San Mateo Medical Center
Integrated Behavioral Health (IBH)
Postdoctoral Fellowship
Program Manual

2021 – 2022

SAN MATEO COUNTY HEALTH

SAN MATEO MEDICAL CENTER

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Introduction

Welcome to San Mateo Medical Center (SMMC) Postdoctoral Fellowship training program! Most of the knowledge and skills we plan to teach are described in this manual. It is our guide upon which we will evaluate your progress, and we have made every effort to describe the skills in operational terms. By covering this material, we hope to consolidate your general clinical skills to recognize and handle a psychiatric crisis, complete an accurate psychological assessment, and conduct a variety of short-term psychological interventions with a broad range of patients who may have comorbid medical issues. You will be exposed to the ethical issues that psychologists commonly encounter and the skills required to work effectively with medical care providers.

A great deal is included in this manual, and not every Fellow will be exposed to every condition within it. However, this manual can serve as a working guide to better understand how this training program views competence and excellence. It can provide a guideline for Fellows working under supervision to follow when they take on cases in areas that they may not have previously explored. It is meant to create a positive structure and to outline our expectations for specific types of work. Finally, it lays out certain administrative aspects of the Fellowship program with which every trainee should be familiar.

Training Program Mission and Values

Our training program emphasizes utilization of scientific literature to inform and shape clinical practice in a culturally sensitive manner. We value and strongly promote regular collaboration with multidisciplinary medical teams to ensure that all aspects of biological, psychological, and social functioning are considered in the assessment, diagnosis, and formulation of patient care. We have a commitment to diversity and multicultural awareness in all aspects of our training and practice. Our mission is to provide culturally sensitive and compassionate behavioral health care to those in need, regardless of their ability to pay. We also aim to foster well-rounded health psychologists through the variety of formal training and clinical experiences that we offer. Satisfactory completion of the Fellowship training program meets the Postdoctoral supervised practice requirements for licensure with the California Board of Psychology.

San Mateo Medical Center's Training History

San Mateo County Health System has historically provided training to various types of mental health trainees including psychiatry residents, MFT interns, social work interns and psychology practicum students, interns and postdoctoral fellows since the opening of outpatient community mental health clinics in the 1970s and 80s. Integrated Behavioral Health (IBH) services at SMMC began training psychology doctoral students in 2004. The IBH training program draws from various disciplines including psychiatry, internal medicine, and medical specialties. Currently, we have three Postdoctoral Fellowship positions available each training year. Fellows must have completed all doctoral degree requirements from an APA-accredited program as well as an APPIC-member internship before beginning postdoctoral training.

Population Served

As a county hospital, SMMC serves a medically-underserved population who faces economic, cultural, and/or linguistic barriers to health care. Fellows treat patients who represent diversity in race, ethnicity, age, culture, socioeconomic status, disability status, sexual orientation, and clinical severity. A vast majority of SMMC's patient population either receives publicly-funded health insurance (Medicare, Medi-Cal, or the County's insurance program for undocumented residents, ACE) or is uninsured. Many of our patients are homeless or have low income, disabilities, and/or limited educational backgrounds. Some of our patients have no formal education and have low literacy. We serve individuals from various ethnic backgrounds, including but not limited to Latinx, African-American, Caucasian, Asian, and Pacific Islanders. Fellows provide psychological services to our adult clinics, but also have opportunities to work with young adults and the elderly population.

Integrated Behavioral Health also provides linguistically- and culturally-sensitive evaluations and treatment to a large immigrant population, mostly monolingual Spanish-speaking, with psychiatric issues. These issues include acculturation, immigration abuse/trauma, somatic complaints, difficulty maintaining tradition and family, and building community connections. Fellows may consult with bilingual, bicultural staff to provide these services. Medical interpretation services are often needed and easily accessible to Fellows including by video and phone.

For our outpatient psychotherapy services, most IBH referrals come from SMMC's Primary Care Clinics, but we also support medical specialties such as Endocrinology, Neurology, and Cardiology. Typical referrals addressed by IBH are for individuals with mild to moderate psychopathology and consist of depression, anxiety, trauma, bipolar II disorder, relationship problems, stress or adjustment disorders related to patients' medical or social issues. In general, we provide individual and group therapy as well as educational classes, with occasional opportunities to engage in couples therapy. Our services span specialty categories of health psychology, behavioral medicine, and community mental health, whereas preferred treatment modalities are brief and evidence-based.

Separately, IBH supports the provision of psychological assessment and therapy services to various parts of the hospital, encompassing psychodiagnostic and neuropsychological testing. Referral conditions include victims of cerebrovascular accident and stroke, geriatric populations experiencing new onset memory difficulties, dementia, Parkinson's, mental health patients experiencing cognitive impairment, substance abuse, and adults with various somatoform disorders, traumatic brain injuries and other psychiatric illnesses.

Training Objectives, Goals, and Competencies

The primary focus of training is primary care behavioral health, particularly brief evidence-based individual and group psychotherapy in a medical context. Our model is best described as practitioner-scholar, with an emphasis on research-supported clinical practice. Our approach is integrationist, within the realm of empirically-supported practice, and broadly biopsychosocial, incorporating different theories and orientations, while always keeping in mind individual patient characteristics (including cultural considerations) and preferences. We recognize as well that individual Fellow characteristics and preferences are an important consideration in training. Training, like therapy, is a process that works best when it is flexible and individualized. Our goal is to help Fellows develop their own perspective on brief psychotherapy, while providing the didactic, supervisory, and experiential opportunities to move them closer to integrating evidence-based frameworks and techniques.

Other foci of training include clinical assessment, crisis intervention, psychoeducation, community outreach, and collaboration with multidisciplinary medical teams. With regard to neuropsychological assessment rotation, there is an emphasis on choosing, administering, and interpreting empirically validated measures in a clinically and culturally sensitive but largely standardized approach. The use of contemporary peer-reviewed research in neuropsychology informs assessment methodology, case formulation, and treatment recommendations.

Our overarching training program goals and objectives are as follows:

Goal 1: Help prepare our Fellows to be competent, ethical health service psychologists. By the end of the training year, Fellows will be expected to:

a) Demonstrate awareness, knowledge, and appreciation of the role of cultural and individual diversity in the professional practice of psychology.
b) Demonstrate the ability to independently conduct competent psychological intakes/assessments/evaluations in a medical setting. (Assessment rotation: perform competent neuropsychological evaluations.)
c) Demonstrate the ability to independently provide competent case formulations and choose appropriate, empirically-supported interventions.
d) Demonstrate understanding of applicable laws and ethical principles.
e) Demonstrate appropriate professionalism and socialization for independent practice within the field of psychology, including appropriate use of supervision and consultation.

Goal 2: Produce clinicians who can work effectively and ethically in a multidisciplinary medical environment. Toward this end, we strive to develop Fellows' abilities to:

a) Collaborate and communicate assertively and respectfully with medical providers, in person and in writing.
b) Gain the requisite medical knowledge to effectively treat patients with chronic health conditions (Assessment rotation: deepen the requisite knowledge to understand brain-behavior correlations as they pertain to relevant neurological damage/disorders).
c) Understand and employ the principles of integrated behavioral health.
d) Gain experience and comfort working in outpatient clinic, medical inpatient, and/or psychiatric inpatient settings.

e) Function increasingly independently in their roles as mental health providers in a medical setting.

Within these training objectives, Fellows are expected to develop the following competencies: (a) appreciation of individual and cultural differences as they affect psychology and the psychotherapeutic relationship; (b) utilize research literature and personal competencies to choose appropriate empirically-supported interventions; (c) ability to establish and maintain rapport in therapy, and deliver empirically-supported time-limited treatments; (d) knowledge of the medical and psychological aspects of chronic health conditions; (e) function as a member of a multidisciplinary team; (f) demonstrate knowledge of the APA ethics code; (g) seek consultation with supervisor regarding ethical issues if/and when appropriate; (h) manage his or her clinical schedule and provide outreach to patients and community agencies; (i) provide succinct and accurate notes for the medical record.

Training Location

San Mateo Medical Center (SMMC) is an approximately 100-bed county hospital that provides inpatient and outpatient medical and psychiatric services to low-income county residents. In addition to the main hospital location, SMMC also manages several community clinics, including our Redwood City location, Fair Oaks Health Center (FOHC). Integrated Behavioral Health works in partnership with primary care and specialty clinics in the care of a diverse patient population at SMMC's main hospital and at FOHC. Fellows typically provide clinical and assessment services at both locations in any given week. At times, transfer between the clinics will be needed during the workday. San Mateo County offers transportation options for the Fellows main place of work to the affiliated field clinics, if needed. Under certain circumstances, Fellows may also provide telehealth services from one of the clinic locations or via telework, if appropriate. .

Training Description

The 12-month, full-time (40 hours/week; minimum of 1800 hours of supervised professional experience per training year with a target of at least 2000 hours) psychology Postdoctoral Fellowship at SMMC offers training and experience in several aspects of health psychology and behavioral medicine. It is sequential and cumulative, and is designed to produce competent, ethical, independently functioning clinicians, ready to enter the field of professional psychology. The training program encompasses not only primary care and medical specialties, but also include service provision arrangements with the medical and psychiatric inpatient units.

Fellows work alongside primary care providers, medical specialists, nurses, social workers, and medical assistants to offer comprehensive, collaborative care to our patients. We primarily provide individual and group therapy as well as outreach and workshops, with limited opportunities to engage in couples therapy. Services are provided both in-person and via tele-behavioral health.

The training program is seamlessly integrated into the larger IBH organization. In most cases, Fellows provide substantially similar services as IBH staff psychologists, but are uniquely supported through participation in staff meetings, case consultations, didactic seminars, individual and group supervision. Every IBH psychologist is involved in training activities to a

significant degree, from didactic instruction to supervision. During their training, Fellows are in daily contact with IBH and primary care staff. Professional socialization, one of our training goals, emerges naturally in this close, collegial environment.

Integrated Behavioral Health provides a breadth of training in the following ways:

(1) Exposing Fellows to a broad array of patient populations (e.g., patients with chronic illness, medical and/or psychiatric inpatients); medical settings (e.g., primary-care clinic, specialty clinics, acute medical inpatient unit); and psychological interventions (e.g., short-term psychotherapy, risk assessment, crisis intervention). In each setting, Fellows are appropriately instructed and/or supervised, and there is usually a formal didactic component tailored to the setting. A crucial aspect of Fellows' experience is interfacing closely with medical teams and social workers.

(2) Individual supervision. Each Fellow has both a primary and secondary staff psychologist supervisor and may also receive supplementary supervision from clinical psychologists or psychiatrists on an ad hoc basis as appropriate. In addition, Fellows receive instruction and oversight by licensed psychologists and board-certified psychiatrists specific to each rotation.

(3) Group supervision. Fellows meet as a group for two hours per week to present cases and discuss diagnoses, psychotherapy models, and other issues associated with the psychological services we offer here (e.g., coordinating with medical staff, cultural issues, etc.)

(4) Supervision for group therapy and/or supervision in clinical psychology. Fellows are expected to design and co-facilitate several outpatient psychotherapy groups during the year. Regular meetings are devoted to discussing psychotherapy groups, problem-solving, and learning group theories and practices to promote clinical growth in this treatment modality. In addition, the fundamentals of supervision in clinical psychology are explored and practiced with the Fellows in didactics, seminars, or special trainings.

Training Rotations

YEAR-LONG TRAINING AND DUTIES

Throughout the year, Fellows carry a caseload of individual therapy outpatients, averaging 20-30 at any one time, as not all patients are followed weekly. In addition, trainees conduct 3-6 intake evaluations per week. A majority of the clinical presentations we encounter are depression, anxiety, trauma, interpersonal issues, stress, and adjustment disorders related to patients' medical, psychological, and/or social issues. (Patients with severe mental illness, acute substance use, or criminal justice involvement are referred to other, more specialized county mental health agencies.) Our patient population is very diverse, and a large proportion of our patients are monolingual Spanish speakers. For them, we provide Spanish-speaking clinicians, telephonic, video, or in-person interpreter services. (Interpretation services are also available in many other languages). The clinic utilizes a short-term, evidence-based model of psychotherapy; however, Fellows are also able to see a couple of patients for long-term treatment. On occasion, Fellows may have the opportunity to provide couples therapy, neuropsychological evaluations, and/or personality testing according to the patients' needs. Psychotherapy services are typically offered in-person, but an increasing number of encounters are taking place over HIPAA-compliant telehealth platforms.

Throughout the year, Fellows design and co-facilitate outpatient therapy groups, generally 6-12 weeks in length. Past groups have included CBT for Depression, Mindfulness, Acceptance and Commitment Therapy (ACT), Weight Management, Diabetes, and CBT-Insomnia groups, among others. They also lead or co-lead open workshops covering mental health topics of general interest to the hospital population such as stress management, mood management, mindful movement, and sleep health. Most groups and workshops are offered with simultaneous interpretation in Spanish.

CLINICAL SERVICE ROTATIONS:

Primary Care Behavioral Health: All Fellows will participate in this foundational yearlong rotation that integrates primary care providers and the behavioral health team to offer comprehensive care to our patients with both acute crises and chronic illness. Fellows are available to medical staff on an on-call basis to respond to any urgent psychological patient needs and to orient patients to behavioral health concerns. Fellows utilize crisis interventions and conduct brief assessments to support the patient and/or staff members. Fellows also provide short-term treatment targeting chronic medical conditions (e.g., diabetes, heart disease, obesity) leveraging individual or group therapy or medication referrals to help patients effectively manage the psychosocial issues associated with their chronic illnesses. Being knowledgeable and efficient with diagnosis and crisis management is necessary in this role and these positions are highly visible within the medical center.

Consultation Liaison (CL): All Fellows will rotate through the CL placement for 2-4 discrete weeks each during the training year, providing comprehensive psychological care for patients on the acute inpatient and long-term care medical units. Under the guidance of a psychiatrist, Fellows learn the skills of chart reading, acute psychiatric assessment, and medical note writing, and have the opportunity to follow certain patients for the duration of their hospitalization. Fellows often consult and collaborate with physicians, nurses, and social workers. As they shadow a CL psychiatrist for the entirety of their work week, they will receive one-on-one didactics on topics ranging from medical issues such as dementia, delirium, cardiac, endocrine, or gastroenterology concerns, to legal and ethical matters such as psychiatric holds and decision-making capacity.

Neuropsychology/Assessment: One of the IBH Fellows can participate in an adjunct yearlong rotation working on SMMC's neuropsychology/assessment services for 40% of their time (two days/week). The primary focus of Assessment rotation is to train Fellows in completing comprehensive neuropsychological evaluations for outpatients and, less often, inpatients, thereby deepening their knowledge to understand brain-behavior correlations as they pertain to relevant neurological damage/disorders. Most outpatients are cared by our Senior Care Center and present with a wide variety of psychopathology, personality disorders, cognitive and neurodegenerative conditions. Duties include clinical interviewing, test administration, report writing, and feedback delivery. In the Assessment rotation, Fellows receive one hour per week of secondary supervision by a neuropsychologist.

Pain Management Clinic: One of the IBH Fellows can participate in an adjunct yearlong rotation working on SMMC's multidisciplinary Pain Management Clinic (PMC) for 20% of their time (one day/week). The goal of SMMC's PMC is to affect change in our patient's lives by

increasing physical functioning, improving pain coping skills, and restoring quality of life. The Fellow will have the opportunity to learn directly from and be supervised by PMC team members and will apply Cognitive-Behavioral Therapy (CBT), Mindfulness, and Acceptance and Commitment Therapy (ACT) in the treatment of chronic pain disorders. They will embrace a bio-psycho-social model and learn the roles and responsibilities of a pain psychologist through co-facilitation of psychotherapy groups and provision of individual therapy.

Gender Clinic: One of the IBH Fellows can participate in an adjunct yearlong rotation working on SMMC's gender clinic for up to 10% of their clinic time. SMMC's gender care multi-disciplinary team offers gender-expansive patients with access to hormone therapy, psychotherapy, gender-reassignment surgery evaluations, referrals, and social work support in a gender-affirming space. Fellows participate in monthly clinic team meetings and follow gender clinic patients for individual psychotherapy and for surgery evaluations during their clinic time.

Biofeedback Clinic: One of the IBH Fellows can participate in an adjunct yearlong rotation working in SMMC's Biofeedback Clinic for approximately 10-20% of their week (up to one day/week). The Biofeedback Clinic offers psychophysiological treatment of stress, anxiety symptoms, headaches/other pain presentations, hypertension and somatization issues. The Fellow will have the opportunity to engage in didactic and mentored learning to build their capacity to successfully administer biofeedback treatments. Didactic learning includes selected articles, slide presentations and videos; mentored learning will involve direct observation (i.e. co-treatment, observation of staff psychologist and observation of trainee), supervision, coaching and consultation by a biofeedback-trained IBH psychologist. Particularly in the beginning of the rotation, mentored learning will occur for one hour per week in addition to direct clinical care. Over-arching training goals include 1) to develop an understanding of psychophysiology, 2) the ability to administer a 5-session biofeedback protocol, 3) to utilize multiple biofeedback modalities and 4) to learn how to blend psychotherapy with biofeedback.

In-Patient Services: One of the IBH Fellows can participate in an adjunct yearlong rotation working with patients admitted to one of SMMC's skilled nursing, rehabilitation or psychiatry units for approximately 5-10% of their week (up to half a day/week). This rotation provides a Fellow with the opportunity to conduct very short-term behavioral interventions to patients during their in-patient stays. Common referrals include anxiety (e.g., about using a walker after a fall), depressed mood after surgery, loss of functioning, coping with new diagnoses, behavioral problems etc.

Supervision

Supervision (primary and secondary) is provided by licensed psychologists on the IBH staff. Fellows are provided at least 10% of their total weekly hours in the form of individual and group supervision. At a minimum, Fellows receive two hours of face-to-face weekly supervision with their primary and delegated supervisors, who are licensed psychologists. Group supervision takes place on a weekly basis for two hours by a licensed psychologist or a board-certified psychiatrist. Supervision time is protected and ensured each week. Supervisors arrange alternate supervision times for Fellows during absences and supervisees are encouraged to seek additional supervision as needed.

Supervision is intended to foster clinical growth while developing professional independence. It is based on verbal accounts, direct observation, and video recordings of therapy sessions. During individual and group supervision, ethical principles and behaviors are frequently reviewed as they relate to the Fellows' caseload. Fellows are encouraged to utilize supervision to develop their clinical skills, enhance their diagnostic abilities, as well as discuss issues relevant to their professional growth.

Our training program greatly values regular feedback to Fellows focused on their clinical and professional growth. During the training year, supervisors complete a mid-year and end-of-year written evaluation and review them with their supervisee(s). Based on the outcome of this evaluation, the Fellow's specific goals and expectations may be revisited. In addition to this evaluation process, Fellows will receive regular feedback through the course of their training year.

Our program also values the development of self-reflection and active engagement in one's own professional growth. An individualized supervision plan is developed between the supervisee and the supervisor at the outset of the supervisory relationship, considering the Fellow's goals for their postdoctoral experience. At the start and end of the training year, Fellows are encouraged to evaluate their skillset, using the rubric found in the mid-year and end-of-year evaluation form as a guideline, and to discuss areas of strength and opportunities with their supervisor.

The Training Director oversees the IBH postdoctoral fellowship program across all sites, being closely involved in didactic programming, clinical consultation, program development, and certain professional development activities such as training in supervision. The training director meets regularly with all Fellows to monitor progress and assess opportunities for change and improvement, if any. In addition, the training director is available throughout the week to both Fellows and supervisors in-person, phone, text, email, or video call, as needed.

All supervisors are employees of San Mateo Medical Center. Currently, there are nine full- and part-time licensed clinical psychologists and one full-time psychiatrist who serve as regular supervisors in the postdoctoral fellowship program. All supervisors are significantly involved in the training program through individual supervision, group supervision, didactics presentations, co-facilitation of group psychotherapy and outreach workshops, as well as by providing input for training program monitoring and development. SMMC supervisors share a specialization area in primary care behavioral health, which is the main focus area of the training program, acquired via clinical training (several supervisors have completed postdoctoral fellowships on behavioral medicine and similar topic areas), coursework (all supervisors participate in continuing education sponsored by SMMC and outside sources regularly), and direct practice. They maintain professional responsibility for all cases followed by each fellow by i) discussing cases in supervision, ii) reviewing and counter-signing all assessment reports, progress notes, and patient communication records, and iii) reviewing video or audio recordings of clinical encounters when available.

Group Supervision

Group supervision focuses on consolidating and integrating clinical skills. In addition to giving and receiving feedback from colleagues on case presentations, group supervision allows for

unique opportunities to discuss multiple and often controversial issues in the ever-evolving field of psychology and the subspecialty of health psychology. Group supervision focuses on evidence-based therapeutic modalities associated with cultural diversity of patients and Fellows, therapeutic relationships, therapy processes and outcomes, as well as self-assessments.

Structure of Group Supervision

Each Fellow is responsible for several case presentations throughout the training year. This series of presentations begins once the Fellow gets established with their outpatient caseload and clinical rotations. Group supervision is divided into case presentation/feedback and discussion of professional issues/concerns. This open discussion allows for reflection on professional development topics, theoretical discussions, interventions, personal issues as they arise, transference and countertransference issues, and other therapy-related angles.

Active group participation in discussions is essential to group supervision/case consultation. Readings of book chapters and recent research articles are often assigned to ground discussion and expand knowledge. Fellows are expected to complete the readings and be prepared to discuss them in supervision.

Didactic Training

For two to three hours each week, Fellows attend a didactic seminar that provides training on professionally relevant topics such as psychiatric disorders, psychological interventions, and various medical disorders affecting cognitive and emotional functioning. Most of the seminars are jointly attended by both psychology postdoctoral fellows and psychiatry residents.

The didactic seminar focuses on three major areas including:

i) empirically-based clinical interventions, assessment of various medical and psychiatric conditions and their treatment implications, e.g. psychiatric illnesses, specific cognitive-behavioral interventions or therapy types, neuropathology & neurodegenerative disorders, cognitive assessment;
ii) multi-cultural competency-based trainings focused on particular ethnic or cultural populations, e.g. cultural humility, therapy skills focused on special populations, cultural and ethical considerations in assessment and treatment.
iii) professional development issues in developing a professional identity as a psychologist;

These didactic seminars are grounded in evidenced-based practice and legal and ethical guidelines, and presented by licensed psychologists and psychiatrists, as well as invited guests and psychiatry residents.

Didactic seminars may include up to four additional hours of Grand Rounds presentations per month, covering Psychiatry, Primary Care, and Hospital grand rounds. Grand round presentations may take place at SMMC main campus, FOHC, offsite county locations, or online.

Additional Didactic Information:

- Fellows are expected to attend all didactic seminars, unless discussed in advance with their primary supervisor and/or training director. Fellows are asked to notify their primary supervisor and program coordinator if they are unable to attend.
- Didactic seminars are typically held on Fridays from 8:30am-10:30am (for psychology only) or 9:00am-12:00pm (jointly with psychiatry residents) at one of SMMC's conference rooms or via online meeting programs.
- Fellows are expected to be prepared for and actively participate in all didactic trainings. On occasion, Fellows may be asked to present a case relevant to the didactic topic.
- Fellows are required to complete Didactic Training Evaluation Forms following each weekly presentation.
- In addition to didactic training, clinical rotations may trainings focused on specialized evidence-based treatment and case discussion.

Work Schedule

Most fellowship hours are completed Monday through Friday, between 8am and 5pm. Some rotations may allow evening hours, but these instances are infrequent and are subject to supervisor approval. Fellows may not work more than 44 hours per week. Fellows are asked to complete their Supervised Professional Experience (SPE) log on a weekly basis and to provide a copy of their SPE log to the training director or assistant training director at the end of each month.

Distribution of Training Hours

A sample of a typical weekly distribution of time for a Fellow is detailed below:

<u>Direct Clinical Service:</u>
15-25 hours of face-to-face outpatient psychotherapy (individual and group)
4-12 hours of assessment/consultation service

<u>Training and Supervision:</u>
2 hours of individual supervision (in-person with primary and secondary supervisors)
2 hours of group supervision
3 hours didactics and seminars, mostly coordinated with the Psychiatry residency program and including attendance of Psychiatry, Primary Care and/or Hospital Grand Rounds

<u>Clinical Support and Professional Development:</u>
0.5 hour case consultation/schedule coordination per day
1.5 hour weekly staff meeting
4-6 hours for documentation/administrative duties (e.g. outreach calls, note-writing)

Seminar topics include topics related to Health Psychology, Professional Development, psychotherapy techniques, assessment/ neuropsychology, supervision, and professional development. Didactic seminars are often conducted in conjunction with the psychiatry residency program and presented by staff psychologist, psychiatrists, other licensed medical and mental health professionals.

Compensation

Postdoctoral Fellows receive a regionally competitive financial stipend of $57,000 paid as an hourly wage with a 12-month training commitment. The full stipend accounts for the allotted time off and county holidays and assumes 40 work hours weekly for the duration of the training period. If worked hours fall below that, the final stipend may also be below its target. Fellows also have access to health care benefits, on-site fitness facility, free parking, and a monthly credit if using public transportation. Fellows are required to submit their actual work hours onto the county's payroll system by end-of-day on the Friday of each week.

Holidays and Leave

Paid time-off during the fellowship encompasses 12 designated San Mateo County holidays, 10 days of vacation, 5 days of professional leave time for conferences and preparing for licensure, as well as sick days. Professional leave time for conferences, licensure examinations, and job interviews may be credited as training hours, when appropriate, but requests must be reasonable, made in advance and in writing, and cleared by the primary supervisor and training director. San Mateo County observes the following holidays: Labor Day, Columbus/Indigenous Peoples' Day, Veterans Day, Thanksgiving Day, Day After Thanksgiving, Christmas Day, New Year's Day, Martin Luther King, Jr., Presidents Day, Memorial Day, Fourth July.

All time off requests must be approved by both the primary supervisor and training director; time off requests are not guaranteed. No more than two Fellows can take time off at any given time.

Training Resources

Designated psychotherapy offices are located in outpatient clinics at SMMC and FOHC, where patient services are provided. Most training activities take place at SMMC. Fellows are assigned a dedicated or shared work space, depending on work schedules. Fellows are responsible for clerical duties such as documentation, scheduling, and outreach to patients; however, full-time clerical support is provided throughout the training year. Fellows also have access to San Mateo Health System's online learning management system and online educational library, which consists of several medical and psychiatry resources. Fellows are assigned lab tops with appropriate security systems to be used when teleworking.

Fellow Rights and Responsibilities, Due Process Policy, and Grievance Procedure

FELLOW RIGHTS AND RESPONSIBILITIES:

FELLOW RIGHTS:
Throughout the training year, the IBH training program and staff are responsible for respecting the following Fellow rights to:

1. Receive a clear statement of the standards, expectations, and goals by which they are evaluated, at the commencement of training.
2. Receive training by licensed clinicians who behave in accordance with APA Ethical Principles and Code of Conduct, through supervision and didactic training.
3. Be treated with professional respect and recognition of skills and experience a Fellow brings to the program.
4. Ongoing evaluation that is respectful, pertinent, and constructive through supervision and formal biannual written evaluations.
5. Provide ongoing feedback about progress and/or concerns regarding the IBH training program or staff. Should there be a concern, Fellows have a right to informally or formally address their concern through a meeting with the individual concerned, individual supervision, meeting with the training director, biannual evaluations, grievance procedures, or APPIC's informal problem consultation process (www.appic.org/problemconsultation).
6. Due process procedures.

FELLOW RESPONSIBILITIES:
Fellows have the following responsibilities to:

1. Ensure clear understanding of Fellow rights and responsibilities by reviewing them and seeking clarification when necessary.
2. Function in accordance with the APA Ethical Principles and Code of Conduct.
3. Function in accordance with the laws and regulations of the State of California.
4. Function in accordance with the policies and procedures of Integrated Behavioral Health and San Mateo Medical Center.
5. Demonstrate proficiency in relevant clinical and administrative skills necessary to successfully perform the duties of the Fellowship in integrated behavioral health.
6. Demonstrate openness and professionalism when providing and receiving feedback from supervisors, peers, and staff, including if due process is initiated.
7. Demonstrate awareness, sensitivity, and responsiveness to cultural and individual diversity.
8. Participate in training, service, continuing education, and overall IBH activities.

DUE PROCESS POLICY AND PROCEDURES:

SUBJECT: Procedures for resolving conduct and performance problems within the Psychology training program.

PURPOSE: This due process document provides Fellows and staff with definitions and appropriate courses of action to respond to problems with conduct or performance. It also reviews available options for remediation and due process. During the orientation period, Fellows will be informed of all policies/procedures and will receive in writing Integrated Behavioral Health Services' expectations related to professional functioning. The training director will also discuss these expectations in both group and individual settings. Primary supervisors will explain evaluation procedures to Fellows at the start of the training year, which will include how and when evaluations will be conducted.

If a Fellow fails to meet accepted standards of conduct or performance, she/he/they may be subject to corrective or disciplinary action. Corrective action includes verbal and written counseling, warning letters, and letters of reprimand. Disciplinary actions include suspensions of clinical duties, disciplinary letters and dismissal.

DEFINITIONS:

Defining Conduct Problems:
Conduct problems include but are not limited to: absence without leave; conviction of a criminal offense which is substantially related to the Fellow's position; dishonesty; damage to public property or waste of public supplies or time through willful misconduct; insubordination; sexual harassment; disrespectful or discourteous conduct toward a County officer or official, another employee or member of the public; excessive absenteeism or tardiness; impairment due to being under the influence of alcohol or drugs while at work or the use of alcohol or drugs during working hours except where such drugs have been prescribed and are being used in accordance with specific instructions from a licensed physician; or failure to meet the terms of her/his/their contract.

Defining Performance Problems:
Fellow performance problems may include but are not limited to the following: (1) an inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior; (2) an inability to acquire professional skills in order to reach an acceptable level of competency; (3) an inability to control personal stress, strong emotional reactions, and/or psychological dysfunction which interfere with professional functioning; or (4) a lack of self-awareness and the impact of personal feelings or judgments, which interfere with clinical duties. These various deficits may be demonstrated by specific behaviors or characteristics such as:

- Not acknowledging, understanding, or addressing problems when identified;
- The problem is not merely a reflection of a skill deficit which can be rectified by academic or didactic training;
- The quality of services delivered by the Fellow is negatively affected;

- The problem is not restricted to one area of professional functioning;
- Disproportionate amount of attention by training personnel is required;
- The Fellow's behavior does not improve within a reasonable period of time in response to feedback or remediation efforts.

NOTICE OF IDENTIFIED PROBLEMS:

During the course of the training year as supervisors evaluate each Fellow's clinical performance, problems of conduct or performance may be identified. The following serve as recommended guidelines and timelines for due process procedures, and while every effort will be made to follow the recommendations, recommended timelines are not guaranteed in every situation.

If a problem of conduct or performance is identified, the primary supervisor will provide a verbal notification to the Fellow as soon as is reasonably feasible, and will meet with the Fellow informally, by the next weekly individual supervision meeting or within five (5) working days, to address the subject and identify what actions, if any, may need to be taken in the future to address the problem. Documentation of this meeting will be limited to supervisory notes maintained by the supervisor.

If it appears that the Fellow is unable to understand or resolve the problem within a reasonable time after informal discussion with the Fellow about the problem, a formal written notice will be provided to the Fellow. For problems of a more serious nature, a written notice may be provided sooner, possibly contemporaneously with the initial discussion. The written notice will include a description of the Fellow's unsatisfactory conduct or performance and actions needed by the Fellow to correct her/his/their behavior(s). The letter will also specify a timeline for correcting the problem and what sanction(s) may be implemented if the problem is not corrected. The Fellow is also notified of her/his/their right to be heard on the matter and right to appeal a determination regarding sanctions.

Biannual written evaluations document feedback that is delivered regularly to Fellows throughout the training year through individual supervision. If a Fellow disagrees with feedback provided in the evaluation, the Fellow will document the point(s) of disagreement, including rationale and pertinent background information supporting the disagreement, to the written evaluation that will be a permanent part of the training documentation. This documentation is to be submitted within ten (10) working days of when the evaluation is delivered to the Fellow. The Fellow is encouraged to discuss the feedback with her/his/their supervisor to facilitate understanding and resolution of the disagreement at the following weekly supervision meeting, or as soon as is reasonably possible. A summary of the discussion, including agreed upon action steps and conclusions, is to be documented by the supervisor and maintained in the Fellow's training file. If a Fellow feels that the issue has not been satisfactorily addressed at this point, she/he/they may contest the evaluation and invoke the grievance procedures, starting with informal grievance and proceeding with formal grievance if warranted (see Grievance Procedures).

REMEDIATION PROCEDURES FOR IDENTIFIED PROBLEMS:

Resolving Conduct Problems:
When a Fellow is alleged to have engaged in misconduct, an investigation will be conducted, within five (5) working days of the supervisors learning about it or as soon as is reasonably feasible, to determine whether the allegations are true and whether corrective or disciplinary action is warranted. This investigation will include, at the minimum, an interview with the Fellow to allow him/her the opportunity to be heard and to answer the allegations. This interview will be conducted jointly by the primary supervisor and secondary supervisor. If it is determined that disciplinary action (suspension, disciplinary letter or dismissal) is warranted, a discussion will be held with the training director and program director, within three (3) working days or as soon as is reasonably feasible. The Fellow will then be issued a written notice, within three (3) working days of the meeting, stating (1) the nature of the disciplinary action to be taken against the Fellow, (2) the charges against him/her/them, and (3) the reasons for the disciplinary action. The Fellow may formally appeal the imposition of the disciplinary action as described below.

Resolving Performance Problems:
If informal notice to the Fellow does not resolve a performance problem within fifteen (15) working days of the supervision meeting addressing the issue with agreed upon action steps, a meeting will be held with the primary and secondary supervisor, the Fellow, and the training director. The purpose of the meeting will be to further clarify expectations and develop a written plan of improvement specifying steps needed to remedy clinical performance and the time frame for re-evaluation. The written plan of improvement, which the training program will provide to the Fellow, will also list the steps the training program may take to assist the Fellow in improving. Steps that the training program may take to assist the Fellow in improving performance may include, but are not limited to: (1) Schedule modification (e.g. reducing patient load); (2) Increasing or modifying supervision; (3) Recommending professional psychological assistance/consultation; (4) Temporary suspension of direct clinical services; (5) Administrative review of clinic policies and procedures; (6) Academic coursework; or (7) Additional reading(s).

REVIEW AND HEARING PROCEDURES:

If the above steps (informal notice, formal written notice, and written plan of improvement) do not result in the necessary level of improvement within the expected timeframes articulated in the plan, the following procedures will be instituted.
1. A committee composed of the program director, training director, primary supervisor, and secondary supervisor will be formed. The committee will meet to discuss the unsatisfactory performance and determine what action needs to be taken to address the issue reflected in the Fellow's performance.
2. After the committee meeting, the Training Director will notify the Fellow that such a review occurred. The Training Director will inform the Fellow that the committee would welcome information provided in writing within three (3) working days.
3. The committee will schedule a time to meet with the Fellow within five (5) working days of receiving the Fellow's written communication, if any, and will notify the Fellow of the meeting time and of her/his/their right to appear and be heard at the committee meeting. Timely requests by the Fellow to reschedule the meeting will be accommodated if good cause is shown.

4. At the committee meeting, the Fellow will be asked to respond to a prepared list of specific concerns identified in writing. This response will include (1) any factual inaccuracies identified in the documentation or disagreements with the documented concerns and (2) any proposed action or suggestion that the Fellow may have regarding the concerns. These written concerns will be provided to the Fellow at least one (1) day before the scheduled meeting.
5. After the Fellow is excused from the meeting, the committee will make a determination about the Fellow's clinical competence and will make written recommendations to the program director within three (3) days. The recommendation will be either to (1) continue the Fellow in the program; (2) continue the Fellow conditionally (i.e., placed on probation); or (3) terminate the Fellow from the program. The program director will then adopt, reject, or modify this recommendation and notify the Fellow of her/his/their decision within three (3) working days or as soon as is reasonably feasible.
6. If the Fellow is conditionally continued in the program, the committee will reconvene in 30 days to review the Fellow's progress. After that review, the committee will then make a recommendation to the program director, within three (3) days, to either continue the Fellow in the program or terminate the Fellow from the program. The program director will then adopt, reject, or modify this recommendation and notify the Fellow of her/his/their decision within three (3) working days or as soon as is reasonably feasible.
7. Should a Fellow disagree with the decision made in Steps 5 or 6, she/he/they should submit a formal appeal, as described below.

APPEAL: Should a Fellow wish to appeal a disciplinary action, the Fellow should file a formal appeal in writing with all supporting documents and submit it to the program director. The appeal must be submitted within seven (7) calendar days from verbal or written notification to the Fellow of the disciplinary action. Thereafter, the Fellow will meet with the training director within three (3) working days of submission to review additional information and outline any factual inaccuracies or disagreements with circumstances of the issue or the disciplinary action. After the conclusion of the meeting, the training director will then make a recommendation to the program director to sustain, modify, or rescind the disciplinary action. Within three (3) working days of the meeting, that program director will then notify the Fellow in writing of her/his/their decision on the appeal, which is final.

GRIEVANCE PROCEDURE:

PURPOSE: Fellows have a right to express concerns about the training program or Integrated Behavioral Health staff members, and the IBH training program has the right and obligation to respond to such grievances. The following serve as recommended guidelines and timelines for due process procedures, and while every effort will be made to follow the recommendations, recommended timelines are not guaranteed in every situation.

A. Informal Grievance Procedure

In the event a Fellow has complaints about the training program, a Fellow can:

1. Discuss the issue with the staff member(s) involved as soon as is reasonably feasible.
2. If such informal discussion does not resolve the issue, the Fellow may discuss the concern with the training director, who may then consult with the program director and/or other staff members. If the concerns involve the training director, the Fellow can consult with the program director directly. The training director (or program director, as appropriate) will follow up with the Fellow regarding the grievance within five (5) working days or as soon as is reasonably feasible.

B. Formal Grievance Procedure

If the informal grievance procedure does not resolve the issue, the Fellow may file a formal written grievance with all supporting documents and submit it to the training director. Within ten (10) working days of the training director receiving the formal grievance, the training director will initiate Review Procedures as described below and notify the Fellow that such procedures have been initiated.

Review Procedures

1. A Review Panel will be formed, consisting of the training director, the Fellow's primary supervisor, and the Fellow who filed the grievance.
2. Within ten (10) working days, the Review Panel will meet to review the grievance and to examine any supporting documents related to the grievance.
3. Within five (5) working days after the completion of the review, the Review Panel will generate a written report and submit it to the program director, which will include any recommendations for further action. Recommendations made by the Review Panel will be made by majority vote if a consensus is not reached.
4. Within five (5) working days of receipt of the recommendation, the program director will either accept or reject the Review Panel's recommendations. If the program director rejects the recommendation, she/he/they may refer the matter back to the Review Panel for further deliberation or issue a decision, which revises the panel's recommendations.
5. If referred back to the Review Panel, a revised report will be presented to the program director within ten (10) working days of the receipt of the program director's request of further deliberation/revisions. The program director will then make a decision regarding what action is to be taken and inform the training director and assistant training director.

6. The training director will then inform the Fellow, staff members involved, and any other members of the training staff as necessary of the decision and any action taken or to be taken.
7. If the Fellow objects to the program director's decision, the Fellow has the right to submit an appeal to the program director, who will determine if a new Review Panel should be formed to re-examine the grievance or if the decision should be upheld.

Competencies/Principles

Competencies expected from graduating Fellows listed herein stem from (i) broader profession-wide expectations as published by the American Psychological Association for all postdoctoral fellowship programs and (ii) program-specific areas of focus related to primary care behavioral health as practiced at San Mateo Medical Center. Those are available for review in more details under separate cover in IBH's "Postdoctoral Competencies" document. In general, it is expected that upon completion of the program, all Fellows will demonstrate competence in the following domains:

Level 1: Competency areas required of all programs at the postdoctoral level relevant to advanced practice, as appropriate to the setting, the population served, and the focus or specialty area:

a. Ethical and legal standards, including professional conduct, ethics and law, and professional standards.
b. Individual and cultural diversity.
c. Integration of science and practice.

Level 2: Program-specific or area-of-focus competencies
In addition, in this Fellowship, the following areas are specifically evaluated: Collaboration and Professionalism, Multi-disciplinary Practice, Psychological Intervention, and Tele-Behavioral Health.

The following sections lay out core administrative procedures and clinical competencies that we expect all postdoctoral fellows to build throughout their training and fully exhibit by completion of this postdoctoral program. Topics where the Fellow may not yet possess skills and knowledge to meet these expectations should be individual focus areas for individual and group supervision as well as additional didactics and self-led research for each trainee.

Clinical Procedures

The following tasks are universal and required of each Fellow. You will notice that there are categories of "Acceptable" and "Unacceptable" performance listed under each area of competence. Unless otherwise discussed and approved by the training director, and Fellows are required, at minimum, to perform at the "Acceptable" level.

Please note that a Fellow is unlikely to perform at the "Unacceptable" level while under supervision. Unacceptable behavior generally occurs when a Fellow works without consultation on novel cases. On the rare occasion when a Fellow continues to behave in an "unacceptable" manner, this will result in a clear discussion of expectations in supervision and/or other corrective actions. In other words, if you feel uncomfortable with being able to perform at what is listed as an acceptable level, seek supervision.

1. **The Fellow evaluates and processes referrals for treatment on a timely manner.**

When a referral is received, the referral may be sent to you by the clinic coordinator for clearance. The patient is deemed appropriate if her/his/their needs are suitable for behavioral health services with IBH. The referral is deemed inappropriate if the patient is currently

endorsing active psychosis, substance abuse, chronic suicidality/homicidality or needs more specific/intensive mental health treatment, as outlined in IBH's clinic appropriateness document.

If the patient is deemed appropriate for treatment with Integrated Behavioral Health, the referral is sent back to the office coordinator with instructions to schedule an assessment. If not, the Fellow responsible for clearing the referral will need to refer the patient to an outside resource for more appropriate and/or intensive mental health care when necessary. If additional issues need to be addressed regarding the referral clearance, the office coordinator will send the referral back to, or consult with, the Fellow who is responsible for that particular clearance. The Fellow is responsible for following through with addressing remaining issues pertaining to the referral and may consult with supervisor/attending psychologists for assistance.

Acceptable
(a) Referral is processed with a planned disposition within two business days of being assigned to Fellow.
(b) Referral is escalated to supervisor or clinic director for further evaluation within two business days.
(c) Cleared patient meet clinic appropriateness criteria.

Unacceptable
(a) Fails to follow up on an assigned referral in a timely manner (ie, within two business days).
(b) Repeated incidents of failing to contact patients not appropriate for IBH with pertinent referrals.
(c) Consistently clears patients who do not meet clinic appropriateness criteria.

2. **The Fellow carries responsibility for a patient's treatment needs until treatment is completed or another provider takes over the case.**

You have an obligation to the patient to complete a defined treatment, or stay with them in a crisis, until the problem is resolved or the treatment completed. For example, check in with group leaders to ensure that the patient has attended a group to which they were referred; ensure that a requested consultation to another service was placed on your behalf; follow up with a primary care provider on requests made, etc.

The patient's safety is always of primary importance. It is considered abandonment if you fail to provide care when it is indicated. Abandonment is illegal and unethical. If you cannot treat the patient, the only alternative is to transfer the case to another qualified clinician or to another mental health care facility as is determined to be clinically appropriate. You could be guilty of abandonment if you were seeing an agitated patient on a legal hold and left the patient unattended in a situation where they could elope.

In the unlikely event that you come upon someone who is having a medical emergency, you are to seek help (pick up the nearest hospital phone and dial 2121), return to the patient and direct the emergency staff to them. In emergencies, keep track of the time since you discovered the patient and remain available to emergency team to answer questions. You are not responsible for providing lifesaving treatment, but you are responsible for getting help and remaining available.

Acceptable
(a) Able to perform basic safety tasks in an emergency and carry out interventions with consultation. Follows through with patients to see they are provided help.
(b) Assists in transferring cases to other providers as appropriate and follow a proper termination procedure when appropriate.

Unacceptable
(a) Does not obtain help during emergencies.
(b) Fails to stay with a patient during an emergency or when they are on a hold and not in a secure place.
(c) Comes upon a patient who is very confused and seems lost but fails to stop to help or escort them to someone who can help.
(d) Sees a referred patient once and fails to conclude whether treatment should occur or not, or decides to pursue treatment but fails to follow up.

3. The Fellow completes all documentation on time.

Progress notes, initial assessment notes, transfer or termination summaries are legal documentation. A progress note, however brief, is required for each session or telephone contact that has clinical importance. If a patient cancels an appointment, or no-shows, this should be charted in an effort to record patient behavioral patterns. Failure to write or dictate progress notes is considered to be negligence by the Health Care System and the courts.

Progress notes should be written and given to your supervisor within one working day of the session for brief interventions and individual therapy and within 2 working days for psychosocial intakes. All progress notes are to be written for and/or dictated into the hospital dictation system or eCW. All progress notes, letters, or any piece of paper with a Fellow's signature that has to do with clinical activities is to be cosigned by their supervisor. It is expected that Fellows will complete their progress notes and written work on time without constant oversight.

Acceptable
(a) Routine progress notes are submitted to the supervisor within one working days of the therapy session.
(b) Other required reports are completed on time.

Unacceptable
(a) Repeated incidents of progress notes not completed on time.
(b) Fails to complete missed progress notes, e.g., when this error is realized and no action is taken.
(c) Fails to document clinical encounters.

4. The Fellow exhibits professional behaviors, is on time for appointments, shows appropriate demeanor and appearance.

Offering your services as a psychologist requires that you (a) put aside your own personal needs when you are with a patient (e.g. want to be liked by others, talk about things you are interested in), (b) maintain a formal working relationship with your patient and (c) attempt to be forthright and honest with your patient. You are on time for your appointments, dressed in professional attire, and are pleasant. If you are going to be late, always call ahead and let someone know who can tell the patient that you will be delayed. You minimize dual relationships, avoid conflict of interest, or other encumbrances that might interfere with your ability to be a neutral observer and guide. You maintain an appropriate reserve with your patients and observe the boundaries of a therapeutic relationship. A clinician's work, especially psychotherapy, is predicated on the notion that the patient's problems are the focus - not the Fellow's problems or failures.

Acceptable
(a) On time for appointments, appropriately attired and maintains appropriate boundaries with patients.
(b) Recognizes dual and conflict of interest relationships and moves to resolve them.
(c) Delivers evidence-based, comprehensive care and maintains a productive therapeutic relationship.

Unacceptable
(a) Frequently late for appointments.
(b) Inappropriate attire (clothing that is not congruent with the clinic's 'business causal' dress code).
(c) Fails to maintain a formal, therapeutic distance and appropriate boundaries with patients.
(d) Repeatedly talks about issues of personal interest instead of those important to the patient's case.
(e) Engages in inappropriate dual relationships.
(f) One or more of these problems occurs more than once and the Fellow was advised of the problem and did not correct it.

5. The Fellow attends supervisory sessions and scheduled seminars, on time and well prepared.

Part of independent practice is your continuing education and seeking consultation when you need it. We prefer you come to see supervision as personally enriching instead of just evaluative. Nonetheless, we expect you to be responsible for scheduling weekly individual and group supervision and making up missed supervisory hours. Staff may not remind you when you miss or are tardy, but these absences will be part of your evaluation. Should you be delayed or have to miss a session you are expected to let your supervisor know. This is professional and personal courtesy and it should be practiced. Being prepared for a supervisory session is also required. You should be thinking about your cases, identify video segments to review, have issues and questions ready to discuss - especially therapeutic problems where you are unsure of what to do. In group supervision it is important that you are on time and prepared.

Acceptable
(a) On time for appointments, informs supervisor if late or unable to attend.
(b) Absence is reasonable.

(c) Fellow reschedules missed supervisory sessions.
(d) Preparation is manifest by signs the Fellow has thought about their patient's issues and the Fellow's own personal issues.
(e) Pertinent video segments of therapy sessions are identified and brought in for review.

Unacceptable
(a) Several late or missed sessions without adequate explanation or effort to reschedule.
(b) Repeated evidence of poor preparation.
(c) Repeated perfunctory discussion of patients is without thoughtfulness about the patient's problems or an effort to decide upon a treatment plan.
(d) The supervisor counsels the Fellow regarding these problems, but no change occurs.
(e) No video recordings of sessions are available.

6. The Fellow is an active participant in supervision and is responsive to feedback.

Fellows are expected to bring their own thoughts and ideas regarding clinical diagnosis and treatment to the supervision session. It is a Fellow's responsibility to express her/his/their own opinions, especially when they differ from those of the supervisor, and make a case for this point of view. When recommendations are made to Fellows it is expected that the Fellow will respond in an open and non-defensive manner. If a Fellow is experiencing problems with a supervisor, it is the Fellow's responsibility to first address these concerns directly with the supervisor. Problems that are worrisome or troubling to the Fellow should be identified as they occur rather than waiting until rating periods to initiate discussion with a supervisor. It is also expected that when the supervisor urges a particular course of action, the Fellow will act on these recommendations promptly and fully.

Acceptable
(a) Responds professionally and non-defensively to feedback.
(b) Is an active participant in feedback.
(c) Able to act on suggestions from the supervisor in a timely manner.

Unacceptable
(a) Fellow does not express opinions in supervision or is unable to make persuasive arguments for a different perspective.
(b) Ignores suggestions or takes several sessions to act on them.
(c) Does not address potential shortcomings in supervision with supervisor first.

7. The Fellow will turn in monthly logs to their primary supervisor by the first Monday of the new month.

Fellows are expected to have their monthly logs completed and signed by their primary and secondary supervisors and to give a copy of each log to the program coordinator each month. These monthly logs serve two purposes. The first is to provide you with documentation of the work performed in the event you are audited by the California Board of Psychology when applying for licensure. The second is for the medical staff office and the IBH administration to

track productivity of our Fellows. Failure to turn in logs by the first Monday of the new month may result in suspension of privileges to see patients, delaying completing your program.

Assessment

This section refers to the skills necessary for psychological evaluation and diagnosis, including the determination of a patient's risk for harm to self or others. Most of the skills listed below refer to assessment issues that are relevant to a clinical/counseling psychologist in any setting. Clinical disorders or presenting problems included below are those that a psychologist is most likely to encounter when working within a medical setting. Fellows are required, at minimum, to perform at the "Acceptable" level as indicated below. **Starred items** (*) are behaviors that are deemed to be so egregious that even one example of this during a rating period would constitute failure of the item.

1. Fellow is aware of and responds to patient's suicidal ideation and references.

When confronted with a patient in acute distress or one reporting depressive symptoms, Fellow asks about suicidal thoughts, intent, and plans. Fellow also follows up on vague references to suicidal ideation in any patient (e.g., "feel at the end of my rope," "I'd like to just give up," "it's not worth it").

Acceptable
(a) Responds to subtle and overt statements about suicidal ideation.
(b) Assesses suicidal ideation in all severely depressed and distressed patients.
(c) Follows up on references made by patients who do not appear to be high risk.
(d) An effort is made to maintain rapport with patient during such inquiries and to convey a sense of concern about the patient's welfare.

Unacceptable
(a) **Fails to inquire about suicidal plans in any patient expressing suicidal ideation.***
(b) Fails to inquire about suicidal ideation in a depressed or an acutely distressed patient who has not spontaneously expressed suicidal ideation.

2. Fellow is able to conduct a lethality assessment

Fellow is aware of demographic factors associated with higher suicide risk and routinely documents this on intake using the suicide risk template. Fellow inquires about current or recent past suicidal ideation, past attempts, suicidal plan, means to follow through with plan, social support, factors associated with impulsive behavior (substance abuse, certain personality disorders, psychosis), history of past suicide attempts, family history of suicide or suicide attempts, notes the patient's gender, and current health problems.

Acceptable
(a) Demonstrates an awareness of factors associated with higher risk for suicide.
(b) Assesses for these factors whenever a patient expresses suicidal ideation or acknowledges a suicidal plan.

(c) An effort is made to maintain rapport with patient during this assessment and to convey a sense of concern about patient's welfare.

Unacceptable
(a) Does not fully assess for suicidal lethality in a patient who reports suicidal ideation.
(b) This may include repeated incidents of inquiring about a patient's suicidal plan but failing to comprehensively inquire about other relevant factors which contribute to lethality risk.
(c) Not aware of which categories of patients are high risk for suicide.

3. Fellow demonstrates understanding of Involuntary Holds.

Fellow demonstrates an awareness of when a patient should be involuntarily hospitalized and seeks supervision as needed. The Fellow is able to apply this knowledge to a decision-making process when confronted with a high-risk patient.

Acceptable
(a) Demonstrates good understanding and decision-making regarding holds in all relevant clinical situations.
(b) Strong clinical judgment demonstrated in a clinical situation where a patient presents in a particularly vague or evasive manner
(c) Displays good decision-making skills in applying criteria to a clinical situation.

Unacceptable
(a) Does not seem to understand circumstances under which a patient should be hospitalized.
(b) Demonstrates some understanding of involuntary holds but seems unable to make a reasonable decision about hospitalization when confronted with a high-risk patient.

4. **Fellow knows what actions to take when confronted with a patient who is a danger to self or others.**

The Fellow is capable of taking appropriate steps to hospitalize an "at risk" patient, including alerting supervisor, remaining with patient until another professional takes responsibility, clearly presenting case to other personnel, and writing progress note which convey key information regarding patient's risk for suicidal or homicidal behavior.

Acceptable
(a) Makes appropriate decisions regarding hospitalization.
(b) Consults with supervisor regarding these decisions.
(c) Writes well-organized progress note which clearly communicates information about patient risk for suicidal or homicidal behavior.
(d) Stays with patient "at risk" until relieved by a staff member.
(a) Consistently demonstrates through both hypothetical case discussion and in a clinical situation ability to take all appropriate steps in hospitalizing a patient who is a danger to self or others.

Unacceptable

(a) Understands when a patient should be hospitalized but relies solely on supervisor to take him/her through process.
(b) Takes appropriate steps to hospitalize an "at risk" patient by contacting a supervisor immediately and working with the supervisor to properly assess and document the patient's risk for harm to self or other or grave disability.
(c) Fails to appreciate the necessity of taking immediate action by discharging the patient from the clinic appointment and/or only bringing up risk with supervisor later in the day or week after the patient has already left the clinic.
(d) **Abandons patient before another mental health care provider takes over responsibility for case, and thereby increases opportunity for patient elopement.***

5. Fellow can assess for depression severity using DSM-5 criteria.

The Fellow can distinguish between various levels and syndromes of depression (adjustment disorder, persistent depressive disorder, major depression, schizoaffective disorder) and demonstrates an ability to assess for presence or absence of depressive symptomatology when a depressive disorder seems likely.

Acceptable
(a) Consistently and competently assesses for depression whenever appropriate.
(b) Can arrive at accurate diagnosis within the depressive spectrum.

Unacceptable
(a) Does not initiate an assessment for depression when presented a patient who displays sadness, is tearful, or claims to be depressed.
(b) Makes diagnosis of depressive disorder without assessing for depressive cognitions, mood, and neurovegetative signs.

6. Fellow can assess common forms of anxiety, stress, and trauma using DSM-5 criteria (e.g., panic, phobias, generalized anxiety, PTSD).

The Fellow is able to identify anxious rumination, hypervigilance, avoidance, or psychomotor agitation as indicative of an anxiety, stress or trauma-related disorder. The Fellow is capable of "thinking on her/his/their feet" when confronted with an anxious patient or questioned by a supervisor (i.e., can identify criteria associated with various anxiety, stress, or trauma-related disorders).

Acceptable
(a) Consistently and competently assesses for anxiety, stress and trauma-related disorders whenever appropriate. Is able to make correct diagnosis at time of initial interview.
(b) Is thorough in assessment of anxiety, stress, and trauma-related disorders, competing psychological diagnoses, medical, or pharmacological contributions.

Unacceptable
(a) Does not seem to recognize symptoms of anxiety in a patient.
(b) May inquire about some anxiety symptoms but seems unclear about differential diagnosis.

7. Fellow can conduct a screening for psychosis.

The Fellow is observant for disorganized speech (blocking, circumstantiality, perseveration, flight of ideas, mutism), delusions, and hallucinations in a patient. The Fellow is vigilant for behavioral suggestions of the presence of delusions or hallucinations in a patient who may deny these experiences.

Acceptable
(a) Consistently performs competent assessment for psychosis.
(b) Can determine accurate diagnosis independently.
(c) Uses both patient's self-report as well as behavioral observations in determining diagnosis of psychosis.
(d) Considers competing diagnoses (e.g., substance abuse, dementia, acute metabolic disorder).
(e) Can distinguish between various psychotic disorders.

Unacceptable
(a) Does not appear to recognize psychotic symptoms.
(b) Fails to assess for thought disorder and the presence of hallucinations or delusions in a patient with suspected psychosis.
(c) Does not consider psychological history and mental status in evaluating for suspected psychosis.

8. Fellow can conduct a screening for alcohol or drug abuse.

The Fellow assesses for history or current substance abuse in all patients. She/he/they can distinguish between abuse and dependence and assesses for social, occupational, medical, and legal problems associated with substance abuse. The Fellow is aware of symptoms of tolerance and withdrawal. Safety issues are considered when patient is acutely intoxicated, and Fellow makes appropriate arrangements for patient. She/he/they is generally aware of referral options when assessing a patient who has a positive screen and makes referrals when clinically appropriate.

Acceptable
(a) Consistently and competently screens for substance abuse.
(b) Shows understanding of motivational interviewing.
(c) Demonstrates ability to routinely and competently screen for substance abuse.
(d) Independently considers referral options for patients with a positive screen at time of intake.

Unacceptable
(a) Does not routinely assess for substance abuse during intakes.
(b) Generally, assesses for substance abuse but consistently avoids screen for selected patient groups (e.g., the elderly or physically frail).
(c) Does not inquire beyond quantity and type of substance used when it is apparent there is a problem.

(d) **Releases an acutely intoxicated patient without making arrangements to assure safety of patient or others.***

9. Fellow considers personality factors and disorders in an evaluation.

The Fellow can recognize enduring patterns of behavior or cognitive profiles that are pervasive, inflexible, and stable over time, that appear to have an early onset, that deviate markedly from the expectations of an individual's culture, and that lead to distress or impairment in interpersonal functioning. Fellow can differentiate between personality disorders and determine when an individual may be described more accurately as having certain personality traits rather than a disorder. Fellow considers possibility of a personality disorder in every patient and is able to see how such diagnoses or personality traits can influence presentation of a psychiatric disorder and impact treatment.

Acceptable
(a) Always considers possible contribution of personality factors.
(b) After identifying problematic personality traits, can determine whether symptoms justify a personality disorder and can make reasonable case for a specific diagnosis.
(c) Excellent differential diagnosis of personality disorders.
(d) Can anticipate impact of these personality factors on psychological and/or medical treatment plans.

Unacceptable
(a) Rarely considers personality disorder diagnoses or significant personality traits during assessment.
(b) Too readily or stereotypically diagnoses personality disorder pathology based on insufficient information.

10. Fellow considers cultural issues or physical disabilities which may influence a patient's presentational style or world view.

The Fellow is aware of ethnic, regional, racial, socioeconomic, sexual orientation, or physical ability differences between self and a patient and can anticipate possible influences this difference may have on patient's comfort level and ability to trust. The Fellow recognizes when it may be necessary to seek out consultation because of absent or limited experience with issues relevant to such differences. The Fellow considers her/his/their own comfort level when working with a patient who is different from oneself and addresses these issues in supervision.

When appropriate, the Fellow assesses for level of acculturation, immigration history, and facility with the English language as these variables typically influence a patient’s view of illness and relationships with health care providers (primary language used is a required component of evaluations). She/he/they inquires about health beliefs, family support, and use of alternative healers (e.g., acupuncturist, herbalist, curandero).

The Fellow should remain cognizant of how certain cultural differences or sensory impairments can influence responses in clinical interview or performance on tests and should consider these

factors in completing assessment. A medical interpreter is always offered and used when deemed appropriate.

Acceptable
(a) Always considers possible impact of individual and cultural differences on assessment and treatment planning.
(b) Is able to comfortably address the issue of differences with patient when appropriate.
(c) Is cognizant of individual and cultural differences in assessment and seeks consultation when needed.
(d) Is able to achieve and maintain an empathic stance with patients from different backgrounds. Makes appropriate referrals to culturally-competent professionals as needed.
(e) Skillfully offers and utilizes language translation services as necessary.

Unacceptable
(a) Expresses reluctance to work with a patient due to patient's identity or background without first evaluating the patient or discussing the case in supervision.
(b) Does not consider recognize the importance of these variables on the patient's presenting problems, perceptions of self, health beliefs, and behavior patterns.
(c) Does not consider her/his/their own limitations when working with a patient from a different cultural background, sexual orientation or one with physical disabilities.
(d) Does not offer language translation services when relevant.
(e) Fellow receives supervisory feedback on these issues and no change results.

11. Fellow considers which additional information should be gathered after initial assessment.

The Fellow demonstrates ability to make good use of available sources of information about new patients (e.g., reviews chart, ascertains listing of patient's current medical problems and medications, history of psychiatric treatment, hospital admissions). When relevant, the Fellow considers requesting additional psychological or medical reports from outside sources or meeting with family members given patient's approval. The Fellow can determine when testing may be useful to provide additional information and which tests would be most appropriate for a given patient.

Acceptable
(a) Reviews available information.
(b) Independently determines which additional information should be gathered after an initial assessment.
(c) Independently determines when testing may be appropriate.
(d) Exercises good judgment in selection of appropriate tests.
(e) Ethically and competently seeks out other sources of relevant information.
(f) Has a plan for how to proceed with completion of assessment after initial intake.

Unacceptable
(a) Uses poor ethical and clinical judgment when obtaining information for assessment.
(b) Does not appear to fully utilize readily available resources in completing assessment.

12. Fellow writes succinct but thorough assessment documentation.

The Fellow writes assessment reports which includes referral question, history of presenting problem, family, educational, and occupational history, overview of medical history and current medications, alcohol and drug use, overview of psychological history and treatment, mental status exam and behavioral observations, and DSM-5 diagnosis(es). The format for these reports is available from your supervisor. Written reports should be organized under a series of appropriate headings for clarity and information presented under headings should be specifically relevant to that topic. Report may offer summary regarding how various diagnoses interrelate and must include plans for treatment or referral. Reports should be jargon-free and avoid detailed explanations or quotations except when essential to understanding.

Acceptable
(a) Consistently writes succinct but thorough assessments.
(b) Writes assessment reports as soon as information has been obtained.
(c) Reports are organized within topical areas.
(b) Detailed explanations or quotations are included only when they are essential to understanding.

Unacceptable
(a) Assessment reports lack essential information or are grossly disorganized.
(b) Reports are over inclusive, redundant, unnecessarily lengthy or full of jargon.
(c) Assessment report fails to include DSM-5 diagnosis(es) or plans.

13. Fellow can conduct an assessment of a patient with chronic pain.

The Fellow assesses for intensity, duration, and frequency of pain complaint, notes pain behaviors, gathers history regarding onset and progression of pain and response to treatment, previous coping with medical problems or early exposure to pain models, antecedents to waxing and waning of pain, and consequences of pain behavior. The Fellow inquires about pending litigation, disability, or compensation evaluations. The Fellow considers impact of concurrent psychological diagnoses or coping styles on patient's pain behaviors and response to treatment. Uses assessment measures when appropriate and uses pain template available through the Pain Management Clinic.

Acceptable
(a) Consistently performs comprehensive assessment of pain complaint.
(b) Integrates data gathered from assessment of pain complaint, other psychological disorders, and coping style to provide meaningful information to referral source or to provide basis for planned interventions.

Unacceptable
(a) Fails to make pain complaint a focus of the clinical interview.
(b) Limits assessment to an examination of the nature and history of pain complaints without evaluating other medical and psychosocial factors related to pain.

(c) Does not assess for concurrent psychological problems or maladaptive coping.

14. Fellow can conduct an assessment of a patient with sexual dysfunction.

The Fellow assesses for problems with decreased sexual interest, arousal, and/or orgasm. She/he/they considers role of medical conditions, medications, and substance abuse in etiology of problem. Fellow assesses for relationship problems, inadequate sexual repertoire, or recent sources of significant stress and reviews relevant laboratory tests when appropriate. The Fellow is aware of psychological, medical, or surgical treatment options and is prepared to discuss these with patient when relevant.

Acceptable
(a) Completes comprehensive assessment of a patient with sexual dysfunction.
(b) Can integrate information into a reasonable formulation of the case.
(c) Can assist patient with comfortably discussing sensitive personal issues related to sexuality.

Unacceptable
(a) Fails to make sexual dysfunction a focus of the interview.
(b) Does not assess for psychological or relationship factors which could cause, exacerbate, or maintain problem.
(c) Does not consider role of medications or medical disorders in formulation.

15. Fellow can conduct an assessment of a patient referred for weight management.

The Fellow assesses for type and extent of patient's obesity as well as patient's general activity level. She/he/they ascertains family and patient's history of obesity and patient's history of previous weight loss attempts. The Fellow assesses for binge-eating and antecedents to this activity. She/he/they considers role of medical problems or substance abuse on patient's activity level and obesity. The Fellow considers how psychological or relationship factors, socioeconomic status, and culture could influence eating behavior, activity level, or affect current motivation for behavioral change.

Acceptable
(a) Completes comprehensive assessment of patients referred for obesity problems.
(b) Can independently integrate information obtained into a coherent conceptualization of patient’s weight problem.

Unacceptable
(a) Fails to make obesity a focus of the interview.
(b) Does not assess for other potential psychological or relationship issues.
(c) Does not consider impact of medical condition on weight or activity level.

16. Fellow can conduct an assessment of tobacco users and identify variables that may make quitting difficult.

The Fellow inquires about extent of current habit and history of attempts to quit. Daily tobacco use is reviewed, nicotine dependence is assessed, and the patient is helped to tailor interventions to meet personal needs. She/he/they assesses for current and past psychological disorders and ascertains if patient may be at increased risk for exacerbation or recurrence of psychological problems with nicotine withdrawal. Reviews medical history with patient and addresses any relevant concerns with patient's health care provider. Referrals are made for nicotine patches or gum and psychotropic medications as needed. There is a smoking cessation class that is available for all patients should they choose to stop smoking.

Acceptable
(a) Performs comprehensive assessment of tobacco user.
(b) Recognizes psychiatric problems that make quitting smoking difficult.
(c) Uses available referral sources as appropriate.

Unacceptable
(a) Does not inquire about tobacco use in course of interview.
(b) Neglects to obtain adequate psychological or medical history.
(c) Does not consider impact of nicotine withdrawal on patient's mental health.

17. Fellow can conduct an assessment of a somatically-based psychological disorder.

When encountering a patient with unusual somatic complaints, Fellow is capable of ruling out a delusional disorder and considering possibility of various and multiple somatically-based disorders. The Fellow understands differences between different somatic symptom disorders, factitious disorders, and malingering and asks relevant questions to determine differential diagnosis. Fellow is careful to consider impact of patient's documented medical disorders, medications, and/or psychosocial factors (e.g., culture) on the patient's presentation. She/he/they also considers potential impact of such psychological diagnoses on patient's medical care and takes steps to assure that patient's needs are not overlooked.

Acceptable
(a) Consistently performs competent assessments of somatically-based psychological disorders
(b) Demonstrates understanding of differential diagnosis for somatically-based disorders.
(c) Considers possible impact of this diagnosis on patient's medical care.
(d) Takes steps to assure patient and referral source fully understand diagnosis.

Unacceptable
(a) Fails to consider a somatically-based psychological disorder in a patient with unusual medical complaints.
(b) Hastily arrives at a somatically-based diagnosis without fully considering possible medical or pharmacological factors.

18. Fellow can conduct an assessment of health behaviors in a patient with a chronic medical condition.

The Fellow seeks out information about type of illness, treatment options, and obtains some understanding of patient's prognosis within their cultural context. The clinician also seeks out information about possible side effects of medical treatment if relevant to presenting problem. She/he/they assesses for the patient's understanding of treatment choices and prognosis and considers possible reluctance of patient to obtain more information. When working with terminal patients, the Fellow is able to inquire about patient's anxieties and fears around death and dying. When not essential to patient's medical management (i.e., no urgency to make treatment decisions), the Fellow respects patient's defenses in conducting assessment.

Acceptable

(a) Can assess for the patient's immediate concerns related to illness and treatment.
(b) Able to identify broader existential issues related to coping with a possible life-threatening disease.
(c) Seeks out information about the nature of the disease process, likely prognosis, and implications of treatment to have better understanding of how patient is perceiving and responding to illness and treatment.
(d) Consistently performs competent assessments of patients with severe chronic illness.
(e) Can follow patient's lead in sessions, knowing when patient wishes to back off on particular topics and when patient desires assistance in tackling difficult issues.
(f) Utilizes behavioral medicine interventions when appropriate to facilitate the successful management of the condition.

Unacceptable

(a) **Inappropriately discusses patient's medical diagnosis or prognosis without first determining what patient has been told by medical staff**.*
(b) Pushes patient unnecessarily on issues she/he/they is clearly reluctant to address.
(c) Avoids affect-laden topics that patient is willing to discuss.

Treatment Plans

Rational treatment planning requires an accurate diagnosis. As the patient's problems become understood a decision is made about what, if anything, should be done. These decisions are based upon the urgency of the problem, the patient's safety, the severity and chronicity of the problem, what interventions are best known to help, and the appropriateness of IBH for treating the patient. The Fellow should have a grasp of these issues with each patient. **Starred items** (*) are behaviors that are deemed to be so egregious that even one example of this during a rating period would constitute failure of the item. Fellows are required, at minimum, to perform at the "Acceptable" level as indicated below:

1. The Fellow can specify short and long-term goals.

The key to this element is that the Fellow recognizes problems that must be treated first (e.g. suicidal thoughts). The Fellow can state what these short-term treatment goals should be.

She/he/they can also identify goals that need a longer-term view or which goals should be a focus later in treatment.

Acceptable
(a) Fellow can describe short and long-term goals that cover most or all of the patient's problems.
(b) As new information is provided she/he/they is able to modify the treatment goals as the session progresses.
(c) The treatment goals are relevant to the referral question.

Unacceptable
(a) The Fellow cannot state short or long-term goals after three sessions.
(b) The Fellow can identify either some short-term or some long-term goals, but their list is incomplete and critical problems are ignored.
(c) The Fellow is counseled on this problem, but no improvement occurs.

2. The Fellow can specify the medical, psychological or social interventions that are required for attainment of each goal.

Acceptable
(a) Can adjust psychological interventions to each patient.
(b) Is knowledgeable about medical and social interventions and knows when to provide or consult regarding their patient.
(c) Aware of other interventions beyond their own skills or training and when they need consultation or to refer the case.

Unacceptable
(a) **Unable to specify any intervention ***.
(b) Very restricted in the interventions that they will consider.
(c) This is repeated in a variety of cases and persists despite counseling and training in describing appropriate interventions.

3. The Fellow considers and selects an appropriate treatment modality, frequency, duration and sequence (individual therapy, family therapy, etc.).

Acceptable
(a) The Fellow is able to consider a variety of interventions and changes the modality, frequency, duration and sequence of them as best fits the patient's needs.
(b) The Fellow may disagree with the patient about some of these issues but are mindful of therapeutic resistance to some of the treatment plans and integrate the patient's responses into treatment.

Unacceptable
(a) Very restricted range of intervention skills.
(b) The Fellow does not appear to consider or understand when other interventions, besides their own, might be more appropriate.

(c) This problem persists despite counseling or teaching.

4. The Fellow considers and can specify the appropriate treatment setting (can triage to variety of SMMC and San Mateo County Mental Health Services or community resources) for each intervention.

Acceptable
(a) Is able to consider a variety of treatment settings as best fits the patient.
(b) Works with other staff in and the patient in a multidisciplinary manner to find the best treatment setting possible.

Unacceptable
(a) Very restricted in their choice of intervention.
(b) Does not appear to consider or understand when other treatment settings might be more appropriate.
(c) This problem persists despite counseling or teaching.

5. The Fellow can specify outcomes and optimal methods to monitor each patient's progress.

Acceptable
(a) Regularly monitors outcome and may have several individualized measures for each patient.

Unacceptable
(a) Unable to specify treatment outcomes and ways of monitoring progress.

6. The Fellow can set a time frame to reach a treatment outcome and can make a reasonable estimate of the likelihood of reaching this outcome (prognosis).

Acceptable
(a) Routinely sets time limits for therapy.
(b) Recognizes when changes are required to the treatment contract, schedule and goals and initiates this discussion with the patient.
(c) Has a good grasp of the limits of therapy for specific problems and targets those problems that may be helped within the limits of the treatment period.
(d) May be able to work on some bigger problems but recognizes the limits of success in the time-limited setting and may set intermediate goals to be achieved by the patient.

Unacceptable
(a) Does not set a time limit for therapy.
(b) Is not able to recognize whether their goal is reachable in the time they have to see the patient.

Interventions

This includes the processes and techniques of therapy. Fellows are required, at minimum, to perform at the "Acceptable" level as indicated below:

1. The Fellow considers issues that would prevent them from taking an assigned case.

There are two principles to follow here: (a) your competence with this kind of case (or your supervisor's limited expertise) and (b) the patient's background and comfort with you. Regarding competence, you must know whether or not you or your supervisor have enough experience with individuals, couples, families, specific diagnoses, etc. to offer treatment to that patient. Discovering whether you are competent to see a case may require that you actually meet with the patient(s). If you determine that you are not competent to take on a case, you need to follow the tenets of Clinical Procedures/Principles mentioned above. You should not abandon this patient, but rather assist them to find appropriate services with another IBH provider or facilitate the referral process with an outside mental health agency. You are expected to communicate with your supervisors on a regular basis about your cases to determine if patients are appropriate for our clinic.

The patient's background and comfort are also concerns. You may be referred a patient of a different race, or ethnic background, especially someone who was raised in a different culture and English may be their second language. It is important that the patient believes that you are capable of understanding their problems and worldview. Many times, the patient will allow you to proceed, but occasionally it is important to find another provider who is more knowledgeable about the patient's culture.

Acceptable
(a) Considers their own expertise to handle the case.
(b) Knowledgeable about ethnic, cultural differences.
(c) Engages supervisor in a discussion of expertise and experience with this kind of case.
(d) Discusses with the patient the ethnic, cultural or racial differences to see if they consider it a problem.
(e) Is aware of the cultural and ethnic differences that might be a limit to psychological assessment instruments or psychological interventions.
(f) Recognizes the limits of their clinical skill with the patient.
(g) Seeks consultation when appropriate and reads the relevant literature

Unacceptable
(a) The Fellow fails to consider their expertise with a case
(b) The Fellow fails to consider their supervisor's expertise with a case.
(c) Addresses one but not the other.
(d) Never considers the patient's background or comfort.
(e) Considers patient's background/comfort but fails to heed the patient's concerns.
(f) Practices but fails to seek consultation.

2. The Fellow is able to work with patients from different racial, ethnic, cultural, and socioeconomic backgrounds, sexual orientations, and/or physical ability levels.

The Fellow demonstrates awareness of socio-cultural concerns, cultural norms, and physical disabilities. She/he/they works within the limits of her/his/their competence but does not

automatically refuse to see patients of different backgrounds. The Fellow seeks consultation when needing additional information or clarification about socio-cultural norms. She/he/they can describe the cultural etiology of behavior patterns and adjust interventions as necessary to be culturally relevant (i.e., consistent with the patient's values and worldview). The Fellow makes and facilitates appropriate referrals to other treatment providers if patient problems are clearly beyond one's area of competence.

Acceptable
(a) The Fellow is aware of individual and cultural differences in choosing appropriate interventions.
(b) Seeks consultation when limited knowledge or skills, or Fellow-patient differences begin to interfere with treatment efficacy.
(c) Is able to address comfortably the issue of differences with the patient when appropriate.
(d) Able to achieve and maintain a good therapeutic alliance and empathic stance with patients from diverse backgrounds.

Unacceptable
(a) **Uses derogatory language or makes offensive comment or stereotypical joke about patient's identity or background.***
(b) Exhibits blanket refusal to work with a patient due to patient's identity, language or background without first evaluating the patient and discussing the case in supervision.
(c) Relies only on stereotypical knowledge to understand patient (e.g., "Latino patients always somaticize").
(d) Chooses interventions based on stereotypes (e.g., "ethnic minorities only respond to problem-solving strategies").

3. The Fellow is able to establish a productive therapeutic alliance.

Alliance is broadly defined as the Fellow and patient working together toward some agreed upon goals within a context of trust and acceptance. The Fellow should be able to determine if she/he/they is able to establish an agreed upon treatment goal, and if the patient is feeling comfortable, trusting and values the session. The key is that the Fellow is aware of the relationship and has an opinion about the state of the alliance. If the patient appears uninterested in treatment, then it is expected the Fellow would talk with the patient about whether or not a second session is warranted. If the issue is trust or the value of the session it is expected the Fellow would recognize that issue and speak to the patient about it. Perhaps halting therapy or referral to another IBH provider would be reasonable.

Acceptable
(a) The Fellow is aware when the alliance is not well established.
(b) Most patients (75%+) who say they will return for a second session usually do.
(c) She/he/they may be able to predict those who will not return even though they say they will.

Unacceptable
(a) Patient fails to return for a second session when the Fellow was reasonably sure they would.
(b) Fellow seems not to know if an alliance was made with the patient.

(c) The Fellow patient's drop out more than 50% of the time.

4. The Fellow understands and responds appropriately to a patient's emotions.

Patients often display many emotions, some of them very intense and powerful. These emotions are often the most important events in therapy. It is part of your training to come to understand the patient's feelings and to learn to respond to them appropriately. Some psychotherapy systems focus on transference as a primary process of therapy. No matter what your theoretical view, the patient's emotions are to be integrated into the therapeutic process and the Fellow should respond appropriately when emotions are expressed. Some examples of inappropriate responses include ignoring the emotion and acting like it didn't occur, making light of it, or invalidating the emotion. These problems sometime occur with the Fellow is uncomfortable with emotion. It is required that a Fellow be sufficiently comfortable with patient's emotions that they can be therapeutic in the consulting room.

Acceptable
(a) The Fellow is able to control their emotions with provocative or disturbed patients
(b) The Fellow is able respond appropriately to strong emotion.
(c) Uses the patient's feelings in a constructive way.
(d) Uses the patient's emotions and behaviors therapeutically in session as the emotions are happening.

Unacceptable
(a) **The Fellow is grossly inappropriate with a patient by responding with great anger, verbal abuse, or ridicule *.**
(b) The Fellow responds indifferently, incongruently (laughing or making light of a problem when the patient is sad), or negatively to a patient's emotion.
(c) They repeatedly show poor judgment in choosing what they say to a patient or how they say it.
(d) When emotion is expressed they often change the subject or ask questions to halt it.
(e) One or more of these behaviors are observed and feedback is provided. The problem recurs despite this intervention.

5. The Fellow demonstrates an ability to have empathy and understanding of the patient.

Having empathy, understanding of what it is like to be in the patient's circumstance, is a critical skill in psychotherapy. Accurate empathy enhances the patient's feeling of being understood and enhances patient trust in the Fellow.

Acceptable
(a) Reflections are on target for feelings.
(b) The patient feels heard and may feel relieved that someone understands their problems.
(c) Patients who are reactant, paranoid or angry hear a restatement of their concerns, including their concerns about the Fellow's ability to help, empathize, etc.
(d) The patients are more often willing to be in therapy.

(e) The supervisor concludes the Fellow understands the patient.

Unacceptable
(a) Unable to understand patient's problems or limited ability to understand the patient's complaints.
(b) Can reflect only the most obvious statements of feeling.
(c) Patients frequently feel misunderstood or may state that the Fellow's understanding is wrong.
(d) Patients may say they do not feel they are getting anything from the session and may refuse to return.
(e) The supervisor concludes the Fellow does not understand the patient.

6. The Fellow develops an understanding of the overt problems (e.g. anxiety, depression) and the underlying psychological mechanisms that propel the problems.

Acceptable
(a) Accurately diagnoses the overt problem (e.g. depression) and can identify psychological mechanisms (e.g. difficulty in social relationships, low self-esteem) in the first sessions.
(b) As new observations are made they integrate them into the therapy (e.g. the patient is depressed, has difficulty with social relationships, but is observed to have a personality style that includes rigid values, and lack of empathy toward others. These observations are interpreted or reflected to the patient in an appropriate manner).

Unacceptable
(a) Cannot accurately determine the overt problem (diagnosis).
(b) May be able to describe the overt problem but is unable to describe mechanisms that motivate it.

7. The Fellow keeps the session focused on the patient's problems.

To keep a session focused a Fellow must be thinking about the patient's overt problems, the patient's way of operating (process, or coping style) and help the patient learn to be an active participant in their own therapy.

Acceptable
(a) Fellow kept the session focused on the issues and re-directs the patient when they appear to lose track or when the patient moves to a less sensitive topic after talking about a difficult issue.
(b) The Fellow can identify new issues or observations and can integrate them within that therapy session.

Unacceptable
(a) **Fellow directs or keeps the conversation on a topic of interest to the Fellow but has no relationship to the patient's problems** *.
(b) Fellow is unfocused, and many topics are discussed without direction.
(c) The Fellow is easily distracted and appears to provide no direction to the sessions.

(d) The Fellow misses new and important information.

8. The Fellow is attentive to verbal and non-verbal cues.

A patient cannot or does not always speak directly to her/his/their problem(s). The Fellow must often observe and draw conclusions about the patient's inner state by facial expression, tone of voice, and/or body movement. Even when a patient talks to the Fellow, the patient may be unable to speak directly to an issue, and the Fellow may need to discern that a problem exists or help the patient identify the problem.

Acceptable
(a) The Fellow is aware of obvious and subtle verbal and nonverbal cues and acts on them by modifying their approach or hypotheses within the therapy hour.
(b) Identifies several verbal and non-verbal cues of anxiety and depression.
(c) Identifies verbal and non-verbal cues of psychosis.
(d) Identifies verbal and non-verbal cues one might expect to see in someone who is suicidal but is not stating so directly.
(e) The Fellow can accurately observe anger, fear, and sadness from facial and voice cues. The Fellow can offer hypothesize their origin.

Unacceptable
(a) **The Fellow misses direct references to depression and suicide***
(b) The Fellow ignores or misses obvious and subtle (verbal and nonverbal) cues that indicate prominent moods such as anger, sadness, fear, depression or anxiety.
(c) They are unable to describe verbal and nonverbal cues that occur during a session.

9. The Fellow prompts the patient to draw conclusions, meaning, understanding and attributions about their own behavior.

Acceptable
(a) The Fellow consistently elicits conclusions, meaning, understanding or attributions and follows up appropriately and substantially.
(b) Knows when to ask the patient to reflect and can justify why they did not do so in specific circumstances.
(c) There is an effort to integrate the patient's insight into larger personal issues (e.g. coping with pain, social functioning, etc.).

Unacceptable
(a) The Fellow ignores opportunities to ask or prompt the patient to draw conclusions, meaning, understanding or attributions about their own behavior.
(b) Prompting a patient to draw conclusions, meaning, etc. is done occasionally.
(c) The Fellow does not seem to understand when or how they should assist the patient to reflect on their own behavior.
(d) They may tend to lecture or interpret behavior and do not allow the patient an opportunity for self-discovery.

10. The Fellow integrates their observations of the patient's behavior and the patient's history into the therapy session.

This is an ongoing process within therapy. The patient's history is typically taken during the initial evaluation. As treatment progresses, it is common for the patient to tell more about their past and to reveal themselves through their conduct with the Fellow. The task is to use the information and observations wisely to help the patient. Typically, the Fellow uses observations or historical information to comment on present behavior. It could also include comparisons of data collected by the patient.

Acceptable
(a) Fellow links the patient's past frequently to the current problem(s).
(b) Fellow points out behavioral and cognitive patterns by commenting frequently past actions or incidents in therapy and how they are relevant in the current discussion.

Unacceptable
(a) Fellow does not address the development of the patient's problems.
(b) Does not link past history with the current problem.
(c) Does not identify how actions, verbal report in past sessions have bearing on the current issues.
(d) They may ask about the past but does not link this information to the current problem.

11. The Fellow checks their understanding of the patient's perceptions.

One common error of new clinicians is the assumption they understand what a patient means when the patient makes a statement. For example, a patient might say, "My dad was always a real straight guy." The word "straight" may have many meanings, and it is important for the Fellow to clarify this with the patient. Ideally this is done quickly and at a time when it does not interrupt the patient's thinking, or process.

Acceptable
(a) The Fellow clarifies patient's statements when necessary and it is apparent the Fellow understands the patient.
(b) The clarification is typically brief and does not interrupt the patient's train of thought.

Unacceptable
(a) Fellow fails to clarify the patient's statements about feelings and impressions.
(b) Fellow frequently fails to clarify the patient's statements.
(c) The supervisor observes this to happen. The Fellow is given feedback but does not change.

12. The Fellow uses clinical judgment during sessions.

Good judgment requires critical thought and caution. It is a combination of knowledge of the principles and theory of Psychology, the practice of psychology, listening carefully to the patient and noting inconsistencies in their presentation, having a good grasp of reality and possibility.

Acceptable
(a) Fellow can identify inconsistencies in a patient's presentation and explores them.
(b) Fellow uses caution when using the data from a patient's self-report.
(c) When confronted with a legal or ethical dilemma the Fellow is cautious and seeks consultation.
(d) Fellow can cite a rationale for their clinical actions.
(e) Fellow is knowledgeable about empirically based treatments but fits these models to the needs of the individual.
(f) Fellow reviews the need for consultation and acts on what is best for the patient.
(g) Fellow responds to the patients changing needs. When a crisis or new problem arises, the clinician is able to draw a conclusion about its importance and proceed in the best interests of the patient.
(h) Fellow develops the themes or problems from the patient interview and continuously keeps these in mind. The Fellow finds a way to bring the patient back to these issues.

Unacceptable
(a) Fellow continues to follow the orders of a consult or directions of a supervisor with a formula treatment or assessment when the patient presents other problems or crisis that was not anticipated.
(b) Fellow overestimates the importance of a problem a patient introduces, spends entire session focused on a minor problem and ignores larger issues.
(c) Fellow is unable to determine what is the most important issue to follow in a session.
(d) Fellow fails to consider safety needs of patients.
(e) Fellow accepts whatever the patient says to them without critical appraisal.
(f) Fellow decisions are based on a misunderstood view of the patient and/or circumstances. This is repeated and fails to change with supervisory consultation.
(g) Fellow is unable to incorporate obvious information and clinical decisions are flawed as a result.

13. The Fellow appropriately and timely employs evidence-based therapy techniques that help patients to change behaviors.

Some of these techniques include, but are not limited to, encouraging expressions of feelings, psychoeducation, reflective listening, behavioral interventions, motivational interviewing, cognitive re-structuring, values exploration, mindfulness practice, etc.

Acceptable
(a) Demonstrates effective basic skills in reflective listening, eliciting emotions and guiding self-discovery.
(b) Uses several intervention techniques and modify them according to the patient and circumstance.
(c) Modifies the techniques in the process of the therapy hour as needed.
(d) Is comfortable with silences in the therapy hour and uses them therapeutically.
(d) Identifies process or coping style issues and respond therapeutically to them as well as to overt problems.

Unacceptable
(a) Unable to proceed beyond assessment and asking questions.
(b) May use only one or two techniques such as lecturing or providing information when other skills are required.
(c) Chooses the wrong time to begin an intervention (e.g. gives details of weight monitoring when the patient is crying).
(d) Chooses an intervention that is inappropriate for the circumstance (e.g. Begins stress management when the patient may need more exploration, reflective listening to help them arrive at an agreement on the problem).
(e) The Fellow constantly talks and controls the session (works too hard) so that the patient is passive and awaits direction. This occurs constantly .
(f) The Fellow has great difficulty allowing silences. This occurs with most all their patients.

14. The Fellow is able to conduct an intervention for an overweight or obese patient.

Acceptable
(a) Able to help patients to define their reasons for seeking a healthy lifestyle through motivational interviewing techniques.
(b) Able to integrate behavioral medicine interventions, such as behavior modifications into the patient's life circumstance.
(c) Use cognitive and behavioral techniques as needed, and proceeds to more complex therapeutic interventions when required.

Unacceptable
(a) Not knowledgeable about obesity or reasons for losing weight or increasing fitness.
(b) Unable to apply cognitive interventions for dietary or exercise modification or coping skills for dealing with urges to over eat or treatment noncompliance.
(c) May be unable to recognize specific personal problems or life circumstances that impede obesity treatment.

15. The Fellow is able to conduct a behavioral intervention for chronic pain.

Acceptable
(a) Able to help patients understand ways they can manage their pain.
(b) Able to integrate behavioral management of chronic pain into the patient's life circumstance.
(c) Use cognitive and behavioral techniques as needed, and able to proceed to more complex psychotherapeutic interventions when required.

Unacceptable
(a) Not knowledgeable about psychological contributions to chronic pain.
(b) Unable to apply cognitive behavioral interventions for decreasing pain, including relaxation training.
(c) May be unaware of or unable to recognize specific personal problems or life circumstances that interfere with treatment of chronic pain.

16. The Fellow is able to deliver a treatment intervention designed to enhance compliance with a medical regimen.

Acceptable
(a) Shows sensitivity and skill in determining when patient is ready to hear information and work out behavioral strategies to promote compliance with medical regimens.
(b) Seeks out consultation with medical professionals when appropriate.
(c) May arrange for conjoint sessions with medical personnel.
(d) May involve family members in the treatment with patient consent.
(e) Utilizes both psycho-educational and cognitive-behavioral strategies to encourage patients' belief in the efficacy of their medical regimen and their self-efficacy for compliance.

Unacceptable
(a) Does not examine patients' beliefs regarding the accuracy of their medical diagnoses, the known efficacy of prescribed medication, diet, or exercise regimens in managing their illness, or the medical consequences of noncompliance.
(b) Fails to provide education as appropriate.
(c) Is non-directive in working with a patient who clearly requires assistance in developing a behavioral plan to enhance compliance.

17. Fellow demonstrates skill in use of various anxiety/stress management techniques.

Skills may include expertise in progressive muscle relaxation, attentional breathing exercises, hypnosis, meditation, or mindfulness techniques.

Acceptable
(a) Demonstrates skill in modifying strategies to meet specific needs of patients without compromising essential elements of the technique.
(b) Demonstrates skill in three or more of these strategies
(c) Follows up to assess compliance with these strategies and helps patient to work through barriers to noncompliance

Unacceptable
(a) Is unable to teach any relaxation strategy or is limited to skill in just one such intervention
(b) Utilizes other strategies which are not empirically supported.
(c) Exclusively relies on taped exercises made by others to teach patients these skills
(d) Is consistently awkward, rushed, or ineffective in teaching these techniques to patients

18. The Fellow is able to conduct a behavioral intervention for sexual dysfunction.

Acceptable
(a) Able to help patients understand ways they can ameliorate sexual dysfunction.
(b) Able to integrate behavioral treatments of sexual dysfunction into the patient's life circumstance adjusting for other life problems and circumstances.
(c) Use cognitive and behavioral techniques as needed, and able to proceed to more complex psychotherapeutic interventions when required.

(d) Recognizes when patient and/or partner are resisting or sabotaging treatment and tries to effectively deal with this in the therapy.
(e) Seeks supervision as needed.

Unacceptable
(a) Not knowledgeable about psychological contributions to sexual dysfunction.
(b) Unable to apply cognitive behavioral interventions for treatment of sexual dysfunction.
(c) May be unaware of or unable to recognize specific personal problems or life circumstances that contribute to sexual dysfunction.

19. Fellow utilizes family interventions to enhance therapeutic outcomes when opportunities arise.

Acceptable
(a) Elicits cooperation between the patient and family to meet a health care goal.
(b) Works to help family members understand the limits of the patient's circumstance
(c) Demonstrates both respect and sensitivity toward each member of family, taking care to avoid appearing aligned with any one person
(d) Facilitates communication between family members. Exercises good judgment in determining when referrals should be made for family members.
(e) Intervenes effectively and respectfully when strong conflicts arise in the therapy session.
(f) Demonstrates awareness of how age and developmental differences may affect each family member's capacity to understand or cope with the identified problem

Unacceptable
(a) **Without the patient's prior permission, Fellow discusses the patient's diagnoses, therapy, or recommends other involvement in patient's care to the family ***
(b) Approaches family in confrontational manner or limits role to that of patient advocate without obtaining family's perspective.
(c) Places self in conflicted role of being individual Fellow to more than one family member

20. The Fellow demonstrates expertise in conducting psycho-educational group therapy and classes.

Acceptable
(a) Uses empirically-supported approaches to group treatment and educational classes. Is able to follow evidence-based manuals.
(b) Uses supplemental, clearly written handouts or slides to facilitate learning.
(c) Is sensitive to subtle, nonverbal cues that suggest some members may be struggling to understand new material.
(d) Uses good clinical judgment in choosing appropriate level of complexity for material presented to intended audience.
(e) Uses good clinical judgment in determining type and amount of homework that may be appropriate for group or workshop members.

(f) Uses a teaching style that is interactive and engaging to promote rapport building, group cohesiveness, and a high level of patient engagement in group sessions.
(g) Administers appropriate assessment measure to monitor treatment outcomes.

Unacceptable
(a) Is unprepared for psycho-educational group therapy or workshop
(b) Focuses exclusively on group process
(c) Presents psycho-educational material in a disorganized, hurried, or unclear manner
(d) Does not appear to assess for group understanding or agreement with material presented or does not use this information to modify style of presentation

21. The Fellow appropriately assigns patients to brief behavioral interventions or traditional individual psychotherapy visits.

Not all patients are ready to engage in or can benefit from traditional (50-minute) individual psychotherapy visits. Often times, patients' problems, lifestyles, and psychological sophistication dictate that shorter visits focused on specific issues that can be addressed in a few encounters are more effective. In those cases, the Fellow must triage each patient on their caseload to decide which treatment track would be most beneficial for the patient.

Acceptable
(a) Triages patients to brief interventions vs. specialty mental health tracks based on severity, engagement, and treatment goals.
(b) Uses functional assessment, chart information, and initial contacts to make determination of best treatment path.
(c) Revisits decision as patient's history and response to treatment unfolds.
(d) Carries a balanced caseload with typically 40-60% of patients in a brief intervention track.
(e) Sets appropriate goals for patients in each treatment path.

Unacceptable
(a) Places every patient in a specialty mental health track to address current presenting concerns and history of mental health issues in one treatment course.
(b) Does not transition patients from brief interventions into specialty treatment track when it is clear that goals are not been met in the brief model.
(c) Is unable to independently assign patients to the most appropriate tracks and build a balanced caseload.

22. The Fellow selectively uses telehealth approaches when clinically appropriate.

Patients have many difficulties accessing behavioral health care and telehealth technologies have made it possible for them to receive services at home/work, using both audio and video platforms. However, not all patients and presenting concerns are conducive to successful remote treatment. The Fellow must understand which individual, clinical, and risk factors make patients suitable for telehealth and how to translate in-person approaches to the virtual realm.

Acceptable

(a) Understands the unique issues related to telehealth including appropriateness for audio/video services, risk management, and environment set up.
(b) Demonstrates an ability to build rapport and effectively deliver psychotherapy interventions tailored to phone or video conferencing.
(c) Maintains appropriate boundaries with patients while using telehealth.

Unacceptable
(a) Indiscriminately offers or fails to offer telehealth treatment.
(b) Does not consider medium-specific nuances in the delivery of interventions.
(c) Is unable to build rapport or set therapeutic boundaries via telehealth.

Consultation and Liaison

Part of the role of an IBH Fellow is to help bridge the gap between medicine and mental health. Referrals are generally made to IBH by physicians or nurse practitioners. On occasion, Fellows also must coordinate treatment with community providers. Being available, accessible, affable, and competent are the cornerstones to successful consultation and liaison skills. Items listed below refer to such behaviors. Fellows are required, at minimum, to perform at the "Acceptable" level.

1. The Fellow has pleasant, professional demeanor when interacting with staff from other disciplines or other psychology programs.

The Fellow is expected to respond to questions or feedback from other professionals in a cooperative and courteous manner. It is not acceptable to refuse to see a patient because the request has come during another training task. It is also not acceptable to convey to the referral source that a request is a burden or imposition.

Similarly, when making requests of another professional, the Fellow is careful to respect that individual's professional expertise and judgment. If the Fellow lacks expertise with a particular problem, she/he/they should request assistance from supervisor.

Acceptable
(a) Is courteous, professional, and cooperative with staff from other disciplines or other psychology programs.

Unacceptable
(a) Is discourteous toward staff from other disciplines.
(b) Complains about timing or nature of consultation requests.
(c) Refuses request to see a patient or recommends to the referral source that they call someone else.
(d) Refuses to engage with urgent clinical requests from broader treatment team due to administrative responsibilities.

2. The Fellow contacts referral source directly when a patient reveals information in session that may have impact on primary care provider's diagnosis or treatment.

Patients frequently share concerns or information with their psychologist that they may have neglected to mention to their medical provider(s). This may include discontinuing or altering the regimen of certain medications because of actual or feared side effects, taking OTC medications, using recreational drugs, or seeing multiple health care providers (outside SMMC system). This may also include unusual beliefs about medical conditions (e.g., "people who have angina should abstain from sex") or medications (e.g., "it's a good idea to take drug holidays from your insulin"). Patients may also reveal their reasons for refusing certain medical procedures to you (e.g., a patient w/ PTSD refuses to undergo an MRI; a sexually abused patient refuses colonoscopy) and this may explain why practitioner's efforts at educating patient about the procedure are not having an impact.

It may be helpful to acknowledge factors (such as anxiety, depression, beliefs about doctor-patient relationships) that may have influenced the patient to think or behave in a certain manner when communicating this information to a provider. In some cases, the Fellow may offer to meet with patient and primary care provider together so that the Fellow may later be able to reiterate information shared, assess for understanding of technical terms, or discuss multidisciplinary treatment plan. When the Fellow learns of information, which would be expected to have a direct impact on the patient's medical care, she/he/they should contact provider directly through the e-charting messaging system (TE), e-mail, voicemail, or phone. It is insufficient to include such information only in a progress note.

Acceptable

(a) Fellow promptly (within 24 hours) shares information with primary care provider that seems to have direct relevance to a patient's medical care.

Unacceptable

(a) Fellow is aware of patient behavior or beliefs that may be exacerbating her/his/their medical condition, interfering with treatment outcome or completion of appropriate diagnostic tests and neglects to directly inform primary care provider.

3. The Fellow always remains cognizant of the scope of a psychologist's practice and functions only within these limits.

Patients sometimes regard all of their health care providers as interchangeable - particularly when they are used to seeing several members of a team during one medical appointment. It is not unusual, therefore, for patients to ask a Fellow to provide medical information or advice to them at the time of an appointment. This may be in the form of requests to look up laboratory test data, radiology reports, or medical diagnoses in their charts. They may question the Fellow about her/his/their opinion of a particular diagnosis, course of treatment, diet plan, exercise regimen, or medication. Occasionally, they may request "permission" from a Fellow to increase, decrease, or discontinue a particular drug. In each case, the psychologist should refrain from providing medical information, opinions, or advice. Instead, the patient should be encouraged to speak with the appropriate medical provider(s).

One exception to this may be in the case of a patient who has repeatedly demonstrated some confusion over a diagnosis, prognosis, or medical regimen and this problem has been jointly

discussed with the primary care provider. In this case, the role of the Fellow may be to reiterate information they have both heard from the patient's provider.

Acceptable
(a) Fellow functions only within the scope of practice of a psychologist.
(b) Fellow refers patients to the appropriate health professional for their medical, pharmacological, social, dietary, or physical therapy needs.

Unacceptable
(a) Fellow provides patient with medical diagnoses, opinions, or recommendations.
(b) Fellow offers opinions regarding diet or appropriate exercise regimen for a patient with medical limitations.
(c) Fellow provides the services of a social worker or benefits counselor.

4. The Fellow can present to a multidisciplinary audience on IBH topics.

The role of psychologist within multidisciplinary or interdisciplinary settings includes educating other professionals. It is possible that each Fellow in IBH may offer at least one presentation during the year that may help other providers better understand how psychologists may assist in patients' health care. This experience requires some understanding of what other professionals may know about mental health issues. Information should be presented in a manner that is jargon-free, respectful of other's perspectives, and attempts to "bridge the gap" between Psychology and other clinical services. Fellows should be assertive in offering such presentations without waiting to be invited. A proposal for such a program should be suggested to the supervisor prior to launching the program to other disciplines.

Acceptable
(a) Arranges and carries out presentation for multidisciplinary audience, which is educational while also demonstrating spirit of cooperation and respect among professionals.

Unacceptable
(a) Does not follow through with presentation to multidisciplinary group.
(b) Makes presentation that grossly underestimates other providers' understanding mental health issues or fails to address how multiple disciplines can work together for optimal patient care.

5. The Fellow consults with professionals from other disciplines to assist them in providing optimal patient care.

When the services of another professional are needed, the Fellow consults with the appropriate discipline. This may involve sending a consult to another program (e.g., agencies such as Pre-to-Three, CORA) or discipline (e.g., mobile support, mental health access) to have patient seen, or informally conferring with a physician or nurse specialist who may be able to determine the patient's appropriateness for admission to a specific clinic. She/he/they may have additional information about a patient's medical condition or prognosis. If the Fellow surmises that a patient may require the services of a particular medical specialist (e.g., Neurology), the Fellow

should address these concerns with the patient's primary care provider and allow this individual to arrange for further medical follow-up.

Acceptable
(a) The Fellow routinely consults with other professionals to provide comprehensive patient care.

Unacceptable
(a) The Fellow does not follow through with referrals when they are warranted.
(b) The Fellow seeks medical specialty services without first conferring with a patient's primary care provider.

Empirically-Based Approach to Treatment

The Fellow should show evidence of their ability to integrate research and practice. IBH embraces an evidence-based approach to treatment that favors cognitive, behavioral, interpersonal, values- and mindfulness-based approaches to psychotherapy that have been demonstrated in the scientific literature to produce measurable reduction in symptomatology in relatively short periods of time. We encourage trainees to build their practice on the strength of the extent research evidence, but always tailor intervention and pace to the specific individual who they are treating. Fellows are required, at minimum, to perform at the "Acceptable" level as indicated below.

1. **The Fellow is able to review the literature effectively to identify empirically-supported treatments for patient's problems.**

Acceptable:
(a) Knowledgeable about the empirically based interventions for common forms of psychopathology that presents in primary care and outpatient mental health clinics.
(b) Checks the literature to be aware of empirically based treatments that are available for patients she/he/they is treating.
(c) Monitors patients' response to treatment and adapts approach accordingly.

Unacceptable:
(a) Fails to investigate a treatment area for empirically supported interventions
(b) Makes obvious misuse of the findings of empirically supported treatments.
(c) Fails to use outcome monitoring.

2. **The Fellow is able to find and incorporate relevant data from the literature into case conceptualization and interventions for complex cases in which standard empirically-supported interventions do not fully address the specified problems.**

Acceptable:
(a) Can apply the empirically-validated treatment interventions to aspects of a complex case.
(b) Recognizes the difficulties that are posed and can describe the potential problems and limitations of what they are doing.

Unacceptable:
(a) Unable to search the literature or locate evidence of empirically supported treatments.
(b) Uses relevant literature without awareness the case is very complex and does not fit the sample upon which the empirically supported intervention was based.

3. The Fellow demonstrates a systematic hypothesis-driven approach to case conceptualization and treatment with individual patients.

Acceptable
(a) Makes hypotheses about a patient that follow from a recognized body of knowledge and theory.
(b) Can modify the hypotheses based on data gathered from the patient.

Unacceptable
(a) Unable to formulate a hypothesis about why the patient acts as they do.
(b) Makes no provision for learning if a hypothesis is correct.
(c) Hypotheses about a patient are poorly formed and lack knowledge of a theory or body of research on behavior change.

Ethics

It is difficult to separate ethics from anything one does in clinical psychology. In past sections of these Competencies there are items that are ethical as well as procedural or skill-based. This section contains other ethical issues not previously covered. Fellows are required, at minimum, to perform at the "Acceptable" level as indicated below.

Virtue ethics focuses on the character of the Fellow. In essence it is not an issue of what you should do, but rather "Am I doing what is best for my patient?" or "I should do no harm." Virtue ethics are the values we hold as to what is good and desirable for our patients. Principle Ethics, on the other hand, is the codification of right and correct action. These are usually principles or rules adopted by an individual or group to establish right conduct. The two elements are important to ethical conduct and Fellows should be aware of both.

1. The Fellow strives to help the patient function more effectively.

This may include increased levels of autonomy, improved self-care, better functioning within social relationships, or within a social structure or culture.

Acceptable:
(a) Helps the patient to understand how they can manage their problems.
(b) Identifies the issues that produced the current problems.
(c) Works with the patient to better understand their role in creating the conditions in which they find themselves.
(d) Is aware of and modifies the treatment plan to meet the social role expectations of the culture of the patient.

Unacceptable:
(a) Fellow **rescues** the patient. They solve the patient's problems, but don't help the patient to learn how to solve the problem themselves.

2. The Fellow does no harm.

Acceptable:
(a) Does not exploit patients.
(b) Manages major personal issues so that they do not intrude upon a patient's therapy.
(d) Seeks consultation to insure appropriate treatment is rendered.

Unacceptable
(a) **The Fellow exploits a patient for personal gain**.*
(b) The clinician has personal issues that intrude on the process or outcome of therapy.
(c) The Fellow's behaviors severely impair treatment (e.g. sleeps during therapy, is **under the influence of alcohol or drugs during therapy**,* is so stressed by personal circumstances they cannot focus on the patient's problems).
(d) Fellow provides an inappropriate treatment that may be harmful.

3. The Fellow protects patient confidentiality.

Acceptable
(a) The Fellow does not talk about their patients except to people who have a need-to-know.
(b) The Fellow is careful to shut the door and avoid confidential conversations in the hallway.
(c) The Fellow does not share their hospital computer codes with anyone.
(d) Records and charts, including computer records, are kept secured.
(e) Hospital clinical charts are quickly returned so others can use them.
(f) The Fellow reviews the limits of confidentiality during the first visit.
(g) The Fellow questions the need-to-know of persons who would ask about a patient.
(h) The Fellow verifies another person's need-to-know before proceeding.
(i) In communications with persons outside the Medical Center the Fellow minimizes the information provided to meet the requirements of the report in order to minimize the intrusions on privacy.

Unacceptable
(a) The Fellow talks about a patient to someone who does not need-to-know.
(b) The Fellow gives access to patient records to someone who does not have a need to know**.**
(c) The Fellow gives someone else her/his/their computer codes**.**
(d) The Fellow is overheard or might be overheard by someone who does not need-to-know.
(e) Does not protect confidential records, including computer records, by leaving them out for others to see.
(f) Repeatedly violates HIPAA standards.

4. The Fellow protects test security.

Acceptable

(a) Declines to give out copies of tests.
(b) Can give rationale to the patient why this should not be done.
(c) Fellow tries to determine if there is a clinical issue behind the request.

Unacceptable
(a) **The Fellow gives copies of testing materials to a patient**.*
(b) The Fellow tells a patient or non-professional answers to test items including mental status questions.
(c) Unable to give rational why these are prohibited.

5. The Fellow avoids false or deceptive statements.

Acceptable
(a) Correctly identifies him-/her-/themselves to patients as unlicensed professional at the beginning of treatment.
(b) Progress notes accurately describe the patient's status.
(c) Corrects misinterpretations or possible misinterpretations by the patient when possible.

Unacceptable
(a) Misrepresents their training, experience, or level of competence.
(b) Fails to inform patients that they are not licensed and are being supervised.
(c) Writes information in the chart that may be false, misleading or deceptive.

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

San Mateo Medical Center
Integrated Behavioral Health
Mid-Year and End-of-Year Fellow Evaluation Form

Postdoctoral Fellow: Date:
Primary Supervisor: Term of Evaluation:
Secondary Supervisor:

The following scale is used to rate the fellow's performance on the below listed competencies. The postdoctoral Fellow must be in good standing receiving minimum ratings of 3 for each item by the end of the year review to successfully complete the postdoctoral fellowship. It is expected that by the end of the year review the Fellow will be performing at level 4.

1 **Very Poor** Needs basic training, and/or modeling, and/or supervision in most aspects of professional activities, and/or basic help or extra time in supervision; Concerns about professional, ethical, and/or clinical behavior arise and need to be addressed. Performance plan recommended.

2 **Poor.** Basic psychotherapy skills are intact however improvement is needed; Basic documentation skills are present but time management needs work. Needs supervision for integration of findings, conceptualization, recommendations, and intervention implementation; Behavior is typically professional and ethical but supervision, role modeling, and direction is be needed.

3 **Fair.** Minimal level of performance needed to complete postdoctoral fellowship. Expected level of performance during the first 6 months of the fellowship. Able to perform with minimal supervision in typical clinical situations; Needs assistance with novel ethical, clinical and professional situations. Generally, exercises good clinical, ethical, and professional judgment and seeks supervision when concerns arise; At times needs to be prompted by supervisor to address issues and modifies behavior when indicated.

4 **Good.** Expected level of performance by the end of the fellowship. Performs independently; Seeks supervision/consultation as needed on difficult or complex cases; Reviews clinical work, professional behavior, and ethical issues in a proactive manner with colleagues/ supervisors at a collegial level. Demonstrates confidence in clinical thinking skills and seeks consultation appropriately.

5 **Excellent.** Exceeds standards expected of a fellow. Functions independently in clinical tasks and actively collaborates with the team and primary care clinic. Exhibits strong ethical, clinical and professional judgment. Actively seeks opportunities for learning and comes to supervision to discuss solutions and thoughts about clinical questions.

N/A Not applicable or not observed.

Professionalism

Demeanor & Conduct

	Very Poor	Poor	Fair	Good	Excellent	
Attends and is on time to all scheduled meetings with patients, colleagues and supervisor(s)	1	2	3	4	5	N/A
Establishes and maintains effective professional relationships and boundaries with co-workers	1	2	3	4	5	N/A
Establishes and maintains appropriate boundaries with patients	1	2	3	4	5	N/A
Demonstrates courtesy and respect in interpersonal interactions	1	2	3	4	5	N/A
Complies with IBH's dress code	1	2	3	4	5	N/A
Adheres to clinic work hours and punctuality expectations	1	2	3	4	5	N/A

Comments:

Collaboration and Interpersonal Communication

	Very Poor	Poor	Fair	Good	Excellent	
Recognizes and values the role and expertise of patients, family members, and primary care team members	1	2	3	4	5	N/A
Serves as an effective member of the treatment team by helping identify patient's strengths and opportunities to use behavioral interventions in the service of overall wellness	1	2	3	4	5	N/A
Utilizes clear and concise language when communicating with treatment team	1	2	3	4	5	N/A
Recognizes and manages personal biases in the choice of treatment approaches and interventions	1	2	3	4	5	N/A
Listens actively and effectively (as demonstrated by ability to quickly grasp presenting problem, needs and preferences communicated by others, and reflect information to ensure that others have been accurately understood)	1	2	3	4	5	N/A

Comments:

Supervision

	Very Poor	Poor	Fair	Good	Excellent	
Demonstrates willingness to discuss clinical material in supervision/seminars	1	2	3	4	5	N/A
Presents cases for supervision in an effective and appropriate manner	1	2	3	4	5	N/A
Uses video and audio recordings to augment growth opportunities	1	2	3	4	5	N/A
Demonstrates familiarity with assigned readings through active discussion in meetings, seminars and supervision	1	2	3	4	5	N/A
Is receptive to feedback and integrated it into his/her clinical practice	1	2	3	4	5	N/A
Demonstrates the ability to utilize supervision and consultation effectively	1	2	3	4	5	N/A
Maintains appropriate boundaries with supervisor(s)	1	2	3	4	5	N/A

Comments:

Professional Development

Demonstrates awareness of strengths as a clinician	1	2	3	4	5	N/A
Demonstrates awareness of areas for growth as a clinician	1	2	3	4	5	N/A
Seeks self-directed training and opportunities to increase skill set	1	2	3	4	5	N/A
Prevents burnout through self-care and pursuit of balance	1	2	3	4	5	N/A
Demonstrates knowledge of licensure requirements	1	2	3	4	5	N/A

Investigates post-licensure career options	1	2	3	4	5	N/A

Comments:

Ethics

	Very Poor	Poor	Fair	Good	Excellent	
Demonstrates working knowledge of the APA ethical guidelines	1	2	3	4	5	N/A
Demonstrates working knowledge of HIPAA and California laws governing professional practice	1	2	3	4	5	N/A
Practices within established level of competence and scope of practice	1	2	3	4	5	N/A
Demonstrates the ability to recognize potential ethical dilemmas with colleagues or supervisor(s)	1	2	3	4	5	N/A
Demonstrates the ability to recognize potential ethical dilemmas with patients	1	2	3	4	5	N/A
Demonstrates an understanding of when consultation is necessary	1	2	3	4	5	N/A

Comments:

Integration of Science and Practice

	Very Poor	Poor	Fair	Good	Excellent	
Able to apply relevant literature to case conceptualization, treatment planning and clinical-decision making	1	2	3	4	5	N/A
Implements evidence-based interventions, modifying and adapting approaches when scientific literature is lacking	1	2	3	4	5	N/A
Tracks intervention effectiveness and adapts goals and methods according to ongoing symptom evaluation	1	2	3	4	5	N/A

Comments:

Multicultural Humility/Competence

Awareness

	Very Poor	Poor	Fair	Good	Excellent	
Demonstrates the ability to articulate own intersecting cultural identity(s)	1	2	3	4	5	N/A
Demonstrates ability to articulate how own background affects how they interact with people different from themselves	1	2	3	4	5	N/A

Comments:

Knowledge

	Very Poor	Poor	Fair	Good	Excellent	
Demonstrates familiarity with the current theoretical and empirical knowledge base as it relates to addressing diversity in all professional activities including research, training, supervision/consultation and interventions	1	2	3	4	5	N/A
Demonstrates openness and willingness to grow working knowledge about a variety of cultural groups	1	2	3	4	5	N/A
Demonstrates the ability to use appropriate language when referring to people of various cultural backgrounds	1	2	3	4	5	N/A
Demonstrates working knowledge of the social, economic and political factors impacting various cultural and ethnic groups	1	2	3	4	5	N/A
Demonstrates working knowledge of the impact of privilege, prejudice, and discrimination on a patient's functioning	1	2	3	4	5	N/A
Demonstrates working knowledge of how variants of cultural factors may influence clinical care	1	2	3	4	5	N/A

Comments:

Skills

	Very Poor	Poor	Fair	Good	Excellent	
Considers variants of cultural factors in assessment, diagnosis, and treatment	1	2	3	4	5	N/A
Communicates effectively and appropriately with clients of diverse cultural backgrounds, including use of an interpreter when necessary	1	2	3	4	5	N/A
Develops and maintains rapport with clients from a variety of cultural backgrounds	1	2	3	4	5	N/A
Demonstrates the ability to be flexible when working with clients from a variety of cultural groups	1	2	3	4	5	N/A
Provides clinical services in a manner that is culturally appropriate	1	2	3	4	5	N/A

Comments:

Clinical Competence

Administrative Skills

	Very Poor	Poor	Fair	Good	Excellent	
Demonstrates the ability to utilize SMMC's electronic record-keeping system	1	2	3	4	5	N/A
Prepares case notes and assessment reports in a timely manner	1	2	3	4	5	N/A
Consistently prepares notes according to IBH models and templates	1	2	3	4	5	N/A
Prioritizes work tasks appropriately	1	2	3	4	5	N/A

Comments:

Multi-Disciplinary Practice Skills

	Very Poor	Poor	Fair	Good	Excellent	
Understands and operates comfortably in the fast-paced team-based culture of primary care	1	2	3	4	5	N/A
Demonstrates understanding, flexibility and comfort operating across multiple hospital settings	1	2	3	4	5	N/A
Demonstrates a basic understanding of the different models of primary care behavioral health (e.g., co-located, integrated, etc)	1	2	3	4	5	N/A
Efficiently manages time while navigating scheduled brief intervention appointments and warm hand offs	1	2	3	4	5	N/A
Gathers pertinent information including medical record number, referral source, room/contact number, presenting problem, relevant psychosocial and medical histories during warm hand off call	1	2	3	4	5	N/A
Proactively evaluates appropriateness of warm hand off patients to clinic setting using all available information	1	2	3	4	5	N/A
Prioritizes clinical visits where risk factors may be present	1	2	3	4	5	N/A
Briefly introduces him/her/themselves as part of the patient's medical team and sets an agenda for the appointment	1	2	3	4	5	N/A
Completes functional assessment during most warm hand off visits including briefly assessing symptoms, providing a brief intervention, and discussing treatment options	1	2	3	4	5	N/A
Appropriately provides outside referrals as needed	1	2	3	4	5	N/A

Comments:

Clinical Evaluation

	Very Poor	Poor	Fair	Good	Excellent	
Demonstrates the ability to critically evaluate clinical information	1	2	3	4	5	N/A
Provides appropriate DSM diagnosis/es, when necessary	1	2	3	4	5	N/A
Conceptualizes cases following coherent psychological models and theories	1	2	3	4	5	N/A
Demonstrates flexibility in case conceptualization and modifies as necessary throughout treatment	1	2	3	4	5	N/A
Utilizes screening measures to track symptoms and treatment progress including administering self-report measures at least once every 5 visits	1	2	3	4	5	N/A

Comments:

Therapeutic Skills

	Very Poor	Poor	Fair	Good	Excellent	
Establishes rapport with patients	1	2	3	4	5	N/A
Demonstrates empathy for patients	1	2	3	4	5	N/A
Appropriately confronts patients when clinically indicated	1	2	3	4	5	N/A
Establishes effective and relevant treatment plans informed by scientific literature in collaboration with patients	1	2	3	4	5	N/A
Demonstrates ability to set and attain specific goals in time-limited approaches	1	2	3	4	5	N/A
Demonstrates good time management of 30-minute appointments including setting an agenda for the session and reviewing previously assigned home practice	1	2	3	4	5	N/A
Provides psychoeducation and tools directly related to the patient's presenting problem and	1	2	3	4	5	N/A

cultural perspective during brief intervention appointments						
Modifies treatment plan and interventions used as necessary during the course of treatment	1	2	3	4	5	N/A
Demonstrates the ability to assess patient readiness for termination	1	2	3	4	5	N/A
Demonstrates the ability to manage termination issues with patients	1	2	3	4	5	N/A
Attends to and manages countertransference	1	2	3	4	5	N/A
Demonstrates awareness of personal style and the use of self in providing psychological services	1	2	3	4	5	N/A

Comments:

Telehealth Skills

	Very Poor	Poor	Fair	Good	Excellent	
Demonstrates understanding of unique risk issues related to telehealth including consent, patient location, remote risk management, and availability of emergency contacts	1	2	3	4	5	N/A
Demonstrates understanding of how to set up the environment for telehealth including camera position, height, and backdrop	1	2	3	4	5	N/A
Effectively screens patients to determine if and when telehealth services are appropriate and when to revert to in-person visits	1	2	3	4	5	N/A
Demonstrates ability to build rapport remotely and deliver psychotherapy interventions adapted to phone or video conferencing models	1	2	3	4	5	N/A
Maintains appropriate boundaries with patients while using telehealth	1	2	3	4	5	N/A
Understands the capabilities and limitations of telehealth technical platforms	1	2	3	4	5	N/A

Comments:

Crisis Intervention

	Very Poor	Poor	Fair	Good	Excellent	
Appropriately recognizes urgent/emergent/crises situations	1	2	3	4	5	N/A
Appropriately recognizes when a patient is a danger to self, danger to other(s), or when there is evidence of child/dependent adult/elder abuse	1	2	3	4	5	N/A
Appropriately and efficiently evaluates the patient(s) mental status in urgent/emergent situations	1	2	3	4	5	N/A
Provides appropriate interventions based on the nature of the urgent/emergent situation	1	2	3	4	5	N/A
Provides appropriate referral(s) and follow up in urgent/emergent situations	1	2	3	4	5	N/A
Seeks consultation appropriately from supervisors or others in urgent/emergent situations	1	2	3	4	5	N/A

Comments:

Group Psychotherapy and Workshops

	Very Poor	Poor	Fair	Good	Excellent	
Demonstrates the ability to identify patient(s) who may benefit from interventions in group format	1	2	3	4	5	N/A
Differentiates between patients who can benefit from single-session classes vs. sequential and cumulative group content	1	2	3	4	5	N/A
Demonstrates the ability to effectively plan and prepare a group syllabus	1	2	3	4	5	N/A
Delivers psychoeducational presentations with confidence and mastery of subject matter	1	2	3	4	5	N/A
Demonstrates understanding of the stages of group development	1	2	3	4	5	N/A

Makes appropriate interventions at the individual and group level	1	2	3	4	5	N/A
Works effectively with group co-leader(s)	1	2	3	4	5	N/A
Processes interactions with group co-leader(s) in a constructive manner	1	2	3	4	5	N/A

Comments:

SUMMARY OF RESIDENT EVALUATION

Strengths

Areas of Growth

Recommendations

I have read and discussed the contents of this evaluation with my supervisor. I understand that I have the right to provide comments to the evaluation and that my signature does not imply agreement with this evaluation. I understand that I have the right to receive a signed copy of this evaluation.

Trainee's signature:_____ Date_____

Primary Supervisor's signature:_____ Date_____

Secondary Supervisor's signature:_____ Date_____

San Mateo Medical Center
Integrated Behavioral Health Services
SUPERVISOR EVALUATION FORM

Supervisor_____ Fellow_____(optional) Date_____

0-Not applicable
1-Behavior never displayed/observed
2-Behavior rarely displayed
3-Behavior often displayed
4-Behavior Typically Displayed
5-Behavior displayed without exception

General

Interest/commitment	0	1	2	3	4	5
Knowledge of areas being supervised	0	1	2	3	4	5

Structure

Time:

Promptness	0	1	2	3	4	5
Meeting times regularly scheduled	0	1	2	3	4	5
PRN Availability for consultation / Emergencies	0	1	2	3	4	5
Provides for back-up supervision during absences	0	1	2	3	4	5

Information:

Describes / Explains model / Approach for supervision at outset	0	1	2	3	4	5
Adjusts teaching model to skill / ability level of Fellow (e.g., less teaching/more deference to Fellow over year)	0	1	2	3	4	5
Provides own work samples to illustrate specific issues	0	1	2	3	4	5

Comments: _____
_____
_____

Process

Personal Characteristics:

Demonstrates respect for Fellow, clients, and colleagues	0	1	2	3	4	5
Open to feedback from Fellow	0	1	2	3	4	5
Creates/maintains emotionally safe environment for Fellow	0	1	2	3	4	5

Interpersonal Characteristics:

Gives regular, clear feedback verbally in supervision meetings	0	1	2	3	4	5
Observes both positive and negative Fellow behaviors	0	1	2	3	4	5
Explores Fellow countertransference reactions	0	1	2	3	4	5
Maintains appropriate professional boundaries	0	1	2	3	4	5
Demonstrates empathy and use of relevant self-disclosure	0	1	2	3	4	5

Comments: _____
_____
_____

Written Material:

Reports / Intakes returned w/ commentary within one week	0	1	2	3	4	5
Progress notes co-signed and returned within 2 days of receipt	0	1	2	3	4	5
Written feedback consistent w/verbal discussions/feedback	0	1	2	3	4	5

Comments: _____
_____
_____

Content

Conceptualization:

Assists in development of cogent case formulation	0	1	2	3	4	5
Provides input consistent w/developmental needs of Fellow	0	1	2	3	4	5
Encourages use of specific cases as examples of larger issues	0	1	2	3	4	5
When appropriate, refers Fellow to colleagues / research	0	1	2	3	4	5

Ethical Concerns:

Highlights potential client risk areas and assists in determining appropriate action(s) needed	0	1	2	3	4	5
Notices and processes w/ Fellow any diversity issues	0	1	2	3	4	5
Delineates resources for client safety (e.g., PES)	0	1	2	3	4	5
Guides / assists Fellow with interdisciplinary communication	0	1	2	3	4	5

Professional Responsibility:

Uses case examples to make Fellow aware of impact of their particular beliefs, personality or behavior	0	1	2	3	4	5
Explicitly addresses potential boundary violations	0	1	2	3	4	5
Provides formal evaluations at least twice per training year	0	1	2	3	4	5

Comments: _____
_____
_____

Overall Rating

Other comments: _____
_____
_____
_____
_____
_____
_____

Circle Overall Rating

0 – Poor Supervision Relationship
1 – Fair Supervision Relationship
2 – Adequate
3 – Good
4 – Strong, Informative & Supportive
5 – Consistently Excellent Overall

Signature: _____ Review Date: _____

San Mateo Medical Center
Integrated Behavioral Health Services

END-OF-THE-YEAR PROGRAM EVALUATION FORM

Fellow Name _____ Date _____

- Overall, how would you rate your experience in the past academic year?
- In your opinion, what were the highlights or strengths of the SMMC Psychology training program?
- What were the lowlights or areas for improvement in the training program?
- What suggestions do you have for short- or long-term program changes that would add to future Fellows' experience?
- Please indicate your level of satisfaction with each of the training program areas below.
    - Onboarding and orientation
    - Didactic seminars
    - Group supervision
    - Individual supervision
    - Group therapy training
    - Psychiatry grand rounds
    - Size of case load
    - Breadth of clinic intervention experience
    - Exposure to cultural diversity
    - Multi-disciplinary collaboration
    - 3AB inpatient rotation
    - CL inpatient rotation
    - FOHC outpatient rotation
    - Staff meetings
    - Clarity of expectation and responsibilities of Fellows
- Anything else you'd like to share?

_____

San Mateo Medical Center
Integrated Behavioral Health Services
Evaluation of Didactic Presentation

To improve the quality of trainings being offered in our psychology training program, we would appreciate you taking a few minutes at the end of the didactic presentation to complete this evaluation form. Your feedback will help us to plan for future trainings. Please fill out this form in ink.

Date of Presentation: _____ Presenter: _____

Presentation Topic: _____

	Strongly Agree	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**
The presenter was well-prepared for the presentation:					
The teaching format/method of the presentation was appropriate:					
The material presented was interesting:					
The material presented was informative:					
I acquired new skills or knowledge in relation to the topic discussed:					
The time of the presentation was used effectively:					
The presenter addressed relevant diversity issues:					
The presenter answered questions accurately, clearly, and effectively:					
	Excellent	**Good**	**Undecided**	**Bad**	**Very Bad**
On the basis of my overall impression of this presentation, I would evaluate it as:					

What aspect of the presentation did you like most and why?

What aspect of the presentation did you like least and why?

Suggestions for improvements in the topic or the presentation:

Didactic Schedule

- IBH didactics schedule is available online at the IBH shared folder and updated throughout the year whenever needed.
- Psychiatry, primary care and hospital grand rounds schedule are published on a rolling six-month basis and available from the SMMC continuing education department at https://smcgov.sharepoint.com/sites/Health/HA/Pages/Medical-Education.aspx
- Independent learning opportunities are available through 'my career development' County website at https://sanmateocounty.csod.com/client/sanmateocounty/default.aspx

Fellow Supervisee Weekly Log of Activities

Month

Supervisee's Name	
Work setting in which supervision took place	**San Mateo Medical Center, 222 West 39th Avenue, San Mateo, CA 94403**

Supervised hours for the week ending:	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**TOTAL**
Supervision & Training						
Face-to-face individual supervision with primary supervisor						**0**
Group supervision with primary supervisor						**0**
Face-to-face individual supervision with delegated supervisor						**0**
Group supervision with delegated supervisor						**0**
Training activities (e.g., didactics, case conferences, etc.)						**0**
Professional Services Performed						
Individual psychotherapy						**0**
Couples, children &/or family psychotherapy						**0**
Group psychotherapy						**0**
Testing & assessment (administration, scoring, interpretation, report)						**0**
Intakes						**0**
Consultations						**0**
Other Work Performed						
Staff meetings						**0**
Administrative duties (e.g., paperwork, review/update case file)						**0**
Other professional activities (e.g., phone calls, collateral contacts, travel)						**0**
Total number of hours of supervised experience per week	**0**	**0**	**0**	**0**	**0**	**0**

Primary supervisor's printed name and psychology license number:

Primary supervisor's signature and date

Delegated supervisor's printed name, license type and number:

Delegated supervisor's signature and date

Delegated supervisor's printed name, license type and number:

Delegated supervisor's signature and date

Delegated supervisor's printed name, license type and number:

Delegated supervisor's signature and date

Supervisee's signature and date

I certify that the information on this form accurately represents the training activities

of _____

at **San Mateo Medical Center, 222 West 39th Avenue, San Mateo, CA 94403**

Primary supervisor's printed name and psychology license number:

_____

Primary supervisor's signature and date