Ombudsman

Goals:

1. Residents will become knowledgeable about the fundamental techniques and background knowledge needed to begin child and adolescent specialty training, including the history of Child Psychiatry, diagnostic interview of a child, history taking, interviewing skills, parent management training and psychological testing. (Medical Knowledge, Patient Care)

2. Residents will become knowledgeable about various ACGME core competencies. (Professionalism, Systems-Based Practice, Practice-Based Learning)

Objectives:

1. Residents will attend 80% of seminars

2. Residents will actively participate in discussions. (Practice-Based Learning)

3. Residents will demonstrate knowledge of the diagnostic interview of children and adolescents, the assessment of children/adolescents in crisis and suicide. (Medical Knowledge, Patient Care)

4. Residents will demonstrate knowledge of parenting techniques and principles of psychological testing. (Medical Knowledge, Patient Care)

5. Residents will identify key aspects of the core competency areas and teaching strategies. (Professionalism, Systems-Based Practice, Practice-Based Learning)

Life After Residency/ Private Practice/ Managed Care

4 sessions, 1 hour each.

Faculty in private practice will present to the residents topics relevant to the practice of child psychiatry in the private sector. These include starting a solo practice, joining a group, managed care, insurance and malpractice issues, establishing a referral network and an
introduction to managed care.

**Goals:**

1. Residents will become familiar with private practice options and how to set up a private practice. *(Systems-Based Learning, Professionalism)*

**Objectives:**

Residents will become familiar with practice types, including solo practice or joining a group. *(Systems-Based Learning, Professionalism)*

Residents will become familiar with issues of managed care, malpractice issues and establishing a referral network. *(Systems-Based Learning, Professionalism)*

**Forensic Child Psychiatry**

6 sessions, 1 hour each

Introduction to the general area of forensic issues in child and adolescent psychiatry to include history of child forensic psychiatry, child forensic evaluation, child custody evaluation, testifying in court and sexual abuse.

**Goals:**

1. Residents will become knowledgeable about forensic issues in child and adolescent psychiatry. *(Medical Knowledge, Systems-Based Learning)*

**Objectives:**

1. Residents will attend 80% of seminars.

2. Residents will actively participate in discussions. *(Practice-Based Learning)*

3. Residents will demonstrate knowledge of the child forensic evaluation and child custody evaluation. *(Medical Knowledge, Systems-Based Practice)*

4. Residents will become knowledgeable about testifying in court. *(Systems-Based Practice)*
EDUCATIONAL ACTIVITIES
SECOND RESIDENCY YEAR

Sexual Abuse Trauma Clinic Seminar

This seminar focuses on children and adolescents who have been exposed to actual trauma such as a sexual abuse, physical assaults, motor vehicular accidents or children who have experienced the sudden and unexpected death of loved one.

Second year residents, Alternates weekly with Consult/Liaison Seminar, July - May.

The first fifteen minutes will be reserved for case presentations on an as needed basis. This will be followed by a reading seminar. A bibliography is provided. The residents and psychology interns and practicum students will present the readings for discussion.

Goals:

1. Residents will learn how to reduce the acute and enduring psychological morbidity of children who have been exposed to traumatic stressors in which the individual has experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others. (Medical Knowledge, Patient Care)

2. Residents will learn how to provide psychological and psychiatric assessment and evaluation of children and adolescents who have been sexually abused or traumatized that we might make an informed decision regarding case management and treatment interventions. (Patient Care)

3. Residents will learn how to decrease the risk of children who have been sexually abused form becoming sexually reactive perpetrators. (Patient Care)

Objectives:

1. Residents will demonstrate knowledge of the evaluation of children and adolescents who have been sexually abused or traumatized. (Medical Knowledge, Patient Care)

2. Residents will demonstrate knowledge about the spectrum of interventions that have been proven to be efficacious in the treatments of children and their families who are the victims of traumatic experiences. (Medical Knowledge, Patient Care)

3. Residents will present scientific articles and actively participate in discussion. (Practice-Based Learning)

Consultation/Liaison Seminar

Second year residents, July – June, Alternating weekly with Sexual Abuse Trauma Clinic Seminar, 20 sessions, 1 hour each

Seminar will focus on topics relevant to a child and adolescent psychiatric consultant in a large pediatrics hospital. Presenters will be from both within and outside of the CAP faculty, and residents will be expected to present cases/topics. Topics covered will include coping with chronic illness, specific illnesses and relation to psychiatric disorders, family issues, medical disclosure, pain management, etc.

Goals:

1. Residents will become knowledgeable about childhood chronic illness and the relation to psychiatric disorders, family issues, medical disclosure, and pain management. (Medical Knowledge, Patient Care)
Objectives:

Residents will attend 80% of seminars

1. Residents will actively participate by means of presentations and critical analyses of the literature and real life cases. (*Practice-Based Learning*)

2. Residents will complete assigned readings and actively participate in seminars. (*Practice-Based Learning*)

3. Residents will use case material to illustrate relevant C/L issues. (*Patient Care, Medical Knowledge, Practice-Based Learning*)
EDUCATIONAL ACTIVITIES DURING BOTH RESIDENCY YEARS

Child Rounds Conference

Child and Adolescent Psychiatry faculty, September - May, 1 ½ hours each, 29 sessions.

The Child Rounds Conference is the formal educational activity of the Division, in which all faculty, residents and other trainees participate and interact in a scholarly activity. The conference consists of scholarly presentations, case conferences, journal club and ethics case conferences.

Child Rounds

Child Rounds are a formal part of the educational/training program and consist of presentations by both local and visiting "experts" in a variety of areas of special interest to child and adolescent psychiatry.

Goals:

1. Residents will become familiar with current areas of special interest in the field of child and adolescent psychiatry. (Medical Knowledge)

Residents will interact with psychology interns, residents, and medical students and faculty members of all disciplines and discuss a variety of patients and families in a formal manner. (Professionalism, Interpersonal and Communication Skills)

Objectives:

1. Residents will attend 80% of rounds

(Practice-Based Learning)

3. Residents will demonstrate appropriate knowledge base about relevant topics in the field by their participation in discussions. (Medical Knowledge)

4. Residents, when appropriate, will demonstrate competence in acting professionally and using adequate interpersonal and communication skills. (Professionalism, Interpersonal and Communication Skills)

Clinical Case Conference/Ethics Case Conference

This conference is planned and presented as a formal learning experience. The resident presents a case and the faculty member interviews the child or adolescent and facilitates the case discussion.

Goals:

1. Residents will become knowledgeable about child and adolescent psychopathology, psychodynamic formulation, and transcultural experiences and therapeutic issues as represented by patients undergoing evaluation and/or treatment. (Medical Knowledge, Patient Care, Practice-Based Learning)

2. Residents will become knowledgeable about common ethical issues faced by child and adolescent psychiatrists. (Medical Knowledge, Patient Care, Professionalism)

3. Residents will become knowledgeable about psychological testing and interpretation. (Medical Knowledge, Patient Care)

4. Residents will interact with psychology interns, residents, and medical students and faculty
members of all disciplines and discuss a variety of patients and families in a formal manner. (Professionalism, Interpersonal and Communication Skills)

Objectives:

1. Residents will attend 80% of rounds

2. Residents will actively participate in discussions. (Practice-Based Learning)

3. Residents will demonstrate competence in presenting cases in a formal manner before a professional audience. (Interpersonal and Communication Skills, Professionalism, Patient Care)

4. Residents, when appropriate, will demonstrate competence in acting professionally as the primary discussant of case presentations. (Professionalism)

5. Residents demonstrate adequate knowledge of the range of psychopathology, psychodynamics, therapies represented in the caseload of the clinical services comprising the training resources of this program and ethical issues. (Medical Knowledge, Patient Care)

General Guidelines. Each clinical case conference will be 1 hour, 30 minutes in duration and will be started and ended promptly at the time announced; Each participant will be required to complete a form evaluating various aspects of each conference.

Guidelines for Presenter. The presenter will be expected to do the following:

1. The resident is expected to contact the responsible faculty 2 weeks in advance to identify an appropriate case and submit the power point presentation one week prior to the Case Presentation.

2. Discuss in advance with the Chief Resident, the moderator, the interviewer, and the formal discussant the desired focus and format of the conference, including how and by whom live interviews are to be conducted, the time allotted as to the presentation, patient/parent/family interviews or video tape, etc. The trainee is responsible for selecting discussant interviewers and inviting the participation of other treatment team members.

3. Present the case in a formal manner, including all relevant information (history, mental status examination, special examination, progress in treatment etc.) but not including (except as part of the general discussion) the presumptive diagnosis, the psychodynamic formulation, or the pro's and con's of an actual or contemplated treatment plan. Presentation of diagnostic test results (such as psychological testing should be coordinated with the tester.

4. Act as formal discussant when appropriate.

5. Provide a copy of the presentation material (in narrative or outline form), identified by the patient's hospital or clinic number, for inclusion in the evaluation package.

Child and Adolescent Psychiatry Journal Club

The child psychiatry resident, in conjunction with their faculty discussant, provides a brief series of articles on a single topic, to the faculty and trainees in the division. The support staff will assist in photocopying and distributing these articles. Articles should be distributed at
least one week in advance. Questions about the appropriateness of the topic, the number, type and source of the articles should be addressed with Dr. Shaw.

The purpose of the journal club is to expand the knowledge base of the participants and attendees of the journal club, to compare and contrast the differences in professional journals and to critically look at the research and the authors’ conclusions.

As the attendees are expected to have read the article beforehand, the presentation of the article should be a specific summary and not a reading of the article. Emphasis should be placed on the study design, methods employed, findings and conclusions. Ongoing exchange between the presenters and attendees is encouraged during the presentation though the faculty discussant will lead the discussion of the article or articles after the presentation is complete.

All residents and faculty participate in a review, moderated by a faculty member, of current key journals in child and adolescent psychiatry.

**Goals:**

1. Residents will become aware of published research that is directly relevant to the practice of child and adolescent psychiatry. *(Practice-Based Learning)*

2. Residents will develop competence in critically appraising of published research. *(Practice-Based Learning)*

3. Residents will participate in intellectual exchange with faculty and other professionals. *(Interpersonal and Communication Skills)*

**Objectives:**

1. Residents will attend 80% of rounds

2. Residents will actively participate in discussions. *(Practice-Based Learning, Interpersonal and Communication Skills)*

3. Residents will demonstrate the ability to understand scientific reasoning and methodologies. *(Practice-Based Learning)*

4. Residents will demonstrate knowledge of common statistical procedures. *(Practice-Based Learning)*

**Departmental Grand Rounds**

First and third Wednesdays of each month, September-May, 1 ½ hours

All residents are expected to attend this part of the general educational activities of the Department of Psychiatry.

**Psychotherapy Seminar & Continuous Case Conference**

27 seminar sessions, 1 hour each.

The Psychotherapy Seminar provides a review of the current empirically based studies on the efficaciousness of the various psychotherapeutic interventions in children and adolescents. Specific topical areas addressed include: the frame work of treatment, scheduling and attendance, the therapeutic relationship, the child’s mode of expression, the role of play in child psychotherapy, psychodynamic therapy, interpretation and intervention, collateral treatment with parents, cognitive behavioral therapy, interpersonal psychotherapy with children and adolescents, integrated therapy, brief and time limited psychotherapy, the effects of medication on the
process of psychotherapy, termination. Several sessions at the end of the year are reserved for a Continuous Clinical Case Conference, which consists of a child and adolescent being presented by a second year resident and represents an ongoing psychotherapeutic process in which the case material is presented either by videotape or transcription of an audiotape. This format presents the opportunity for close monitoring of the therapeutic process, strategies of intervention, a discussion of transference and counter transferences mechanisms, the elaboration of technique, intervention tactics, and its allegiance and fidelity to a specific manualized approach. Emphasis is placed on understanding the various intervention paradigms and the importance of defining therapeutic goals and objective and establishing measures with which to evaluate course and outcome.

Goals:

1. Residents will be knowledgeable about the various psychotherapeutic interventions in children and adolescents. (Medical Knowledge)

2. Residents will become knowledgeable about the therapeutic process, strategies of intervention, transference and counter transference mechanisms, and allegiance and fidelity to a specific manualized approach. (Medical Knowledge, Patient Care)

3. Residents will understand the various intervention paradigms and the importance of defining therapeutic goals and objectives and establishing measures with which to evaluate course and outcome. (Medical Knowledge, Patient Care)

Objectives:

1. Residents will attend 80% of rounds

2. Residents will actively participate in discussions. (Practice-Based Learning)

3. Residents will use case examples to contrast formulations and approaches to treatment indifferent developmental stages. (Practice-Based Learning, Medical Knowledge, Patient Care)

4. Residents will demonstrate the ability to formulate a treatment plan using various psychotherapy treatment modalities. (Patient Care)

5. Residents will present a case which represents an ongoing psychotherapeutic process, in which case material is presented either by videotape or transcription of an audiotape. (Patient Care, Practice-Based Learning)

6. Residents will discuss areas such as the frame work of treatment, scheduling and attendance, the therapeutic relationship, the child’s mode of expression, the role of play in child psychotherapy, interpretation and intervention, collateral treatment with parents, the effects of medication on the process of psychotherapy, and termination. (Patient Care)

Cognitive Behavioral Therapy

4 sessions, 1 hour each.

This seminar will review the development of Cognitive Behavioral Therapy theory, the Cognitive Behavioral case formulation, and the application of Cognitive Behavioral case formulation to a case. It will also review the integration of Cognitive Behavioral formulation and development theory and the application of the cognitive behavioral principles to different developmental stages. Two case examples (preschooler and teenager) are used to contrast formulations and approaches to treatment. In addition, the application of specific Cognitive
Behavioral Protocol for OCD and phobias will be reviewed.

**Class 1: The Blueprint**

The initial evaluation is essential in designing a creative therapeutic process tailored to the particular needs of the child presenting for help.

**Class 2: Collaborative Empiricism and Crafting a Process**

Collaborative empiricism involves perpetual curiosity, mentalization and tolerance of ambiguity. Based on the blueprint of the initial evaluation, a process is crafted whereby the basic structure of the session is tailored to the child, the family and the individual situation.

**Class 3: Designing and Carrying out the Session Structure**

Introducing the treatment model, identifying and connecting feelings and thoughts, and some techniques.

**Class 4: Working with Parents**

Awareness of the patient as part of a system is essential at all ages. The approach to intervention is initially crafted according to the blueprint and is tailored as the work progresses.

**Goals:**

1. Residents will become knowledgeable about the principles of Cognitive Behavioral Therapy theory and the application of CBT case formulation to a case. (*Medical Knowledge*)

2. Residents will become knowledgeable about the application of Cognitive Behavioral Therapy to different developmental stages. (*Medical Knowledge, Patient Care*)

**Objectives:**

1. Residents will attend 80% of seminars

2. Residents will actively participate in discussions. (*Practice-Based Learning*)

3. Residents will use two case examples (preschooler and teenager) to contrast formulations and approaches to treatment. (*Patient Care, Medical Knowledge*)

4. Residents will demonstrate the ability to formulate a treatment plan using basic principles and basic terminology of Cognitive Behavioral Therapy. (*Patient Care, Medical Knowledge*)

5. Residents will demonstrate the ability to formulate individualize CBT treatment plan by integrating concepts of developmental theory. (*Patient Care, Medical Knowledge*)

6. Residents will learn a specific protocol for the treatment of Obsessive Compulsive Disorder and Simple Phobia using CBT. (*Patient Care, Medical Knowledge*)

**Mentalization Based Therapy**

4 sessions, 1 hour each

This seminar provides residents with an overview of Mentalization Based Therapy (MBT), initially developed for the treatment of borderline personality, although it is now being used on a wide range of disorders.

**Goals:**

1. Residents will become familiar with the concepts of MBT.

2. Residents will develop the clinical skills to utilize this therapeutic modality. (*Medical Knowledge, Patient Care*)
Objectives:

1. Residents will attend 80% of seminars.

2. Residents will be able to describe the key concepts of Mentalization Based Therapy. (*Medical Knowledge*)

3. Residents will actively participate in discussion. (*Practice-Based Learning*)

4. Residents will become knowledgeable about the development of empathy and the capacity to self-soothe.

5. Residents will become knowledgeable about the biology of mentalization.

Dialectical Behavior Therapy

4 sessions, 1 hour each

This seminar provides residents with an overview of dialectical behavior therapy (DBT), initially developed for treating borderline personality disorder and proven effective as treatment for a range of other mental health problems, especially for those characterized by overwhelming emotions.

Goals:

Residents will become familiar with the concepts of DBT and develop the clinical skills to utilize this therapeutic modality. (*Medical Knowledge, Patient Care*)

Objectives:

1. Residents will attend 80% of seminars.

2. Residents will be able to describe the four main concepts of mindfulness, emotional regulation, distress tolerance and interpersonal effectiveness skills. (*Medical Knowledge*)

3. Residents will actively participate in discussion. (*Practice-Based Learning*)

4. Residents will demonstrate the ability to formulate an individualized DBT treatment plan. (*Medical Knowledge, Patient Care*)

Family Therapy Seminar

6 sessions, 1 hour each

Introduction to family systems models – This seminar provides an overview of theoretical models, needs assessments and goals of family therapy. Instructional modalities include lecture, case examples from fellows and from books, case consultation, videotapes and readings. One of the goals of this seminar is to get you to think systemically, not just about families but also about your relationship with your patients, and your place in other systems in which you live and work. This will help you understand what’s going on and open up avenues of solutions to problems. A system is comprised of parts that are interdependent or interrelated. Human systems, such as the family, have rules that regulate behavior and reciprocal processes such that the behavior of one part of the system influences the behavior.
of other parts, i.e., persons respond to each other’s behaviors. This seminar is intended to complement the Family Therapy Case Conference.

Goals:

Residents will become knowledgeable about family systems theory, the sociocultural role of family, characteristics of the dysfunctional family, and structural family theory. *(Medical Knowledge)*

Residents will become knowledgeable about processes of restructuring and elements of family therapeutic intervention. *(Medical Knowledge, Patient Care)*

Objectives:

Residents will attend 80% of seminars

Residents will actively participate in discussions. *(Practice-Based Learning)*

Residents will demonstrate an adequate knowledge of family therapy principles and intervention strategies. *(Medical Knowledge)*

Residents will demonstrate ability to understand that families have rules that regulate behavior and reciprocal processes such that the behavior of one part of the system influences the behavior of other. *(Patient Care, Medical Knowledge)*

**Continuous Child and Adolescent Case Conference and Individual Psychotherapy Seminar**

7 seminar sessions, 1 hour each.

The Psychotherapy Seminar provides a review of the current empirically based studies on the efficaciousness of the various psychotherapeutic interventions in children and adolescents. Four sessions are dedicated to psychodynamic psychotherapy and three sessions to IPT. Following this introduction specific topical areas are addressed to include: the frame work of treatment, scheduling and attendance, the therapeutic relationship, the child’s mode of expression, the role of play in child psychotherapy, psychodynamic therapy, interpretation and intervention, collateral treatment with parents, cognitive behavioral therapy, interpersonal psychotherapy with children and adolescents, integrated therapy, brief and time limited psychotherapy, the effects of medication on the process of psychotherapy, termination.

The Continuous Clinical Case Conference consists of a child and adolescent being presented by a resident and represents an ongoing psychotherapeutic process in which the case material is presented either by videotape or transcription of an audiotape. This format presents the opportunity for close monitoring of the therapeutic process, strategies of intervention, a discussion of transference and counter transferences mechanisms, the elaboration of technique, intervention tactics, and its allegiance and fidelity to a specific manualized approach. Emphasis is placed on understanding the various intervention paradigms and the importance of defining therapeutic goals and objective and establishing measures with which to evaluate course and outcome.

Goals:

1. Residents will be knowledgeable about the various psychotherapeutic interventions in children and adolescents. *(Medical Knowledge)*

2. Residents will become knowledgeable about the therapeutic process, strategies of intervention, transference and counter transference mechanisms, and allegiance and fidelity to a specific manualized approach. *(Medical Knowledge)*

3. Residents will understand the various intervention paradigms and the
importance of defining therapeutic goals and objectives and establishing measures with which to evaluate course and outcome. *(Medical Knowledge, Patient Care)*

**Objectives:**

Residents will attend 80% of rounds

Residents will actively participate in discussions. *(Practice-Based Learning)*

Residents will present a case which represents an ongoing psychotherapeutic process, in which case material is presented either by videotape or transcription of an audiotape. *(Patient Care, Medical Knowledge, Interpersonal and Communication Skills)*

Residents will discuss areas such as the frame work of treatment, scheduling and attendance, the therapeutic relationship, the child’s mode of expression, the role of play in child psychotherapy, interpretation and intervention, collateral treatment with parents, the effects of medication on the process of psychotherapy, and termination. *(Patient Care, Medical Knowledge)*

**Family Continuous Case Conference**

8 seminar sessions, 1 hour each.

This conference alternates with the Continuous Child and Adolescent Case Conference. It consists of a family therapy case being presented by second year resident. Family therapy sessions are conducted by the resident and the faculty member behind a one way mirror and observed by residents and medical students. Cases are used to illustrate family therapy principles and intervention strategies.

**Goals:**

Residents will demonstrate ability to conceptualize cases from a systems point of view. *(Patient Care, Systems-Based Practice, Interpersonal and Communication Skills)*

Residents will demonstrate knowledge about the therapeutic process and strategies of intervention in working with families. *(Patient Care, Medical Knowledge)*

**Objectives:**

Residents will attend 80% of seminars

Residents will actively participate in discussions. *(Practice-Based Learning)*

A resident and the family therapy supervisor will conduct several sessions with a family behind a one-way mirror. *(Patient Care, Interpersonal and Communication Skills, Systems-Based Practice)*

Residents will use the case material to illustrate family therapy principles and intervention strategies. *(Patient Care, Medical Knowledge, Systems-Based Practice)*

**Child and Adolescent Growth and Development Seminar**

July – Jan, 23 sessions, 1 hour per week

The Child and Adolescent Growth and Development Seminar will focus on the child's development with emphasis on the burgeoning research in the area of infant development, temperament, attachment behavior, Piagetian and psychoanalytic concepts of internalization, oedipal conflicts, middle childhood and adolescent experience. Specific attention will be given to the role of the family and the socio-cultural milieu and the biological dimensions as they influence and determine the developmental process within the context of the family.

**Goals:**

Residents will develop knowledge on child
development, including temperament, attachment behavior, Piagetian and psychoanalytic concepts, oedipal conflicts, middle childhood and adolescent experience. *(Medical Knowledge)*

**Objectives:**

Residents will attend 80% of seminars.

Residents will complete assigned readings and actively participate in seminars. *(Practice-Based Learning)*

Residents will use case material to illustrate developmental stages. *(Patient Care, Medical Knowledge, Practice Based-Learning)*

**Child Psychopharmacology Seminar**

July – November, 15 sessions, 1 hour per week

The Child Psychopharmacology Seminar’s goal is to provide a clinical logic that incorporates contemporary knowledge about drug therapies into the management of mental disorders and behavioral disturbances in children and adolescents. The seminar will review the major psychopharmacologic medication groups used to treat children and adolescents. Additional topics to be covered include pharmacokinetics, mechanisms of drug action, drug study designs, clinical therapeutic strategies, polypharmacy, medico-legal and ethical issues, safety monitoring, and manage care conundrums. Residents are expected to be active participants by means of presentations and critical analyses of the literature and real life cases.

**Goal:**

Residents will demonstrate knowledge on a clinical logic that incorporates contemporary knowledge about drug therapies into the management of mental disorders and behavioral disturbances in children and adolescents. *(Medical Knowledge, Patient Care)*

**Objectives:**

1. Residents will attend 80% of rounds

2. Residents will actively participate by means of presentations and critical analyses of the literature and real life cases. *(Patient Care, Practice-Based Learning)*

3. Residents will demonstrate knowledge about pharmacokinetics, mechanisms of drug action, drug study designs, clinical therapeutic strategies, polypharmacy, medico-legal and ethical issues, safety monitoring, and manage care conundrums. *(Medical Knowledge, Practice-Based Learning)*

**Child and Adolescent Psychopathology Seminar**

July – June, 20 sessions, 1 hour per week.

The seminar will focus on the psychiatric syndromes of children and adolescents, such as ADHD, Depressive Disorders, Bipolar Disorder, Anxiety Disorders, OCD, Tic Disorders, Learning Disorders, Psychotic disorders, as well as factors, such as divorce and child abuse, which may lead to psychiatric problems. Other topics covered include interviewing skills, adoption, acculturation, aggression, Personality disorders, attachment disorders, and gender identity.

**Goals:**

Residents will develop knowledge about the psychiatric disorders of children and adolescents, other factors which may lead to psychiatric problems, such as divorce and child abuse, and other topics, including adoption, acculturation and aggression. *(Medical Knowledge)*
Objectives:
Residents will attend 80% of seminars.

Residents will complete assigned readings and present selected readings to the peer group and supervisor. (*Practice-Based Learning*)

Residents will demonstrate knowledge about the epidemiology, etiology, clinical presentation, diagnosis and treatment of the various psychiatric disorders affecting children and adolescents. (*Medical Knowledge*)

Residents will demonstrate knowledge about family and sociocultural issues affecting children, including divorce, child abuse, adoption, acculturation and aggression. (*Medical Knowledge*)

Special Seminars
There is a series of seminars on special topics in Child and Adolescent Psychiatry to include the following, Ethics, Genetics, Divorce and Adoption, Transcultural Issues and Acculturation, Neuroimaging, Substance Abuse and Research Methodology.

Ethics in Child and Adolescent Psychiatry
This seminar will review the concepts of ethics and morality, the major ethical theories and principles, the manners in which moral decisions are justified, and the principles of psychiatric ethics elaborated by the AMA and AACAP.

From this, using the case method, the seminar participants will endeavor to reach decisions on some of the "typical" moral dilemmas which confront the child and adolescent psychiatrist.

Goals:

Objectives:
Residents will review concepts the major ethical theories and principles, the manners in which moral decisions are justified and the principles of psychiatric ethics elaborated by the AMA and AACAP. (*Professionalism*)

Objectives:
1. Residents will actively participate in discussions. (*Practice-Based Learning*)

2. Residents will use case material to illustrate ethical principles. (*Professionalism*)

Acculturation and Transcultural Issues in Child and Adolescent Psychiatry
2 sessions, 1 hour each

This seminar focuses on issues related to child psychiatry and child rearing practices from a multicultural perspective e.g. Hispanic, African American, Haitian cultures. Other issues such as the effect of migration on the developmental process and psychiatric syndromes across different cultures will be discussed.

Goals:
Residents will become knowledgeable about the influence of culture on family development across different cultures. (*Medical Knowledge, Patient Care, Professionalism*)

Objectives:
1. Residents will actively participate in discussions. (*Practice-Based Learning*)

2. Residents will be able to identify common child rearing practices from a multicultural perspective (*Patient Care, Medical Knowledge, Professionalism*)

3. Residents will become familiar with the effect of migration on the developmental process and psychiatric syndromes across different cultures. (*Medical knowledge, Professionalism*)
**Interpreting Psychological Testing Seminar**

2 sessions, 1 hour each.

An introduction to child testing, including: intelligence, achievement, projective and neuropsychological assessment. The seminar will also focus on interpretation of scores to help the resident understand and interpret test reports.

**Goals:**

1. Residents will become knowledgeable about the different types of psychological testing available for children and adolescents. (Medical Knowledge, Patient Care)

2. Residents will become knowledgeable on the interpretation of testing scores. (Medical Knowledge, Patient Care)

3. Residents will review actual psychological testing material to understand and interpret reports. (Medical Knowledge, Patient Care)

**Objectives:**

1. Residents will attend 80% of seminars.

2. Residents will actively participate in discussions. (Practice-Based Learning)

3. Residents will read assigned readings. (Practice-Based Learning)

4. Residents will review actual psychological testing material to understand and interpret reports. (Practice-Based Learning, Medical Knowledge, Patient Care)

**Substance Abuse Seminar**

3 Sessions, 1 hour each.

These seminars cover the epidemiology, pathophysiology, and clinical presentation of substances of abuse and dependence common in adolescence, with a specific focus on a developmental perspective.

**Goals:**

1. Residents will develop adequate knowledge about the epidemiology, pathophysiology and clinical presentation of common substances of abuse and dependence. (Medical Knowledge, Patient Care)

2. The resident will also become familiar with developmental issues related to substance use disorders in adolescents. (Medical Knowledge, Patient Care)

**Objectives:**

1. Residents will attend 80% of seminars.

2. Residents will actively participate in discussions. (Practice-Based Learning)

3. Residents will demonstrate knowledge of child and adolescent psychopharmacology and will use case material to facilitate discussion of various agents and psychopharmacological principles. (Patient Care, Medical Knowledge)

**Research Methodology and Research Mentoring**

6 sessions, 1 hour each.
These sessions on research methodology serve as an introduction to the seminars in the second year and are intended to help first year residents develop their scholarly projects by discussing aspects involved in a research study, such as study design, setting up a database and analyzing data.

During the research mentoring sessions, the following topics will be covered:

- Selection of the hypothesis to be tested or questions(s) to be answered.
- Originally of the proposed study.
- Is the resident aware of what has been done in the field? (Background)
- Why is the study worth doing? (Significance)
- Specific objectives of the study.
- Appropriate methodology.
- Available resources (subjects, project site, etc.)
- Time frame for the study.
- What are the expected results?

Second year residents will focus on hypothesis testing procedures, alpha/beta errors, and internal/external validity. In addition, descriptive statistics, such as mean, standard deviation, and correlation, as well as inferential statistics, such as ANOVA, Chi Square, and regression will be covered. Also, the basic criteria for evaluating or writing a research paper will be presented.

Goals:

1. Residents will become knowledgeable about study design, research methodology, data analysis, interpretation of results, and protection of human subjects. (Practice-Based Learning, Professionalism)

2. Residents will become familiar with hypothesis testing procedures and various statistical concepts. (Practice-Based Learning)

Objectives:

1. Residents will attend 80% of seminars
2. Residents will actively participate in discussions. (Practice-Based Learning)
3. Residents will demonstrate ability to design a study, including methodology, data analysis and interpretation. (Practice-Based Learning)
4. Residents will demonstrate knowledge of guidelines for human subject protection. (Professionalism)
5. Residents will be able to describe hypothesis testing procedures. (Practice-Based Learning)
6. Residents will demonstrate knowledge of alpha/beta errors and internal/external validity. (Practice-Based Learning)
7. Residents will be able to describe various descriptive statistics. (Practice-Based Learning)

Research Timeline – Class of 2015

Sept, 2014 Present progress report to Training Committee
Nov, 2014 Present progress report to Training Committee
Feb, 2015 Present progress report to Training Committee
June, 2015 Division Research Symposium

Research Timeline – Class of 2016

Sept, 2014 Select research idea and mentor
Nov, 2014  Prepare proposal with faculty mentor and Present to Training Committee

Dec, 2014  Submit proposal to IRB if indicated

Feb, 2015  Begin project once IRB approval is received

Sept, 2015  Present progress report to Training Committee

Nov, 2015  Present progress report to Training Committee

Feb, 2016  Present progress report to Training Committee

June, 2016  Division Research Symposium
CHAPTER 5

ACGME Requirements
New ACGME Requirements for Handoffs:
Guidelines for AADPRT Members

Handoffs Subcommittee: Melissa Arbuckle, Claudia Reardon, John Young (Chair)

Executive Summary
New requirements bring new challenges. A summary of our recommendations follows with more detailed discussion in the main body of the report for the benefit of health care providers. The good news is that there are many resources available to you. At the end of the report, we provide links to slide-sets, curricula and assessment tools, previously published and easily accessible on-line.

Effective July 1, 2011, residency training programs will need to comply with new ACGME requirements for handoffs:

- Programs must design clinical assignments to minimize the number of transitions in patient care.
- Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes that facilitate both continuity of care and patient safety.
- Programs must ensure that residents are competent in communicating with other members in the hand-over process.
- The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient’s care.

As each training program implements these new requirements, we recommend the following principles:

1. Train residents in close collaboration with clinical service/system in safe and effective handoffs. It is important to synchronize this training with the processes that will be used by the service.
2. Assess competence with giving and receiving sign-out. Chart audit of written transfer summaries, direct observation with structured feedback and multisource feedback are three excellent approaches to this.
3. Standardize both written and verbal sign-out; link to EMR when possible.
4. Adopt process (e.g., whether verbal sign-out required on all patients) and information requirements to the specific type of handoff (e.g., outpatient vs. inpatient, permanent change in clinician vs. covering during leave/vacation).
5. Primary responsibility lies with each clinical service and the licensed system in which it exists.

The ‘best practice’ models of handoffs include the following elements:

1. Structured verbal (including face-to-face) sign-out with interactive questioning in a quiet setting free of interruptions. Multiple structured formats have been developed for verbal sign-out. The key is that the clinical services/systems choose an approach and train clinicians accordingly.
2. Written sign-out supported by computer-based, standardized templates that prompt for handoff relevant information and ideally are linked to the EMRs to
reduce redundant data entry (and errors);  
3. Identification of acute or higher risk patients for enhanced sign-out/care;  
4. Definitive transfer of professional responsibility at a specific time.

Handoffs Guidelines for AADPRT Members: Full Report

Handoffs: Overview

Transfers of patient care from one physician to another, a process known as “handoffs,” are ubiquitous in healthcare. 2 The frequency of handoffs has increased with the restriction of resident duty hours by the Accreditation Council on Graduate Medical Education (ACGME) in 2003 followed by additional restrictions scheduled for July, 2011. Handoffs are vulnerable to communication failures, which can lead to medical errors and harm to patients. The Joint Commission (JC) has found that two out of three sentinel events have communication errors as a contributing cause and that over half of these errors involve handoff failures. 3 Critical incident analyses and surveys of trainees indicate that handoffs are rarely standardized and often quite variable, even within a given department or institution.

Communication failures during handoffs are characterized by omissions of important medical information and/or failure-prone communication processes. The failure-prone communication processes include unstructured written and verbal communication, non-face-to-face sign-out, poorly communicated rationale for the clinical plan, inadequate training of clinicians in handoff communication, occurrences of handoffs in settings that are neither quiet, private, nor free of interruptions, and the lack of infrastructure to support handoffs such as protected time (overlapping shifts) or a structured electronic written template linked to the EMR.

Purpose of Handoff

The responsibility of patient care transferred from one physician to another is considered a handoff, and the information transferred to manage this discontinuity is referred to as the sign-out. The purpose of any handoff is to establish a shared mental model about a patient in order to avoid unwarranted changes in goals, decisions, priorities, or plans.

Regulatory Response

The potential for harm during these transitions has led to regulatory and policy initiatives. The Institute of Medicine recommended and the ACGME will require, as of July, 2011, enhanced training for residents regarding handoffs. 4 Similarly, the JC has mandated a standardized approach to handoff communications. 5

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Programs must design clinical assignments to minimize the number of transitions in patient care.</td>
<td>• Implement a standardized approach to “handoff” communications including an opportunity to ask and respond to questions.</td>
</tr>
<tr>
<td>• Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes that facilitate both continuity of care and patient safety.</td>
<td>• Expectations:</td>
</tr>
<tr>
<td>• Programs must ensure that residents are competent in communicating with team members in the hand-over process.</td>
<td></td>
</tr>
<tr>
<td>• The sponsoring institution must ensure the availability of schedules that inform all members of the</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 of 7  6/7/11 7:52 AM
Making Handoffs Safer: Research to Date
Considerable attention has been focused on interventions to improve patient safety and reduce errors during transitions in care, many of which have been adapted from industries such as nuclear power and space aviation in which transition errors have high consequences.

These interventions typically include:

1. Structured verbal (including face-to-face) sign-out with interactive questioning in a quiet setting free of interruptions. Multiple structured formats have been developed for verbal sign-out. The key is that the clinical services/systems choose an approach and train clinicians accordingly. Examples include:
   - SBAR (Situation-Background-Assessment-Recommendation)
   - BSTART (Background-Situation-Treatment-Assessment-Recommendation)
   - SIGNOUT? (Sick/Not Sick – Identifying Information – General Hospital Course – New Events – Overall Status – Upcoming Events – To Do List – Questions?)
   - I PASS the BATON (Introduction-Patient-Assessment-Situation-Safety Concerns-Background-Actions-Timing-Ownership-Next)
   - ANTICipate (Administrative data-New Information-Tasks-Illness severity-Contingencies)

2. Written sign-out supported by computer-based, standardized templates that prompt for handoff relevant information and ideally are linked to the EMR to reduce redundant data entry (and errors);

3. Identification of acute or higher risk patients for enhanced sign-out/care;

4. Definitive transfer of professional responsibility at a specific time; and

5. Train clinicians in effective giving and receiving of handoffs, including teamwork training such as TeamSTEPPS.

Limited data exist on the impact of handoff interventions on clinical outcomes. Handoff interventions have been reported to decrease missing information and improve efficiency on rounds. Most of the research to date focuses on transitions necessitated by transfer to a different setting of care (e.g., transfer from a general ward to an ICU, or discharge from the hospital) or by the end of a hospital shift. Few transfer studies have addressed the ambulatory setting.

Best Practices
A review of the literature suggests the following best practices:

<table>
<thead>
<tr>
<th>Best Practices for Handoffs</th>
<th>Content</th>
<th>Infrastructure</th>
<th>Communication Process</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key demographic information</td>
<td>Easily accessible information technology (e.g., printers, computers, phones)</td>
<td>Structured written and verbal (often ideally face-to-face) sign-out that uses same/complimentary format</td>
<td>Adopt standardized approach to handoffs</td>
<td></td>
</tr>
<tr>
<td>Contact information for other members of treatment team</td>
<td>Structured written electronic template</td>
<td>Opportunity for interactive questioning, read-backs, review of anticipated problems</td>
<td>Train clinicians in handoffs communication</td>
<td></td>
</tr>
<tr>
<td>Summary of diagnoses</td>
<td></td>
<td></td>
<td>Assess competence with giving and receiving</td>
<td></td>
</tr>
<tr>
<td>Clinical status, and treatment plan</td>
<td>Pre-populated with information from EMR when possible</td>
<td>Handoffs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Active issues (e.g., pending titration, recent relapse, new stressor)</td>
<td>• Quiet setting for handoffs</td>
<td>• Minimal interruptions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assessment of acuity</td>
<td>• Overlapping shifts or protected time for handoffs</td>
<td>• Prepare the patient as well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 'Tasks to be done'</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anticipatory guidance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• (If-Then statements)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STANDARDIZING THE HANDOFF OF HOSPITALIZED PATIENTS WITH DPAC-Q**

**Efrén C. Manjarrez Jr., M.D., SFHM**  
Assistant Professor of Clinical Medicine  
Associate Chief  
Division of Hospital Medicine  
Associate Chief Patient safety and Quality Officer  
University of Miami Health System
What is a Handoff?

• Handoff = transfer of professional responsibility and information between physicians in a HIPAA compliant manner with a standardized approach
• A handoff is NOT an H&P....
• Rather, a handoff briefly conveys:
  1. Why the patient is here
  2. What is their current clinical condition
  3. What is the plan going forward...

Handoffs take multiple forms

- Consulting Service
- Ward Nurse
- Cross-Covering Physician
- Pharmacist
- Primary Care MD
- ER Physician
- ER Nurse
- Lab
Communication in Healthcare

- Failures in communication are the most common root cause of sentinel events reported to JCAHO

Root Causes of Sentinel Events (All categories; 1995-2004)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent of 2001 events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>60%</td>
</tr>
<tr>
<td>Orientation/Training</td>
<td>23%</td>
</tr>
<tr>
<td>Patient assessment</td>
<td>18%</td>
</tr>
<tr>
<td>Staffing</td>
<td>8%</td>
</tr>
<tr>
<td>Availability of Info</td>
<td>5%</td>
</tr>
<tr>
<td>Competency/credentialed</td>
<td>4%</td>
</tr>
<tr>
<td>Procedural compliance</td>
<td>3%</td>
</tr>
<tr>
<td>Environ. safety/security</td>
<td>3%</td>
</tr>
<tr>
<td>Leadership</td>
<td>2%</td>
</tr>
<tr>
<td>Continuum of care</td>
<td>2%</td>
</tr>
<tr>
<td>Care planning</td>
<td>1%</td>
</tr>
<tr>
<td>Organization culture</td>
<td>1%</td>
</tr>
</tbody>
</table>

Sentinel Event Statistics. Available at: [http://www.jcaho.org](http://www.jcaho.org)
Handoff Basics—Before you begin...

• This information is “discoverable” by malpractice attorney’s, so be careful what you type into the computer...
• Limit interruptions
• The handoff should be verbal interactive communication between off-going and ongoing provider
• All patients that are handed off are included
• A standard computerized template is updated and printed out prior to each handoff session

Proposed Verbal Handoff Script DPAC-Q

D= Demographics
P=Problems
A=Anticipatory Guidance
C=Checklist
Q=Questions?
Proposed Handoff Script DPAC-Q

**Demographics**

<table>
<thead>
<tr>
<th>ID</th>
<th>“Mr. Martinez is a 50 yo WLM”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Status</td>
<td>“He is Full code”</td>
</tr>
<tr>
<td>Illness Severity</td>
<td>“He is one of my sickest patients for tonight”</td>
</tr>
</tbody>
</table>

**Problems**

<table>
<thead>
<tr>
<th>Reason for admission</th>
<th>“He was admitted for unstable angina”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active/ unstable</td>
<td>“DM and Htn are both uncontrolled”</td>
</tr>
<tr>
<td>Chronic Stable</td>
<td>Gout</td>
</tr>
<tr>
<td>Allergies</td>
<td>“Allergic to penicillin”</td>
</tr>
<tr>
<td><strong>Current clinical condition at handoff</strong></td>
<td>“At 5 PM, I just started nitro drip due to recurrent chest pain with 1 set of (-) cardiac enzymes and nonspecific T wave changes on EKG”</td>
</tr>
</tbody>
</table>
Proposed Handoff Script DPAC-Q

**Anticipated complications** “**If this happens, then do X, Y, and Z**”

<table>
<thead>
<tr>
<th>“Potential Complications overnight include...”</th>
<th>“He is on ACS protocol with B Blocker, statin, ACE, nitrates, O2, LMH heparin, ASA, and Plavix, so...”</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ If he develops chest pain again, then transfer to CCU and call the cath fellow</td>
<td></td>
</tr>
</tbody>
</table>

| “If he develops ____, then please do the following: A,B, and C” | ○ If his dinner BS > 300, then increase his basal insulin at bedtime from 10 units to 15. |

---

Proposed Handoff Script DPAC-Q

**Checklist/ To Do list specific to next shift**

- “The to-do list for the next shift is...”
- “The checklist for the next shift is...”

<table>
<thead>
<tr>
<th>“Please check” Check CBC at midnight</th>
<th>(Specific task, not vague) Transfuse 2 units prn Hb&lt;8.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>“Please check the Cardiology note to see if going to Cath in AM”</td>
<td>(Specific task, not vague) ○ If so, then make npo, decrease his PM basal insulin to 8 units, and start D5 IVF at 75 ml/hr at 6AM instead of “make npo and decrease his insulin”</td>
</tr>
</tbody>
</table>
Proposed Handoff Script DPAC-Q

Questions

• “When is the third set of cardiac enzymes due?”

Verbal Checklist

<table>
<thead>
<tr>
<th>Competency</th>
<th>Present or absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td></td>
</tr>
<tr>
<td>• ID</td>
<td></td>
</tr>
<tr>
<td>• Illness Severity</td>
<td></td>
</tr>
<tr>
<td>• Code status</td>
<td></td>
</tr>
<tr>
<td>Problems:</td>
<td></td>
</tr>
<tr>
<td>• Reason for admission</td>
<td></td>
</tr>
<tr>
<td>• Active/ Unstable</td>
<td></td>
</tr>
<tr>
<td>• Chronic/ Stable</td>
<td></td>
</tr>
<tr>
<td>• Allergies</td>
<td></td>
</tr>
<tr>
<td>• Current Condition at Handoff</td>
<td></td>
</tr>
<tr>
<td>• Anticipatory guidance</td>
<td></td>
</tr>
<tr>
<td>• Checklist for next shift</td>
<td></td>
</tr>
<tr>
<td>Repeat Questions asked</td>
<td></td>
</tr>
</tbody>
</table>

UHealth UNIVERSITY OF MIAMI HEALTH SYSTEM
Summary

As a physician you assume ownership of all patients that you handoff and cross-cover.

- High quality handoffs are the responsibility of all physicians- patient safety depends on it
- UHealth has now provided a standard handoff script for guidance
- The checklist is the minimum required handoff elements- each facility’s computer template may have variations
Child and Adolescent Psychiatry Residency Program

Core Competency

PATIENT CARE

A. Core Competency in Psychotherapy

1. Knowledge
   a. Theory seminar: covering psychoanalytic, learning, systems and group theory
   b. Technique Seminars: Individual child therapies; family therapy; group therapy sequences with accompanying observational sessions, demonstrating each therapy technique
   c. Supervision: 2-4 hours per week of individual supervision. Observed Senior Faculty interviews

2. Behaviors
   a. Resident attends 75% of all offered psychotherapy seminars. Resident reads assigned readings for seminars
   b. Resident actively participates in seminar discussion
   c. Resident attends 75% of supervisory hours and uses written notes to describe patient-doctor interactions

3. Skills
   a. Resident develops skills to conduct individual interview of child or adolescent patient, using techniques of play therapy, direct questioning, and empathic listening as indicated
   b. Resident develops skills to conduct parent/family interview using knowledge of systems theory, psychodynamic theory, family functioning and attributional theory
   c. Resident can formulate case from interview, mental status exam, and historical material in multiple settings: clinic, inpatient unit, forensic
   d. Resident can conduct a psychotherapy over a substantial period of time, formulating and implementing a treatment plan, with the goal of resolving certain identifiable symptoms
   e. Expectations:
      i. Resident is familiar with all theories of psychotherapy and has treated at least one case with each method
      ii. Resident is competent in interviewing all ages of child and adolescent, is comfortable with both genders of patients, and engaging the system within which the patient is embedded.
      iii. Upon graduation, the resident is familiar with all schools of therapy, is competent in referring to subspecialties

4. Attitudes
   a. The resident in Child and Adolescent Psychiatry will attend all seminars and supervisions at greater than a 75% rate.
   b. Resident will meet programmatic immersion criteria for numbers of cases, ages, gender, diagnostic grouping of patients
   c. Resident will share personal reactions to patients with their supervisors, so as to develop increased clinical precision, assure the presence of thoughtful boundaries
d. Resident will insure the quality of their work in making it visible to designated supervisors/faculty members through use of one-way mirror, videotaped sequences, and our directly witnessed sessions

e. Medical director on inpatient services provides informal consultation to one’s work

B. Core Competency in Psychopharmacology

1. Knowledge
   a. Seminars in neuroscience, neurochemistry, and clinical psychopharmacology
   b. Seminars on descriptive psychiatry and symptom assessment and diagnosis
   c. Supervision of clinical psychopharmacology

2. Skills
   a. The resident will have learned research-based clinical care and safe methods for the empirical dosing of symptoms with singular and multiple drugs
   b. The resident will learn methods of evaluating the efficacy of any prescribed drug
   c. The resident will learn dosages of medications, their interactions with other psychiatric and medical drugs, and learn the relationship of dose with regard to age, gender, and size of child patient
   d. The resident will learn how to formulate a case and anticipate how these issues would influence compliance
   e. The resident will learn how to manage drug abuse clients and the prescription of scheduled drugs
   f. The resident will learn the skills of a psychopharmacology consultant and how to integrate his/her care with that of a primary therapist or pediatrician
   g. The resident will learn the skills of integrating psychopharmacology interventions within the context of an ongoing psychotherapy within one’s independent practice.

3. Behaviors
   a. Resident attends 75% of all offered psychotherapy seminars. Resident reads assigned readings for seminars
   b. Resident actively participates in seminar discussion
   c. Residents will prescribe medications safely and effectively
   d. Residents will prescribe medications within the context of an ongoing psychotherapy, with another psychotherapist or within one’s own practice

4. Attitudes
   a. The resident will avail themselves of seminar and supervision teaching at a 75% attendance record or better

5. Measurement/Assessment
   a. Supervision Assessment of clinical work
   b. Completion of CHILD PRITE annually and review of individual scores with training director
   c. Regular documentation by clinical and teaching faculty of participation in didactic modules, case conferences, etc. to potentially include documentation of attendance as well
   d. Supervision
      i. Documentation of resident performance in areas relevant to clinical science by supervision outpatient and on-rotation faculty
   e. Clinical Skill Evaluation
      i. Direct observation of the individual resident’s clinical and didactic activities by identified faculty
ii. Annual clinical exam of the “mock boards type
iii. Review of the clinical exam performance with the training director
iv. Observation and evaluation of videotaped patient interactions by supervisors and/or other teaching faculty on a regular basis
f. Independent learning
g. Demonstration of self-initiated as well as directed study through leadership of discussion in both didactic and clinical activities and through presentation to the residency program in various formats (e.g., required paper presentations; grand rounds presentations, etc.)
h. Deficiency remediation
i. Regular review of the various measures of performance and competence for each individual resident with the training director, identifying specific deficits and developing specific remediation plans based on the particular deficiencies identified
ii. Documentation of all identified areas where remediation or focus may be needed, remediation plans developed and assessment of outcome based on the assessment method originally used to identify the deficit (e.g., evaluation of area of relative deficits identified on the CHILD PRITE might be reassessed by later performance on CHILD PRITE; identification of deficits through supervisory process to be reassessed by subsequent supervisory reports specifically aimed at assessing identified deficiencies, etc.)

Child and Adolescent Psychiatry Residency Program

Core Competency

MEDICAL KNOWLEDGE

1. Knowledge
   a. Definition: Residents, by the time they graduate, must possess an adequate fund of knowledge in established and evolving biomedical, clinical, epidemiological, and psychosocial science domains to assure the understanding and practice of child and adolescent psychiatry
   b. Expectation
      Residents will master the basic information integral to the basic academic and clinical principles of child and adolescent psychiatry as presented in the didactic and clinical curriculum and augmented by self-directed learning. Suggested broad topics though not inclusive or necessarily required include:
      i. Development
      ii. Biological Sciences related to Child and Adolescent Psychiatry
      iii. Clinical Sciences related to Child and Adolescent Psychiatry
      iv. Psychopathology/ classification/ differential diagnosis
      v. Assessment procedures
      vi. Treatment to include somatic, psychological and residential treatments as well as cultural competency
      vii. Consultation, both pediatric and community agencies
      viii. Issues in practice not specified under other topics
      ix. Prevention

2. Skills
a. Definition: The resident will acquire knowledge regarding the basic and clinically supportive sciences through participation in didactic and clinical discussions and be able to apply this information to both didactic and clinical situations

b. Expectations
   i. Attend and participate in didactics, demonstrating the ability to learn and disseminate effectively relevant data and knowledge about child and adolescent psychiatry
   ii. Demonstrate through the provision of care for children, adolescents and families the ability to apply the fund of knowledge in clinical science gained in didactic and clinical situations

3. Behaviors
   a. Resident attends 75% of all offered psychotherapy seminars. Resident reads assigned readings for seminars
   b. Resident actively participates in seminar discussion

4. Attitudes
   a. Definition: Residents must have an analytic and investigatory approach to clinical situations
   b. Expectations:
      i. Participate actively in didactic offerings by being able to discuss assigned readings and effectively present various topics in different forums, making relevant comments during discussions
      ii. Participate actively in clinically based conferences, bringing to these conferences literature and knowledge from the clinical sciences that are relevant to the clinical situation being discussed.
      iii. The resident will immerse themselves in the clinical situation
      iv. The resident will immerse themselves in the training and mentoring opportunities of a residency
      v. The resident will be able to offer informed psychotherapy services to all patients presenting themselves in their independent practices

5. Assessment/Measurement
   a. Supervisor evaluation
   b. An observed “mock board” interview
   c. Presentation of several videotaped excerpts from ongoing clinical cases
   d. Tutorials with regard to theory and the practice of psychotherapy
   e. Expectations:
      i. The resident will actively demonstrate their capacity to provide psychotherapy services.

Child and Adolescent Psychiatry Residency Program

Core Competency

INTERPERSONAL AND COMMUNICATION SKILLS

1. Knowledge
   a. Definition
      Interpersonal and communication skills are defined as the specific techniques and methods which facilitate effective and empathic communication between the psychiatrist, patients, colleagues, and staff. In addition to specific skill acquisition, interpersonal skills require an underlying set of attitudes involving the resident’s personal beliefs and values, self-
understanding, opinions about other people, and understanding of the child and adolescent psychiatrist’s role as a consultant to patients and their contextual system. Development of interpersonal skills is enhanced by acquisition of basic information about interpersonal communication.

b. Expectations:
   i. At regular intervals during subspecialty training, the child and adolescent psychiatry resident will demonstrate progressive attainment of the knowledge, skills and attitudes required to develop and maintain appropriate interpersonal therapeutic relationships; and communicate effectively with patients, their patients’ families, professional associates, and the public. Competence in interpersonal and communication skills must be demonstrated in order to graduate: Specific expectations for knowledge skills and attitudes are outlined below.
   ii. Residents are expected to develop a knowledge base relating to interpersonal skills appropriate to their level of training. Specifically child and adolescent psychiatry residents should demonstrate knowledge of variety of interviewing techniques that facilitate:
      1. effective understanding of the concerns of children, adolescents, and families
      2. effective communication including education about psychiatric disorders and their treatments
      3. establishment and maintenance of a therapeutic contract and therapeutic alliance
      4. delivery and reception of difficult formation in an empathic manner
   iii. the impact of the patient’s emotional reactions and associations to the therapist (and vice versa) on psychiatric evaluation and treatment
   iv. techniques for communicating effectively with allied professionals
   v. the structure and function of multidisciplinary teams in various settings
   vi. cultural differences and their impact

2. Skills
   The competent resident is able to demonstrate the following:

   a. Interpersonal skills with reliability and efficiency in a wide range of settings, appropriate to their level of training. Specifically, child adolescent psychiatry residents should be able to:
      i. Listen to, understand, and communicate effectively with children, adolescents, adults and families
      ii. create and sustain a therapeutic alliance and ethically sound relationship with patients and caregivers
      iii. elicit and provide information using effective verbal and nonverbal interactions
      iv. use negotiation to develop an agreed upon health care management plan with patients and caregivers
      v. educate children, families, and professionals about medical, psychological and behavioral issues in the life of children and families in a clear effective manner
      vi. self-observe and appropriately manage the physician’s own feelings and behavior in psychiatric interactions
      vii. work effectively within multidisciplinary team structures as member, consultant or leader
viii. exhibit culturally sensitive, professional, ethnically sound behavior and attitudes in patient and professional interactions
ix. to be able to write and express clinical thoughts and impressions in a correct manner

3. Behaviors
   a. Resident attends 75% of all offered psychotherapy seminars. Resident reads assigned readings for seminars
   b. Resident actively participates in seminar discussion

4. Attitudes
   a. Residents are expected to identify and develop attitudes
      i. Child and adolescent psychiatry residents should demonstrate
         1. an underlying attitudes of respect for others, even those with differing points of view or from different backgrounds
         2. the desire to gain understanding of another’s position and reasoning
         3. a belief in the intrinsic worth of other human beings
         4. the wish to build collaboration and achieve mutual understanding
         5. the desire to share information to an open rather than dogmatic fashion
         6. the willingness to continuously self-observe and confront one’s own biases and emotional reactions, and
         7. a willingness to act as the patient’s advocate as indicated

5. Assessment/ Measurement
   a. Residents should show increasing effectiveness and consistency of interpersonal and communication skills over the course of their training
   b. Continuing formative assessment of the residents’ knowledge, attitude, and skills; with feedback, should occur on an ongoing basis through closely supervised clinical encounters
   c. Methods of evaluation of interpersonal skills include:
      i. Standardized patients
      ii. Oral clinical examinations with evaluation of observed interviews (e.g., objective structured clinical examinations, or Boards format)
      iii. Patient survey questionnaires
      iv. Direct observations in clinical settings, videotape observation, chart review for written skills (i.e., letters of evaluation reports)
      v. Supervisory evaluations from clinical rotations (including global rating evaluations from clinical personnel who work with the resident)
   d. Identified and deficiencies should be followed up by suggestions for improvement and specific objectives and timeline for evaluation of successful remediation
Core Competency

PROFESSIONALISM

The residency program must ensure that its residents, by the time they graduate, demonstrate the fundamental qualities of professionalism, “in the best interest of child.”

1. Knowledge
   a. The AACAP Code of ethics
   b. Legal and ethical principles of
      i. Confidentiality
      ii. The minor’s and guardian’s rights to receive and refuse treatment
      iii. Involuntary commitment
   c. Assent and consent principles in research
   d. Cultural competence in the areas of:
      i. Cultural diversity of the US population and cultural differences on children’s development
      ii. Cultural influences on identification of mental health problems and help seeking behavior
      iii. Etno-cultural influences in psychopharmacology and psychosocial interventions

2. Skills
   The resident should demonstrate competencies in the following areas:
   a. To review and discuss the institutional and governmental ethical guidelines
   b. Legal and ethical principles
      i. To obtain and discuss treatment consent forms
      ii. To observe and participate in involuntary commitment procedures
   c. To review and discuss research consent/assent forms
   d. Cultural competencies
      i. To interview children and families from different ethnic groups with openness and sensitivity to cultural differences and communication
      ii. To formulate treatment plans which are culturally sensitive to the child’s and parent’s concept of mental illness
      iii. To provide clinical care with an understanding of possible cultural differences in treatment expectations
      iv. To work with health care system’s professionals of diverse backgrounds

3. Behaviors
   a. Resident attends 75% of all offered psychotherapy seminars and reads assigned readings for seminars.
   b. Resident actively participates in seminar discussion

4. Attitudes
   Residents should demonstrate in their behavior and demeanor the following:
a. Respect, regard and integrity, and a responsiveness to the needs of patients and society that supersedes self-interest; assume responsibility and act responsibly; and a commitment to excellence

b. Commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices

c. The capacity to know when and how to challenge/provide procedures and practices for the patient’s benefit, consistent with ongoing research and practice development in child and adolescent psychiatry

d. Sensitivity and responsiveness to cultural differences, including awareness of their own and their patients’ cultural differences, including awareness of their own and their patient’s cultural perspectives

5. Assessment/Measurement

a. Evaluation by clinical supervisors in relation to confidentiality, informed consent, and patients’ rights to providing assessment and treatment of children and adolescents

b. Observation of patient interviews, simulated oral boards examination, with regards to ethical principles and cultural competence

c. A periodic review of case log for diversity in terms of ethnic, racial, gender, age and socioeconomic backgrounds

d. Evaluation of participation in case conferences, didactic seminars and CHILD PRITE performance in the relation to ethical, forensic areas, and cultural competence

e. Overall review of professionalism, ethical standards, responsibility, and cultural competence in resident evaluation process in relation to program standards
Child and Adolescent Psychiatry Residency Program

Core Competency

PRACTICE BASED LEARNING AND IMPROVEMENT

A. Identification and Self-Remediation of Gaps in Knowledge, Skills and Attitudes
   1. Knowledge
      a. Recognize that knowledge is inherently incomplete
      b. Definition
         Throughout a professional’s career, new knowledge or treatments are developed and recognized as efficacious. A professional also often encounters clinical problems with which he or she has limited experience. These situations require a willingness to develop new knowledge and skills, a recognition of knowledge and skill gaps, and an approach for continuously evaluating and improving one’s knowledge and skills.
      c. Expectation
         By the time they graduate, residents should be able to investigate, evaluate and improve their patient care practices.
   2. Skills
      a. Accurately assess knowledge, clinical abilities, and practice-based improvement activities using a systematic methodology. Examples of such an approach may include developing a learning and skill development program, as well as critical assessment of new knowledge and techniques and their applicability to one’s practice
      b. Locate, appraise and assimilate “best practices”, practice parameters and treatment guidelines that are relevant to the care of childhood psychiatric disorders
      c. Acquire and integrate information from a variety of sources, including electronic databases, scientific literature, presentations and consultations, to support clinical care, patient education and one’s own education
   3. Behaviors
      a. Resident attends 75% of all offered psychotherapy seminars. Resident reads assigned readings for seminars
      b. Resident actively participates in seminar discussion
   4. Attitudes
      a. Recognize the need for lifelong learning and monitoring of one’s own practice
      b. Willing to pursue continuing education and supervised experience to keep one’s own practice commensurate with the community standard of care
      c. Willing to obtain information from databases and scientific literature in child and adolescent psychiatry and related fields
   5. Assessment/ Measurement
      a. Residents are expected to take an area of knowledge and/or clinical practice which in unfamiliar to them and develop a systematic methodology to remedy this gap. Examples of an approach may include the following:
         i. Review literature
         ii. Attend workshops, seminars or clinical consultations
iii. Develop a presentation for a seminar or grand rounds. During this process the resident should demonstrate to the training director or a supervisor how he or she gained the knowledge and how he or she is using those skills

iv. Supervision records, resident self-assessment, self-directed learning and skill development and utilization of methods of gaining new knowledge and skills

v. Course directors to assign seminar topics by course directors to trainees and evaluate their capacity to obtain and use new information

B. Use of Scientific Literature

1. Knowledge
   a. Definition
      To review and critically assess the scientific literature to determine how quality of care can be improved in relation to one’s practice (i.e., reliable and valid assessment techniques, treatment approaches with established effectiveness, practice parameter adherence).
   b. Expectation
      The resident should be able assess the generalizability or applicability of research findings to one’s patients, in relation to their sociodemographic and clinical characteristics
   c. Be familiar with the scope of recent scientific literature in child and adolescent psychiatry and related fields
   d. Be familiar with research designs and statistical methods

2. Skills
   a. Critically read the scientific literature and apply information from scientific literature and apply to current patient/clinical problems. Examples of such a skill include the following:
      i. Identify and utilize appropriate journals and knowledge of what are necessary parts of successful research, clinical and review articles
      ii. Ability to apply one’s knowledge of study designs and statistical methods to appraise information on diagnostic validity and/or therapeutic effectiveness
      iii. Evaluate research with apparent differing conclusions and determine how research methodologies may have contributed to such findings.

3. Behaviors
   a. Resident attends 75% of all offered psychotherapy seminars. Resident reads assigned readings for seminars
   b. Resident actively participates in seminar discussion

4. Attitudes
   a. Willing to remain abreast of scientific advances, new clinical approaches and investigation of clinical outcome
   b. Recognize that the scientific literature is constantly evolving, that no one report or idea is necessarily true for all situations, and that the literature should be critically judged for its methodology and applicability

5. Assessment/ Measurement
a. Residents are expected to identify a knowledge gap and develop a systematic approach using relevant scientific literature to remedy this gap. Examples of an approach may include the following:
   i. A journal club during which a resident presents a critical review of selected articles and comments upon the applicability to a clinical case
   ii. A graduation paper or scholarly presentation during which a resident receives an evaluation of their ability to utilize and synthesize the scientific literature
   iii. An evaluation of a resident’s ability to utilize and synthesize scientific literature in relationship to clinical problems and patient care dilemmas by course directors or supervisors
**Child and Adolescent Psychiatry Residency Program**

**Core Competency**

**SYSTEMS-BASED CARE**

Definition: Treatment of children and adolescents with psychiatric problems is undertaken in the context of multiple, complex systems. The most important competencies in systems-based care are:

a. works in a mutually respectful, culturally competent manner with systems of care including various family compositions and extended family,
b. demonstrates a working knowledge of the diverse systems involved in treating children and adolescents, integrates multiple systems of care in treatment planning,
c. effectively collaborates in developing a shared treatment plan and,
d. advocates for children and adolescents in various systems of care

1. **Knowledge**
   a. Definition: Understands the concepts of systems theory
      i. Expectations: Articulates basic concepts of systems theory, and how they are used in child and adolescent psychiatry
   b. Definition: The resident should demonstrate a working knowledge of the diverse systems involved in treating children and adolescents, and understand how to use the systems as part of a comprehensive system of care in general, and as part of a comprehensive, individualized treatment plan. The resident should also have an understanding of the consultation role with multiple systems and agencies and be able to demonstrate knowledge of consultation principles.
      i. Expectations: There are expectations for several systems, which have variable components among states. These include:
         1. **Education System**
            a. Demonstrates knowledge of the resources available both publicly and privately, for the treatment of learning disorders, and psychiatric/behavioral problems impacting a child or adolescent’s ability to learn
            b. Understands the concept of school-based mental health care
            c. Exhibits knowledge of the legal aspects of education as they impact children and adolescents with psychiatric problems.
            d. Understands the development of Individual Education Plans (IEP) an the child and adolescent psychiatrist’s role in the process for determining the needs of special populations such as learning disabilities classes, behavioral disorders classes, emotionally handicapped classes, etc.)
            e. Understands school culture and the roles and approach of school personnel.
         2. **Social Services**
            a. Knows functions of child welfare services and is able to explain the role and function of the following:
               i. Protective services
               ii. Child welfare outreach services
               iii. Adoption and foster care
iv. Federal and state funding mechanisms
   b. Is familiar with services for physically and developmentally disabled children and adolescents and the federal laws and regulations ensuring availability of services
   c. Understands the role of social services in the treatment system

3. Medical
   a. Demonstrates knowledge of the public and private medical resources available in the community in clinical settings.
   b. Understands the structure and function of primary care and subspecialty pediatrics and related specialties and health care professions frequently involved in the care of children and adolescents
   c. Understands how their patient-care practices and related actions impact component units of the health care delivery system and the total delivery system, and how delivery systems impact provision of health care.
   d. Knows systems-based approaches for controlling health care costs and allocating resources; and practice cost-effective health care and resource allocation that does not compromise quality of care.
   e. Advocates for quality patient care and assists patients in dealing with system complexities
   f. Knows how to partner with health care managers and health care providers to assess, coordinate, and improve health care and knows how these activities can impact system performance.

4. Mental Health System
   a. Has working knowledge of available services in the community, both public and private
   b. Understands the use of home, school, and other community-based treatments such as family preservation, intensive case management
   c. Assesses patients for the level and intensity of care required.
   d. Explain the role of community-based treatment and their appropriate use to supervisors

2. Skills
   a. Definition:
      i. Able to communicate effectively with multiple systems described above.
      ii. Expectations:
         1. Elicits information from community systems involved in the care of a child or adolescent and listens to the input. Shows the ability to use elicited data in the development of a treatment plan.
         2. Able to communicate a child or adolescent’s mental health problems to other systems, including recommendations for the system’s role in the treatment plan.
         3. Communicates in a respectful and culturally sensitive manner.
   b. Definition:
      i. Provides consultation services to multiple systems
      ii. Expectations: develops the ability to skillfully interact with multiple systems in a consultation model
   c. Definition:
i. Uses community resources effectively and focuses on community-based treatments

ii. Expectations:
   1. demonstrates the ability to integrate data from multiple systems in a treatment plan
   2. able to access and use community resources
   3. collaborates with community based programs in the treatment of specific children or adolescents

d. Definition:
   i. Advocates for the child and family within the multiple systems involved with them
   ii. Expectations:
      1. Can explain the roles of various individuals and groups in community systems of care
      2. Demonstrates knowledge of advocacy groups. Examples are the National Alliance for the Mentally Ill and the Tourette’s Disorder Association
      3. Demonstrates an ability to advocate for children and adolescents in various systems of care.
      4. Demonstrates an understanding of the “social authority” of the mental health practitioner in advancing advocacy across policy, program and practice sectors.

3. Behaviors
   a. Resident attends 75% of all offered psychotherapy seminars. Resident reads assigned readings for seminars
   b. Resident actively participates in seminar discussion

4. Attitudes
   a. Definition:
      i. The resident should develop attitudes that reflect respect for the patient, family and other caregivers
   ii. Expectations
      1. works in a mutually respectful, culturally competent manner
      2. acts in the best interest of the child and family
      3. utilizes the concept of “least restrictive environment”
      4. provides treatment services as close to home as possible
      5. expects to collaborate with others to enhance a child or adolescent’s situation
CHAPTER 6

Clinical Programs
CLINICAL INPATIENT PROGRAMS

Child and Adolescent Psychiatry Acute Inpatient

First year child and adolescent psychiatry residents, PGY II residents and medical students on the child rotation are assigned to the rotation.

The Acute Inpatient Unit provides for comprehensive treatment in a multi disciplinary setting. Initial evaluations, daily rounds and team meetings are performed together with all members of the team. The treatment team consists of the attending, residents, medical students, staff psychologist, staff social worker(s), nurses, occupational/recreational therapists and teachers. Treatment interventions and plans are focused on the elaboration and improvement of acute problems that can be appropriately managed in an acute inpatient setting. Our programs have as their goals to provide the optimum care available to all children and adolescents who present for psychiatric treatment.

Goals:

Residents will develop the ability to work in a multi disciplinary team setting. *(Interpersonal and Communication Skills, Professionalism)*

Residents will develop knowledge and skills necessary to perform appropriate evaluations of children, adolescents and their families in an acute psychiatric inpatient setting. *(Patient Care, Medical Knowledge)*

Residents will demonstrate the knowledge and skills necessary to elaborate appropriate treatment plans and interventions for children, adolescents and their families admitted to an acute psychiatric inpatient setting. *(Patient Care, Medical Knowledge, Systems-Based Care)*

Objectives:

Residents will be able to describe appropriate use of medications and integrating medications in the overall management of children and adolescents. *(Medical Knowledge, Patient Care)*

Residents will be able to describe rationale for the use of specific psychotherapeutic modalities in the overall management of children and adolescents. *(Patient Care, Medical Knowledge)*

Residents will complete documentation and medical records in a timely manner. *(Patient Care)*

Residents will provide supervision of second year general psychiatry residents and medical students. *(Professionalism, Interpersonal and Communications Skills, Practice-Based Learning)*

Child and Adolescent Psychiatry Crisis Service

First and second year child and adolescent psychiatry residents and PGY II residents are assigned to the rotation.
The Children’s Crisis Service is responsible for the evaluation and management of children who present to any of the Medical Center’s emergency areas - Mental Health Emergency Service, Pediatric, Medical, Surgical, Ob-Gyn and Trauma emergency areas. We also provide psychiatric services to the Rape Treatment Center and the Urgent Care Center. The focus is on rapid assessment, appropriate intervention and disposition.

Goals:

Residents will develop the ability to perform appropriate evaluations of children, adolescents and their families in an acute psychiatric emergency setting. *(Patient Care)*

Residents will develop the ability to elaborate and implement appropriate treatment plans and interventions for children, adolescents and their families admitted to an acute psychiatric emergency setting as well as work effectively with various community agencies and providers. *(Patient Care, Systems-Based Practice)*

Residents will demonstrate the ability to determine the necessary level of care required to address the needs of each individual patient, including the need for psychiatric hospitalization. *(Patient Care, Systems-Based Practice)*

Objectives:

1. Residents will demonstrate the ability to conduct comprehensive evaluation of children and adolescents presenting in crisis. *(Patient Care)*

2. Residents will demonstrate the ability to formulate and implement clinically appropriate treatment plans. *(Patient Care)*

3. Residents will coordinate the multiple needs of children and adolescents in an acute emergency setting. *(Systems-Based Learning)*

4. Residents will demonstrate the ability to coordinate the demands of the Crisis Service and other clinical and non-clinical activities. *(Systems-Based Learning)*

5. Residents will completion documentation and medical records in a timely manner. *(Patient Care)*

While on the Crisis Service please remember our motto:

“Life does not entail the elimination of all crisis; it involves the management of crisis”.

**The Child and Adolescent Psychiatry/Psychology Consultation/Liaison Service**

Second year child and adolescent psychiatry residents and psychology interns are assigned to the rotation.

The Child and Adolescent Psychiatry/Psychology Consultation/Liaison Service provide a consultative and collaborative teaching program for many areas of the UM/JMH.

Clinical Rounds are scheduled each week. In addition, didactic seminars are held throughout the
year, beginning with introductory lectures followed by a series of specialty lectures and case presentations.

**Goals:**

Residents will become familiar with the psychological responses of children and families to acute and chronic medical illness of children. *(Medical Knowledge)*

Residents will learn about psychiatric manifestations of physical illness. *(Medical Knowledge)*

Residents will provide consultation to and liaison with medical teams in a professional manner. *(Professionalism, Interpersonal and Communication Skills)*

Residents will become proficient in performing comprehensive psychiatric assessments and disposition of patients admitted on a medical floor. *(Patient Care)*

**Objectives:**

Residents will conduct psychiatric evaluations of children admitted to the hospital for medical illnesses, under the supervision of the attending psychiatrist. *(Patient Care, Medical Knowledge)*

Residents will develop treatment recommendations and an aftercare plan for each patient. *(Patient Care)*

Residents will discuss recommendations with consulting medical team. *(Interpersonal and Communication Skills, Professionalism)*
Assignment to the JMH Child and Adolescent Outpatient Clinic (The CAP Clinic) is planned and organized to provide the resident with the opportunity to evaluate and treat children, adolescents and families presenting with a wide spectrum of psychopathology, some in long term continuous treatment.

The learning goals and objectives for each level of training are as follows:

**First Year Residents**

**Goals:**

- Learn to conduct evaluation of children and adolescents with a wide array of behavioral and emotional problems utilizing a biopsychosociocultural approach; *(Patient Care, Medical Knowledge)*

- Develop appropriate diagnostic impression and treatment plans, including needed family interventions, appropriate laboratory work, necessary consultations, community advocacy, and further psychiatric care; *(Patient Care, Systems-Based Practice)*

- Develop the basic skills necessary to carry out the formulated treatment plans. These skills include: supportive therapy, parental counseling, brief therapy and combined psychotherapy and psychopharmacology. *(Patient Care, Medical Knowledge)*

- Learn about the psychotropic medications commonly used to treat psychiatric disorders in children and adolescents. *(Medical Knowledge)*

**Objectives:**

- Residents will demonstrate the ability to interview children, adolescents and families in a respectful and empathic manner; *(Patient Care, Interpersonal and Communicative Skills, Professionalism)*

- Residents will demonstrate the ability to obtain the necessary information to arrive at a diagnostic impression and formulate treatment recommendations, including obtaining any consultations as clinically indicated. *(Patient care)*

  - Residents will formulate cases in a developmental framework, synthesizing dynamic and non-dynamic factors and arriving at DSM IV diagnoses. *(Patient Care, Medical Knowledge)*

  - residents will develop habits of exemplary documentation for the services provided. *(Patient Care)*

**Second Year Residents**

**Goals:**

1. Become proficient at conducting comprehensive evaluations and carrying out treatment for children and adolescents presenting with complex and often comorbid psychiatric conditions. *(Patient Care)*
2. Learn advanced skills necessary to carry out the formulated treatment plans. These skills include: psychodynamic psychotherapies, cognitive-behavioral therapies, interpersonal therapy and psychopharmacology, among others. *(Patient Care, Medical Knowledge)*

**Objectives:**

1. Residents will demonstrate ability to conduct informative and empathic mental status evaluations of children and adolescents with complex psychopathology; *(Patient Care, Interpersonal and Communicative Skills, Professionalism)*

2. Residents will demonstrate proficiency at gathering and recording pertinent information for diagnostic and therapeutic purposes and formulating comprehensive treatment plans. *(Patient Care)*

3. Residents will demonstrate proficiency at initiating various psychopharmacologic agents, monitoring response and tolerability and manage long term psychopharmacologic cases. *(Medical Knowledge)*

4. Residents will assume increasing clinical responsibility based on proven ability and experience and demonstrate the ability to practice safely and independently. *(Patient Care)*

Ages of patients range from 3 to 21 years. Disorders seen include conduct disorder, attention deficit hyperactivity disorder, separation anxiety disorder, depressive and dysthymic disorders, elimination disorders, eating disorders, oppositional disorder, post-traumatic stress disorder, autistic disorder, learning disorder and organic mental disorders. Patients with disorders less frequently seen and unlikely to be part of every resident's case load are presented in the CAP Clinical Case Conference. This clinic's case load includes a reasonable balance between boys and girls but is now fairly heavily tilted (about 60%) toward youngsters of Hispanic origin. Patients are all seen individually and parent(s) are also always seen, sometimes by the resident in a family approach and sometimes alone in a process parallel to and integrated with the treatment of the child. The usual therapeutic model is psychodynamically-oriented. Brief psychotherapy, and supportive and cognitive behavioral therapies when considered are also utilized appropriately. Each resident also spends four hours each week throughout the year in a specialized clinic for youngsters who require medication and brief supportive visits but who are not candidates for more intensive psychotherapeutic relationships or are receiving additional psychotherapeutic help elsewhere, such as in the school. Each resident receives an hour a week from each of two faculty supervisors for his/her psychotherapy patients, weekly supervision by the group therapist of the group for which the resident is co-therapist, and on-site supervision in the medication clinic.

**SPECIALTY CLINICS**

**Child Trauma Clinic**

Second year child and adolescent psychiatry residents, PGY II’s, child psychology fellows and interns, and medical students on the child rotation are assigned to the rotation.

Mission: To provide psychological and psychiatric services to children who have been the victims of
trauma or children who have experienced the death of a loved one. A particular focus of the clinic will address issues of grief and mourning in children.

Inclusion criteria: Children and adolescents who have been exposed to actual trauma such as a sexual abuse, physical assaults, motor vehicular accidents or children who have experienced the sudden and unexpected death of loved one.

Time and Location: The clinic meets every other Monday from 8:30-9:30am. The first fifteen minutes will be reserved for case presentations on an as needed basis. This will be followed by a reading seminar. A bibliography is provided. The residents and psychology trainees will present the readings for discussion. The meeting takes place in the Child and Adolescent Psychiatry Outpatient clinic (CAP) group room (1401H).

Goals:

1. Residents will learn how to reduce the acute and enduring psychological morbidity of children who have been exposed to traumatic stressors in which the individual has experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others. (Medical Knowledge, Patient Care)

2. Residents will learn how to provide psychological and psychiatric assessment and evaluation of children and adolescents who have been sexually abused or traumatized that we might make an informed decision regarding case management and treatment interventions. (Patient Care)

3. Residents will learn how to decrease the risk of children who have been sexually abused form becoming sexually reactive perpetrators. (Patient Care)

Objectives:

1. Residents will demonstrate knowledge of the evaluation of children and adolescents who have been sexually abused or traumatized. (Medical Knowledge, Patient Care)

2. Residents will demonstrate knowledge about the spectrum of interventions that have been proven to be efficacious in the treatments of children and their families who are the victims of traumatic experiences. (Medical Knowledge, Patient Care)

3. Residents will present scientific articles and actively participate in discussion. (Practice-Based Learning)

Assessment and Evaluation Procedures. The program will focus on the assessment and evaluation of children who have been the victims of actual trauma. The assessment of children who have been sexually victimized will focus on the determination of risk factors which are known to affect course and outcome such as parental and family support systems, degrees of sexual coercion, invasiveness, bodily and life threat, dose and duration of sexual victimization and the use of a weapon. Demographic, developmental and family history and information will be obtained. A referral for standardized psychological testing will be requested if clinically necessary to assess psychological distress, post-traumatic stress symptomatology, and adaptive and coping skills. A comprehensive evaluation of children necessarily requires multiple informants as to the child’s everyday functioning and will include
parent and teacher's report, and self report measures. Special instruments, which may be used, include the Child Behavior Check List (CBCL), The Teachers’ Rating Form (TRF), and the Trauma Symptom Checklist for Children (TSCC), the Pynoos Post-traumatic Stress Disorder Reaction Index (PTSDRI) and the Child Psychiatric Inventory (CPI).

Treatment Program. Children are provided opportunities for either individual, family or group therapeutic approaches depending on the presenting symptoms, risk factors and family configuration. Emphasis is placed on the evidence-based cognitive behavioral model Trauma Focused Cognitive Behavioral Therapy and information processing theory with its focus on explicating the meaning of the sexual trauma and subsequent adaptive and coping mechanism. Parents are involved in a modular parent psycho educational group.

The treatment of victims of sexual crimes is incorporated into the larger mental health activities of the Division of Child and Adolescent Psychiatry with its focus on child and family mental health. Mental health services are provided 24 hours a day for emergency evaluation and crisis intervention. Psychiatric, psychological and social work personnel will be involved.

Administration. The Trauma Clinic operates under the direction of Jon A. Shaw, Director of the Division of Child and Adolescent Psychiatry and Evelyn F. Benitez, Ph.D. Chief of Psychology and Attending Child Psychologist.

First Year Teaching Evaluation Clinic

This clinic is designed to teach first year fellows to assess children, adolescents and families. Fellows are taught the fundamental skills necessary for interviewing children, adolescents and families. Various techniques are utilized, including role playing, video-taping and live interviews.

Goals:

1. Residents will develop interviewing skills needed for evaluating children and adolescents of various ages. *(Interpersonal and Communication Skills, Patient Care)*

2. Residents will develop history taking skills and learn to perform comprehensive evaluations of children, adolescents and families, develop a diagnostic formulation and treatment plan. *(Patient Care)*

Objectives:

1. Residents will demonstrate the ability to interview youth of various ages using developmentally appropriate techniques. *(Interpersonal and Communication Skills, Patient Care)*

2. Residents will participate in role playing and live interviews. *(Interpersonal and Communication Skills, Patient Care, Practice-Based Learning)*

3. Residents will actively participate in discussions. *(Practice-Based Learning)*
**Developmental Disorders Clinic**

First and second year child and adolescent psychiatry residents, PGY II’s and medical students on the child rotation are assigned to the rotation.

The Developmental Disorders Clinic is held Wednesday, 8:30 a.m. to 12:00 noon and 1:30 p.m. to 4:30 pm. The focus of the clinic is the assessment, diagnosis, triage and treatment of children with developmental delays.

**Goals:**

Residents will become knowledgeable about the neuropsychiatric disorders and the autistic spectrum of developmental disorders. *(Medical Knowledge)*

Residents will become knowledgeable about the importance of a multiple modality and multiple disciplinary approaches to the diagnosis and treatment of these conditions. *(Medical Knowledge, Patient care)*

**Objectives:**

Residents will demonstrate knowledge of the autistic spectrum of developmental disorders. *(Medical Knowledge)*

Residents will provide evaluation and treatment to children with developmental disorders as part of a multidisciplinary team. *(Patient Care)*

**Clinic Procedures**

All children/parents seen in DDC will be administered the following research measures which will be discussed with the team to aid in diagnosis and understanding of the child and parent.

Parent Measures: Administered to the primary caregiver:

1. The Scales of Independent Behavior measures the child’s independent functioning in everyday situations, such as communication, motor skills, eating, dressing, time awareness, etc. A total score, the Broad Independence Score, is an average of the four cluster scores: Motor Skills, Social & Communication, Personal Living Skills, and Community Living Skills. The Problem Behavior Scales will also be administered to provide a focus for behavioral modification treatment, if necessary, for each child’s behaviors.

2. The Parenting Stress Inventory measures how much stress the parent currently feels regarding their child’s behaviors.

Child Measures: Administered during the second session with child:

1. IQ Assessment: The strategy for measuring IQ will employ a hierarchy of two tests, depending on the Child’s ability level. The Kaufman Brief Intelligence Test (K-BIT; Kaufman and Kaufman, 1990) is to be
used preferentially when possible. The K-BIT is a brief, individually administered measure of verbal and nonverbal intelligence. While it is not intended to substitute for a comprehensive measure of intelligence, it is adequate for our screening purposes. The K-BIT IQ composite score was correlated .80 with the WISC-R full scale IQ. Children for whom the K-BIT is unfeasible will try the Mullen Scale of Early Development (Mullen, 1995). The Mullen consists of five brief scales that yield a good picture of early cognitive and motor development. It is appropriate for children with autistic disorder and developmental delays.

2. Developmental Screening is completed using a variety of tasks at relatively early developmental levels in order to better understand the child’s developmental level, as well as to assess imitation, ability to follow directions, and engagability. Tasks include putting pegs/shapes into form boards, constructing with blocks, naming colors/shapes/numbers/letters, labeling objects, and recalling pictures of objects.

3. The Childhood Autism Rating Scale is completed at the end of the evaluation. This measure utilizes direct observation of the child’s behaviors during the interview, parent report, informal testing, and record review to make judgments on 15 behaviors that are primary or secondary features of autism. Consideration of the peculiarity, frequency, intensity, and duration of the behavior is important.

4. The Aberrant Behavior Checklist (ABC; Aman et al., 1985; Marshburn & Aman, 1992). The ABC is a 58-item rating scale that was developed primarily to measure the effects of pharmacological intervention in people with mental retardation. Several psychometric studies have proven the reliability and validity of the ABC in children with autism. The ABC will be completed during each scheduled visit.

**The Children’s Illness Clinic (CHIC)/The Healing Place**

Second year child and adolescent psychiatry residents and PGY II’s on the child rotation are assigned to the rotation.

The Children’s Illness Clinic (CHIC) is a specialty clinic dedicated to providing psychiatric and psychological services for children and families living with HIV/AIDS. It operates under the auspices of the Healing Place, a mental health clinic providing services to HIV infected individuals of all ages and their families.

**Goals:**

Residents will become proficient in the psychiatric evaluation and treatment of children and adolescents who have been infected by HIV or whose illness has progressed to AIDS. *(Medical Knowledge, Patient Care, Interpersonal and Communication Skills, Professionalism)*

Residents will become familiar with the array of family and biopsychosocial stressors that impinge on the child with chronic medical illness. *(Medical Knowledge, Patient Care)*

Residents will become familiar with the developmental and neuropsychiatric manifestations of HIV/AIDS in children and adolescents. *(Medical Knowledge)*
Residents will conduct psychiatric evaluations of children and adolescents living with HIV. *(Patient Care)*

Residents will provide psychiatric treatment to children and families living with HIV, in coordination with the primary care team caring for the child. *(Patient Care, Interpersonal and Communication Skills, Professionalism)*

**Clinic Procedures**

A first year child psychiatry resident, PGY II’s on their child rotation and psychology post doctoral fellows are assigned to the clinic.

The focus of the clinic is the assessment, diagnosis, triage and treatment of children and adolescents who are infected with or affected by HIV.

The clinic is held on Friday, 8:30 am. to 12:00 pm. An initial evaluation is scheduled from 8:30 to 10am and medication appointments are scheduled from 10am to noon. Follow up appointments are scheduled in coordination with medical appointments to the greatest extent possible.

Linkage with referral sources is very important to insure proper coordination of the treatment regimen. Therefore, ongoing communication with the Pediatric Special Immunology or Special Adolescent Clinic teams is critical for optimal treatment of children and adolescents with co-existing medical and psychiatric disorders.

**Psychopharmacology Clinics**

First and second year child and adolescent psychiatry residents, PGY II’s and medical students on the child rotation are assigned to the rotation.

The Psychopharmacology Clinics have two specialty clinical tracks, one dedicated to mood and anxiety disorders and the other to ADHD and disruptive behavior disorders. Three child and adolescent psychiatry residents, a PGY II and medical students are assigned to each track, which is supervised by a Child and Adolescent Psychiatry faculty member.

**Goals:**

1. Residents will demonstrate the knowledge and skills necessary to provide psychopharmacologic treatment of children with various psychiatric disorders. *(Medical Knowledge, Patient Care)*

2. Residents will demonstrate knowledge of the various psychopharmacologic agents used to treat psychiatric disorders of children and adolescents. *(Medical Knowledge)*

3. Residents will demonstrate knowledge of the side effect profiles, laboratory testing and the ongoing monitoring of various psychopharmacologic agents. *(Medical Knowledge)*

**Objectives:**

Residents will demonstrate knowledge of how to think about whether medications are needed and to consider alternative treatments. If a medication is the choice of treatment, how to choose based
on cost, efficacy and side effects. *(Medical Knowledge, Patient Care)*

Residents will demonstrate how to decide if a medication is having the desired effect and if not, whether this means that the diagnosis should be questioned. *(Patient Care)*

Residents will discuss treatment options with patients and families, under supervision of attending psychiatrist. *(Patient Care, Interpersonal and Communication Skills)*

Residents will review side effects with patients and families. *(Patient Care, Interpersonal and Communication Skills)*

Referrals to medication clinic are initially done at the disposition conference. Patients referred to medication clinic include: a) patients taking medication but not requiring individual psychotherapy (some of these patients also attend group therapy); b) patients with a poor record of attendance to individual appointment, that usually show up only when medication runs out; and; c) patients not amenable to psychotherapy due to lack of interest, compliance or other limitations, who also not in need of supportive interventions but who need occasional medication prescription renewed. In addition residents may transfer cases into their own medication clinic. In order to do so, the resident must provide the name of the child to Hodalys Barrios and submit the chart for review prior to setting an appointment for medication clinic. Therapists may refer patients for evaluation of need for psychotropic medication.

Structure. Medication clinic appointments are kept in the Cerner System. All problems can be consulted with Dr. Folstein. Cases are assigned to each individual resident by the attending. The resident reviews the chart and consults the case with the medication clinic attending. Disposition is accomplished by giving the patient a follow up appointment and logging the appointment in the Cerner system. A copy of the appointment slip should be given to the patient, and the other copy to the clinic staff. This is the responsibility of the resident. The Medication Clinic has been expanded to two afternoons and will have a strong psychopharmacology research component. All patients and their parents who agree to participate, will be administered research instruments by a research assistant and occasionally, by a resident or fellow. This will provide trainees with a research experience and an opportunity to derive their own senior research projects from these clinics.

**Debbie School for Child Enrichment**

First year child and adolescent psychiatry residents are assigned to the rotation.

First year residents will rotate through early development classes at the Debbie School for Child Enrichment for one half day per week for a ten week period. This rotation, which allows residents to observe typically developing children ages 0-5, is intended to serve as a companion activity for the Growth and Development Seminar. By the end of the rotation, the resident should have completed write ups on children of various ages.

**Goals:**

To become familiar with normal development of preschool children. *(Medical Knowledge)*

**Objectives:**
Residents will observe preschool classrooms of children 0-5 years. *(Medical Knowledge)*

Residents will share direct observation during the Growth and Development Seminar. *(Medical Knowledge, Practice-Based Learning)*

**School Consultation**

Second year child and adolescent psychiatry residents are assigned to the rotation. Residents provide consultation to school personnel under the supervision of a Child and Adolescent Psychiatrist.

**Goals:**

1. To become proficient at providing psychiatric consultation for children in school programs for emotionally disturbed children and adolescents. *(Patient Care)*

2. To become familiar with the behavior of children and adolescents. *(Medical Knowledge)*

3. To develop adequate knowledge about the school consultation model, school problems, and the perceived efficaciousness of the different intervention strategies and demonstrate necessary skills needed to work in a school consultation model. *(Medical Knowledge, Patient Care, Systems-Based Practice, Interpersonal and Communication Skills, Professionalism)*

4. To become familiar with administrative policies governing special education programs. *(Systems-Based Practice)*

**Objectives:**

1. Residents will provide psychiatric consultation of children with emotional and behavioral problems in a school consultation program. *(Patient Care)*

2. Residents will demonstrate ability to work with school staff in a collegiate and professional manner. *(Interpersonal and Communication Skills, Professionalism, Systems-Based Practice)*

3. Residents will demonstrate knowledge about school problems encountered as a consultant, services rendered, and various intervention strategies utilized. *(Patient Care, Medical Knowledge, Systems-Based Practice)*

4. Residents will become familiar with the administrative policies for school placement of emotionally disturbed children. *(Systems-Based Practice)*

5. Residents will observe the behavior of children and adolescents not identified as patients. *(Medical Knowledge, Practice-Based Learning)*
Parenting Skills Training

Parents of CAP Clinic patients should be encouraged to attend parenting sessions that are led by psychologists and trainees. Interventions focus on how to increase positive interactions between parent and child, as well as how to decrease disruptive and increase compliant behaviors using behavior modification strategies. Parents are given parenting materials to reinforce techniques learned in the groups.

To refer a parent, complete a therapy referral form, check off “parenting” and discuss the referral with the clinic attending. Please refer to Appendix A.
CAP GENERAL GUIDELINES

Clinic Hours

The CAP clinic is open Monday through Friday from 8:00 AM to 4:30 PM. Please be aware that the client may need to go to registration before being checked in for their appointment. You may not leave the clinic during your scheduled time without checking with the clinic attending.

Vacations

The leave policy for the CAP clinic fellows is as follows:

1. Child Psychiatry residents shall obtain clinical coverage from a fellow resident. The resident providing clinical coverage shall sign the leave slip indicating that he/she has accepted covering.
2. Leave requests shall be signed by the Chief Resident, who will ensure that adequate clinical coverage is in place. The Chief resident will keep a copy of the leave request slip.
3. All leave requests shall next be approved and signed by the rotation attending.
4. Leave requests must be submitted at least one month in advance prior to your requested leave otherwise, you will be responsible to re-schedule the evaluations at your own time.
5. Only after steps 1-4 above have been completed will Dr. Shaw authorize in writing the leave request which will be turned in to Michelle Hurtado who will file it and forward a copy to Andrea Santo for HR purposes. The request will also be sent to the CAP clinic staff for scheduling and to alert them to clinical coverage.
6. All clinic notes must be completed before going on leave. If any notes are outstanding, leave will not be granted.
7. Before going on leave the resident is responsible for setting up their office voicemail indicating their leave, when they will return and who they can contact if the matter is urgent. Also the resident is responsible for activating their Out of Office Assistant in Microsoft Outlook with information regarding their leave and coverage.

Please note that no leave request will be considered granted until the entire procedure is complete.

Sick Calls

1. You must contact the Training Office, and the Chief Fellow who will arrange coverage of patients scheduled that day.
2. You must let the staff in room 1527 know so that if a patient of yours comes, they can alert the resident who is covering.
3. You must call and speak directly to a clinic attending.
4. You should attempt to contact all of your scheduled clients and reschedule their appointments (especially psychotherapy).
5. You must provide the clinic staff with the name of the resident covering for you.
Clinic Expectations

You are expected to be physically present and on time for all your clinic appointments and to remain in the clinic until the end of the work day.

Apart from evaluations assigned by the Intake staff in check-in area, residents are responsible for scheduling their own therapy clients. Attention should be paid to appropriate scheduling throughout a clinic.

Therapy clients should be seen at the time that the appointments were scheduled. If client arrives 40 minutes late for their appointment the provider will speak with the client and reschedule. Medication management clients are also given a set appointment. Clients who arrive more than 15 minutes late or walk-in without appointments, they can be rescheduled or asked to wait until it is possible to see them without inconveniencing the clients who have arrived on time for their appointment.

You must keep a record of appointments you have scheduled to avoid overbooking clients. You are not to schedule 2 therapy appointments at the same time or during your medication clinic.

All appointments MUST be ordered at least 72 hours before the scheduled day. Exceptional are made due to clinical reasons and client can be scheduled within 24 hours but resident would need to inform the check-in staff of the exception to prevent delays in checking in the patient. The client is also informed to come at least 20 minutes earlier to their appointment since Finance needs to clear their insurance before getting checked-in.

If you make an error scheduling an appointment and cannot come to see a client who has arrived for an appointment, you will be asked to speak to the client to reschedule, ask them to wait, or make arrangements for another resident to see them.

Residents are expected to set up their voice mailboxes with an appropriate greeting and instructions for patients. And it is the expectation that you will return phone calls as soon as possible but no later than 24 hours (Please refer to Appendix E). Resident will need to follow the steps in changing their voicemail when they will be out of the office and cannot return the call within 24 hours (i.e., vacation, out sick).

Please refer to JMH Policies and Procedures that are listed in Appendix F.

CLINIC PROCEDURES/CASE ASSIGNMENTS

How patients are assigned and what all residents and interns should know about CAP Clinic.

Initial Evaluations:

Parents/legal guardian calls Jackson Behavioral Health Hospital Help Line (305-324-4357) to request psychiatric services. A brief intake is taken over the telephone and the patient is scheduled for a psychiatric or psychological evaluation.

Psychiatric Evaluations:

Second year residents are assigned between one and four evaluations per week, depending on their primary assignment. First year residents will be assigned a maximum of two evaluations per week throughout the year.

The Resident will be expected to conduct the evaluation, interviewing parents and child, and obtaining information from outside sources, so as to arrive at a differential diagnosis, case formulation, and treatment plan. Residents discuss all new cases with a clinic attending, in addition to discussion
with their individual supervisors.

1. CAP clinic charts are all documented electronically in Cerner. The psychiatric evaluation will be written in Cerner Powernote however, the treatment plan and any other documents that need signatures (i.e., consent to communicate) or are collected (i.e., psycho-educational testing reports, self-administered measures, etc.) will be placed in medical record bin with client’s name, medical record number to be scanned in clients charts.

2. Follow up evaluation appointments should be scheduled within 1 week after initial evaluation and no later than 2 weeks.

3. If the client does not return for the follow up evaluation this must be documented in the medical record. The resident must contact the patient to reschedule the appointment.

4. All fellow must present all evaluations to the clinic attending and submit electronic documentation for signature. The attending will see the patient and write a note in the electronic medical record.

5. All evaluations must follow the format outlined in the training manual. (Please refer to Appendix G.)

6. Check over your evaluation to make sure all items are covered before submitting to your attending. Make sure all areas are addressed even though they are WNL (e.g. no hospitalization, N.K.D.A., etc.).

7. The evaluation must be submitted electronically to the supervisor within 24 hours of completion of the evaluation.

**Therapy Patients**

Residents are encouraged to pick up therapy patients during clinical rotations, both inpatient and outpatient. Other patients who are referred for individual or family therapy will be assigned by the Training Director based on current resident therapy caseload to ensure a broad clinical experience.

**DOCUMENTATION AND PATIENT RECORDS**

1. A progress note must be written regarding the service rendered and the electronic **CHARGE VOUCHER** must be completed on the day of service.
   a. Follow up appointments are written on the check-in appointment sheet and given to patient at the end of the session. The patient is informed to go to the patient check-out office (Rm # 1527) to check-out and have next appointment entered into the system.
   b. **CHARGE VOUCHERS** - Must be completed electronically on the day of service.

2. Each resident will receive the CAP Outpatient Handbook which provides detailed instruction on how to complete orders and charge vouchers.

3. **Medical Records:**
   All patient documentation is completed in the Cerner electronic health record. However, any paperwork which needs client’s signature remains on paper and is scanned to the electronic medical chart.
4. Chart Forms

Forms are kept in the file cabinet in the office. Please ask the office staff if you are unable to find something you need.

Chart Elements. All outpatient child evaluation and therapy charts will have the following elements:

a. Therapy Treatment Plan C-430
b. Medication Treatment Plan C-429EC
c. Growth Chart (as needed)
d. Clinic Demographics
e. Medication Release and Treatment Forms
f. General Consent for Treatment C-613
g. Authorization for Medications if receiving an injection
i. Therapy Care Plan Review C-431
j. School Forms
k. Self-Administered measures (i.e. ADHD Rating Forms, CBCL)

5. Treatment Plans

All patients must have a treatment plan and must be completed by the second visits. Please note that there are two different treatment plans (i.e., medication or therapy treatment plans). Depending on the services provided you must complete either one or both treatment plans. A treatment plan review must be completed every 6 months. Treatment Plan Reviews for medication charts must be documented on C-429EC and for therapy cases on the C-431. These should be put in the box for scanning into the EHR. Since there is no paper record, the 6 monthly treatment plan review must be completed on a new form.

6. Therapy Notes

All patient therapy encounters are documented electronically in Cerner in the Powerchart BH therapy note.

a. In the content of your note indicate the amount of time you saw the patient
b. All entries should reflect the goals that have been identified in the patient’s care plan.
c. For all patients who are seen for both therapy and Medication management by the same fellow, a Powerchart BH Therapy note must be completed and medications recorded in the Cerner system.
d. Health Insurance Portability and accountability Act (HIPPA) re Psychotherapy Notes: Should not be made available beyond the treating provider without the client’s/guardian’s consent.
e. All therapy notes should be completed on day of visit. Progress Notes should be concise and may include references to current life situations, transference developments, themes, reconstruction of the past, major interventions, significant behavioral changes, nature of the therapeutic alliance patients motivation of treatment, and developmental of insight. A brief mental status must be documented.
f. All documentation of telephone calls to clients or other treatment providers, missed
appointments, rescheduled appointments are to be documented in the electronic medical record. This becomes important in the event the chart is closed.

g. All correspondence pertaining to the client should be copied and placed submitted to medical records with patient’s name and medical record number to be scanned in electronic chart.

7. Content of a Therapy Note:

1. Demographic and diagnosis: Client is a 15 year old female with a diagnosis of Major Depression Disorder single episode.
2. Content and Duration
   “Client was seen for individual therapy for 45 minutes....”
3. Clinical Presentation/Signs and Symptoms
   “Client’s mood and affect were......Continues with symptoms of depression characterized by ......Continues on (medication name(s)).”
4. Primary Themes of Session
   (Brief and vague discussion of themes)
   “Client continues to struggle with interpersonal difficulties.”
5. Intervention Provided
   “Utilized Angry Monster game to begin teaching anger management skills“ or “Utilized Good Touch/Bad Touch booklet to begin teaching self protective strategies and /or appropriate boundaries.”
6. Client’s Response to Intervention
   “Client responded well, but continues to struggle with low self esteem.”
7. Plan
   “Continue to follow” or “Continue with above next session.”
8. Date and time of next appointment.

8. Therapy Treatment Plans
   Treatment plans must be done for all clients being seen for therapy on the C-430 form. Client, legal guardian, and attending must sign the plan. Therapy Treatment Reviews are documented on C-431 and completed every 6 months.

9. Medication Clinic Notes

a. Clients that are transferred to medication clinic must have a complete evaluation in the medical record.

b. All patients seen for medication only must have a Powerchart BH Psychiatric Amb Svc Pt Contact Record completed and forwarded to the clinic attending electronically for signature.

c. You must document on the Powerchart BH Psychiatric Amb Svc Pt Contact Record that you informed the patient and/or parent/legal guardian of medication side effects every time you start or change a medication.

d. All medication clinic patients must be presented to the attending, who will see the patient and write a note in the electronic record.

e. Children in foster care must have a medical affidavit completed, notarized, and filed with the courts. A court order must be obtained and placed in the chart prior to initiating medications.

f. Any individual started on injection medication must have an authorization for medication form
initiated prior to ordering.
g. Children receiving medication in school need an Authorization for Medication in School form filled out. This form must be completed and signed by the provider.
h. Treatment Plan C-429EC must be completed at the initial time medications are prescribed. Client, legal guardian and attending must sign.
i. **RESIDENTS ARE NOT PERMITTED TO GIVE CLIENTS DRUG SAMPLES.** See Jackson Policy included in this manual.

j. Prescription Pads are not to be used. All prescriptions must be written in Cerner on EZ Script (except for controlled substances) (Please refer to Appendix H)
k. Class II medications MUST be written on a separate prescription from other medications. This includes such drugs as Ritalin, Dexedrine, benzodiazepines and related medications.
l. Client’s parents should be encouraged to follow up with all recommended medical appointments so that their medical conditions can be appropriately monitored.
m. Communication either by phone or mail to the client’s PCP or specialist regarding treatment and medication should be noted in progress note and if applicable a copy of letter sent in medical paper chart.

n. **ABSOLUTELY NO ABBREVIATIONS OF MEDICATIONS IN YOUR DOOCUMENRTATION IS PERMITTED.**
o. Prescribing instructions and quantities must be documented fully on the BH Psychiatric Amb Svc Pt Contact Record.
p. **CLIENT EDUCATION** - There must be evidence of client education in all of your medication management documentation:
   “Medication(s) was/were discussed including indications, options and alternatives. Dosage, duration of treatment, side effects (specifically list side effects that were discussed), risks, contraindications and interactions”

We ask that all that users of the offices be considerate and clean up after each session. Please remember to keep an eye on younger siblings when seeing an entire family in the office.

10. No Show or Telephone Contact

All documentation of telephone calls to clients or other treatment providers, missed appointments, rescheduled appointments are to be documented in the electronic medical record. This becomes important in the event the chart is closed.

11. Laboratory Tests

a. All lab orders must be requested electronically and written on a lab request form and the patient should take the request form to the outpatient office staff in Rm. 1527, who will schedule labs.
b. Based on the child’s insurance they will get their labs drawn at JMH, Quest or LabCorp.
c. You must legibly print out your name; provide your MD identification number and your beeper number in the little box on the lower left corner of the lab request voucher.
d. In addition, in the Miscellaneous Text box on the lower right side of the voucher you must write the DSM-IV code.
e. After voucher is completed you must send the client to the clinic office to make an appointment in CERNER. Failure to do this will result in delay of the child having their labs drawn.
12. Off Service Notes

As required by ACGME, verbal and written handoffs are expected on each clinical service. Therefore, if you are transferring a child to another resident, you must write an electronic off service/transfer note summarizing the course of treatment using a BH progress note.

*Details of content of transfer note are provided in the CAP Outpatient Handbook.

13. Closed Charts

All charts to be closed must be presented to their supervisor. Documentation of the chart’s closing is done in Powerchart after appropriate closing steps have been taken:

   a. Warning letter **Copies of these letters must be in the chart**
   b. Closing letter (copy of letter filed in medical chart and a note in Cerner documenting that a letter was sent and the reason for termination)
   c. If a patient has not been to the clinic for 6 months, the chart is to be closed by the provider.

**APPOINTMENTS**

It is imperative that you place an Order for an appointment for all your patients. If you are rescheduling an appointment the Order must be placed at least 3 days prior to the scheduled session otherwise your patient will be seen as a “walk-in” and must obtain financial clearance (up to 45 minutes wait) prior to meeting with you. In exceptional case that you must see your patient less the three days, please inform the patient that they must come at least half an hour earlier than their scheduled appointment to obtain financial clearance. Make sure you place the Order in Cerner and notify the office staff of the situation to assist in the process.

**MAKING REFERRALS TO CAP**

**From Inpatient:**
Clients coming to the CAP Clinic from the Inpatient unit do not require another evaluation. The client will be scheduled as a follow up evaluation through the Intake Coordinator located in the Check-In front lobby. At the time you see the client a note is required in the C-255 summarizing the need for outpatient follow up after transfer form inpatient care. You must initiate the treatment plan.

**From Consult/Liaison**
Refer the child to the Outpatient Intake Coordinator (Alma or Genia (304-355-7047). who will verify insurance coverage, do the screening and give an appointment. The C/L evaluation consult takes the place of the evaluation. The first visit should be a follow up evaluation and all information not addressed in the consult must be obtained and documented in Powernote.

**From Crisis**
The client must call the Outpatient Intake Coordinator at (305) 324-4357 to set up the initial evaluation. If a Child resident is going to follow the client he/she will be required to complete a consult and the first CAP clinic appointment is a follow up evaluation.

**From Provider**
CAP providers (psychology) will refer one of their clients for a psychiatric evaluation. The provider will contact the Outpatient Intake Coordinator and obtain an appointment from the list of open evaluation
CHAPTER 7

Administrative Policy
and Procedures
ON-CALL DUTIES AND RESPONSIBILITIES

The Child Residents are on night call in a supportive capacity to the general psychiatric resident, who is asked to evaluate a child or adolescent. General psychiatry residents on call complete evaluations of children and adolescents under the supervision of the ER psychiatric attending. If there are any questions or concerns, the psychiatry resident contacts the Child Resident through the on-call beeper or cell phone to discuss the case and plan an appropriate disposition. A Child Psychiatry attending is available at all times to the child psychiatry resident for consultation on an as needed basis.

If the case demands it, the Child Resident is obligated to come to the hospital and personally evaluate the child. Then he is to discuss the case with the resident and other staff involved in the Child's care. Therefore, the Child Resident should always be available to come in during his on-call week (i.e., therefore no moonlighting).

Each first Child Resident will be on-call approximately every eight to ten weeks for a period of seven days. Each Second year Child Resident will be on call approximately one time per year for a period of 7 days. A faculty member will be on call each week along with the Residents as well.

TERMS OF APPOINTMENT

The general (institutional) terms of your residency appointment in this training program are contained in the Letter of Agreement and Collective Bargaining Agreement which you signed on acceptance of your appointment. As you surely already know, this covers such conditions of employment as stipends and benefits, working conditions, general institutional rules and regulations, and the basis for handling disciplinary matters and grievance procedures. If you haven't done so already, you should make yourself familiar with this document. Additional rules and regulations are sometimes adopted by our training program to deal with issues that might be unique to our service. These will, of course, always be consistent with the agreement you have with the institution.

If you are assigned to another institution for part of your training, you would, of course, be expected to adhere to any special rules and regulations it might have. These should, however, be consistent with the terms of your basic agreement with JMH, and any differences or apparent conflicts should be brought to the attention of the Training Director for Child and Adolescent Psychiatry.

RECORDING YOUR CLINICAL EXPERIENCE

The Special Requirements for Psychiatry, as established by the Accreditation Council for Graduate Medical Education (ACGME), contains the following section: “There must be a record maintained of specific cases treated by residents, in a manner which does not identify patients, but which illustrates each resident’s clinical experience in the program. This record must demonstrate that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. This record should be reviewed periodically with the program director or a
designee, and be made available to the surveyor of the program.”

The American Board of Psychiatry and Neurology (ABPN) expects that such a record be maintained accurately and in detail and may require that such information be submitted as part of the credentials accompanying an application for admission to examination for certification in psychiatry. If you are in your PGY-IV year, you will recall that the first residency year in child and adolescent psychiatry constitutes the fourth year of required training for certification in general psychiatry. As such, it is evaluated when you apply for admission to examination for your certification in general psychiatry.

It is a good idea, though, for those of you who are at PGY-V level, whether in your first or second residency year, to maintain such a record in the event that you are ever asked to produce it.

Our program regards the maintenance of such a record as the personal responsibility of the individual Residents. You should immediately initiate such a record as a running "log" of your clinical experience. A suggested format is attached. For each activity recorded and each assignment completed, you should obtain the initial or signature, as appropriate, of the responsible faculty supervisor.

SELECTIVE PROCEDURE
FOR CHIEF RESIDENT

The Residents will get together and nominate two or three candidates for the position of Chief Resident. Their names will be given by the outgoing Chief Resident to the training committee, who will in turn make the selection of Chief Resident. If the names submitted are not deemed acceptable for such position, the faculty reserves the right to select another person.

Responsibilities of the Chief Resident

The Chief Resident for Child and Adolescent Psychiatry will carry responsibility for the following: The Chief Resident will serve as the primary liaison between faculty and all those who are in training status in our clinical service—child and adolescent psychiatry residents, PGY-3 interns, junior and senior medical students:

1. Responsibility for maintaining the on-call schedules for faculty and trainees;

2. Responsibility for planning, implementing, and chairing the monthly Child and Adolescent Psychiatry Grand Rounds;

3. Assisting the Chief, Child and Adolescent Psychiatry Division and the Training Director in planning, organizing, and implementing the weekly Child and Adolescent Psychiatric Clinical Case
Conferences;

4. Serving on the Child and Adolescent Psychiatry Training Committee;

5. Working appropriately with the representative(s) of each of the trainee groups;

6. Chairman, Playroom Committee;

7. Assisting the Chief of the Child and Adolescent Psychiatry Division in various other clinical/administrative matters as designated.

SUBPOENAS

From time to time a Resident may be served with a subpoena. The proper procedure to implement immediately is as follows:

1. Make two copies of the subpoena;

2. Take the original to the administrator of the Mental Health Services Hospital Center;

3. Place a copy in the clinic/ hospital chart;

4. Take the other copy to the faculty member responsible for supervising your work with the patient to whom the subpoena refers and discuss the issues involved.

5. Do not talk to outside attorneys without prior consultation with supervisor and Risk management representatives.
YOUR ROLE AS AN EXPERT WITNESS

At some time during your training you may have opportunity (we hope you do have, but it depends on factors over which we have incomplete control) to act as an expert witness in the process of litigation. Whether or not you will need to participate actively in the litigation process (conferring with legal counsel, preparing a report, giving a deposition or testimony in court, etc.) will depend on the administrative and legal matters at issue.

Areas of our professional work in which this may occur include, but are not necessarily limited to, the following: Involuntary hospitalization of a child or adolescent; custody issues; physical and/or sexual abuse; competency and criminal responsibility issues.

MEDICAL LICENSURE

Preparing adequately for such an experience makes the difference between effective or ineffective performance in the role of expert witness. Under no circumstances should you agree to appear in such role without detailed discussion with the staff supervisor with whom you are carrying the case. The Executive Training Committee of the Psychiatric Service has established the following policy regarding Florida Licensure: "Residents will be required to take a state medical licensure examination no later than PGY-II and to have a copy of their license in our office no later than the end of PGY-III. Advancement to the PGY-IV or residency year will be contingent on completion of the above."

To be consistent with this policy, eligibility for appointment to a residency in child and adolescent psychiatry on or after 1 July 1990 will include the possession of a valid and current license to practice medicine and surgery in the State of Florida.

CHECKOUT PROCEDURE FOR GRADUATING RESIDENTS

Upon termination of the residency, the residents must checkout with the training office of the Division of Child and Adolescent Psychiatry and the Director of the CAP clinic. Keys and beepers must be returned to the Training Office of the General Psychiatry Department. Check out procedures that apply to house staff should be followed. The final signature for clearance will be given by the Training Office and the Office of Physician Services. Residents without formal clearance, graduation certificates will not be issued.
OTHER ADMINISTRATIVE INFORMATION

Keys

A special "T" key is needed to go into the locked inpatient wards and other offices in the Mental Health Building at JMH. Residents will receive their keys at the beginning of the training period. Lost keys must be reported immediately to the Training office.

Parking

Residents and residents can get Parking Forms from Physician Services. These parking forms must be taken to the Parking Garage. The Parking Garage office is located on the south end of the Main Parking Garage, first floor.

CHILD AND ADOLESCENT PSYCHIATRY RESIDENCY TRAINING PROGRAM
DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
UNIVERSITY OF MIAMI/ JACKSON MEMORIAL HOSPITAL

POLICY AND PROCEDURES DUTY HOURS

The Child and Adolescent Psychiatry Residency Training Program’s policy and procedures for resident duty hours, in compliance with the Accreditation Council of Graduate Medical Education (ACGME), are as follows.

A House Staff Officers must not be scheduled for more than 80 hours averaged over a four-week period.

B House Staff Officers must have one full day in seven off free of duties, averaged over a four-week period.

C House Staff Officers must not be assigned in-house call more often than every third night, averaged on a four-week period.

D House Staff Officers must have a minimum rest period of 10 hours between duty periods.

E Continuous time on call is limited to 24 hours. House Staff Officers may not assume responsibility for patients after 24 hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical care.

F No new patients may be accepted after 24 hours of continuous duty.
G At-home call (or pager call) is defined as a call taken from outside the assigned institution.

H The frequency of at-home call is not subject to the ever-third night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

I When House Staff take call from home and are called in to the hospital, the time spent in the hospital must be counted toward the weekly duty hour limit.

J The program director and faculty will monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

K Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of internal moonlighting. Note: Beginning on July 1, 2011, all internal and external moonlighting will be considered part of the 80-hour weekly limit on duty hours.

L The program director and faculty will monitor individual resident moonlighting hours each month to assure that moonlighting activities do not contribute to excess fatigue or detrimental educational performance. Permission to moonlight may be withdrawn if the activities adversely affect House Staff performance.

M The program director will monitor individual resident duty hours on a monthly basis to ensure compliance with duty hour requirements.

N Residents found to be in violation of this policy will be subject to disciplinary action as detailed in the Collective Bargaining between the Public Health Trust and the Committee of Interns and Residents (CIR)
Specialty-specific Duty Hour Definitions
(4/29/2011)

Below are the specialty-specific duty hour definitions that will be incorporated into each respective set of program requirements on July 1, 2011 and specialty-specific FAQs. Additional definitions and FAQs will be developed over time.

| VI.D.1. | In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care. |
| VI.D.5.a)(1) | Supervision of Residents: In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.] |
| VI.E. | Clinical Responsibilities: The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. [Optimal clinical workload will be further specified by each Review Committee.] |
| VI.F. | Teamwork: Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. [Each Review Committee will define the elements that must be present in each specialty.] |
| VI.G.5.b) | Minimum Time Off between Scheduled Duty Periods: Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. |
| VI.G.5.c) | Minimum Time Off between Scheduled Duty Periods: Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. |
| VI.G.5.c)(1) | Minimum Time Off between Scheduled Duty Periods: This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. |
| VI.G.6. | Maximum Frequency of In-House Night Float: Residents must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.] |
The Child and Adolescent Psychiatry Training Program utilizes the Institutional Moonlighting Policy. Residents are permitted to moonlight as long as training is progressing satisfactorily and the moonlighting does not interfere with training activities.
EXTRACURRICULAR-PROFESSIONAL ACTIVITY (MOONLIGHTING)

MEMORANDUM

TO: Jon A. Shaw, MD

RE: Extracurricular Professional Activity (MOONLIGHTING)

THIS MEMO MUST BE SIGNED AND RETURNED TO THE TRAINING OFFICE BY SEPT. 1st of the academic year. NO EXCEPTIONS!

I propose to engage in the following professional activity outside the regularly scheduled child and adolescent psychiatric residency program. I understand that these moonlighting activities are confined to basic on-call medical management and/or general psychiatry but preclude working as a child and adolescent psychiatrist. I request approval according to the following arrangement:

1. Institution or facility in which this activity will occur.
   Address: Phone:

2. Individual to whom I will be directly and legally responsible in this activity.

3. Nature of this activity:
   a. I consider this activity as medical management
      ( ) in a psychiatric facility
      ( ) in a non-psychiatric facility

4. Individual who will provide professional supervision for my work:

5. Exact hour and day I will engage in this activity.

6. Method by which I will be paid:
MEMO: Extracurricular professional activity (Moonlighting)

I understand that professional liability insurance provided by Jackson Memorial Hospital covers only those activities directly associated with the residency training program and in no way will apply to extracurricular activities such as outlined in this letter. I further understand that it is my personal responsibility to obtain individual professional liability insurance or institutional coverage when it is available through the institution at which I might perform extracurricular activities.

I am aware that any extracurricular work I do must not conflict with any aspect of the formally constituted psychiatric residency program and in no case will ever be considered a valid reason for absences from any of its scheduled activities or for failure to carry out the clinical duties or academic responsibilities that are part of it.

I am also aware that I must not engage in any psychiatric or other medical activity on a fee-for-service basis or in any other way that requires my billing a patient or an agency for my services.

I am also aware that I must not use any academic title other than "Resident in Child and Adolescent Psychiatry" during my training period.

I recognize that this arrangement for extracurricular-professional activity, if approved, constitutes an agreement the violation of which could result in the loss of credit for part of my residency training or in separation from the training program.

I do not intend to engage in any moonlighting activity.

__________________(Signature)
__________________(Print name)
(Date)

Approved as outlined above:

Training Director
Chief of Service
CE: RMS/cmo
Policy:

It is the policy of the Public Health Trust, Physician Services Administration, to process and credential any and all House Staff Officers who wish to engage in moonlighting activities at the Public Health Trust facilities. House Staff Officers are not required to moonlight and all moonlighting activities are the voluntary choice of the individual House Staff Officer. It is the policy of the Public Health Trust to comply with the Accreditation Council of Graduate Medical Education (ACGME) requirements on House Staff Duty Hours. Moonlighting that occurs within Jackson Health System is counted toward the duty hour limit requirements.

Procedure

1. All House Staff Officers must be credentialed by the Medical Staff and privileges shall be approved prior to being placed on any schedules.

2. All House Staff Officers who are engaged in moonlighting activities must be licensed in the State of Florida for unsupervised medical practice and possess a valid and active license.

3. Exception: All House Staff Officers sponsored by ECFMG are prohibited from moonlighting, regardless if they are licensed in the State of Florida per ECFMG regulations/standards.

4. House Staff Officers are allowed to moonlight upon approval by the Program Director and Jackson Health System Administration.

5. All House Staff Officers must provide the Medical Staff Office with a letter of good standing from the Program Director that must state the maximum number of hours allowed to work per pay period. (The institution will comply with the Florida Board of Medicine regulations and ACGME requirements).

6. All House Staff Officers shall follow their program policy or Board policy regarding moonlighting activities. Program policy should require that moonlighting will not interfere with Housestaff training responsibilities/schedules as well as stipulate consequences for Housestaff who do not comply with the training program policy.
Compliance with the Accreditation Council of Graduate Medical Education (ACGME)

A. House Staff Officers must not be scheduled for more than 80 hours averaged over a four-week period.

B. House Staff Officers must have one full day in seven off free of duties, averaged over a four-week period.

C. House Staff Officers must not be assigned call more often that every third night, averaged on a four-week period.

D. House Staff Officers must have a minimum rest period of 10 hours between duty periods.

E. Continuous time on call is limited to 24 hours. House Staff Officers may not assume responsibility for new patients after 24 hours.

F. When House Staff take call from home and are called in to the hospital, the time spent in the hospital must be counted toward the weekly duty hour limit.

G. Programs are encouraged to monitor all individual resident moonlighting hours each month to assure that moonlighting activities do not contribute to excess fatigue or detrimental educational performance. Permission to moonlight may be withdrawn if the activities adversely affect House Staff performance.

H. Residents found to be in violation of this policy will be subject to disciplinary action as detailed in the Collective Bargaining Agreement between the Public Health Trust and the Committee of Interns.
and Residents (CIR).

RECEIPT OF MOONLIGHTING ACTIVITIES POLICY
AND DUTY HOUR REQUIREMENTS

I have received a copy of the PHT Policy on Moonlighting activities, Policy # 514 which describes the procedures and requirements that govern the time spent in patient care activity external to the educational program (“moonlighting”).

I understand that it is my responsibility to read and be in compliance with this policy and will monitor my work hours and comply with the Accreditation Council of Graduate Medical Education (ACGME) duty hour requirements as listed below:

A. House Staff Officers must not be scheduled for more than 80 hours averaged over a four-week period.

B. House Staff Officers must have one full day in seven off free of duties, averaged over a four-week period.

C. House Staff Officers must not be assigned call more often that every third night, averaged on a four-week period.

D. House Staff Officers must have a minimum rest period of 10 hours between duty periods.

E. Continuous time on call is limited to 24 hours. House Staff Officers may not assume responsibility for new patients after 24 hours.

F. When House Staff take call from home and are called in to the hospital, the time spent in the hospital must be counted toward the weekly duty hour limit.

G. Time spent in patient care activity external to the educational program (“moonlighting”) is counted toward the duty hour limit requirements.

H. Permission to moonlight must be obtained from the Program Director and Jackson Health System.
Administration. Permission to moonlight may be withdrawn for violations of this policy or if the activities adversely affect my House Staff performance.

I also understand that any violation of this policy will be subject to disciplinary action as detailed in the Collective Bargaining Agreement between the Public Health Trust and the Committee of Interns and Residents (CIR).

It is my responsibility to obtain appropriate credentialing and privileges from the Medical Staff in order to be approved for moonlighting prior to being placed on any schedule.

____________________  ___________________________
Signature               Date
____________________
Print Name
____________________  ______________________________
Witness                Graduate Medical Education Director/DIO

11/12/02

Public Health Trust
Jackson Health System

PERMIT TO MOONLIGHT

This will verify that ____________________________, a resident/fellow in the ________________ Residency/Fellowship program at Jackson Memorial Hospital is in good standing.

I, ____________________________, Program Director, authorize him/her to moonlight ____________ hours per pay period depending on rotation as described below in the department of ________________. Attached please find the Receipt of Moonlighting activities policy and Duty Hour Requirements signed by the resident/fellow requesting permission to moonlight.

Sincerely,

__________________
Program Director Signature
Supervision and Increased Responsibility Policy

CHILD AND ADOLESCENT PSYCHIATRY RESIDENCY TRAINING PROGRAM
DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
UNIVERSITY OF MIAMI/ JACKSON MEMORIAL HOSPITAL

SUPERVISION AND INCREASED RESPONSIBILITY POLICY

PURPOSE:

This policy establishes appropriate standards for the supervision and teaching of the Child and Adolescent Psychiatry Residents and their graded responsibility throughout the training program that is consistent with criteria established by “The Essentials of Accredited Residencies in Graduate Medical Education”; recommendations of various appropriate clinical and training committees of the American Academy of Child Psychiatry; the applicable Hospital “Resident Supervision and Teaching Standards”; as well as, the medical and sociocultural needs of the community.

POLICY:

Appropriate supervision means that residents are supervised by a Teaching Attending in such a way that the residents assume increasing clinical responsibility according to their level of education, proven ability, and experience.

Supervision

Outpatient Settings
Each resident receives onsite supervision during initial evaluations and psychopharmacology clinics. Residents are not assigned initial patient evaluations until they have participated in a team evaluation with an Attending and have proven their capability to conduct initial evaluations of children and adolescents. If the Attending feels that the resident should observe more evaluations, the Attending will complete the interview himself/herself. As the year progresses and the skills of the resident increase, the resident is allowed to assume a more clinically responsible role by him/herself but always under the Attending supervision. Each resident also receives one hour per week from each of two faculty supervisors for his/her psychotherapy patients, in addition to teaching conferences and rounds. Attending physicians are available to residents at all times during clinic hours.

Inpatient Settings

Each resident is supervised by an Attending Physician on an ongoing basis during intake evaluations, daily rounds and multidisciplinary team meetings. Supervision occurs immediately at the time that services are being rendered. In addition, residents are provided with 24 hour availability of supervising Attending Physicians for consultation. Residents have increasingly graduated clinical responsibility as he/she demonstrates the necessary clinical skills. As the year progresses, and the skills of the resident increase, the resident is allowed to assume a more active clinical role and to perform responsibilities by him/herself but always under the Attending supervision.

Supervision and Increased Responsibility Policy (cont’d)

Night/Weekend On Call

When the Child Resident is on night and weekend call, he/she is on call with a Child and Adolescent Psychiatry Attending. The Child Residents are on night and weekend call as a consultant for the general psychiatric resident who is asked to evaluate a child or adolescent. After the psychiatric resident on call completes his evaluation of the child, the Child Resident is contacted to discuss the case and plan an appropriate disposition.

The resident calls the Child and Adolescent Psychiatry Attending to present each case in which the patient will be discharged or to discuss any other clinical issues. At the beginning of the year, the resident usually needs more guidance from the Attending on call. As the year progresses the resident gains more clinical experience and knowledge, (as assessed by the Child and Adolescent Psychiatry faculty), feels more comfortable with his/her clinical skills. Nevertheless, the Attending on call is always
available to review cases for which the resident may request assistance. In addition, residents go to the hospital on the weekends to evaluate any new cases that are admitted. Supervision is provided by the on call attending.

**Increased Responsibility**

The Child and Adolescent Psychiatry Residency Program is structured to encourage and permit Residents to assume increased levels of responsibility commensurate with their individual progress and competence in patient care activities. The level of responsibility will depend upon each resident’s knowledge, clinical skills and the severity and complexity of each patient’s status. The Training Director will review each resident’s performance as outlined in the Evaluation Policy and Procedure and supervise progression during their training program.

The Residents are given graded responsibility with respect to longitudinal inpatient and outpatient care. As the Residents advance in their training, they may be given increased responsibilities to conduct clinical activities with limited supervision or to act as teaching assistants for less experienced residents and medical students.

**Monitoring of Resident Supervision**

Monitoring of resident supervision is performed by the Training Committee. Supervisory written evaluations are obtained regularly and are available in the resident’s file. The training director holds semi-annual evaluative meetings with each individual resident to discuss their evaluations of their supervisors and progress in the program. A written summary of these meetings is entered in the resident’s training file.
CHAPTER 8

Evaluations
EVALUATION ACTIVITIES

General Description

Evaluation of everything we do is a regular part of our activities. Most evaluations are required by the Accreditation Council for Graduate Medical Education (ACGME). The program utilizes an online evaluation system, which can be accessed securely through the internet at www.new-innov.com. You will be assigned a User ID and password and will be given the Training Guide for Residents which includes detailed, step by step instructions on how to use the system. You are responsible for logging in regularly to review your evaluations as well as complete required evaluations of the program.

Your performance will be evaluated formally by the attending of each clinical rotation as you leave it and twice yearly by the Training Director and the Chief. The program has implemented 360 degree evaluations, which allow you to receive feedback on your performance from coworkers, including staff, nursing, psychology, and fellow residents. A copy of the resident evaluation is attached for your information (Refer to Appendix I). Once an evaluation has been completed by the attending, a copy will be automatically forwarded to the resident for his/her review and acknowledgement. These evaluations will be discussed with you, not only as an assessment of your performance as such but as a basis for planning your on-going training experiences.

We also strongly encourage you to be an active participant in your own learning throughout your training in child and adolescent psychiatry. To facilitate this process, we ask that you conduct semi-annual self assessments and set learning goals and objectives for your own academic growth.

You will also be asked to evaluate each of your supervisors, seminars, rotations and the overall program twice yearly. You will also be asked to evaluate each clinical service to which you are assigned as you complete your rotation.

Thoughtful input from residents is a key component in the program’s evaluation process. For this reason, ACGME requires that programs or institutions have a system through which residents are able to “raise and resolve issues without fear of intimidation or retaliation.” The program requires residents to complete confidential evaluations on New Innovations twice per year. Additionally, in order to ensure the most candid feedback, the Child and Adolescent Psychiatry Training Committee appointed an ombudsman in Dr. Teresa Carreno. Dr. Carreno is not directly involved in the residency Training Program. She will be available to listen to any concerns and report them to the Training Committee, keeping the individual anonymous. Please refer to Appendix J.

Other aspects of our program are evaluated regularly as well by both faculty and trainees. Each CAP Clinical Case Conference and CAP Grand Rounds is evaluated as it occurs. Each seminar series and the Journal Club are evaluated twice yearly. It is important that you give us your most thoughtful input into this process.

The Special Requirements for Psychiatry, as published in the ACGME’s Essentials of Accredited Residencies, contains the following section: “The Program must formally examine the cognitive knowledge of each resident at least annually in the PG-II through PG-IV years, and conduct an organized examination of clinical skills at least twice during the four years of training.”

To comply with this requirement, you will be given a written examination. The questions will include material from the lecture series, from the resource materials you have been provided, and from your clinical experience. We will also attempt to assess how well you can utilize your knowledge and clinical experience in responding to questions that deal
with issues we may not have specifically or formally covered in your training program.

In the event of less than satisfactory performance in any aspect of your didactic and clinical assignments, your training experience in the CAP Service may be considered as incomplete and special arrangements may be required for its satisfactory completion.
TRAINING DEFICIENCIES

Occasionally, for one or more reasons, a Resident may be deficient in some aspect of his/her training. Deficiencies may be in the area of the knowledge base expected of a resident at a particular stage of training, or they may be errors of commission or omission in performance of clinical responsibilities. The faculty supervisor is expected to identify such deficiencies early and to discuss them with the Resident promptly, even though a formal overall evaluation is not yet due. The goal of such a discussion would be for both supervisor and resident to reach a clear understanding of the matter(s) at issue and to formulate a mutually acceptable plan, including a time frame, for remedying the deficiencies. Such an action would have no punitive implications whatsoever.

If deficiencies are not remedied according to the plan, however, the procedures adopted by the Psychiatric Service as a whole would be invoked, as abstracted below: If deficiencies are not remedied as planned, a next meeting will be scheduled with the Resident, the cognizant supervisor, the Training Director for Child and Adolescent Psychiatry for the purpose of determining the next step;

If the deficiencies are not remedied as expected in the plan adopted at the previous step, either the Training Director for CAP or the Resident may request a conference of all concerned with the Chief of the Child and Adolescent Psychiatric Service; the deficiencies will be presented at the Executive Training Committee, which may recommend that the resident be placed on Special Observational Status, which is conceived to help residents overcome specific training difficulties while refraining from using drastic measures such as probation or remediation. It is not a punishment and should not be thought of as such. It is a tool used to help an individual resident overcome certain professional concerns with regard to their achievement and competency as required by the ACGME. As part of the Special Observational Status, the resident will be provided with a specific action plan and objectives.

If the matter continues unresolved and the deficiency which has not been remedied is regarded as requiring more stringent administrative action, one of two courses may be taken, as follows:

1. The resident's training for the particular assignment in question may be regarded as incomplete and promotion to the next level of training (in the case of a first-year resident) or a certificate of satisfactory completion of residency requirements (in the case of a second-year resident) will be withheld until deficiencies have been remedied, or;

2. In the event that the resident is in the first half of the first residency year, the resident will be notified in writing that he/she will not be reappointed for the next residency level.

As a final step in this sequence, the resident has available the grievance process specified in the JMH House Staff contract (Graduate Medical Educational Agreement...
DUE PROCESS

Guidelines for Dealing with the Resident in Difficulty

1) The evaluation forms attached.

2) Each supervisor working with a resident must complete an evaluation every six months. It is proposed, however, that ongoing evaluation is an absolute necessary and should include both verbal comments to the resident on a daily, moment to moment basis, as well as should there be further difficulty, a written evaluation of specifics, objective data, and a copy of the evaluation form be submitted at any time during the interim period.

3) This written objective evaluation must have the signature of both the faculty supervisor and the resident so that it is formally documented that the resident has been apprised of his particular deficiencies or areas of excellence.

4) The following additional evaluation steps have been recommended for the resident in difficulty.

   A. The supervisor and resident have a conference in which counseling occurs. This leads to the evaluation and documentation as noted above. It can include remedial recommendation and an appropriate time for correction.

   B. If deficiencies continue, the faculty and resident have a second session which includes the Chief of the particular division that the resident is working on, and the Training Director.

   C. The next level of review is the Training Committee is apprized by the Training Director of the difficulties experienced by the resident. The Training Committee consists of the Director, Division of Child and Adolescent Psychiatry; Training Director; all child psychiatry faculty; chief resident; chief, child psychology and chief social work service. The Training Committee recommendations for remedial action are provided by the committee to the Training Director.

   D. The Training Director meets individually with the resident concerned and counsels the resident providing recommendations derived from the Training Committee. Follow up meetings with the Training director are provided with recommendations and/or probationary indications. These are required to be specifically documented with copies provided to the resident. A time is established for correcting the deficiencies.

   E. If again this is not satisfactory in resolution, the resident is required to meet with the chief of Child and Adolescent Psychiatry, or his designee, in order to be provided with a formal documented letter per the guidelines for Grievance Procedures through the Public Health Trust.

   F. A full Grievance Procedure is enacted which includes the Administrators for the Public Health Trust, and a Grievance Committee comprised of various residents and faculty selected by the Public Health Trust. This step-wise evaluation, remedial recommendations, probationary requirements, and grievance process fulfills the requirements of the resident
contract, while at the same time prepares the resident for remedial actions in a step-wise and logical fashion. If extraordinary circumstances arise which will endanger the patients or the program the resident can be reassigned immediately at the prerogative of the Chief of Service.
CHAPTER 9

Appendices
<table>
<thead>
<tr>
<th>Patient Name</th>
<th>JMH #</th>
<th>Age</th>
<th>Sex</th>
<th>Tx Modality</th>
<th>General Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preschool</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td>CBT, IPT</td>
<td>Anxiety, OCD, PTSD, Anxiety, ODD, Panic, Fears, Simple Phobia, Separation Anxiety, ODD, ( \text{Eating DIS} )</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td>CBT, IPT</td>
<td>Anxiety, OCD, PTSD, Anxiety, ODD, Panic, Fears, Simple Phobia, Separation Anxiety, ODD, ( \text{Eating DIS} )</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td>CBT, IPT</td>
<td>Anxiety, OCD, PTSD, Anxiety, ODD, Panic, Fears, Simple Phobia, Separation Anxiety, ODD, ( \text{Eating DIS} )</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td>CBT, IPT</td>
<td>Anxiety, OCD, PTSD, Anxiety, ODD, Panic, Fears, Simple Phobia, Separation Anxiety, ODD, ( \text{Eating DIS} )</td>
</tr>
<tr>
<td><strong>School</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td>CBT, IPT</td>
<td>Anxiety, OCD, PTSD, Anxiety, ODD, Panic, Fears, Simple Phobia, Separation Anxiety, ODD, ( \text{Eating DIS} )</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td>CBT, IPT</td>
<td>Anxiety, OCD, PTSD, Anxiety, ODD, Panic, Fears, Simple Phobia, Separation Anxiety, ODD, ( \text{Eating DIS} )</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td>CBT, IPT</td>
<td>Anxiety, OCD, PTSD, Anxiety, ODD, Panic, Fears, Simple Phobia, Separation Anxiety, ODD, ( \text{Eating DIS} )</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td>CBT, IPT</td>
<td>Anxiety, OCD, PTSD, Anxiety, ODD, Panic, Fears, Simple Phobia, Separation Anxiety, ODD, ( \text{Eating DIS} )</td>
</tr>
</tbody>
</table>
### Resident Therapy Experience

#### APPENDIX A

**Resident Therapy Experience**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>JMH #</th>
<th>Age</th>
<th>Sex</th>
<th>Tx Modality</th>
<th>General Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Brief IPT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Brief Play</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Supportive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Parenting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Brief IPT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Brief Play</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Supportive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Parenting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>Brief IPT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>Brief Play</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>Supportive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>Parenting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Brief IPT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Brief Play</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Supportive</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Parenting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B

CHILD AND ADOLESCENT PSYCHIATRY RESIDENCY TRAINING PROGRAM
DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
UNIVERSITY OF MIAMI/ JACKSON MEMORIAL HOSPITAL

SEMINAR ATTENDANCE POLICY

The goal of each resident is to develop the skills and medical knowledge necessary for the evaluation and treatment of children, adolescents and families. Although this will be obtained via a number of experiences including clinical experiences, supervision and self-learning, seminars are a critical component of the learning process. Seminar attendance and active participation are therefore required for successful completion of the training program. The Department’s Seminar Attendance Policy is as follows:

1. Residents will attend 80% of seminars as a requirement for successful completion of the training program.
2. Residents are expected to arrive on time and prepared for discussion. Arriving late greatly compromises residents’ ability to take advantage of the training experience and is disruptive to the ongoing discussion. The attendance sign in sheet will be picked up after 5 minutes, and late comers will not receive credit for attending.
3. Reasons considered “excused” include approved leave, sick leave, and clinical emergencies. Non-emergent service obligations are not acceptable reasons for missing seminars since your education is of upmost importance to the program. Any questions, issues or concerns should be brought to the training office.
4. After three unexcused absences, a letter will be placed in the resident’s file. For any subsequent absences, residents will be asked to write a 2 page report on an assigned topic to ensure that the assigned reading has been completed and residents have learned the required material.
5. The program monitors attendance routinely. Residents not meeting 80% attendance will be placed on special observational status.
APPENDIX C

THE FOLLOWING PROCEDURE MUST BE UTILIZED TO REFER PARENTS TO PARENTING GROUPS

1. Initial evaluation must be completed, including: follow-up with the school, Connors’ completed by teacher, and/or other pertinent follow-up such as contact with pediatrician, etc. Treatment plan must also be completed.

2. Discuss with the parent why group is recommended and how they would benefit. Parents need to make a commitment to attend sessions every week. Also, parents must be willing to participate appropriately in group discussions and be willing to do some homework.

3. Children do not attend the groups. Parents must be able to give their attention to the group members and group leader.

4. If parent fits the above criteria, discuss your recommendation with your supervising psychiatry attending, complete the referral form, and then put the referral in Dr. Benitez’s mail box.
APPENDIX C (Cont’d)

PARENTING SKILLS THERAPY
REFERRAL FORM

PATIENT’S NAME: ______________________________________________________

JMH #: _______________  AGE:_______  ETHNICITY:_______________

NAME OF PARENT/LEGAL GUARDIAN TO BE CONTACTED:____________________

PHONE:  HOME: _______________  or  CELLULAR:________________________

_____ PARENTING GROUP     OR     _____ INDIVIDUAL PARENTING SESSION

LANGUAGE PARENT PREFERENCES: ______ ENGLISH     OR     _____ SPANISH

NAME OF PERSON REFERRING: _______________  PHONE #: _________________

BRIEF CLINICAL HISTORY/REASON FOR REFERRAL:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________________________________________________

_____   I will be following this child in individual therapy
_____   I will be following this child in medication clinic
_____   I presented referral to supervising Attending before referring

_____________________________                        ________________ Date

Signature

Put completed form in Dr. Benitez’s mailbox.

124
APPENDIX D

THE FOLLOWING PROCEDURE MUST BE UTILIZED TO REFER PATIENTS FOR PSYCHOLOGICAL TESTING

1) Initial evaluation must be complete; including follow-up with the school, Connors completed by teacher, or other pertinent follow-up such as contact with pediatrician, etc. Treatment plan must also be completed.

2) Discuss the reasons you are referring the child for testing with the parent. If the child has a clinic card that requires them to pay for services, they will also be charged for testing. They must be informed that the public schools will provide testing services for free, however, the waiting list is often approximately one year through the school system.

3) If child speaks another language, it is essential to determine whether the child is currently in ESOL Classes OR if the child has been in ESOL Classes within the past two years. If YES, then the child MUST be tested by a bilingual tester. It is essential for us to know this before scheduling the child for testing.

4) If the child is in ESE classes, then by law they must have previous psychological testing. Parents dont always realize that testing is required to be placed in special classes, if the child has had previous testing, we MUST have a copy of the report. Parents have the right to access any of the information in their child's school file and may go to the school to pick up a copy of the report. Another option is to complete a release (with parent signature) and fax it to the school.

5) Complete the referral form for psychological testing and attach copies of the CAP initial evaluation and previous school testing (if applicable). Referrals without these attachments will be returned to you.

6) File a copy of your referral in the patient's chart under the Miscellaneous heading.

7) Please note that we are not able to test children in ESOL with any other language than Spanish (e.g. Creole). They must be referred to their school for testing.
APPENDIX D (Cont’d)

PSYCHOLOGICAL TESTING REFERRAL FORM

CHILD’S NAME: ______________________________________ 

JMH #:___________________________

AGE: _____ GRADE: _____ REGULAR CLASS: ___________ SPECIAL ED* _____________________

MENTAL HEALTH INSURANCE: ______________________________________________________________

CHILD’S PRIMARY LANGUAGE:  English _______ Spanish _______ Other __________

+Please check one if Spanish or Bilingual:  
  Child has never been in ESOL ________
  Child is currently in ESOL Level ____________ Child has been out of ESOL since (date) _________________

PARENT’S LANGUAGE: ENGLISH _______ SPANISH _______ BILINGUAL _______

NAME OF PARENT/GUARDIAN TO BE CONTACTED: _____________________________________________

PHONE: HOME: __________________________ CELL or WORK: _____________________________

NAME OF PERSON REFERRING (Print): __________________________ Phone: _______________________

PREVIOUS PSYCHOLOGICAL TESTING: * YES / NO If yes, date tested: _________________________

CURRENT MEDICATIONS: ______________________________________

BRIEF CLINICAL HISTORY FOR REFERRAL (Question to be answered):

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

____ To provide diagnostic clarification in which a comprehensive clinical assessment cannot provide (i.e., cognitive and emotional functioning).

____ To assess cognitive and neurological functioning that could impede treatment compliance (i.e., Borderline or MR IQ).

____ To determine what modality of treatment would best fit patient needs.

____ To assess emotional functioning (i.e., psychotic processing, thought disorder).

   _____ I will be following this child in individual therapy
   _____ I will be following this child in medication clinic
   _____ I do not feel this child requires any other treatment at this time.

__________________________________________________________________________

__________________________________________________________________________

Signature ___________________________ Date ______________

*Special Ed requires testing for placement. Please obtain a copy and attach it to this referral.

**Note: Put completed form in Dr. Evelyn Benitez’s mailbox. Put a copy of the form in the patient’s chart. Attach initial evaluation and copy of previous psychological testing if applicable. Referral without these attachments will be returned to you.
Appendix E

OpenStage 40 Phone Overview, 4000

1. The Handset lets you pick up and dial calls in the usual manner.

2. The generously sized Graphics Display provides intuitive support for telephone operation.

3. You can customize your telephone by assigning phone numbers and functions to the Programmable sensor keys.

4. You can use Function keys when conducting a call to access frequently used functions, or to open the program/service menu and mailbox.

5. Audio keys are also available allowing you to optimally configure the audio features on your telephone.

6. The 5-way navigator is a convenient navigation tool.

7. The Keypad can be used to enter phone numbers and text.

8. Incoming calls are visually signaled via the Call Display.

Graphics Display

This status line displays the time, weekday, and date and the number of your phone. Icons also signal different situations and options:

- **Ringer is off**
- **Callback requests are active**
- **Do Not Disturb is on**
- **New voice messages**
- **Phone Lock is activated**
- **New entries in Call Lists**
- **Microphone is muted**
- **Call Forwarding is active**
- **A mobile user is logged on**
Appendix E

5-way navigator

- Press ↑ key: Scroll upwards
- Press ↓ key: Scroll downwards
- Press ← key: Cancel function, delete character, left of cursor, go up a level
- Press → key: Call up the context menu, go down a level
- Press 0 key: Confirm input, perform action

HELPFUL HINT: Pressing the right arrow key displays a context menu. The context menu changes for each function or feature the user initiates. To select an option from the context menu, scroll the options and press OK.

Function Keys and Audio Keys:

- End (disconnect) call
- Radial
- Activate/deactivate forwarding
- Turn headset on/off
- Turn microphone on/off

Depending on situation, set volumes for ringer or speaker

Service/Applications menu
Voicemail/Call lists

Program Keys

Your OpenStage 40 Phone has Program Keys, if allowed by your administrator you can program. You can program these keys as required with internal and external phone numbers or frequently used functions. The phone number programmed name of the function is displayed beside the key.

Connectors: at the bottom side of phone

USB memory stick
HiPath
Power supply
Headset
Handset

Key Module
Appendix E

OpenStage Model 40 PHONE
QUICK REFERENCE GUIDE

5-Way Navigator key:
- The **OK** key is used to activate or select a feature (i.e., enter/yes key)
- The “DOWN” arrow key ▼ is used to scroll through the feature menus
- The “UP” arrow key ▲ is used to scroll to previous feature menus
- The “RIGHT” arrow key ► is used to access the sub menu.
- The menus change depending on the state of the phone (i.e. idle, ringing, busy, talking)

To change the ring volume/tone:
- Press the + or - key while phone is idle
- Select (OK) “Ring volume” or scroll and Select (OK) “Ring tone”
- To adjust settings, press + or - key
- Press (OK) to save the setting

To place a caller on hold & answer a call on the other line:
- Press the blinking (ringing) line key to answer the incoming call and it will automatically put your first caller on hold

To toggle between the two callers:
- Press the blinking line key to return to the first caller you placed on hold
- Press the blinking line key to toggle to the second caller on hold, and so on...

To transfer a caller:
- Press the Transfer key OR (OK) at “Start Transfer”
- Dial the 6 digit extension or outside number
- Announce the call & hang up (if transferring to an internal extension), or...
- Announce the call and press (OK) at “Transfer” and hang up (if transferring to an external number)

To reconnect or toggle to the original caller:
- You will be automatically returned to the first party when the current party hangs up, or...
- Press (OK) “Release and return” to disconnect from current party & return to first party, or...
- Press Connect to toggle back and forth between calls OR Scroll to “Toggle” and press (OK)

To place a conference call (up to 8 parties):
- Scroll down and press (OK) at “Start Conference”
- Dial the next internal or external party
- After they answer, press (OK) at “Conference” to join all parties
- To add additional parties, press (OK) at “Add to Conference”
- When party answers, press (OK) at “Conference”...and so on
- If the party does not answer, or does not wish to join, press (OK) “Release & Return”

To program a repdial key:
- Press Program Service Key □□□□ and press (OK)
- Press (OK) at Destinations
- Scroll to and press (OK) at Repdial
- Press blank key to be programmed
- Enter number you wish to program
- Press (OK) at Completed
- Select labeling choice by pressing (OK) at “Use Destination” or “Create Label”
  - If “Create Label” is selected, enter name with keypad
- Press (OK) at “Save”

Last Number Redial:
Lift handset or press speaker key
Press (OK) at “Last Number Redial”

CallBack:
When calling another extension, if there is no answer and you wish to have them call you back:
- Press (OK) at “Callback”
This will light the extensions Mailbox light
Appendix E

To dial a system speed number (already programmed for you):

- Press #61
- Enter the speed dial code (000-999)
- You will be given a list of these numbers

Station Speed:

To program a station speed number
- Press Program Service key [ ] and press (OK)
- Press (OK) at Destinations
- Scroll to and press (OK) at Speed Dial Features
- Dial the code number (00 – 29)
- Enter the number you wish to store
- Press (OK) at “Save”

To dial using a station speed code
- Press #3 plus code (00 – 29) of number you wish to call

To use your Mailbox key:

- When voicemail messages are waiting, the Mailbox [ ] key will be lit
- Press the Mailbox key
- If prompted to “Call Server” Press (OK)
- Follow the prompts to access your mailbox

NOTE: If someone has left you a “Callback” request, your Mailbox light will light and when pressed your display will say “Call Originator”
To call, Press (OK)

Call List/Log

- Open the Idle menu by pressing any key on your navigator
- Press (OK) at menu you wish to view (unanswered, incoming, outgoing)
- Press (OK) at Dial, Details or Delete

Preview

Allows you to preview who is calling on a line without interrupting a call in progress
- While line is ringing, press PREVIEW
- Press the ringing line you wish to preview
- Your display will show the caller ID info
- Press the PREVIEW key again to turn off

PARK

To Park a call to another extension
- While on a call press (OK) at “Park to Station” and enter the extension you wish to park the call to.
To retrieve the parked call from that remote station
- Press the flashing line button, if prompted, press (OK) at “Retrieve Parked Call” or...
- Press Connect

OTHER INFO

To place a call:

- Dial 90+ area code + number for local calls
- Dial 99 + 1 + area code + number for long distance calls
- Dial the 6-digit extension for internal calls
CHANGING YOUR REFERRAL EXTENSION:
If a caller reaches your voicemail greeting, they can press 0 to # and be transferred to your referral extension.

- Press 8 for Answering Options
- Press 3 for Referral Extension
- Press 1 to change referral extension

LISTENING TO YOUR MESSAGES
There are multiple message “queues”:
- Returned messages and Returned Receipt messages
- Urgent messages messages
- Saved messages messages

To listen to your messages:
- Press 3 to listen

Messages are played newest to oldest. To change to play oldest message first:
- Press 9 to 5 to 3 to 2 to # from main menu

While listening to your messages you can use these shortcuts:
- * 2 Skip Forward to the next message
- * 7 2 Go to the previous message
- * 7 3 Start current message over
- * 7 7 Time message was created
- * 7 8 Skip backward 8 seconds
- * 9 8 Skip forward 8 seconds
- * 9 3 Skip to end of Message
- * 4 Save message
- * 6 Delete message
- 7 To decrease the message speed
- 9 To increase the message speed

After Listening to a message:
- Press 4 to save message
- Press 6 to delete message
- Press 2 to skip to next message
- Press 7 to replay message
- Press # to respond to message

Once you have Saved or Deleted a message you may:
- Press # to continue to next message
- Press 1 to reply to the
- Press 9 to forward the message to another mailbox
- Press 70 to call the sender.

RECORDING MESSAGES TO SEND TO OTHERS

- Press 1 to Record
- Record Message
- Press * # when finished recording
- You may cancel recording by pressing * 6 or replay recording by pressing * 7
- Enter extensions or distribution list number followed by # or press * to enter by name.
- Press # if correct or * to choose another name
  (you can continue adding other destinations by pressing # for extensions or * to add by name)
- Press # when done entering destinations, or press 3 for special delivery, or press 6 to cancel delivery.

SPECIAL DELIVERY OPTIONS:
- Press 1 to mark Return Receipt
- Press 2 to mark Private
- Press 3 to mark Urgent
- Press 4 to mark Future Delivery

PRIVATE DISTRIBUTION LISTS
- Press 9 for Mailbox Options
- Press 1 for Private Distribution Lists
  - Press 1 to create a list
  - Press 3 to change a list
  - Press 6 to delete a list
  - Press 9 to review a list
APPENDIX F

JMH POLICIES AND PROCEDURES

Standards of Excellence

SUPERSEDES: 5/01/02  CODE NO. 359

SECTION: 300 - PERSONNEL

SUBJECT: STANDARDS OF EXCELLENCE

POLICY:

Each staff member is a personal and valued representative of the Jackson Health System (JHS) and its care facilities, and is expected to be sensitive and responsive to the needs of the JHS patients, its visitors, suppliers, and other staff members.

To support this philosophy and achieve the single high standard of care to which the JHS is dedicated, each staff member shall follow the "Standards of Excellence," consisting of our credo and performance basics. Individual performance will be evaluated based on these standards.

CREDO:

Patient First

JHS facilities are places where the care and wellness of our patients is our highest mission. They are our reason for being.

Hospitality

We pledge to provide the finest personal service and facilities for our patients, visitors, suppliers, and staff. Staff members will always ask "How may I help you?"

Teamwork

Our daily work, problem resolution, and continuous improvement are based on our working together to anticipate and exceed customer’s needs.

PERFORMANCE BASICS:

1. Smile, Offer help, Say please and thank you.

   Display a positive, helpful and courteous attitude; you represent JHS.

2. Acknowledge others.

   Use eye contact and greet others promptly saying, "Good morning/afternoon/evening"; end the conversation pleasantly by saying "I was happy to assist" etc.

3. Take pride and care in your environment.

   Keep unit and facility neat and clean; maintain a presentable personal appearance and an attractive, organized work area.
### Standards of Excellence (Cont’d)

<table>
<thead>
<tr>
<th>SUPERSEDES:  5/01/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODE NO.  359</td>
</tr>
</tbody>
</table>

**Jackson Health System**

**Policy & Procedure Manual**

<table>
<thead>
<tr>
<th>SECTION: 300 - PERSONNEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBJECT: STANDARDS OF EXCELLENCE</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 4. | Be responsive and responsible.  
*Understand your role in accomplishing the PHT Mission; consistently use scripts to demonstrate friendliness, caring and concern; keep people informed; react quickly to problems; apologize for any inconvenience that may have occurred; follow through.* |
| 5. | Ensure confidentiality and privacy.  
*Avoid and discourage gossip; respect personal space; share information only with those who have a right to know.* |
| 6. | Use professional telephone etiquette.  
*Answer on or before 3 rings; state your department, your name and offer assistance in an upbeat tone.* |

**Authorization:**

Marvin O’Quinn, President, Public Health Trust

**Date:** 1/01/04
Critical Values Communication

POLICY:

It is the policy of Jackson Health System that all critical tests and critical test results and critical values are communicated within the time frame outlined in the policy upon identification to the treating practitioner who can make clinical decisions.

This policy applies to all departments within the Jackson Health System that generate and receive critical test results and critical values.

A good faith effort is made to notify patients who have left the facility of critical test result and values as soon as the results are known.

KEYPOINTS

- Nurses may accept the critical test/critical value/result but must immediately contact the treating practitioner with those results.
- Critical test and critical tests and values are determined by the department where testing is performed according to national standards and guidelines.
- Under no circumstances will critical test or critical results values be left with an answering service, answering machine, email, secretary or unit clerk.
- In the event that the physician cannot be contacted within one (1) hour or during off hours, call the page operator for the pager number of the covering physician/service.
- The receiver of the critical test results or values should document the first and last name of the sender of the critical test results or values and the sender of the critical tests results and values should also document the first and last name of the receiver of the critical value results.
- The ordering physician/designee receives and follows up on the results of all ordered tests.
- The ordering physician/designee has the responsibility to communicate diagnostic tests and assign responsibility for follow up to a covering physician.
- The list of critical test and critical results or values will be reviewed at least annually to evaluate which test will be added or deleted.
- HIPPA regulations are maintained when speaking of critical test and critical values results to next of kin or anyone other than the patient and/or practitioner. Efforts made to notify the patient are documented in the medical record.

DEFINITION OF TERMS

Critical test is defined as tests which require rapid communication of those results which have been determined by the laboratory, radiology, other diagnostics or the ordering physician to be critical to the patient's treatment/outcome.
APPENDIX F (Cont’d)

Critical Values Communication (Cont’d)

SUPERSEDES: 3/20/08  CODE NO. 460

SECTION: 400 – CARE OF THE PATIENT

SUBJECT: CRITICAL VALUES COMMUNICATION

Critical results or values are defined as diagnostic test results that fall outside the normal ranges/values and are determined by the physician, laboratorian, radiologist, or other diagnostician to be critical to the patient’s subsequent treatment decision. Values or interpretations may indicate a significant abnormality that may threaten life, cause significant morbidity, complications or serious adverse consequences unless diagnosis and treatment is initiated in a timely manner. Therefore immediate communication of results to ordering or covering physician is imperative.

Refer to the JHS Manual for laboratory, radiology, and cardiographic critical values and test results.

PROCEDURE

A. In-patient Department

1. Critical Laboratory Values

   Laboratory technologist/technician/designee calls the nurse caring for the patient, or nurse in-charge, or attending physician/ordering physician/designee upon identification of the critical values within 30 minutes.
   a. Document critical values and test results in the medical record.
   b. A “read back” procedure is performed validating the accuracy of the results and accuracy of information provided.
   c. The nurse or designee receiving the critical results/values will call the physician within 15 minutes. The nurse communicating the critical values/results to physician/designee asks the receiver to “read back” to verify the accuracy.
   d. The responsible physician/designee returns call within one hour.

2. Critical Radiographic/Cardiographic Results/Values

A critical radiographic finding is determined by the reading or interpreting radiologist. If the radiologist believes that immediate treatment maybe needed, the guidelines below will be implemented.
   a. The Radiologist notifies the ordering physician/attending physician/ designee of the critical findings.
   b. A “read back” procedure is performed validating the accuracy of the results and accuracy of the information provided.
   c. The Radiologist communicating the critical values or results to the ordering physician or designee asks for a “read back” to verify accuracy of information provided.
APPENDIX F (Cont’d)

Critical Values Communication (Cont’d)

SUPERSEDES: 3/20/08  CODE NO.  460

SECTION:  400 – CARE OF THE PATIENT
SUBJECT: CRITICAL VALUES COMMUNICATION

POLICY & PROCEDURE MANUAL

The responsible physician or designee documents the results in the patient’s record and follows up on the results.

B. Out-patient Department

1. Critical laboratory values/diagnostic testing results will be reported by the respective departmental staff to healthcare professionals upon identification of the critical values within one hour.
2. The ‘read back’ procedure is initiated and documented.
3. Notification process:
   a. If the critical finding relates to an outpatient at a time when a clinic is closed or a patient has been recently discharged from an inpatient unit or the emergency department, the physician on-call/attending from the corresponding service will be paged and a good faith effort will be made by the physician to notify the patient. If the physician on-call is unable to locate the patient for notification, the Administrator-in-Charge will assist in the process, which may include, following consultation and recommendations with the physician, eliciting assistance from the local police department in contacting the patient.
   b. In the primary care centers, the attending of record, physician on call, or the charge nurse of the patient care area is to be notified. That person will make a good faith effort to contact the patient.
   c. In ACC (Ambulatory Care Centers), the attending of record, ordering physician, physician on-call, or the charge nurse of the patient care area is to be notified.
      • In ACC medicine clinics, for reporting of critical values during off hours call MOD, who will make a good faith effort to contact the patient to return to the clinic the next day. If the MOD contacts the patient, she/he will contact/leave a message to the attending physician in the clinic to expect the patient in the clinic. The MOD will contact the Emergency Department physician to expect the arrival of the patient.
   d. In Specialty Clinics, the attending of record, ordering physician, physician on-call, or the charge nurse of the patient care area is to be notified.
      • In sub specialty clinics, contact the ordering physician first, if no response call the MOD and then the Chief of Service.
   e. For Pediatric clinics, contact senior resident to report critical values and test results during off-hours.
   f. When patients have been contacted, they will be directed to report to the Emergency Care Center or to report to the originating outpatient facility.

DATE: 5/09/08

PAGE 3 OF 6
APPENDIX F (Cont’d)

Critical Values Communication

SUPERSEDES: 3/20/08

CODE NO. 460

SECTION: 400 – CARE OF THE PATIENT

SUBJECT: CRITICAL VALUES COMMUNICATION

POLICY & PROCEDURE MANUAL

The Police Department will be given a contact number to report efforts made in contacting the patient.

Unless the physician on-call makes direct contact with the patient, no results will be given to the patient until the patient is seen in the Emergency Care Center or appropriate outpatient facility.

DOCUMENTATION

When communicating critical test results or values the following information must be documented in the medical record:

- Date and time
- Name and credentials of reporter
- Name and credentials of receiver
- Test value/interpretation
- Timely acknowledgement of receipt of critical values from the receiving practitioner that he/she has accepted the responsibility for follow-up
- ‘Read Back” verification of results
- Dictate into clinical notes if record is not immediately available.

Critical values/results will include but not limited to the following:

CRITICAL LABORATORY VALUES

Chemistry Critical Values

Sodium
Less than 110 mmol per L – greater than 160 mmol per L

Potassium
Less than 2 mmol per L – greater than 7 mmol per L

CO2
Less than 10 mmol per L – greater than 40 mmol per L

Glucose – (Adult) (Pediatric)
Less than 40 mg per dL – greater than 700 mg per dL
Less than 30 mg per dL – greater than 300 mg per dL

Calcium
Less than 5.9 mg per dL – greater than 14 mg per dL

Total Bilirubin – (Pediatric)
Greater than 16 mg per dL

Magnesium
Less than 1 mg per dL – greater than 3 mg per dL
APPENDIX F (Cont’d)

Critical Values Communication

SUPERSEDES: 3/20/08  CODE NO. 460

SECTION: 400 – CARE OF THE PATIENT

SUBJECT: CRITICAL VALUES COMMUNICATION

<table>
<thead>
<tr>
<th>Substance</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor Room</td>
<td>Therapeutic Range: 5 – 7 mg per dL</td>
</tr>
<tr>
<td>Lactic Acid</td>
<td>Greater than 3.1 mmol per L</td>
</tr>
<tr>
<td>Lithium</td>
<td>Greater than 2 mmol per L</td>
</tr>
<tr>
<td>CSF Glucose – (Adult)</td>
<td>Less than 40 mg per dL</td>
</tr>
<tr>
<td>(Pediatric, 3 days)</td>
<td>Less than 30 mg per dL</td>
</tr>
<tr>
<td>Calcium, Ionized</td>
<td>Less than 0.75 mmol per L – greater than 1.63 mmol per L</td>
</tr>
</tbody>
</table>

**Critical Values in Hematology and Coagulation**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBC</td>
<td>Less than 1,000 - greater than 50,000 per microliter (if no delta check)</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>Less than 6 gm per dL</td>
</tr>
<tr>
<td>Hematocrit</td>
<td>Less than 18%</td>
</tr>
<tr>
<td>Platelets</td>
<td>Less than 30,000 - greater than 999,000 per microliter</td>
</tr>
<tr>
<td>PT</td>
<td>Greater than 29 seconds</td>
</tr>
<tr>
<td>APTT</td>
<td>Greater than 80 seconds</td>
</tr>
<tr>
<td>Fibrinogen</td>
<td>Less than 100 mg per dL</td>
</tr>
</tbody>
</table>

**Microbiology Critical Values Results:**

- Positive blood cultures
- Positive CSF gram stain and cultures
- Positive AFB smears and cultures
- Positive India ink prps
- Positive malaria smears
- Positive Cryptococcus antigen detection tests
- Positive RSV
- Positive CSF VDRL tests
APPENDIX F (Cont’d)

Critical Values Communication

SUPERSEDES: 3/20/08  |  CODE NO. 460

SECTION: 400 – CARE OF THE PATIENT

SUBJECT: CRITICAL VALUES COMMUNICATION

CRITICAL IMAGING FINDINGS

- Aortic Dissection, Rupture, or Extravasation
- Pneumothorax or Hemothorax
- Intracranial Hemorrhage
- Intracranial herniation secondary to a mass
- Pneumoperitoneum
- Misplaced Tube or Line with the potential of morbidity or mortality
- Acute Cord Compression/Acute Spinal Fracture
- Extensive Myocardial Ischemia or Unsuspected Infarction
- Pulmonary Embolism
- Acute Deep Vein Thrombosis

CRITICAL VALUES FOR ABG

- pH of 7.25 or below
- pH of 7.55 or above
- PCO2 of 65 mmHg or greater
- PCO2 of 25 mmHg or less
- PO2 of less than 50 mmHg
- PO2 of 300 or greater
- THb below 7g/DL
- %COHb of 5% and above
- %METHb of 5% and above

REFERENCES:

2007 Joint Commission Comprehensive Accreditation Manual for Hospitals
2007 National Patient Safety Goals 2C

AUTHORIZATION

Marvin O’Quinn, President, Public Health Trust

DATE: 5/09/08  |  PAGE 6 OF 6
APPENDIX F (Cont’d)

Care of the Patient

SUPERSEDES: NEW

CODE NO. 488

SECTION: 400 - CARE OF THE PATIENT

SUBJECT: Look-a-like Sound-a-like Medications

POLICY:

To identify look-a-like/sound-a-like medication and outline steps to prevent medication errors and patient harm.

DEFINITIONS:

Look-a-like/sound-a-like medications are drugs that have been identified as having an increase of medication errors due to their similarities in spelling or packaging.

PROCEDURES:

1. The look-a-like/sound-a-like medication for the JHS appear on Table 1. Special procedure for procuring, storing, ordering/prescribing, preparing/dispensing, administering and/or monitoring have been developed to minimize the potential for medication errors (see Table 1).

2. The look-a-like/sound-a-like medication will be reviewed and updated on a regular basis as needed by Medication Safety Subcommittee of the Pharmacy and Therapeutics Committee.

REFERENCES:


AUTHORIZATION:

Marvin O’Quinn, President, Public Health Trust
Table 1 Look-a-like Sound-a-like Medications
The following medications may sound/look similar when written or spoken — please spell out!
when administering — please double check!

<table>
<thead>
<tr>
<th>Amphotericin (liposomal)</th>
<th>Amphotericin B lipid complex</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AL</strong>prazolam</td>
<td><strong>LOR</strong>azepam</td>
</tr>
<tr>
<td>Avandia</td>
<td>Coumadin</td>
</tr>
<tr>
<td><strong>CeleBREX</strong></td>
<td><strong>CeleXA</strong></td>
</tr>
<tr>
<td><strong>CeleXA</strong></td>
<td><strong>CereBYX</strong></td>
</tr>
<tr>
<td><strong>CereBYX</strong></td>
<td><strong>CeleBREX</strong></td>
</tr>
<tr>
<td><strong>EPHEDrine</strong></td>
<td><strong>EpiNEPHrine</strong></td>
</tr>
<tr>
<td>Hydr<strong>ALAZi</strong>ne</td>
<td>Hydr<strong>OZYXi</strong>ne</td>
</tr>
<tr>
<td>Met<strong>RONIDAzole</strong> 500mg tablet</td>
<td>Met<strong>FORMIN</strong> 500mg tablet</td>
</tr>
<tr>
<td><strong>TopAMAX</strong> 100mg</td>
<td><strong>TopROL</strong> XL 100mg</td>
</tr>
<tr>
<td><strong>TraMADOL</strong> 50mg</td>
<td><strong>TrazODONE</strong> 50mg</td>
</tr>
<tr>
<td>Vin<strong>BLAST</strong>ine</td>
<td>Vin<strong>CRIST</strong>ine</td>
</tr>
</tbody>
</table>

**Safety Strategies**

**Selection and Procurement**
- Consider the possibility of LASA potential when adding new products to formulary
- Review recommendations from JC\* and/or ISMP**

**Storage**
- Use Tall Man Lettering for labeling, MARs, shelves, and dispensing cabinets
- Affix “name alert” stickers to storage containers
- Store LASA products in separate locations

**Order and Transcribing**
- Maintain awareness of LASA list
- Clearly specify dosage form, strength, and directions on orders
- Give telephone or verbal orders only when truly necessary

**Preparing and Dispensing**
- Use computerized alerts as reminders at order entry and at dispensing cabinets
- List brand and generic names on MARs, drug dictionary, and dispensing cabinets
- Configure computer selection screens to prevent the two confused drugs from appearing consecutively

**Administering**
- Maintain awareness of LASA list
- Determine purpose of medication prior to administering
- List brand and generic names on MARs, drug dictionary, and dispensing cabinets

**Monitoring**
- Report errors and potentially hazardous conditions with LASA products
- Maintain awareness of problematic drug names and error prevention recommendation provided by ISMP**

\* JC = The Joint Commission  **ISMP = Institute of Safe Medication Practices
APPENDIX F (Cont'd)

Cell Phone Use and Dress Code

MEMORANDUM

TO: All Mental Health Hospital Physicians, Training Directors, Interns, Managers, and Staff

FROM: John Repique, RN, MS, NEA-BC Chief Nursing Officer – Mental Health

DATE: June 23, 2010

RE: Cell Phone Use and Dress Code

In our continuing efforts to promote patient safety and ensure the highest standard of professionalism in the workplace, I would like to reiterate the importance of adherence to the following hospital policies.

JHS Policy # 245 [Cell Phones, Camera Phones, and all Other Communication Devices]
JHS acknowledges the widespread availability of cellular communication devices providing instant access to employees during work hours. However, the use of these cellular phones and wireless communication devices can be a distraction and a disruption in the work place. This policy addresses the use of personal cellular phones and all other communication devices in patient care areas, the privacy and confidentiality issues related to camera phones.

MHM Policy # 122 [Dress Code for Non-Uniformed Personnel Policy]
As part of the treatment setting, employees are expected to serve as role models by their appearance and grooming. In order to perform job responsibilities, the dress requirements of employees should take in consideration: safety, protection, appropriate personal appearance, neatness and cleanliness. The JHS Employee Photo ID badge must be worn at all times with their name and picture visible at eye level.

Managers/Supervisors/Training Directors are responsible for monitoring and enforcing the expectations and requirements of this policy in accordance with the Standards of Excellence. Please review attached policies with all your interns and staff.

Thank you for your continued support.

Cc: Melida Akiti, Vice-President/Chief Administrative Officer for Mental Health, JHS
Dr. Karin Esposito, Associate Chief Medical Officer for Mental Health, JHS
Dr Charles Nemeroff, Chair – UM Department of Psychiatry
Dr. Richard Steinbook, Residency Training Director – UM Department of Psychiatry
Evelyn Benitez, PhD, Interim Chief of Psychology – MHH
Nicoletta Tessler, Psy.D., Interim Director for Training/Research, Psychology – MHH

(See Attachments)
APPENDIX F (Cont’d)

Cell Phones, Camera Phones and All other Communication Devices

I. POLICY

This policy addresses the use of personal cellular phones and all other communication devices in patient care areas, the privacy and confidentiality issues related to camera phones, the use of JHS’ phones and business-issued cellular phones, and the safe use of cellular devices by employees while driving in accordance with Florida law.

JHS acknowledges the widespread availability of cellular communication devices providing instant access to employees during work hours. However, the use of these cellular phones and wireless communication devices can be a distraction and a disruption in the work place. JHS is committed to providing optimum patient care services and the misuse of telephone and cellular devices to interfere with the efficient operation of the hospital, to breach an individual(s) right to privacy or confidentiality, or to threaten the integrity of proprietary information will be cause for discipline.

II. PROCEDURES

1. Personal Cellular Phones and wireless communication devices

JHS recognizes that some personal calls during work hours are legitimate, difficult to schedule outside work hours and permit employees to achieve a better work-life balance between work and family responsibility. However, excessive personal calls, regardless of the phone used, interfere with the efficient delivery of patient care services, employee productivity and can be distracting to others.

Jackson Health System has a zero tolerance position for Staff accepting personal cell phone calls or using communication devices while rendering care in the patient care area.

If an urgent or emergency situation should arise and the employee must use their personal communication device or the internal telephone system, the call’s duration should be limited to a maximum of five (5) minutes, and only in areas away from patient care, such as, in the staff lounge, conference room, or private office. Staff shall not talk on their personal cell phones while in the hallways, nurse’s stations, patient rooms, etc.

Employees are urged to make all other personal calls during break periods and on non-work time, and to advise friends and family members of this Jackson Health System policy.

During scheduled work hours, personal cell phones shall be placed on vibration or silent mode.

Jackson Health System will not be liable for the loss of personal cellular phones brought into the workplace.

2. Camera Phones

Jackson Health System prohibits the use or possession of cameras in the workplace. A natural extension of this current policy is the prohibition of the use of camera phones during work hours.

To ensure the privacy of patients, confidentiality of the medical records, and protect business
APPENDIX F (Cont’d)

Cell Phones, Camera Phones and All other Communication Devices (Cont’d)

3. Personal Use of Jackson Health System Provided Cellular Phones

Where job or business needs demand immediate access to an employee, Jackson Health System may issue a business-owned cellular phone to an employee for work-related communications. To protect the employee from incurring a tax liability for the personal use of this equipment, such phones are to be used for business reasons only. Phone logs will be audited regularly to ensure no unauthorized use has occurred.

If an employee experiences a severe personal emergency that results in the need to use the Jackson Health System cellular phone, he or she is required to report this use to the Accounting Department within 48 hours.

Employees in possession of Jackson Health System equipment such as cellular phones are expected to protect the equipment from loss, damage or theft. Upon resignation or termination of employment, or at any time upon request, the employee may be asked to produce the phone for return or inspection.

4. Safety Issues for Cellular Phone Use

The use of cellular phones while driving increases the risk of being involved in an accident.

However, where an employee’s job responsibilities require regular or occasional driving or where emergency access via cellular communication is required, the employee must use a “hands-free” connection tool. Florida Law permits use of a headset in conjunction with the cellular device, provided the headset permits sound through one ear only and allows surrounding sounds to be heard with the other ear.

Special care should be taken to the use of cellular devices in traffic, in unfamiliar areas, or in inclement weather conditions. Employees are encouraged to pull off to the side of the road, or to exit the express-way and to safely stop the vehicle prior to using the communication device and must report any accidents occurring during work hours.

Employees involved in moving accidents or traffic violations will be solely responsible for all liabilities resulting from the accident and will be subject to disciplinary action, up to and including termination.

AUTHORIZATION:

Marvin O’Quinn, President, Public Health Trust
APPENDIX F (Cont’d)

Dress Code for Non-Uniformed Personnel Policy

Effective: January 2007  Supersedes: 1/05  Code No. 122

<table>
<thead>
<tr>
<th>JACKSON HEALTH SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Hospital Center</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section: ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBJECT: Dress Code for Non-Uniformed Personnel Policy</td>
</tr>
</tbody>
</table>

PURPOSE:

To provide guidelines on professional appearance and wardrobe suitable to the work environment.

PROCEDURE:

1. As part of the treatment setting, employees are expected to serve as role models by their appearance and grooming.

2. In order to perform job responsibilities, the dress requirements of employees should take in consideration: safety, protection, appropriate personal appearance, neatness and cleanliness.

3. The Jackson Memorial Hospital Employee Photo Identification badge must be worn at all times with their name and picture visible at eye level.

4. Supervisors are responsible for monitoring and enforcing the expectations and requirements of this policy in accordance with the Standards of Excellence.

5. Refer to Administrative Policy and Procedure Manual Code #313B for further guidelines.

6. Appropriate clothing.
   A. Shirts: Conservative, long or short sleeve shirts (with or without collars with or without buttons). Polo type shirts are acceptable. **KEYNOTE:** T-shirts, midriff blouses, halter tops, sheer tops or deep curved necklines are not permitted. Tops with large graphics and/or large promotional logos and sweatshirts are not permitted.
   B. Slacks: Neatly creased, hemmed and ankle length. Corduroy is acceptable. **KEYNOTE:** Shorts, Denim jeans, capri slacks and stirrup pants or leggings are not permitted.
   C. Skirts: Skirts that are at least knee-length, may be culottes or wrap around. **KEYNOTE:** Denim skirts are not permitted
   D. Dresses and Jumpers: Dresses may be a-line or full. Knee length, short or long sleeve. Jumpers are to be worn with skirts or blouses. **KEYNOTE:** Denim jumpers and sundresses are not permitted.
   E. Jackets, Vests and Sweaters may be worn if coordinated with other clothing.
APPENDIX F (Cont’d)

Dress Code for Non-Uniformed Personnel Policy (Cont’d)

Effective: January 2007  Supersedes: 1/05  Code No.  122

<table>
<thead>
<tr>
<th>JACKSON HEALTH SYSTEM</th>
<th>Section: ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Hospital Center</td>
<td>SUBJECT: Dress Code for Non-Uniformed Personnel Policy</td>
</tr>
</tbody>
</table>

F. Footwear: Should promote balance, provide protections, support, traction and should be coordinated with clothing.

1. Shoes with heel should be appropriate for patient safe environment.

2. Clogs, platform, ankle laced shoes are not permitted.

3. Staff are required to wear closed toe shoes. Males must wear socks and females must wear hose or plain socks with slacks.

4. Leather boots may be worn with slacks on the outside or with skirts/dresses.

G. Clothing for Recreational Activities: (crafts, arts, sports)

1. May only be worn when involved in such activities.

KEYNOTE: When activity is concluded, staff is to change back into professional work attire.

H. Personnel performing direct patient care are not to wear jewelry that interferes with patient care, work performance, or could be used as a source for injury.

KEYNOTE: Examples include but are not limited to hoop or dangling earrings greater than one half inch below the earlobe, no more than 2 bracelets on each arm, no more than 2 necklaces/chains, and no more than 2 rings on each hand.

I. Personnel who render direct patient care and have shoulder length hair or longer are to wear their hair fastened back.

KEYNOTE: No scarves/head coverings, long ties or ribbons are permitted.

11. Grooming:

Hair, beards and mustaches shall be clean, neatly groomed and trimmed. Fingernails should not extend more than one half (1/2) inch beyond the finger pad, be neatly trimmed and suitable to the work environment (i.e. no neon colors, no nail decorations or nail jewelry, etc.). Acrylic nails are not permitted for direct care providers.

12. Pins and Identifications Badges:

A. Insignia denoting union membership, professional affiliations, and Jackson Memorial Hospital slogan pins may be worn, but are not mandatory.

B. Other organization pins and insignias (i.e. political pins and patches) shall not be worn.
APPENDIX F (Cont’d)

Medical Emergency Response Procedure Mental Health Hospital Center

SUPERSEDES: JANUARY 2007

CODE NO. 211

SECTION: CLINICAL

SUBJECT: MEDICAL EMERGENCY RESPONSE PROCEDURE FOR MENTAL HEALTH HOSPITAL CENTER

PURPOSE:

To define nursing staff responsibilities in the event of any potentially life threatening Medical Emergency.

PROCEDURE:

1. The Physician or RN is responsible for determining whether a medical emergency exists.
2. On discovering an unresponsive client, any trained personnel must render assistance and/or initiate CPR.
3. 911 must be called for all life threatening medical emergencies.
4. The Resident-On Call is immediately notified to come to the scene and assist with emergency treatment until 911 arrives and takes over.
5. The AIC is notified. The AIC will respond and assist the patient care center as needed.
6. For additional assistance, other patient care centers may be notified using the overhead paging system.
   - Announce medical emergency and give the exact location.
   - Repeat three times
   - Give exact instructions as to what is needed i.e. “send additional staff, send equipment, clear elevators, etc.”
7. Whenever a cardiopulmonary arrest occurs within the Mental Health Hospital Center, the AED is to be brought to the location of the emergency. The AED is located in the following areas:
   - For emergencies occurring on the first floor, the AED is located on the SIPP/CAAP unit in room #1641D.
   - For emergencies occurring on the second floor, the AED is located in the medication room on the ADI unit.
   - For emergencies occurring on the grounds of Highland Park Pavilion building, the AED is located on the 4th floor unit (HP4) in the “old” medication room near the nursing station.
   - For emergencies occurring in the Mental Health Emergency Service (Crisis) or the Geri-Med unit, the AED is located in the Triage area.
8. Fire Rescue (911) must be directed to transport the client to the JMH Emergency Room.
   KEYNOTE: Even if the JMH Emergency Room is on diversion, Fire Rescue should still be directed to transport the client there to JMH Emergency Room.

DATE: October 2008

Page 1 of 3
9. A physician is responsible for directing the code, notifying the attending and determining who is to notify the client's family of the change of condition.

10. In case of an unusual occurrence the Nurse Manager/AIC/ADON is responsible for notifying:
   - Risk Management via incident report or if a serious event via the risk management beeper.
   - Medical Director
   - Director of Client Care Services

11. The following must occur at the time the client is stabilized and on transport to the Jackson Memorial Hospital Emergency Department.

12. The Physician in charge of the medical emergency must call the JMH Emergency Room and report to the specific ER Physician (medical, surgical, etc.) the client's status and pending arrival. Additionally a written consultation request is completed and forwarded with the client.

13. The RN in charge of the client with the medical emergency must call the JMH Emergency Room and report to the ER RN (medical, surgical, etc.) the client's status and ER Triage RN of the pending arrival.

14. The client's attending physician must be notified of the transfer

**DOCUMENTATION:**

1. Notation is made on the progress note regarding the events immediately preceding the emergency, what action was taken during the emergency and the client's response. Documentation of the instructions given to Fire Rescue Personnel regarding transporting client to the JMH Emergency Room must be documented.

2. If CPR was done, the Cardiopulmonary Resuscitation Record (C-405) is filled out completely by the RN.

3. A copy of the Cardiopulmonary Resuscitation Evaluation form is completed by the RN and faxed to the CPR Committee (#305-325-0293) and a copy given to the Mental Health Quality Management within 24 hours.
   a.) Copies of pertinent documentation forms, i.e. face sheet, history and physical, labs, doctor's orders, consultation form, is to accompany the client to the Emergency room. A Mental Health staff member who accompanies the client to the ER takes the chart from Mental Health to the ER and if not accompanying the client it is walked by a Mental Health staff member to the appropriate ER's attending physician.
   b.) The Head Nurse of designee checks frequently with the ER as to the client's admit status to the general hospital and is responsible for the return of the Mental Health Services Medical Record to the Mental Health Services Medical Records Department.
APPENDIX F (Cont’d)

Hand-Off on Improving Communication Amongst Caregivers

SUPERSEDES: 11/30/07

CODE NO. 720.1

SECTION: Outpatient Clinical

SUBJECT: HAND-OFF ON IMPROVING COMMUNICATION AMONGST CAREGIVERS

- Interruptions during hand-off communication will be limited in order to minimize the possibility that information would fail to be conveyed or forgotten.

PROCEDURES:

The SBARD communication technique will be utilized between and among all health care providers as appropriate.

Examples:

S - Situation:
- Identify yourself (first & last name, department/position)
- Individual’s name and Medical Record Number, Diagnosis, or other absolute identifier to recipient of information (obtain confirmation from recipient of information so that they know which individual is being discussed)
- Situation/problem necessitating communication to another care provider/ department

B - Background:
- State the relevant history, treatment/service course summary, and any pertinent information,
- Medications,
- Strengths/ Recovery Challenges, etc
- Cultural/ethnic needs such as language, decision making, etc

A - Assessment:
- Presenting Complaints/Problem
- Prior Psychiatric/ Substance Abuse Treatment
- Mental status
- Infections, including necessary patient/public precautions
- Risk Alerts- Suicide/Homicide Precaution
- Psychosocial Factors
- General Functioning
- Clinical Impression

R - Recommendations: Offer your conclusions about the present situation and explain what you think needs to be done, what the individual needs, and when. Determine what circumstances/changes to individual condition require follow-up action and who should be notified.

Q – Questions: An opportunity for questions may be provided during or after the SBARQ communication technique. Verify any critical information received, review the history, seek clarification, ask questions, and read or repeat back critical information where relevant.

DATE: 8/31/08
APPENDIX F (Cont’d)

Hand-Off on Improving Communication Amongst Caregivers (Cont’d)

- Interruptions during hand-off communication will be limited in order to minimize the possibility that information would fail to be conveyed or forgotten.

PROCEDURES:

The SBARD communication technique will be utilized between and among all health care providers as appropriate.

Examples:

S - Situation:
- Identify yourself (first & last name, department/position)
- Individual’s name and Medical Record Number, Diagnosis, or other absolute identifier to recipient of information (obtain confirmation from recipient of information so that they know which individuals being discussed)
- Situation/problem necessitating communication to another care provider/department

B - Background:
- State the relevant history, treatment/service course summary, and any pertinent information,
- Medications,
- Strengths/ Recovery Challenges, etc
- Cultural/ethnic needs such as language, decision making, etc

A - Assessment:
- Presenting Complaints/Problem
- Prior Psychiatric/ Substance Abuse Treatment
- Mental status
- Infections, including necessary patient/public precautions
- Risk Alerts- Suicide/Homicide Precaution
- Psychosocial Factors
- General Functioning
- Clinical Impression

R - Recommendations: Offer your conclusions about the present situation and explain what you think needs to be done, what the individual needs, and when. Determine what circumstances/changes to individual condition require follow-up action and who should be notified.

Q – Questions: An opportunity for questions may be provided during or after the SBARQ communication technique. Verify any critical information received, review the history, seek clarification, ask questions, and read or repeat back critical information where relevant.
APPENDIX F (Cont’d)

Hand-Off on Improving Communication Amongst Caregivers (Cont’d)

D – Documentation: Document hand-off communication as appropriate.

1. Person to person communication is preferred when transferring care, however when this is not possible, it is acceptable to provide this information via phone, electronic messaging, hardcopy form, or fax. Follow up transfer of electronic information with person-to-person contact or telephone call, allowing for appropriate feedback and opportunity for questions. The SBAROD format is followed and provisions are made for direct dialogue, including the opportunity to ask questions, between and among caregivers.

2. When possible and appropriate, include the Individual/Guardian and family in the dialogue when relevant.

EDUCATION OF STAFF

There will be an orientation and periodic continuing education programs for all clinical disciplines on:
- S-BARQD
  - Communication techniques like use of language “triggers” to encourage discussion, such as “I am concerned”, “I am uncomfortable with” or “I think we have safety issues”.
  - Environmental factors

Education of staff is accomplished during employee initial orientation, unit/department orientation, staff meetings, and individual staff meetings.

REFERENCES:

JHS Policy Code No. 493


APPENDIX F (Cont'd)
Hand-Off on Improving Communication Amongst Caregivers (Cont’d)

Diagnosis/Chief Complaint:
Language: □ English □ Spanish □ Creole □ Other: 
Other Pertinent Medical/Psych History: □ None □ Yes □ Baker Act □ Comments:
Allergies: □ Pink Band □ None □ Latex □ Contrast □ Proxy/Legal Guardian/Advance Directives:
□ No □ Yes □ N/A □ Comments:
Comments:

Section I: Complete For Every Episode of Hand Off

<table>
<thead>
<tr>
<th>Reason for Hand Off</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure □ Transfer □ Comment:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Identification Completed
□ Identification Band □ Medical Record

Vital Signs
Temp: □ Respirations: □ Pulse: 
Blood Pressure: □ Pain Level (0-10):

Neuro Status/Behavior
□ Awake □ Oriented □ Disoriented □ Confused 
□ Alert □ Combative □ Non-responsive □ Seizure Precautions

Special Considerations
□ DNR □ Yes □ No 
□ Medication Administered and Dosage: 
□ Yellow Fall Band on Patient □ Restraints □ Sitter 
□ Oxygen Therapy: □ Accompanied Baby or Child 
□ Visual/Hearing Impairment □ Equipment: 
□ Comment: 

Diet
□ Nothing By Mouth □ Specify Diet: 

Infection Control Precautions
□ Standard □ Droplet □ Airborne □ Contact □ Other: 

Activity
□ Bathroom Privilege □ Bed rest □ Other (Describe): 

Sedation in Last 24 Hours
□ No □ Yes (Medication and Time of Last Dose):

Dressing/Skin Breakdown
□ No □ Yes Site: 

Drain/Catheter/Tube/Intravenous
□ Drain □ Catheter □ Intravenous □ Tube □ Other:

Belongings
□ None □ Patient □ Family □ In Patient’s Room 
□ Comments:

Family/Proxy/Legal Guardian Notified of Transfer/Procedure
□ No □ Yes (Name of Person Who Was Notified):

Sending Unit, Name of Staff, Signature and Extension Number
Sending Unit: 
Name of Staff: 
Signature: 
Extension Number:

Receiving Unit, Name of Staff, and Signature
Receiving Unit: 
Name of Staff: 
Signature: 

Section II: POST PROCEDURE ONLY

Date: 

Tolerated Procedure: □ Yes □ No □ Describe:

Special Positioning: □ Yes (Describe): □ No

Transfer to: □ Floor: □ Other: □ Comments:

Sending Staff Name and Signature: 
Extension Number:

Receiving Staff Name and Signature: 

Tolerated Procedure: □ Yes □ No □ Describe:

Special Positioning: □ No □ Yes □ Describe:

Transfer to: □ Floor: □ Other: □ Comments:

Sending Staff Name and Signature: 
Extension Number:

Receiving Staff Name and Signature: 

Jackson Hospital System

PATIENT HAND-OFF REPORT CHECKLIST

C-208U Rev. 07/03/08 Page 1 of 2

AFFIX PATIENT LABEL HERE

152
# APPENDIX F (Cont'd)

Hand-Off on Improving Communication Amongst Caregivers (Cont’d)

## Guidelines for Use of Patient Hand Off Report Checklist

<table>
<thead>
<tr>
<th>Section I</th>
<th>TERMINOLOGY</th>
<th>INSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>Write diagnosis of patient; if diagnosis is not available write chief complaint.</td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td>Check appropriate box for language spoken by patient. If patient language is not listed, write it out. If patient has hearing impairment, write on the line provided.</td>
<td></td>
</tr>
<tr>
<td>Medical/Psych History</td>
<td>Check appropriate box for medical or psychiatric history. Complete comments if appropriate.</td>
<td></td>
</tr>
<tr>
<td>Proxy/Legal Guardian/Advance Directives</td>
<td>Check appropriate box if proxy/legal guardian/advance directives were completed. Complete comments if appropriate.</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td>Check appropriate box for allergy. If allergy is not listed write patient's allergy on the line provided. Check box for BAND PLACEMENT.</td>
<td></td>
</tr>
<tr>
<td>Reason for Hand Off:</td>
<td>Check appropriate box and document procedure.</td>
<td></td>
</tr>
<tr>
<td>Patient ID Completed</td>
<td>Check both boxes for ID hand and medical record ONLY after verifying that the patient is wearing the correct ID hand and has the right medical record. Check both boxes. Indicate if the record is electronic.</td>
<td></td>
</tr>
<tr>
<td>Vital Signs</td>
<td>Write out latest patient's temperature, pulse rate, respiration rate, and blood pressure. Document pain level of patient.</td>
<td></td>
</tr>
<tr>
<td>Neurostatus/Behavior</td>
<td>Check appropriate boxes for patient's neurostatus and/or behavior.</td>
<td></td>
</tr>
<tr>
<td>Special Considerations</td>
<td>Check all appropriate boxes that apply to patient. Check box for YELLOW BAND PLACEMENT for patient on Fall Precaution. Write medication administered and dosage in the line provided. Document any STAT/PRN medications that may have an impact on patient's condition during transfer. For routine medications direct staff to refer to MAR. Write on the line provided method of oxygen administration and liters/minute. If patient has equipment, write on the line provided.</td>
<td></td>
</tr>
<tr>
<td>Diet</td>
<td>Write out patient's diet.</td>
<td></td>
</tr>
<tr>
<td>Infection Control Precautions</td>
<td>Check appropriate box as appropriate.</td>
<td></td>
</tr>
<tr>
<td>Special Positioning/Activity Requirement</td>
<td>If yes, write special positioning requirement. Check appropriate box for activity.</td>
<td></td>
</tr>
<tr>
<td>Sedation in Last 24 Hours</td>
<td>Check appropriate box. If yes, write name of medication and time last dose was given.</td>
<td></td>
</tr>
<tr>
<td>Dressing/Incontinence/Bladder (Check all that apply)</td>
<td>Check appropriate box. If yes, write site of dressing/incontinence/bladder.</td>
<td></td>
</tr>
<tr>
<td>Drain/Catheter/Tubing/Intravenous (Check all that apply)</td>
<td>Check appropriate boxes that apply. If product is not listed on the checklist, write it out.</td>
<td></td>
</tr>
<tr>
<td>Family/Proxy/Legal Guardian Notified of Transfer/Procedure</td>
<td>Check appropriate box. If yes, write name of person notified of transfer or procedure.</td>
<td></td>
</tr>
<tr>
<td>Belongings</td>
<td>Check appropriate box to indicate if belongings are with patient/family/in patient room. Complete comments section if appropriate.</td>
<td></td>
</tr>
<tr>
<td>Sending Unit, Name of Staff, Signature and Extension Number</td>
<td>Write unit and PRINT and sign name of staff sending patient. Write extension number of staff sending patient.</td>
<td></td>
</tr>
<tr>
<td>Receiving Unit, Name of Staff and Signature</td>
<td>Write unit and PRINT and sign name of staff receiving patient.</td>
<td></td>
</tr>
</tbody>
</table>

## Section II

### Post Procedure Documentation

Post procedure columns will be completed by Technologist/Nursing Staff and will include any special positioning and any special considerations/occurrences under comment section. If procedure not tolerated describe the event. At completion of the procedure the Technologist/Nursing Staff will document special considerations in POST PROCEDURE COLUMN AND SIGN as staff sending patient.

### Unit, Name of Staff Sending Patient and Extension Number

Write unit and PRINT and sign name of staff sending patient. NURSING STAFF WILL VERBALLY NOTIFY ESCORT OF ANY SPECIAL NEEDS OR CONSIDERATIONS.

### Unit and Name of Staff Receiving Patient

Write unit and PRINT and sign name of staff receiving patient. The Technologist/Nursing Staff in procedure suite will sign as staff receiving patient and review hand off report.

Escort will not sign form when picking up patient. The form will be signed by Nursing Staff/Technologist only when sending or receiving patient. Complete form for every episode of Hand Off and maintain in patient's chart.

---

**Jackson Health System**

**PATIENT HAND-OFF REPORT CHECKLIST**

**C-208U** Rev. 07/2008 Page 2 of 2

---

**AFFIX PATIENT LABEL HERE**
APPENDIX F (Cont'd)

Medication Reconciliation Outpatient

SUPERSEDES: January 2009

SECTION: Mental Health Outpatient Clinics

SUBJECT: Medication Reconciliation Outpatient

Purpose: The purpose is to establish guidelines for reconciling medication for Jackson Health System Mental Health individuals in the outpatient programs to reduce/eliminate potential or actual risk of medication errors by documenting at admission current medications (including over-the-counter medications) and completing the Medication Reconciliation Form at the time of transfer and/or discharge.

Policy:
Jackson Health System Mental Health Center shall complete a Medication Reconciliation Form for outpatient individuals.

Procedure:

1. The Assessment Center clinician will obtain and document a list of all medications the individual is currently using, including over-the-counter medications. This will include name, dose, route, frequency, and if known, the last dose taken (date/time). The Assessment Center clinician will sign and date the form.

2. The completed Medication Reconciliation Form will be placed in the Physician's Order/Miscellaneous section of each individual's medical record.

3. The physician/ARNP will write any prescriptions and changes to medications on the C-442, Patient Contact and Treatment Record.

4. Prior to discharge/transfer from any outpatient program the clinical staff (MD/ARNP, RN, therapist, and/or case manager) discharging or transferring the individual will document the name of all medications at discharge on the Medication Reconciliation Form.

5. At the time of discharge, if the individual has a planned transfer or discharge, the MD/ARNP will document a list of medications and will give a copy of the form to the individual. For transfers, the HIM department will send a copy to the next provider.

6. For unplanned discharge, the MD/ARNP or RN will complete the Medication Reconciliation Form. The HIM department will send a copy of the completed Medication Reconciliation Form to the individual.

Attachment: Outpatient Medication Reconciliation Form

DATE: May 2009

PAGE 1 of 1
## APPENDIX F (Cont’d)

### Medication Reconciliation Outpatient (Cont’d)

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials</th>
<th>Medication Name</th>
<th>Done</th>
<th>Route</th>
<th>Frequency</th>
<th>RECONCILIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C-CONTINUE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R-RESTART</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D-DISCONTINUE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N-NEW</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COMMENTS</td>
</tr>
</tbody>
</table>

**Source of medication list (list all used):**

- No medication prior to admission
- Patient medication list
- Previous discharge records
- Pharmacy
- Pharmacy ToL #

**RECONCILIATION:**
- C-CONTINUE
- R-RESTART
- D-DISCONTINUE
- N-NEW

**Comments:**

---

Initiated by: [Signature]

Discharge: [Signature]

**MEDICATION HISTORY & RECONCILIATION FORM**

**JACKSON HEALTH SYSTEM**

**C-668 (1/06)**

**White - Chart**  **Yellow - Patient**  **Pink - Pharmacy**

---

155
APPENDIX F (Cont’d)

Medication Reconciliation Outpatient (Cont’d)

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials</th>
<th>Medication Name</th>
<th>Date</th>
<th>Route</th>
<th>Frequency</th>
<th>RECONCILIATION</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C-CONTINUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M-MODIFY</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R-RESUME</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M-STOP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D-DISCONTINUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N-NEW</td>
<td></td>
</tr>
</tbody>
</table>

Source of medication list (list all used):
- No medication prior to admission
- Patient medication list
- Previous discharge records
- Pharmacy
- Other

Pharmacy Tel #

Initiated by: ____________________________

Discharge: ____________________________

Admission: ____________________________

JACKSON HEALTH SYSTEM
MIAMI, FLORIDA 33136-1094

C-568 (1/06)

White - Chart  Yellow - Patient  Pink - Pharmacy
APPENDIX F (Cont’d)

Medication Reconciliation Outpatient (Cont’d)

---

**MEDICATION HISTORY AND RECONCILIATION FORM**

*"terminology instruction key on back***

*(PLEASE PRINT ALL INFORMATION)*

<table>
<thead>
<tr>
<th>Source of medication list (list all used):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No medication prior to admission</td>
</tr>
<tr>
<td>□ Patient medication list</td>
</tr>
<tr>
<td>□ Previous discharge records</td>
</tr>
<tr>
<td>□ Pharmacy</td>
</tr>
</tbody>
</table>

**Pharmacy Tel #:**

---

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials</th>
<th>Medication Name</th>
<th>Done</th>
<th>Route</th>
<th>Frequency</th>
<th>RECONCILIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C-CONTINUE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R-RESUME</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D-DISCONTINUE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M-MODIFY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N-NEW</td>
</tr>
</tbody>
</table>

**HOME MEdS**

**DISCHARGE MEdS**

**Comments**

---

Initiated by: ___________________________  Discharge: ___________________________

Healthcare Provider - Print Name

Admission: ___________________________

Healthcare Provider - Print Name

---

**JACKSON HEALTH SYSTEM**

MIAMI, FLORIDA 33138-1094

**MEDICATION HISTORY & RECONCILIATION FORM**

---

White - Chart  Yellow - Patient  Pink - Pharmacy

---

157
**APPENDIX F (Cont’d)**

Medication Reconciliation Outpatient (Cont’d)

**MEDICATION HISTORY AND RECONCILIATION FORM**

**termiology instruction key on back**

*(PLEASE PRINT ALL INFORMATION)*

<table>
<thead>
<tr>
<th>Source of medication list (list all used):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No medication prior to admission</td>
</tr>
<tr>
<td>☐ Patient medication list</td>
</tr>
<tr>
<td>☐ Previous discharge records</td>
</tr>
<tr>
<td>☐ Pharmacy</td>
</tr>
<tr>
<td>☐ Pharmacy Tel #</td>
</tr>
<tr>
<td>☐ Prescription vials/bottle</td>
</tr>
<tr>
<td>☐ Primary care physician</td>
</tr>
<tr>
<td>☐ Patient/family mail</td>
</tr>
<tr>
<td>☐ Facility medical record</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials</th>
<th>Medication Name</th>
<th>Done</th>
<th>Route</th>
<th>Frequency</th>
<th>RECONCILIATION</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C-CONTINUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M-MODIFY</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>H-HOLD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N-NEW</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HOME MEDI</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DISCHARGE MEDI</td>
<td></td>
</tr>
</tbody>
</table>

Initiated by: ____________________________  Discharge: ____________________________

Healthcare provider - Print name

Admission: ____________________________

Healthcare provider - Print name

**JACKSON HEALTH SYSTEM**

Miami, Florida 33139-1094

**MEDICATION HISTORY & RECONCILIATION FORM**

White - Chart  Yellow - Patient  Pink - Pharmacy
### APPENDIX F (Cont'd)

Medication Reconciliation Outpatient (Cont’d)

<table>
<thead>
<tr>
<th>Term</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admit Date</strong></td>
<td>Record date patient was admitted to the hospital</td>
</tr>
<tr>
<td><strong>Discharge Date</strong></td>
<td>Record date patient was discharged from the hospital</td>
</tr>
<tr>
<td><strong>Allergies</strong></td>
<td>Document any patient allergies</td>
</tr>
<tr>
<td><strong>Source of medication list</strong></td>
<td>Check appropriate boxes for home medication information source. Document name(s) of pharmacy(ies) that maintain a patient profile for this patient and can be used as a reference. Include city and phone number.</td>
</tr>
<tr>
<td><strong>Date &amp; Initials</strong></td>
<td>Record date and time information was gathered and initials of interviewer.</td>
</tr>
<tr>
<td><strong>Medication name</strong></td>
<td>Record full name. Include over-the-counter medications, herbals, supplements, inhalers, and eye drops.</td>
</tr>
<tr>
<td><strong>Dose</strong></td>
<td>Record the dosage of the medication.</td>
</tr>
<tr>
<td><strong>Route</strong></td>
<td>Record the route of administration of the medication.</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>Record how often the drug is taken.</td>
</tr>
</tbody>
</table>
| **Home medications reconciliation** | Reconcile MD's initial medication orders with medication history:  
  C = Continue on admission  
  M = Modify - same medication but different dose or schedule or different medication with similar action ordered instead  
  H = Hold - Physician does not want medication given at time of admission  
  D = Discontinue  
  R = Resume |
| **Discharge medication reconciliation** | Reconcile discharge orders with medication history:  
  C = Continue same medication and dose  
  M = Modify - same medication but different dose or schedule or different medication with similar action ordered instead  
  H = Hold medication at discharge  
  D = Medication not to be continued after discharge  
  R = Resume previously held medication  
  N = New medication |
| **Comments** | Record discharge dates or patients non-compliance as appropriate. Record deviations from labeled instructions. Record any pertinent observations or assessments you feel important in understanding patient's therapy/ability to self medicate. Record any special requirements for discharge prescriptions. |
TO FIND OR PRINT A ROSTER OF PATIENTS FOR A RESIDENT/CLINICIAN

1. Log into Scheduling Appointment Book
2. Log in to Jackson Health System
3. Click Appointment Inquiry (Eyeball)
4. Click the Ellipse button next to Resource
5. Type the first two letters of the last name of the resident/clinician you are searching for
6. Select the resource you want (therapy, meds etc)
7. Select the start date you want
8. Click find
9. Print
QUEST DIAGNOSTICS

Contact person: Maria Otalora  
Telephone : 954-378-5000 ext 3513  
FAX :1-954-281-3437  
Email: maria.a.otalora@questdiagnostics.com

Our Account:

Client Name : Mental Health Outpatient Clinic  
Client Numbers : AOPC = 26831  CAP = 26832  
THP =26832  DHH = 26834  Forensic= 26835

To access QUEST type www.care360.com/physicianportal  
Then type login and password

CUSTOMER SERVICE
1-800-697-9302

Client Services #5

DRUG Urines= Drug Abuse Panel 10 Test Code 29423  
( tests for Benzos, Cocaine, Marijuana, Amphetamines, Opiates, Methamphetamine,  
Barbiturates, Methadone, Morphine, Codeine, Hydromorphone, Hydrocodone, Phenacyclidade,  
Propoxicine & Methelquaalude  
***** Must have 60 cc of urine
### APPENDIX G

#### - Visit Information

**Chief Complaint**

<table>
<thead>
<tr>
<th>Description</th>
<th>Other</th>
</tr>
</thead>
</table>

#### - History of Presenting Problem

**Psychiatric History**

<table>
<thead>
<tr>
<th>Alcohol abuse &gt;&gt;</th>
<th>Anxiety disorders &gt;&gt;</th>
<th>Panic attacks &gt;&gt;</th>
<th>Phobic disorders &gt;&gt;</th>
<th>Attention deficit disorder &gt;&gt;</th>
<th>Behavior problems &gt;&gt;</th>
<th>Bipolar disorder &gt;&gt;</th>
<th>Depression &gt;&gt;</th>
<th>Eating disorder &gt;&gt;</th>
<th>Obsessive-compulsive disorder &gt;&gt;</th>
<th>Personality disorders &gt;&gt;</th>
<th>Schizophrenia &gt;&gt;</th>
<th>Substance abuse &gt;&gt;</th>
<th>Suicide problems &gt;&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTHER</td>
<td>Exposure to Trauma</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### - Past Medical History

**Developmental Milestones**

<table>
<thead>
<tr>
<th>Pregnancy &gt;&gt;</th>
<th>Sitting &gt;&gt;</th>
<th>Walking &gt;&gt;</th>
<th>P-B single words &gt;&gt;</th>
<th>Combined words &gt;&gt;</th>
<th>Toilet training &gt;&gt;</th>
<th>Interpersonal relatedness &gt;&gt;</th>
<th>OTHER</th>
</tr>
</thead>
</table>

**Physical Exam**

<table>
<thead>
<tr>
<th>Description</th>
<th>Immunization Status</th>
<th>Vision</th>
<th>Hearing</th>
<th>Dental exam</th>
<th>Chronic Illness</th>
<th>Head Injury/Loss of consciousness</th>
<th>Hospitalizations</th>
<th>OTHER</th>
</tr>
</thead>
</table>

#### - Health Status

OTHER
### APPENDIX G

#### Allergies
- **Allergic Reactions (All)**
  - Severe
  - **Mild**
    - Shellfish- No reactions were documented.
    - Morphine- No reactions were documented.

#### Current medications
- **Problem list**
- **All Problems**
  - BENIGN ESSENTIAL HYPERTENSION / ICD-9-CM 401.1 / *Confirmed

#### Nutrition
<table>
<thead>
<tr>
<th>Diet &gt;&gt;</th>
<th>Any conditions that may affect nutrition &gt;&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Recent changes in appetite &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Recent changes in weight &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Meds interacting with food or nutrition &gt;&gt;</td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
</tbody>
</table>

#### - Results Review
- General results
  - New results
  - Today's results
  - Most recent results >>
  - Other

#### - Family History
- **Family Medical History**
  - **Description**
  - Psychiatric Family History
    - Mental illness >>
    - Substance Abuse >>
    - Suicide >>
  - Other

#### - Social History
- **Education**
  - Years completed
  - Preschool >>
  - Grade school >>
  - Middle school >>
  - High school >>
  - College >>
  - Advanced degree >>
  - OTHER

- **Family/ Social situation**
  - Marital status >>
  - Children >>
  - Dependents >>
  - Caregivers >>
  - Living arrangements >>
  - Pets >>
  - Social support system
<table>
<thead>
<tr>
<th>OTHER</th>
<th>Life Stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Catastrophe &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Death &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Employment &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Family discord &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Family member with substance abuse &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Financial difficulties &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Marital discord &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>New child &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Relocation &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>School problems &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Severe illness &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Unplanned pregnancy &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Violence / abuse &gt;&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER</th>
<th>Alcohol use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Denies</td>
</tr>
<tr>
<td></td>
<td>Frequency &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Type &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Amount &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Onset &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Quit &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Known dependence &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Previous rehabilitation &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>CAGE screening &gt;&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER</th>
<th>Tobacco exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Denies</td>
</tr>
<tr>
<td></td>
<td>Cigarettes &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Cigars &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Chewing tobacco &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Pipe &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Snuff &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Second hand smoke &gt;&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER</th>
<th>Drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Denies</td>
</tr>
<tr>
<td></td>
<td>Amphetamines &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Cocaine &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Crack &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Glue &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Heroin &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>IV drugs &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>LSD &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Marijuana &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Opiates &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>POP &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Prescriptions medications &gt;&gt;</td>
</tr>
<tr>
<td></td>
<td>Solvents &gt;&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER</th>
<th></th>
</tr>
</thead>
</table>
# Hobbies

- Cards
- Collecting
- Computers
- Corresponding
- Crafts
- Gardening
- Genealogy
- Social club
- Sports
- Volunteering
- OTHER

# Sexual history

- Sexually active
- Sexually active since age
- Consistent practice of safe sex
- Risks
- Sexual relationship
- Sexual assault
- Gender identity disorder
- Homosexual
- Transsexual
- Transvestite
- OTHER

# Religious affiliation

- Catholic
- Christian Scientist
- Greek Orthodox
- Hindu
- Jehovah's Witness
- Judaism
- Mormon
- Muslims
- Protestant
- Seventh Day Adventist
- Other
- Health care restrictions
- OTHER

# Legal history

- Denies
- Any Arrest
- Jail / Prison
- Probation
- Other

## Assessment

- Mental status exam
  - Appearance
  - Behavior
  - Orientation
  - Mood and affect
  - Thought Contents
  - Thought process
  - Attention
  - Concentration
# APPENDIX G

## Articulation and speech
- Other

## Functional cognition
- Other

## Comprehension
- Other

## Insight
- Other

## Judgment
- Other

## Biopsychosocial Formulation
- Other

### Progress Note
- Other

### Impression and Plan

**Diagnostic Impressions**

| Axis I: >> | No diagnosis on Axis I | Adjustment Disorder, Mix Dis Em 309.4 | Alcohol Abuse 305.00 | Alcohol Dependence 303.91 | Alcohol Induced Mood Disorder 291.89 | Alcohol Intoxication 303.0 | Alcohol Withdrawal 291.81 | Anxiety Disorder NOS 300.00 | Bipolar NOS 296.80 | Bipolar I, Depressed 296.5 | Bipolar I, MRE Hypomanic 296.40 | Bipolar I, MRE Manic w/ Psychosis 296.44 | Cannabis Dependence 304.3 | Cocaine Abuse 305.6 | Cocaine Dependence 304.20 | Cocaine induced Mood Disorder 292.84 | Cocaine induced Psych Disorder 292.11 | Delirium 293.0 | Dementia NOS 294.8 | Depressive Disorder NOS 311.00 | Generalized Anxiety Disorder 300.02 | Impulse Control Disorder NOS 312.30 | Major Depression, Recurrent 296.33 | Neuroleptic Induced Tardive Dysk 333.82 | Opioid Dependence 304.00 | Opioid Withdrawal 292.00 | Other Substance Dependence 304.90 | Panic Disorder w/ Agoraphobia 300.01 | Panic Disorder w/ Agoraphobia 300.21 | Polysubstance Dependence 304.80 | Post Traumatic Stress Disorder 300.81 | Psychotic Disorder NOS 294.90 | Schizoaffective Disorder, Bipolar 295.70 | Schizophrenia chr disorgan type 295.10 | Schizophrenia chr paranoid type 295.30 | Schizophrenia chr undiff type 295.90 | Other Diagnosis |

### Axis II: >>

### Axis III: >>

### Axis IV: >>

### Axis V: >>

## OTHER Diagnosis

### Orders M
## APPENDIX G

<table>
<thead>
<tr>
<th>Discussed diagnosis with parent/guardian</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>--</td>
</tr>
<tr>
<td>No</td>
<td>--</td>
</tr>
<tr>
<td>OTHER</td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescriptions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OTHER</td>
<td>--</td>
</tr>
<tr>
<td>PRESCRIPTION</td>
<td>--</td>
</tr>
<tr>
<td>OTHER</td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual therapy</td>
<td></td>
</tr>
<tr>
<td>Family therapy</td>
<td></td>
</tr>
<tr>
<td>Group therapy</td>
<td></td>
</tr>
<tr>
<td>Medication clinic</td>
<td></td>
</tr>
<tr>
<td>Psychological testing</td>
<td></td>
</tr>
<tr>
<td>Primary care physician</td>
<td></td>
</tr>
<tr>
<td>Social work follow-up</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning needs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease process</td>
<td></td>
</tr>
<tr>
<td>Medication management</td>
<td></td>
</tr>
<tr>
<td>Drug / food interactions</td>
<td></td>
</tr>
<tr>
<td>Anger management</td>
<td></td>
</tr>
<tr>
<td>Family / support system</td>
<td></td>
</tr>
<tr>
<td>Relapse prevention</td>
<td></td>
</tr>
<tr>
<td>Side effects of medications</td>
<td></td>
</tr>
<tr>
<td>Risks of medications</td>
<td></td>
</tr>
<tr>
<td>Benefits of medications</td>
<td></td>
</tr>
<tr>
<td>Coping skills</td>
<td></td>
</tr>
<tr>
<td>Self care</td>
<td></td>
</tr>
<tr>
<td>Parenting</td>
<td></td>
</tr>
<tr>
<td>Barriers to learning</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
</tbody>
</table>

- Professional Services

| E & M Assistant |  |
| E & M Coding |  |

<p>| Outpatient visit, new |  |
| Outpatient visit, established |  |
| Outpatient visit, emergent |  |
| Outpatient consult, new |  |
| Confirmatory consult |  |
| Postop follow-up |  |
| Fracture follow-up |  |
| Preventive medicine, new |  |
| Preventive medicine, established |  |
| Emergency department visit |  |
| Observation care, initial |  |</p>
<table>
<thead>
<tr>
<th>Observation/same day Inpatient care &gt;&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient care, initial &gt;&gt;</td>
</tr>
<tr>
<td>Inpatient care, subsequent &gt;&gt;</td>
</tr>
<tr>
<td>Inpatient consult, initial &gt;&gt;</td>
</tr>
<tr>
<td>Inpatient consult, follow-up &gt;&gt;</td>
</tr>
<tr>
<td>Home visit, new &gt;&gt;</td>
</tr>
<tr>
<td>Home visit, established &gt;&gt;</td>
</tr>
<tr>
<td>Nursing facility visit, comprehensive &gt;&gt;</td>
</tr>
<tr>
<td>Nursing facility visit, subsequent &gt;&gt;</td>
</tr>
<tr>
<td>Domiciliary visit, new &gt;&gt;</td>
</tr>
<tr>
<td>Domiciliary visit, established &gt;&gt;</td>
</tr>
<tr>
<td>OTHER</td>
</tr>
</tbody>
</table>

169
APPENDIX I

ROTATION ATTENDING EVALUATION OF RESIDENT

New Innovations RMS Evaluations

QUESTIONNAIRE BUILDER

DEPARTMENT OF PSYCHIATRY DIVISION OF CHILD & ADOLESCENT PSYCHIATRY

Evaluator: Subject:

Rotation:

Employer:

ADD INSTRUCTIONS

Q1. MEDICAL KNOWLEDGE

Knowledge:
- Normal and abnormal development.
- Psychopathology and classification.
- Assessment procedures.
- Epidemiology and phenomenology of childhood psychiatric disorders.
- Various psychopharmacological treatment options.
- Various psychosocial interventions, including individual, family, group, and behavioral approaches.
- Demonstrates the ability to formulate a biopsychosocial formulation.
- Demonstrates through providing care for children, adolescent and families the ability to apply the fund of knowledge

Please list by name or letter. In the comment box below, those sub elements which need improvement. Include comments and/or observations.

Excellent Satisfactory Need(s) Improvement: N/A

1 2 3

C C C

Comments

Remaining Characters: 5003

ADD INSTRUCTIONS

Q2.

Required LSN HSN Individual Comments

Grade Scale used: Excellent / Satis / N/A

MEDICAL KNOWLEDGE

SKILLS:
The resident demonstrates the following:
a. Attend and participate in didactics, demonstrating the ability to learn and disseminate effectively relevant data and knowledge about child and adolescent psychiatry.
b. Demonstrate through the provision of care for children, adolescents and families the ability to apply the fund of knowledge in clinical science gained in didactic and clinical situations.

Please list by name or letter, in the comment box below, those sub elements which need improvement. Include comments and/or observations.

Excellent Satisfactory Need(s) Improvement: N/A

1 2 3

Coments

Remaining Characters: 5000

Q3. Edit Question | Cut | Copy | Delete | Required | LSN | HSN | Individual Comments

MEDIAl KNOWLEDGE

ATTITUDE:
The resident exhibits the following qualities and behaviors:
a. Participate actively in didactic offerings by being able to discuss assigned readings and effectively present various topics in different forums, making relevant comments during discussions.
b. Participate actively in clinically based conferences, bringing to these conferences literature and knowledge from the clinical sciences that are relevant to the clinical situation being discussed.
c. The resident will immerse themselves in the clinical situation.
d. The resident will immerse themselves in the training and mentoring opportunities of a residency.
e. The resident will be able to offer informed psychotherapy services to all patients presenting themselves in their independent practices.

Please list by name or letter, in the comment box below, those sub elements which need improvement. Include comments and/or observations.

Excellent Satisfactory Need(s) Improvement: N/A

1 2 3

Coments

Remaining Characters: 5000

Q4. Edit Question | Cut | Copy | Delete | Required | LSN | HSN | Individual Comments

Grade Scale used: Excellent / Satisfactory / Inadequate

N N N Y
PATIENT CARE

Knowledge:
The resident demonstrates an adequate fund of knowledge in the following areas:
a. Individual child therapies; family therapy; group therapy
b. Descriptive psychiatry, symptom assessment and diagnosis
c. Neuroscience, neurochemistry and clinical psychopharmacology
d. Normal growth and development

Please list by name or letter, in the comment box below, those sub elements which need improvement.
Include comments and/or observations.

Excellent Satisfactory Need(s) Improvement N/A
1 2 3 C C

Comments

Remaining Characters: 5000

Q5.

PATIENT CARE

Skills:
The resident demonstrates the following skills:
a. Is able to conduct a child or adolescent interview.
b. Is able to conduct a parent/family interview.
c. Is able to formulate a case from interview, mental status exam, and historical materials.
d. Is able to formulate a differential diagnosis.
e. Is able to elaborate a comprehensive treatment plan based on the information obtained.
f. Is able to conduct a psychotherapy over a substantial period of time, formulating and implementing a treatment plan, with the goal of resolving certain identifiable symptoms.
g. Is able to identify and discuss issues of countertransference with supervisors.
h. Demonstrates caring and respectful behavior when interacting with parents and their families.
i. Gathers essential and accurate information about patients.
j. Takes responsibility for patient care.

Please list by name or letter, in the comment box below, those sub elements which need improvement.
Include comments and/or observations.

Excellent Satisfactory Need(s) Improvement N/A
1 2 3 C C

Comments

Remaining Characters: 5000
**Q6.**

### PATIENT CARE

**Attitudes:**
The resident exhibits the following qualities and behaviors:
- The resident values themselves as an integral part of the team and supervision, maintaining a 75% attendance record or better.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>C</td>
</tr>
</tbody>
</table>

### Required | LSN | HSN | Individual Comments
---|-----|-----|---------------------
N | N   | N   | N                   

Grade Scale used: Excellent / Satisfactory / N/A

**Q7.**

### INTERPERSONAL AND COMMUNICATION SKILLS

**Knowledge:**
The resident demonstrates an adequate fund of knowledge in the following areas:
- Residents are expected to develop a knowledge base relating to interpersonal skills appropriate to their level of training. Specifically, child and adolescent psychiatry residents should demonstrate knowledge of a variety of interviewing techniques that facilitate:
  1. effective understanding of the concerns of children, adolescents, and families
  2. effective communication including education about psychiatric disorders and their treatments
  3. establishment and maintenance of a therapeutic contract and therapeutic alliance
  4. delivery and reception of difficult information in an empathetic manner
  5. the impact of the patient’s emotional reactions and associations to the therapist (and vice versa) on psychiatric evaluation and treatment
  6. techniques for communicating effectively with allied professionals
  7. the structure and function of multidisciplinary teams in various settings
  8. cultural differences and their impact

Please list by name or letter, in the comment box below, those sub-elements which need improvement. Include comments and/or observations.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>C</td>
</tr>
</tbody>
</table>

### Comments

Remaining Characters: 5000

**Q8.**

### Required | LSN | HSN | Individual Comments
---|-----|-----|---------------------
N | N   | N   | Y                   

Grade Scale used: Excellent / Satisfactory / N/A
INTERPERSONAL AND COMMUNICATION SKILLS

INTERPERSONAL AND COMMUNICATION SKILLS

Skills:
The resident demonstrates the following interpersonal and communication skills:
a. Communicates effectively with colleagues, staff, and multiple systems.
b. Listens to, understands and communicates effectively with children, adolescents, and families.
c. Creates and sustains a therapeutic alliance with patients and families.
d. Educates children, families, and professionals about medical, psychological and behavioral issues in a clear and effective manner.
e. Works effectively within multidisciplinary team structures as a member, consultant or leader.
f. Collects and provides information using multiple skills, including effective listening, nonverbal, explanatory, questioning, and writing skills.

Please list by name or letter, in the comment box below, those sub elements which need improvement. Include comments and/or observations.

Excellent Satisfactory Need(s) Improvement N/A

1 2 3

Comments:

Remaining Characters: 5000

Q9.

INTERPERSONAL AND COMMUNICATION SKILLS

Attitudes:
The resident exhibits the following qualities and behaviors:
a. An underlying attitudes of respect for others, even those with differing points of view or from different backgrounds.
b. The desire to gain understanding of another's position and reasoning.
c. A belief in the intrinsic worth of other human beings.
d. The wish to build collaboration and achieve mutual understanding.
e. The desire to share information to an open, rather than dogmatic, fashion.
f. The willingness to continuously self-observe and confront one's own biases and emotional reactions, and

g. A willingness to act as the patient's advocate as indicated.

Please list by name or letter, in the comment box below, those sub elements which need improvement. Include comments and/or observations.

Excellent Satisfactory Need(s) Improvement N/A

1 2 3

Comments:

Remaining Characters: 5000
**Q10.**

<table>
<thead>
<tr>
<th>Required</th>
<th>LS</th>
<th>HS</th>
<th>N</th>
<th>N</th>
<th>N</th>
<th>N</th>
<th>Y</th>
<th>Individual Comments</th>
</tr>
</thead>
</table>

**PROFESSIONALISM**

**Knowledge:**
The resident demonstrates an adequate fund of knowledge in the following areas:

- The AAPA Code of ethics
- Legal and ethical principles
- Confidentiality
- The minor's and guardian's rights to receive and refuse treatment
- Voluntary commitment
- Assent and consent principles in research
- Cultural competence in the areas of:
  - Cultural diversity of the US population and cultural differences on children's development
  - Cultural influences on identification of mental health problems and help seeking behavior
  - Race-cultural influences in psychopharmacology and psychosocial interventions

Please list by name or letter, in the comment box below, those sub elements which need improvement. Include comments and/or observations.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

Remaining Characters: 5000

---

**Q11.**

<table>
<thead>
<tr>
<th>Required</th>
<th>LS</th>
<th>HS</th>
<th>N</th>
<th>N</th>
<th>N</th>
<th>N</th>
<th>Y</th>
<th>Individual Comments</th>
</tr>
</thead>
</table>

**PROFESSIONALISM**

**Skills:**
The resident demonstrates the following skills:

- To review and discuss the institutional and governmental ethical guidelines
- Legal and ethical principles
- To obtain and discuss treatment consent forms
- To observe and participate in involuntary commitment procedures
- To review and discuss research consent/assent forms
- Cultural competencies
- To interview children and families from different ethnic groups with openness and sensitivity to cultural differences and communication
- To formulate treatment plans which are culturally sensitive to the child's and parent's concept of mental illness
- To provide clinical care with an understanding of possible cultural differences in treatment expectations
- To work with health care system's professionals of diverse backgrounds

Please list by name or letter, in the comment box below, those sub elements which need improvement. Include comments and/or observations.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

---

175
Q12. PROFESSIONALISM

PROFESSIONALISM ATTITUDES:

The resident exhibits the following qualities and behaviors:

a. Exhibits culturally sensitive, professional, ethically sound behavior and attitudes in all patient and professional interactions.
b. Adequately understands the legal and ethical principles of confidentiality, minor's and guardian's rights to receive and refuse treatment, and involuntary commitment.
c. Maintains professional and appropriate interactions with treatment teams, peers and supervisors, seeks support as needed, handles differences openly, tactfully and effectively; maintains professional functions and quality patient care.
d. Efficient in accomplishing tasks without prompting, deadlines or reminders. Keeps supervisors aware of whereabouts as needed. Minimizes unplanned leaves, whenever possible.
e. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables and provides clinical care with treatment and understanding of possible cultural differences in treatment expectations.
f. Makes themselves available. Please list by name or letter. In the comment box below, those sub elements which need improvement include comments and/or observations.

Excellent Satisfactory Need(s) Improvement N/A

Comments

Remaining Characters: 5000

Q13. PRACTICE-BASED LEARNING AND IMPROVEMENT

PRACTICE-BASED LEARNING AND IMPROVEMENT

Knowledge:
The resident demonstrates an adequate fund of knowledge in the following areas:

a. Recognize that knowledge is inherently incomplete.
b. Be able to investigate, evaluate and improve their patient care practices.
Please list by name or letter, in the comment box below, those sub elements which need improvement. Include comments and/or observations.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5000

Q14.

PRACTICE-BASED LEARNING AND IMPROVEMENT

SKILLS:
The resident demonstrates the following skills:

a. Accurately assess knowledge, clinical abilities, and practice-based improvement activities using a systematic methodology. Examples of such an approach may include developing a learning and skill development program, as well as critical assessment of new knowledge and techniques and their applicability to one's practice.
b. Locate, appraise and assimilate "best practices", practice parameters and treatment guidelines that are relevant to the care of childhood psychiatric disorders.
c. Acquire and integrate information from a variety of sources, including electronic databases, scientific literature, presentations and consultations, to support clinical care, patient education and one's own education.

Include comments and/or observations.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5000

Q15.

PRACTICE-BASED LEARNING AND IMPROVEMENT

ATTITUDES:
The resident exhibits the following qualities and behaviors:

c. Recognize the need for lifelong learning and monitoring of one's own practice.
**Q16.**

**SYSTEM-BASED PRACTICE**

**SYSTEMS BASED CARE**

Knowledge:
The resident demonstrates an adequate fund of knowledge in the following areas:

- a. Understands the concepts of systems theory.
- b. Demonstrates a working knowledge of the diverse systems involved in treating children and adolescents, and understand how to use the systems as part of a comprehensive system of care in general, and as part of a comprehensive, individualized treatment plan. The resident should also have an understanding of the consultation role with multiple systems and agencies and be able to demonstrate knowledge of consultation principles.

Please list by name or letter, in the comment box below, those sub elements which need improvement. Include comments and/or observations.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**Q17.**

**SYSTEM-BASED PRACTICE**

**SYSTEM BASED CARE**

Skills:
The resident demonstrates the following skills:
a. Advocates for quality patient care.
b. Effectively utilizes hospital resources to achieve appropriate patient care.
c. Effectively utilizes community resources to achieve appropriate patient care.
d. Provides appropriate patient care follow up.
e. Coordinates inpatient and outpatient care.
f. The resident uses practice guidelines when appropriate.
g. Works effectively with nursing staff and ancillary health care personnel and effectively collaborates in developing a shared treatment plan.
h. Demonstrates knowledge of the diverse systems involved in treating children and adolescents.
i. Integrates multiple systems of care in treatment planning.
Please list by name or letter, in the comment box below, those sub elements which need improvement. Include comments and/or observations.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c</td>
<td>c</td>
<td></td>
<td>c</td>
</tr>
</tbody>
</table>

**Comments**

Remaining Characters: 5000

---

**SYSTEM-BASED PRACTICE**

**SYSTEM BASED CARE**

**Attitudes:**

a. The resident should develop attitudes that reflect respect for the patient, family and other caregivers

b. Expectations

i. works in a mutually respectful, culturally competent manner

ii. acts in the best interest of the child and family

iii. utilizes the concept of "least restrictive environment"

iv. provides treatment services as close to home as possible

v. expects to collaborate with others to enhance a child or adolescent's situation

Please list by name or letter, in the comment box below, those sub elements which need improvement. Include comments and/or observations.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c</td>
<td>c</td>
<td></td>
<td>c</td>
</tr>
</tbody>
</table>

**Comments**

Remaining Characters: 5000

---

**Q19.**
TEACHING ABILITIES

The resident demonstrates adequate teaching abilities.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5000

Q20.  

COMMENTS

Resident's overall clinical competence in rotation

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Satisfactory</th>
<th>Need(s) Improvement</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5000
Thoughtful input from residents is a key component in the program’s evaluation process.

For this reason, ACGME requires that programs or institutions have a system through which residents are able to “raise and resolve issues without fear of intimidation or retaliation.”

The program requires residents to complete confidential evaluations on New Innovations twice per year.

Nevertheless, in order to ensure the most candid feedback, the Child and Adolescent Psychiatry Training Committee appointed an ombudsman in Dr. Teresa Carreno. Dr. Carreno is not directly involved in the residency Training Program. She will be available to listen to any concerns and report them to the Training Committee, keeping the individual anonymous.

Dr. Carreno can be contacted at:
305-595-1616
tcarreno@mdpc.cc.