



**BARROW NEUROLOGICAL INSTITUTE
at
PHOENIX CHILDREN'S HOSPITAL**

**DIVISION OF
BEHAVIORAL MEDICINE**

HANDBOOK

2011 - 2012

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INTRODUCTION TO PCH

Phoenix Children's Hospital (PCH), the state's only hospital exclusively for children, serves all of Arizona and surrounding states. Since it was founded in 1983, PCH established its own campus for children from birth to age 18. PCH is one of the 10 largest hospitals of its kind in the United States.

PCH offers virtually every pediatric specialty, including cardiology, cystic fibrosis/pulmonary, dermatology, diabetes/endocrinology, gastroenterology, genetics, hepatology (liver disease), hematology/oncology, infectious diseases, neonatology, nephrology (kidney disorders), neurology, orthopedics and rheumatology. Most surgical specialties are available for infants, children, and adolescents.

Health professionals at PCH keep pace with the latest medical advances, treatments and therapies through continuing education and in-house research.

PCH serves all children of Arizona regardless of race, creed, national origin, or religious preference. The hospital-based physicians, psychologists, and residents help to ensure that the finest medical services are always at hand.

Facilities: In 2011, PCH opened a \$588 million expansion that is one of the 10 largest free-standing children's hospitals in the country ultimately building out to 626 beds. A virtual tour of the new facility can be experienced at <http://www.phoenixchildrens.com/about/expansion/opening-landing.html>. PCH's five-story East building, which opened in May of 2002, is a 265,000 square foot pediatric hospital (including an emergency department). PCH has Specialty Care Centers around the valley and Phoenix Children's main Neonatal Intensive Care Unit (located at Good Samaritan).. Most outpatient visits are scheduled in the PCH Ambulatory building. Some specialty offices, including the dialysis unit and outpatient surgery, are in the Rosenberg building, and several clinics have relocated to the new tower..

Outpatient Care: The hospital's four-story Ambulatory Building, Rosenberg Building and the second floor of the Main Building are full-service outpatient facilities. The outpatient clinics encompass a wide range of care, from well-baby visits to treatment of major childhood illnesses. Besides general pediatric care, the outpatient offices offer specialty clinics for everything from audiology assessments to treatment for cystic fibrosis so that children with chronic conditions can receive treatment from teams of specialization on a regular basis.

BEHAVIORAL MEDICINE SERVICES

The primary goal of the Division of Behavioral Medicine is to improve the quality of life for patients and their families. To this end, members of the department work closely with physicians, nurses, teachers and other professionals to assist children and their families with those behavioral, emotional, social and family issues that impair their physical/emotional health.

The department staff consists of licensed psychologists, child psychiatrists, pre-doctoral interns, predoctoral psychology practicum students, and administrative staff.

Behavioral Medicine is a recognized subspecialty of the Barrow Neurological Institute at PCH which deals with health related issues such as adjustment to a medical diagnosis, its treatment, pain management, resolution of psychological factors affecting a medical condition, maintenance of good health and prevention of illness, and assessment of children and adolescents.

In addition to direct services, the Division of Behavioral Medicine is actively involved in the education and training of health care professionals regarding psychological and behavioral problems and the special needs of hospitalized children and their families. The department functions as an integral part of the hospital structure; staff psychologists serve on a variety of interdisciplinary committees which generate hospital policies and facilitate patient care.

1) INPATIENT SERVICES

1. Direct services include the following:

- Assessment of patients at danger to self and/or others due to psychological problems
- Developmental assessment and consultation
- Neuropsychological testing and consultation
- Evaluation and treatment of such problems as:
 - Anxiety, Depression
 - Adjustment to medical diagnosis
 - Compliance with medical treatment
 - Pain management
 - Parent-child problems
 - Loss and grief issues
 - Acting-out behaviors
 - Neurologically mediated cognitive and behavioral disorders

2. Other services include:

- Participation in both medical and psychosocial rounds in the different hospital subspecialties.
- Consultation with physicians, nurses and other health care professionals regarding Behavioral Medicine issues.
- Supportive interventions with hospital staff to alleviate the stress of patient care.
- Provision of educational seminars to hospital staff.
- Involvement in decisions related to discharge planning.

2) OUTPATIENT SERVICES

1. Direct patient services:
 - Individual, family and group psychotherapy
 - ADHD/LD Assessment
 - Developmental Assessment
 - Neuropsychological testing
 - Behavioral Assessment
 - Services in outpatient medical clinics
2. Other services:
 - Consultation with physicians, schools, and human service agencies and other involved professionals regarding patient care issues.
 - Education of staff or the public on the use of psychological services or particular modes of intervention
 - Coordination of mental health services with community agencies.
 - Referrals to community resources to address special patients' needs.
 - Collaboration and consultation with schools to develop appropriate educational programs for children followed at PCH.

TRAINING PROGRAM

Our Mission is to provide excellence in Behavioral Medicine training to graduate students, interns, and post-doctoral students.

Values:

Integrity – to exhibit high standards ethically and professionally within the practice of psychology.

Dignity – to show dignity and respect through our interactions with our advanced psychology students, our patients, and all others, regardless of culture, race, religion, employment status, or individual differences.

Nurturing – to support our advanced psychology students in a manner which nurtures mastery and excellence.

The purpose of the Training Program within the PCH Division of Behavioral Medicine is to provide a training experience to graduate psychology students within an interdisciplinary hospital setting. We expect that by the end of your training you will have gained knowledge and skills that will enhance your professional development and will allow you to move you closer to independent practice.

Trainees will learn to assess, diagnose, treat and evaluate psychological problems associated with acute and chronic illness in children and their families. In addition, they will provide clinical and consultative psychological services to the inpatient and outpatient programs at PCH.

As a Department, we want to provide the best possible clinical psychology training in Behavioral

Medicine. We continually strive to grow and improve in that arena. Your feedback will be very helpful to us in that process, and we appreciate it.

Predoctoral interns are recruited, screened, and selected in late fall and early winter according to APPIC procedures. Training for both fellows and interns is one-year in length starting in the beginning of July. The Training year ends June 30th of the following year.

Training at the intern level will conform to the guidelines of the APA and the Association of Psychology Postdoctoral and Internship Centers (APPIC). Training for both interns and post-doctoral fellows will meet the standard for State licensure as established by the Arizona Board of Psychology.

The training model at Phoenix Children's Hospital is that of scholar-practitioner. Consistent with this model and its emphasis on the mutuality of science and practice, the focus of our training program is on the practical application of scholarly knowledge in the provision of direct patient care, coupled with the evaluation of the efficacy of those interventions and continued planning to improve those services. Interns are trained to think critically in the delivery of services that take into account individual, cultural, and societal considerations. The majority of current staff members were trained in the scientist-practitioner model and see the inclusion of empirical work as a necessary component for the competent treatment of psychological problems. We strive to provide interns with a breadth and depth of training experiences in the context of utilizing innovative scientific information to guide their treatment planning, conceptualization, and delivery. All staff members remain actively involved in professional associations, continuing education, and reviewing the relevant literature, in order to constantly improve the quality of their work and supervision. Some staff are also involved in ongoing clinical research studies.

Successful Completion of the Training Program

We fully expect that all trainees will successfully complete our training program. We have expectations and specific criterion for the successful completion of your training program, and we want to make sure you were aware of those. We think it's easier if you know exactly what to expect.

Training in a hospital setting can be a unique experience. Often, people come to our site without a large amount of hands-on training in the hospital setting. Therefore, there may be certain areas and skill sets where you will need to gain additional education or complete extra work. In the first two evaluation periods (three or six months), if we identify any of these needs, your supervisors will work with you to develop specific goals to gain this education. (You will be given these evaluation forms during orientation). As a part of developing these goals, your supervisors will also talk with you about a timeline regarding receiving feedback about your progress.

For interns and post-doctoral students, we conduct formal written evaluations two times per year (at the end of six months and at the end of the year). We have different training goals for each level of training. In general, we expect that practicum students will be focusing more on skill acquisition. We expect the internship year to focus more on integration of these skills along with the development of your professional identity. We expect the post-doctoral fellowship year to focus more on the refinement of therapy and/or assessment and professional skills to the level of the independent practitioner.

For practicum students, we expect you will need more practice and fundamental knowledge-building for some skill areas at the beginning of the training year. Thus, we expect that your skills will continue to develop from those that need close supervision to ones that can be practiced with direct or guided supervision by the end of the training year.

For interns, we expect that initially, you will need more supervision and guidance, so supervision will be more hands-on. Thus, it would be expected that many of your initial ratings will be in the E (Entry level/Continued intensive supervision is needed) to HI (High Intermediate/Occasional supervision needed) range. There may even be areas where you might get an R (Needs remedial work). Again, that's not unexpected as you are learning a new system and set of skills. By the end of the year, we expect that you will receive a rating of HI or A (advanced) for at least 90% of the training criterion on the rating forms.

For post-doctoral fellows, we expect that, initially, you will have well developed skills in some areas and need additional practice in others. Thus, we expect that the majority of initial ratings will be in the I (Intermediate/Should remain a focus of supervision) to A (Advanced/Skills comparable to autonomous practice at the licensure level) range. By the end of the training year, we expect that you will receive a rating of HI or A or at least 90% of the training criterion on the rating forms with the majority of ratings being in the A range.

For all levels of training, we also expect that trainees will adhere to the Department and Hospital Policies and Procedures.

There may be some times when you and your supervisor develop an educational plan, and there are still difficulties and concerns after finishing the plan. In this case, we may talk with you about whether there is a need to place you on probation. We would never place someone on probation without a great deal of discussion and advance warning, so you don't need to be worried about someone surprising you. We will go over the probation policy during orientation, and a copy is in your manual.

Evaluation of Trainees

For interns and post-doctoral fellows, individual evaluations are conducted three times a year; formal written staff evaluations are conducted at three months, at the end of six months, and at the end of the training year. These evaluations look at the students' strengths in a variety of areas including diagnostic skills, interventions, testing, ethics, professional development and response to supervision. Evaluation results are shared with the trainees so that goals can be defined and planned for and refinements in trainee performance can occur. We will provide initial informal feedback about trainee performance by the middle of October. A copy of the evaluation forms will be handed out at orientation. This feedback is intended to be helpful in establishing training goals for the remainder of the year. Trainees are also asked to evaluate their supervisors and the Training Program at the end of six months and at the end of the year. Supervisor and Training Program evaluations are used to review and clarify track strengths and weaknesses, supervisor performance and program efficacy.

In addition, we will ask you to evaluate yourself. At the beginning of the training year, we will ask you to complete the Evaluation form. We would like you to really think about what you perceive to be your strengths and areas that you would like to work on further. We won't ask you to share your actual evaluation (but do save it to review at the end of the year, as you may

be surprised at how you grew).

Signing off on Training Hours

Licensing Boards will want information that your internship or postdoctoral fellowship hours have been completed. It is our procedure that we do not sign off on those hours until you have completed your internship or fellowship training. The Director of Training will be happy to sign off on those hours on the last day of your training, so you can complete the forms and have those ready for signature at that time.

Graduation Letters

On occasion, interns have requested letters regarding the successful completion of internship in order to participate in an official graduation ceremony from their doctoral program. While we cannot provide a letter saying that you have completed your internship until June 30th, we can provide a letter stating how many hours you have completed, what your current standing is in the program, and whether or not you are likely to complete the program successfully.

Library Resources:

The Medical Library is located in the Administration Building. We also have The Emily Center located in the East Building of the hospital which is a resource for the entire community with books and articles relating to many of the illnesses/diseases of our patients. You may check out books, journals, videos, and other educational material from both sources. Please remember all materials must be returned on time. The library also provides literature searches (predominantly in Medline rather than Psychlit), that they can interoffice mail to the department as soon as they arrive/are available.

SUPERVISION

Current Internship Supervisors:

Dr. John Barton is the Director of Training for the Internship and Director of Clinical Psychology Services. He has been a licensed psychologist for the past 25 years. He is a diplomate of the ABPP for Clinical Child and Adolescent Psychology. Dr. Barton is Director of the Clinical Psychology Center at Arizona State University and supervises graduate students at Phoenix Children's Hospital in outpatient therapy as well. In addition to providing supervision to graduate students at ASU and PCH, he also teaches courses on assessment and therapy. He provides invited lectures on child and pediatric health issues to psychologists, physicians, educators, and the community at large.

Dr. Michael Lavoie, the Director of Neuropsychology Services, has been a licensed psychologist for 20 years and had two years of post-doctoral experience in Neuropsychology. He has been training students and conducting neuropsychological evaluations for the past 20 years. He has taught undergraduate and graduate courses in Brain Development, Brain and Behavior Relationships, Anatomy and Physiology, Human Physiology, and Clinical Neuropsychology at Assumption College and Clark University in Worcester, Massachusetts, and at Arizona State University. Dr. Lavoie has lectured at local and state conferences, and has presented at national conferences. He is a member of the Neuroscience Advisory Committee and the Professional Health Committee at Phoenix Children's Hospital, and is the past president of the Arizona Neuropsychological Society.

Dr. Joy Goldberg has been providing pediatric psychology services to children for over 10 years. Dr. Goldberg worked as a school psychologist in the Tempe and Glendale Elementary School Districts for over four years and then completed two years of a post-doctoral fellowship at Phoenix Children's Hospital, specializing in the field of Neuropsychology. She has co-written books on the importance of neuropsychology in the hospital setting and is an active speaker at local and state conferences. She is a member of the American Psychological Association, National Academy of Neuropsychology, Arizona Psychological Association, and Arizona School Psychology Association. Her interests include assisting families and patients with navigating the special education system and researching the varying neuropsychological effects of Epilepsy.

Dr. Karen Peterson has worked across several different types of medical settings since becoming a licensed psychologist 23 years ago. She has worked across settings with children, adolescents, and adults. Dr. Peterson has co-edited a book on AIDS Prevention and Treatment and written other books/chapters on health psychology and stress management. She has provided coursework and continuing education seminars for health care professionals.

Dr. Jeanette Smith has been providing assessment and treatment to children and families as a licensed psychologist for the past 18 years, working in both outpatient settings and medical inpatient settings. She completed her predoctoral internship and post-doctoral fellowship at Children's Hospital, Boston. She has provided continuing

education seminars for physicians, psychologists, other health care professionals, as well as psychology and medical resident training.

Expectations You Should Have of Supervisors:

We believe that our training program should be of benefit to all trainees. A key way to ensure that the training program is of benefit is to ensure that we meet certain standards in our supervision. In order to provide our trainees with the best supervision possible, PCH supervisors and personnel aspire to provide the following:

1. At least four hours of supervision each week, at least two of which are face-to-face individual supervision. We will try to reschedule or make up for supervision if the supervisor is unavailable.
2. A consistent, safe, judgment-free environment, which is focused on learning and the avoidance of non-constructive criticism.
3. Modeling, direct instruction, and processing as needed.
4. Direct supervision (observation and co-therapy) at the beginning of the year for consults, as well as on high-risk and complicated consults throughout the year.
5. A licensed clinician or supervisor available at all times to consult on difficult cases or emergency situations.
6. Sufficient training to address the needs of both the developing clinician and his or her patient.
7. Opportunity to listen to concerns and complaints of the trainees and attempt to problem solve issues or conflicts.
8. Careful observation of trainees in multiple situations (live, video recordings, written work, and self report) and give feedback in a constructive fashion.
9. Regular feedback so that evaluations are not a surprise.
10. Encouragement for practicum students, interns and fellows to reach goals for improved techniques and clinical understanding.
11. We will make every effort to minimize trainee's time spent on time-consuming activities that are not obviously educational in nature, although a certain amount of these activities are a part of any clinical practice and thus we feel it can be educational.
12. Supervision time is designed to meet the professional and educational needs of the trainee. Supervisors will avoid using the trainee's time to meet the needs of the supervisor.
13. We recognize that supervision is, by its nature, imbalanced in power. Because of this, it is possible that you will be aware of this differential and feel uncomfortable disagreeing or standing up to your supervisor. Supervisors at PCH will work hard to make supervision a comfortable experience and to develop an environment where you feel comfortable sharing

your concerns.

14. Supervisors will work within their area of expertise.

We aspire to provide all of the above. Being human, we may make mistakes along the way. We encourage you to communicate with us when this happens. At other times there may be miscommunication or other reasons, where you may feel that these standards haven't been followed. In these cases, we encourage direct communication with the supervisor in question. If this is not possible, we also encourage the trainee to discuss their concerns with the Director of Training. If you have concerns with the Director of Training, please address your concerns to the Director of Behavioral Medicine. (See Grievance and Appeals Procedures for more detail.)

Preparation for Supervision

In order to most fully benefit from supervision time, past trainees have found the following suggestions to be useful:

1. Prioritize patient needs and clinical difficulties.
2. Collect charts of existing patients and referral forms of new patients, to be brought to supervision.
3. Arrive on time for supervision.
4. Present up-to-date edited progress notes for co-signature.
5. Present clients in order of most to least concerning, attempting to consider the number of patients to discuss when deciding what level of detail to address in supervision.
6. Be sure to inform your supervisor when you feel the need for additional supervision. Informal brief case consultation is typically available as needed throughout the week.
7. If you have video recorded a session, please review the session ahead of time and be prepared to suggest what part of the session should be reviewed.

Supervision - Patient Load:

It is your responsibility to inform your supervisor of your current patient load. This should be done by completing the Patient Tracking form distributed at orientation and reviewing periodically during supervision. It is important to inform a supervisor when you are considering picking up a new patient. It is also important that both you and your supervisor assess if you are carrying too many patients to effectively supervise during your supervision time each week. If you and/or your supervisor feel that you have too many patients to effectively supervise, please inform the Director of Training.

Supervisor Signatures:

All of your patient contact must be supervised by a licensed psychologist. Therefore, all notes, reports, and correspondence (to or about a patient) must be co-signed by the supervisor for that track. Failure to obtain a co-signature could be cause for disciplinary action.

Training Program: Important Policies and Procedure

DUE PROCESS AND GRIEVANCE PROCEDURES

Problems that Could Arise:

At this level of training, interns are not expected to be independently functioning psychologist. However, it is expected that interns: always consider the best interests of their patients, be aware of limitations and when more supervision is necessary, be assertive about needs for additional supervision, follow the APA Ethics Code, work hard, be conscientious, and avoid of the work infractions listed below.

Minor infractions will typically be brought to the intern's attention by their primary supervisor or the Director of Training as soon as possible. The first goal is to work with the intern if there are any concerns. Interns should be aware of the steps that can be taken if there are repeated problems or if individuals are not willing to work on the problems identified.

Minor infractions typically involve a verbal warning. If repeated, these may lead to a written notice. Depending on the situation, one or more written notices may lead to a referral for counseling. Examples of minor infractions include inappropriate dress, uncooperative attitude, and repeated tardiness.

Moderate infractions typically result in a written warning, which is placed in the intern's personnel file. Depending on the situation, Phoenix Children's Hospital reserves the right to take additional disciplinary action, such as temporary absence without pay. Examples of moderate infractions include improper or abusive language, refusal to perform work as instructed, disclosure of confidential information, and unexcused or misrepresented absences.

Serious infractions require disciplinary suspension or discharge. Examples of such inappropriate behavior for the work place are: intoxication, jeopardizing the health and safety of a patient, or insubordination.

Major infractions generally lead to discharge, but are limited to extreme behavior such as physical assault, theft, immoral conduct, or sexual harassment.

Policies Governing Development and Performance Plan, Resignation, and Appeals Process

While it is expected that all trainees will successfully complete the program, there are guidelines for placing trainees on a Development and Performance Plan if problems cannot be resolved informally and for terminating the individual if problems cannot be resolved with a formal

Development and Performance Plan. As noted below, there are numerous steps involved and interns will be fully informed before these processes would be initiated.

There is an appeals process in place if interns disagree with the decisions made by the Training Program. Policies that guide the early resignation process from the program are also present.

Development and Performance Plan and Termination

If, despite informal instruction from supervisors, a trainee does not perform his/her duties as required, or if the trainee conducts himself/herself in a manner that is contrary to the interest of the hospital, the Director of Training may place them on a Development and Performance Plan according to the following procedures:

1. Initial Reprimand:

The Director of Training and/or supervisors will discuss matters of concern with the psychology practicum student/intern as they become evident.

2. Written Reprimand:

This is a more serious and higher level of discipline which may be taken by the Supervisor or Director of Training.

A written reprimand should document the following:

- 1) Intern's name;
- 2) person(s) present at the meeting in which the Supervisor or Director of Training gives the written reprimand to the Intern;
- 3) the reason for the reprimand;
- 4) a brief description of the incident or conduct for the reprimand;
- 5) the dates and times of the conduct for which the Intern is being reprimanded;
- 6) dates of prior discipline regarding such conduct and any recommendations to correct deficiencies; and
- 7) a signature line for the Intern and Director of Training.

By signing the document, the Intern is simply acknowledging receipt of the document. If the Intern refuses to sign the document, the Director of Training should make that notation on the document, sign and date it. The written reprimand may include a monitoring or observation period, state the standards for judging the Intern's improvement and how often during this period the Intern will be evaluated.

3. Concern Status:

This is a level of formal discipline less serious than the Development and Performance Plan. An Intern may be placed on Concern Status by the Director of Training for a period up to six months. The Director of Training must notify the Chief of Behavioral Medicine and the Medical Education Committee in writing of placement of an Intern of Concern Status. Any extensions thereof or move to a Development and Performance Plan Status requires approval of the Chief of Behavioral Medicine and/or the Phoenix Children's Hospital Medical Education Committee. There are three types of Concern Status: Clinical, Academic and Professional. Clinical Concern includes unsatisfactory performance on the clinical portions of the internship program. Academic Concern includes unsatisfactory performance in the knowledge base portions of the internship

program. Professional Concern includes behaviors that call into question the ethical, personal or moral attributes of the intern as they relate to fitness to practice psychology. During the period of Concern Status, the Director of Training shall evaluate the Intern monthly; shall inform the Intern in writing of the deficiencies and expectations for remediating concern status and may remove Intern from such status by written notice with copies sent to the Chief of Behavioral Medicine.

4. Development and Performance Plan:

This is a period of critical examination of an Intern to determine if the person is fit to continue in the program. A Development and Performance Plan may be preceded by Concern Status (clinical, academic or professional) but may be imposed without such prior discipline if warranted by the seriousness of the precipitating circumstances. The Development and Performance Plan may be imposed for up to three months by the Medical Education Committee upon recommendation of the Director of Training and the Chief of Behavioral Medicine. Extended Development and Performance Plan status shall be reviewed by the Medical Education Committee. During the period of a Development and Performance Plan, the Director of Training shall evaluate the Intern monthly; shall inform the Intern in writing of the deficiencies and expectation and may remove Intern from such status by written notice with copies sent to the Chief of Behavioral Medicine and the Medical Education Committee.

SATISFACTORY REMEDIATION

If the psychology practicum student/intern has satisfactorily met the conditions of the remediation contract, according to written input from supervisors and other relevant hospital staff, the psychology practicum student/intern will be removed from Development and Performance Plan status. The Director of Training will also notify the Training Director of his/her doctoral training program of successful remediation.

TERMINATION FOR CAUSE

The Phoenix Children's Hospital Psychology Internship Program Committee may recommend the termination of an Intern's Contract for any of the causes enumerated in the Intern Contract. Approval to terminate must be obtained from the Chief Executive Officer of PCH. If a practicum student or intern is terminated, a letter will be written by the Division of Behavioral Medicine Psychology Director of Training to the University's Director of Training outlining the problems, the attempts at resolution and the reasons for the decision to terminate the trainee.

* The above mentioned policy may be used in conjunction with the policies already established.

Appeals Procedure:

If a Psychology practicum student/intern is dissatisfied with the decisions regarding the practicum student/intern, the following procedures will be utilized:

1. The Psychology practicum student/intern will discuss the matter with the Chief of the Division of Behavioral Medicine. The Chief of the Division of Behavioral Medicine will meet with all concerned members as deemed appropriate.
2. If the matter is not satisfactorily settled in Step 1, the Psychology trainee may appeal in writing to the Chief of the Division of Behavioral Medicine. The appeal shall include all pertinent facts and the remedy requested by the trainee. The Chief of the Division of Behavioral Medicine will again meet with all concerned members as deemed appropriate.

3. If the decision of the Chief of the Division of Behavioral Medicine is not acceptable to the intern/fellow, he/she may appeal to the Graduate Medical Education Committee. The GMEC may appoint a subcommittee of its members to serve as an Appeals Subcommittee to handle formal grievances initiated by an Intern.
4. The Chief Medical Officer will render a decision which in all events shall be final and binding on all parties.

GRIEVANCE PROCEDURE

Purpose:

The Phoenix Children's Hospital Internship Program is committed to maintaining a fair method of resolving Intern concerns and answering questions. To this end, all Interns are encouraged to informally raise any questions or concerns they have about the terms or conditions of their employment. If informal methods are not satisfactory, the Intern Grievance Policy makes a four-step process available to Interns who wish to file a grievance. Phoenix Children's Hospital Internship Program is also committed to preventing any retaliation against persons who raise legitimate questions about the terms and conditions of employment in good faith.

Policy:

Interns are encouraged to raise questions or concerns about the Intern Employment Contract, academic programs and policies, departmental work rules, and unsafe or unhealthy work environments. Interns should discuss these issues with their Supervisors or Director of Training whenever possible to resolve the concerns. If the concerns cannot be resolved to the Intern's satisfaction by the Intern's Supervisors or Director of Training, this procedure provides for additional, prompt, review by the Directors of Behavioral Medicine, Medical Education and the Chief Medical Officer.

Procedure:

Step 1: Ordinarily the Intern is expected to start by seeking answers to a question or resolving a concern by an informal discussion with his or her Supervisors or Director of Training.

Step 2: If the question or concern cannot be resolved informally, the Intern may file a formal grievance and again discuss the question or concern with his or her Supervisor, Director of Training, and Director of Behavioral Medicine. The Intern should clearly document their grievance, the date of occurrence, and results of any prior discussion regarding the matter with their supervisor or Director of Training.

Step 3: If the Intern is not satisfied with the response of the Supervisor, Director of Training, and Director of Behavioral Medicine to Step 2, the Intern may forward his or her concern to the Graduate Medical Education Committee. The GMEC may appoint a subcommittee of its members to serve as a Grievance Subcommittee to handle formal grievances initiated by an Intern.

Step 4: If the Intern has taken Step 3 and still is not satisfied with the response that has been received, (or a timely response has not been provided to the Intern), the Intern may address a written request for review to Phoenix Children's Hospital CMO. Where appropriate, the CMO or

designee will investigate, review, and discuss the Interns concern with the Intern as soon as possible. The CMO or designee will provide a written response to the Intern, which will be the final decision and resolution of the Interns concern.

Retaliation:

Phoenix Children's Hospital Psychology Internship Program is committed to preventing any retaliation against persons who, in good faith, raise legitimate questions about the terms and conditions of their employment. All managers and supervisors at all levels are expected to take the time to answer questions, and work toward the resolution of workplace concerns.

Phoenix Children's Hospital Psychology Internship Program will provide Interns with fair and reasonable procedures for due process that minimize conflict of interest by adjudicating parties in addressing:

- Academic or other disciplinary actions taken against Interns that could result in dismissal, non-renewal of a Intern's agreement, non-promotion of a Intern to the next level of training, or other actions that could significantly threaten a Intern's intended career development; and,
- Adjudication of Intern complaints and grievances related to the work environment or issues related to the program or faculty.

The above mentioned policy may be used in conjunction with the policies already established at PCH.

Resignation Procedure for Trainees

It is the policy of the Department of Pediatric Psychology to have a protocol for the early withdrawal or resignation of a trainee. The protocol will clarify the Departmental expectations of trainees, who may, for personal reasons or reasons of dissatisfaction, wish to terminate their tenure prior to the date set forth in the training agreement.

1. The psychology trainee who is considering early termination of the training year will first discuss this issue with the Director of Training. The goal will be to clarify reasons for the decision and develop a plan to improve the problems and to create options.
2. In the event that resignation appears to be the only viable solution, the trainee will meet with the Director of Training and Chief of the Psychology Department and other relevant staff members, in order to discuss the matter of resignation and create a time line for ending. Issues of patient care will be given priority consideration in developing a time-line for resignation.
3. Should it be a practicum student or intern requesting premature termination from his/her training experiences, the Director of Training from his/her home doctoral program is to be consulted regarding this request.
4. After meeting with the PCH Division of Behavioral Medicine's Director of Training (and, for practicum students and interns, speaking with their University's Director of Training), the trainee will submit a written letter of resignation to the Division of Behavioral Medicine's Director of Training.

5. After officially resigning, a letter will be written by the PCH Division of Behavioral Medicine's Director of Training to the University's Director of Training outlining the problems, the attempts at resolution and the trainee's decision to terminate his or her position.
6. The trainee will be expected to complete all charting responsibilities and to follow standard termination procedure prior to leaving the site.
7. Psychology interns will only receive credit for the hours of training completed up to the point of the resignation.

ADMINISTRATIVE ISSUES

Departmental Policies

Working Hours and Off Hours Coverage:

The Department of Behavioral Medicine office is open from 8:00am to 5:00pm, Monday through Friday, throughout the calendar year. There is flexibility in the working hours based on your patient schedule. Please work with your supervisors and the Director of Training to set your schedule.

There are office staff on duty from 8:00am to 4:30pm Monday through Friday. At all other times, there is a voice mail pick-up, which instructs that emergency calls be diverted to the hospital operator. The operator will then page the psychiatrist on call.

All consults that are referred to the Department between 8:00am and 4:30pm are handled by the daytime consultants. Consults will be handled by the daytime consultants until 4:30pm (giving them one hour to begin the consult prior to 5:30pm). If a consult is called after 4:30pm, the daytime consultant will call the medical team and determine the priority. Decisions about whether the consult must be done that evening or can wait until tomorrow are made in conjunction with the supervising psychologist.

Emergency coverage is provided on weekends from Friday, beginning at 4:30pm to Monday, at 8:00am and weekdays from 4:30pm to 8:00am the next day. This coverage is provided by the psychiatry department on a rotating basis. The psychologist and trainee carry their pagers at all times during the day. Please reply promptly to pages.

Vacation and Holidays:

PCH provides Paid Time Off benefits to interns for vacations, holidays, personal needs, and illness through Paid Time Off (PTO). Paid Time Off is provided to interns for “periodic rest and relaxation” away from the job. The PTO time given also includes days for attendance at conferences, job interviews, licensure courses, and dissertation defense time. All trainees receive their PTO for the entire year at the start of their training experience. Given that some holidays are celebrated by certain religions and not others, we do not mandate holidays. However, if there are no supervisors working, interns are not allowed to see patients on those days. Interns may use the time for report writing, scoring tests, or catching up on other internship-related paperwork.

Requests for vacation must be submitted to the Director of Training for approval. These requests should be submitted two weeks in advance. Exceptions may be made on a case by case basis, with sufficient rationale for a delayed request. Unused Paid Time Off benefits are not paid out at the end of the year.

Please coordinate your PTO with your fellow trainees and your supervisors whenever possible (and note that your Director of Training will ask if you have done this prior to signing your request). We are likely to approve PTO for more trainees at times during periods of reduced patient volume. After your PTO has been approved, please place your initials on the time-off calendar in the administration office. Also, provide the information to our Internship Coordinator,

Paula Delgado.

Illness or Absence:

In the case of illness or unforeseen absences, all trainees will notify the department office staff as early as possible. Please request that the staff inform the Director of Training, patients that are scheduled for outpatient visits or inpatients who are expecting to see you, and any supervisors/staff members with whom you have scheduled meetings. Please also request that the staff member write on the staff board that you will be out.

Working in a hospital can bring special considerations for when you are sick. We have worked with the medical staff to identify when it is safe to see patients and when it is important that you stay home for the safety of the patients and the hospital staff.

GUIDELINES FOR PATIENT CONTACT WHEN YOU HAVE ILLNESS SYMPTOMS:

COMMON QUESTIONS	GUIDELINES
What symptoms indicate to absolutely avoid the hospital area?	<ul style="list-style-type: none">• If fever over 100 degrees• If have active gastrointestinal symptoms (diarrhea, vomiting) <p>* You should stay home from work in these instances, both to take care of yourself and due to possible contagion</p>
How long should you wait after an illness before seeing patients?	24 hours after above symptoms subside
Is it ever okay to see patients if you are having illness symptoms?	Yes. If cold symptoms (sore throat, cough, or runny nose) then can see patients with precautions. <ul style="list-style-type: none">• Wash hands before contact• Wear mask if sneezing, coughing to prevent spreading germs

Name Badges:

Employees who have patient contact are required to wear name badges. The Hospital's

interpretation of this requirement is that all employees potentially have contact with patients, therefore, all employees and full/part-time staff are required to wear name badges while on duty. Other staff will check to see if you have a name badge on, and you will not be allowed to enter the hospital without a name badge.

If an employee loses his/her identification badge, he/she must go directly to the Security Services office for a new photograph. Please call Security Services at extension 3-1745 to arrange a time to be photographed.

Employees who are terminating employment with PCH must turn in their name badges to Security or Personnel prior to receiving their final paycheck.

Dress Codes:

PCH maintains a dress code for all employees.

1. All team members, including faculty and residents, are required to wear PCH picture identification and safety information badges at all times. These badges must be clearly visible.
 - a. The PCH identification badge is a proxy card and allows the individual access into the hospital, parking areas and certain restricted areas as appropriate for their job responsibilities.
 - b. Because the PCH identification badge is a proxy card, no stickers and pins are permitted to be displayed on the ID badge – pins will disrupt the proxy reader technology.
2. All team members, agency and temporary workers, volunteers and contract staff are expected to dress in a neat, clean and business-like fashion appropriate to their job responsibilities. Proper personal hygiene is expected, including no excessive scents or odors (tobacco odor is to be considered).
3. Each work area/department is expected to develop its own professional attire guidelines that are consistent with this overall policy and that have appropriate Vice President approval.
4. Hair must be neat, clean and appropriately styled. Long hair must be secured so as not to fall into the face and interfere with work activities. No extreme hair colors or styles are allowed. Beards, mustaches and sideburns must be clean and neatly trimmed.
5. Nails should be clean, short, and neatly manicured. Artificial fingernails and fingernail enhancements are not permitted for those with patient contact. See the “Fingernail Standards” policy for more information.

6. Body tattoos should be covered whenever possible. Any tattoo designs that are unable to be covered must be appropriate for children and families.
7. Team members should not wear garments to work that may be distracting, unsafe, unusually revealing, discriminatory or offensive in any way. Appropriate under garments, which are inconspicuous, must be worn at all times, and should not be visible outside or through clothing.
8. Jewelry must be worn in good taste and not interfere with normal job activities. Visible body piercing (including tongue piercing) other than ears is prohibited.
9. Shoes are to be worn at all times, and must be clean, in good repair and professional in appearance. Open-toed shoes are not allowed, as they do not meet safety and OSHA standards.
10. PCH has implemented a casual dress program as a privilege for team members and allows casual dress in some areas on Fridays. Casual dress is not a policy; it is a program and may be, in management's sole discretion, changed at any time. Casual dress must be appropriate for the job responsibilities. Blue jeans of any type are not permitted for any reason.
11. Each work area/department should establish guidelines for casual day dress that are consistent with these overall guidelines and approved by the appropriate Vice President.
12. Team members attending meetings or training on company time are expected to be in appropriate attire per these guidelines.
13. Any initial noncompliance with the above guidelines may in management's sole discretion, result in corrective action. Repeated noncompliance will result in definitive corrective action.
14. In developing the dress guidelines for the department, the following should be considered:
 - Need for specific types of clothing (i.e. scrubs, polos, other uniform type clothing) relative to the business needs of the department,
 - Expectations of the patients and families (and other customers),
 - Safety and Infection control, Professional image to be portrayed, and
 - Be non-discriminatory based on gender, race, sex, disability and religion or any other, federally protected status
15. The following items are not allowed:

Jeans	Stretch pants	Shorts
Halter tops	Sandals/clogs	Sweat pants
See-through clothing	Open-toed shoes	

Voicemail:

Your office phone is connected to a voicemail system for messages when you are on the line or away from your desk. During orientation you will receive voicemail information sheets that will guide you through setting up your voicemail.

“You have reached the voice mail of *** in the Behavioral Medicine Psychology Department of Phoenix Children’s Hospital. Please leave your number and the reason for your call, and I will call you back as soon as possible. If you need to reach me more quickly, please call (602) 933-0414 to reach our department administrative assistants. In the future, you can bypass this message by pressing the pound key. Thank you.”

Please change your voice mail message when you are out of the office on vacation so caller will know to wait until your return or contact the Department directly if they need immediate assistance .

Notification of Important Information:

Messages, mail and other communications will be left on your voicemail, pager, email, in your mailbox, or on your desk. It is important to check these throughout the day. Notification of upcoming events of interest, canceled or rescheduled meetings, and other information often is delivered via email.

Parking:

All employees may park in the parking lots designated around the hospital. Your badge provides entry to these lots.

Supplies:

The Department will have all office supplies that you need to do your work. If you have special requests please let the Director of Training know; he can determine if the Department can make that order. If you notice that a particular supply is very low and needs reordering, please notify the department office staff.

Testing Materials:

Testing materials for older children are kept in the testing room on the left (Testing Room #1) when facing the observation room. Testing materials for younger children are in the room on the right side (Testing Room #2). Additional protocols are stored in the locked cabinets near the administrative assistants’ room.

Because we do a significant amount of testing in this department, maintenance of the testing

equipment is imperative. Return all manuals and tests by the end of the day or sooner when possible. Please verify that you are putting the test in its correct location (based on type of test and alphabetical order). In addition, please return the tests in a “ready-to-use” condition. Finally, please do not take one of the last copies of a test booklet or questionnaire without both requesting Billie to order more protocols and notifying your supervisor or administrative assistants so they can make interim arrangements until the materials arrive. Please assist us in keeping these tests both protected and available for future use.

Reserving Therapy and Assessment Rooms:

We have two assessment rooms and two rooms available for therapy use. To reserve these rooms, please schedule in advance in the appropriate book located in the psychology administrative assistant office. Please write your name under the appropriate date and time, not the patient’s name. Please leave these rooms ready for the next person’s use. If there are any significant needs (e.g., a patient vomits), please notify our administrative assistants who will contact housekeeping immediately.

Audiovisual Equipment:

Through the IT Department at PCH, we have access to equipment such as cameras, LCD projectors, laptop computers (for presentations only). We have some equipment located in our department as well. If you require audiovisual/presentation services, please notify Paula Delgado who can assist you in making reservations. Please be specific about the equipment needed, length of time needed, where it is to be set up, and who will be involved in the use of the equipment.

Policy & Procedures, Hospital-wide:

Trainees are considered members of the Department of Behavioral Medicine and must abide by all policies and procedures of the Department. While several policies are outlined below, a full description of all policies can be found in the Policy and Procedure Manual. This manual is located in the cabinets near the water cooler, behind the front desk. Additional PCH policies can be found at <http://pch4u.phoenixchildrens.com> under the “Policies” tab.

Security:

Within the Department of Behavioral Medicine, security must be maintained to ensure against theft and to protect patients’ confidentiality. You will be given a key to your office and the therapy/assessment rooms. The outpatient building is locked each night and on weekends. You may gain entry with your ID badge. If you are locked out of the building or your office and need to gain entry, you may call Security (3-4400) and ask them to unlock the door for you.

It is important that any valuables or purses be carried or locked in one of the offices (desk drawer, cabinet, etc.). Please notify Security if any items are taken from the Department (3-4400). At the end of training you will need to return all keys in your possession prior to receiving a final paycheck.

Security is also available for escorts to your car. Their non-emergency number is 3-4400. In

case of emergency, please call security at ext 3-5500.

Patient Care: Outpatient

Billing:

Charge documents are located at the front desk and can be picked up when you go to the waiting room to retrieve your patient. Patient charts will be left in your box/on your desk. After seeing the patient, please sign the billing sheet and record the services rendered and the patient's diagnosis on the prepared charge document. Then give this to your supervisor to sign. You or your supervisor will place billing sheet document in the "charge tickets" in the psychology secretary office. These charge documents are to be turned in **within 48 hours**. If there are no charge slips at the front desk, please request to have them generated. Frequently, patients in our department are seen by more than one clinician on the same day. In order for each clinician to have access to the patient's chart, the chart may need to be taken immediately upon finishing their appointment with you.

Billing procedures will be reviewed thoroughly during orientation. If you have questions about the bills sent out, please discuss those concerns with the financial coordinator, after discussing such questions with your supervisors and the Director of Training.

Completing Billing Form (please see examples distributed at orientation)

Appointment Scheduling:

Scheduling is done on a continual basis through a computer program by the administrative staff. After you have confirmed with your patient and the room availability, please email Karen Autrey requesting that they enter the appointment into the computer data base. A day schedule is printed each morning for each clinician and charts are placed in your box/desk. If you forget to inform the administrative staff of an appointment, no file will be pulled and no charge slip created. It takes quite a bit of time to register a patient, so please try to remember to schedule them in advance. If you forget, please let Karen know as soon as possible.

Patient Charts:

All patient charts are identified by the child's name (last name first) and their medical record number. Charts are maintained in the Medical Records Department. **All charts must be returned to the administrative assistant office by the end of the day.**

UNDER NO CIRCUMSTANCES ARE CLIENT RECORDS TO BE REMOVED FROM THE HOSPITAL. Carefully read the policies and procedures related to charting, report writing, and record keeping.

New Outpatient Charts:

A chart will be established at the time of the initial or treatment session when a patient or member of a patient's family is seen by a member of the department on an outpatient basis.

Charting:

1. Department staff members shall chart outpatient progress notes on all significant contact with patients, including patient cancellations or no shows and phone calls. This will include notes on all individual sessions, group sessions, family therapy sessions and following all psychological testing sessions. Progress notes are dictated, and are then available for retrieval. All intakes, progress notes, and testing reports should be edited and signed by yourself and your supervisor. Your therapy/process notes should be kept in your locked cabinet in a locked room. Inform your supervisor where these files are located.
2. Any correspondence sent regarding a patient will be noted in a dated progress note or a copy of the correspondence will be placed in the chart.
3. Any change in diagnosis or treatment plan will be dated and documented in the chart progress note as well as at the front of the chart.
4. By the third session, an Outpatient Treatment Plan must be completed for all patients. These can be found in our department Administrative Staff office. These should be revised every three months or sooner, as needed.
5. If you need to obtain a chart, you may contact outpatient Medical Records by calling 3-1490.

Guidelines for Charting:

1. All notes are to be dictated using MedQuist dictation system. To help you practice, you may choose to type your notes at first and then dictate them. Make sure these notes are password protected and that you delete them after your dictation.
2. Any abbreviation used MUST be contained in PCH's standard abbreviation list.
3. No mention by name is to be made in the chart about others, e.g., other patients, other staff or outside persons. If need to indicate other person, use broad categories such as "female peer" or "male staff," etc. The exception is in stating the name of your supervisor and their presence.
4. When mentioning self in the chart, indicate this writer, this interviewer, or this consultant.
5. Content should include behavioral description and actual observations, and statements, either direct or paraphrased, made by patient to back up feeling states or concerns expressed by the patient. Interpretations should not be made unless clearly supported by

information in the chart. Avoid value judgments and labels (except for diagnoses in the diagnosis section).

- Example: Patient appears depressed, i.e., "eye contact is poor, minimal interaction with others, frequently has head down and indicated that he feels worthless and has no friends."
6. Content should address the goals set by the therapist in the initial treatment plan.
 7. A Discharge Summary form is completed for all patients for whom you have discontinued treatment, stating the progress made since the initial session and reason for termination of treatment.

Steps for Dictating

To ensure the correct spelling of names, the person dictating needs to spell out names at the beginning of the dictation. You may also refer to the Telephone Dictation card that reflects the instructions below:

1. Dictation must be completed from a touch-tone telephone, but the call can be placed either within the department or outside the hospital.
 2. Call 1 (888) 840-4022 from outside the hospital or within the hospital.
 3. Then enter the 2-digit report type code (19 for Outpatient; 20 for Inpatient).
 4. After listening to a brief announcement, enter your 5-digit identification number, which will be assigned to you.
 5. Enter three digit Work type (i.e., 210-Neuropsychological Eval; 211-Progress Note; 212-Psychological Report; 213-Psychological Testing Initial Evaluation for approval of testing; 214-Developmental Psychology Evaluation; 215-Psychology Initial Evaluation) then hit the pound (#) key.
 6. Finally, enter the patient's medical record number, which can be found on the top left hand corner of the white sticker, followed by # key.
 7. Prior to dictating the content of the session, state that the dictation will require two signature lines, one for you (spell out your name and list credentials) and the second one for you supervisor (spell out name and list credentials).
 8. Begin dictating the patient's report (see Sample report in Sample section).
- To pause, press 4.
 - To resume dictation, press 2.
 - To back up, press 3.
 - To listen to your own dictation, press 1.
 - To disconnect from the dictation system press 0 and hang up.
 - Press 5 to start your next report. Do NOT press 5 in the middle of dictating a note/report, as this separates your report. If you do this by mistake, call transcription to request assistance.
 - Dictated reports should be transcribed within 24 hours into the ChartMaxx system. Each morning, the administrative staff has to "release" all of the dictations that were done the day before. If your note/report is not found in ChartMaxx, ask one of the administrative staff to make sure that they release all the notes for that day. If you cannot locate your note/report, contact Andrea Cabrera by e-mail or at 933-1410.

8. Refer to the "Clinician Quick Start Reference" to assist with navigating the ChartMaxx system. Review and sign your dictated report as soon as possible. The note/report should have a signature option for your supervisor. If signature line is missing, contact Andrea Cabrera. Once you electronically sign the document, you will not be able to make changes to it. If he or she chooses, your supervisor may sign-off the note/report without you having to sign it first, since their signature supersedes yours.

For further instruction on dictation, please refer to the Telephone Dictation instructions as outlined on the MedQuist Card given out during orientation.

Incomplete Charts:

All charts are periodically reviewed for completion of necessary documents. This quality review will identify incomplete charts. A percentage of missing documents will be detailed for each clinician.

ASSESSMENT AND TESTING:

- The department has many assessment protocols in stock. Forms for all Assessment protocols (including those kept on the shelves) are found in the filing cabinet or in the testing room.

INPATIENT CONSULTS

The Department of Psychology receives consults from throughout the hospital.

Charts/Records:

Most inpatient records are kept at the nursing station on the floor while the child is in the hospital, according to room number. In the main tower, the medical record charts are outside the patient's room. Nursing notes and those from many ancillary services, such as social services and child life, are kept under a separate tab from Medical Staff notes. You may want to check these sections for additional valuable information. Training will be provided on how to access these charts. To obtain inpatient records for children not currently in the hospital you may contact the Inpatient Medical Records Department (x3-1490). In addition, the Medical Records department is generally happy to fax a copy of previous psychological or medical reports about your patient at your request.

UNDER NO CIRCUMSTANCES ARE CLIENT RECORDS TO BE REMOVED FROM THE HOSPITAL. Carefully read the policies and procedures related to charting, report writing, and record keeping.

Charting:

Inpatient consultations require an initial evaluation with a clearly stated diagnosis. Complete the Psychology Inpatient Consultation form and place this in the patient's chart after obtaining supervisor signature. This form should contain the following: Identifying data, Reason for referral, Sources of information, Mental status and behavioral observations, School and family history, Summary, Diagnosis, and Initial Recommendations.

When an order is placed in the inpatient chart for a consult for a recently previously seen patient (within past three weeks), a progress note referring to a previously completed report is a sufficient response to the order. However, if it has been some time since the patient was last seen, an initial evaluation form may be in order.

All reports must be signed by both you and your supervisor. It is your obligation to make sure that your supervisor signs all documentation.

Charting After Initial Consult:

1. Division of Behavioral Medicine consultants need to document in the inpatient chart all significant contact with the patients. These would include individual and family sessions, case conferences, committee discussions (e.g., team meetings), significant phone or in-person contact with persons regarding patient and other pertinent information.
2. Each entry shall begin with date, "Psychology Note" and time of notation. If the entry is late (i.e., a significant amount of time after the contact), include an explanation (such as, "chart missing due to patient being in x-ray").

3. Progress notes should include pertinent findings relevant to patient's immediate care. These might include relevant discussions with the patient, family members, or outside sources (such as social workers, teachers, outside psychologists, etc.).
4. Each entry must be signed by clinician, followed by title (Psychology intern or practicum student). Remember to leave a space for your supervisor to co-sign the note.

Guidelines for Charting:

1. Write clearly and concisely (if you can't write legibly - PRINT).
2. All entries must be written in black ball-point ink. No blue ink pens, felt-tip pens or erasable ink.
3. Each page must have the patient's name and Medical Record Number label placed at top of page or printed legibly at the top.
4. Each entry must have the complete date and time and be signed with clinician's name and title.
5. There should be no blank spaces between end of entry and signature. If there is a space, a line needs to be drawn. Leave space for supervisor signature.
6. Errors should have a **single line** drawn through, with "error" written and initialed. All errors must be treated in this manner. No White-Out is to be used.
7. Any abbreviation used MUST be contained in PCH's standard abbreviation list.
8. If the note is to be continued, "Continued (Page 1 of *)" must be written at the bottom of initial page and "Continued (Page 2 or 3 of *)" written after date on each new page. You must sign the bottom of each page.
9. No mention by name is to be made in the chart about others, e.g. other patients, other staff or outside persons. If it is necessary to indicate another person, use broad categories such as "social worker" or "child life," etc.
10. When mentioning self in the chart, indicate this writer, this interviewer, or this consultant.
11. Content should include behavioral description and actual observations, and statements, either direct or paraphrased, made by patient to illustrate feeling states or concerns expressed by the patient. Interpretations should not be made unless clearly supported by information in the chart. Avoid value judgments and labels (except for diagnoses in the diagnosis section).
 - Example: Patient appears depressed, i.e., "eye contact is poor, minimal interaction with others, frequently has head down and indicated that he feels worthless and has no friends."
12. Content should address the referral question and provide recommendations made by the clinician in the initial consult.

Billing:

When you arrive on the inpatient floor, retrieve a white patient sticker from the patient's chart (this has the patient's name, medical record number, date of birth imprinted on it). Obtain a patient label for every patient that you see to bring back to the outpatient building for billing. From the outpatient building, administrative assistant room, obtain a "psychology" charge ticket. The sticker goes in the upper right hand area on the back side of the charge ticket. Complete the bill in the same manner as the outpatient bill, including the type of encounter and patient diagnosis. Place the completed bill in the "charge slip box" in the administrative office.

Billing procedures will be reviewed thoroughly during orientation. If you have questions about the bills sent out, please discuss those concerns with the financial coordinator, after discussing such questions with your supervisor.

CHILD ABUSE

Child Abuse Reporting:

The Department of Behavioral Medicine will adhere to hospital guidelines and State law in reporting instances of suspected child abuse or neglect that come to light in the course of providing both inpatient and outpatient psychological services.

If you suspect/are informed of abuse, immediately discuss this with your supervisor. If the child is in potential danger at home, do not end the session without first consulting with your supervisor. At times, social work will be asked to do the reporting (Maritsa Saucedo-Graham or Nancy Jonap). At other times, we will report and document that report on the *Child Protective Services Report Form*. You and your supervisor will make this decision. This will be documented in triplicate, with one copy for the medical record and the other given to the Patient and Family Services Department. Psychologists will follow the guidelines for reporting child abuse/neglect as outlined, with the exception above:

For Internal Use Only

Phoenix Children's Hospital

Scope: Organization Wide

Administrative

Abuse and Neglect, Suspected

Effective Date: April 8, 2011

RELATED FORM(S)

1. Suspected Non-Accidental Trauma (50-0033)
2. Referral to Child Protective Services
3. Pediatric Social Work Screen

RELATED POLICIES

1. Substance Exposed Newborns (#584)
2. Child Sexual Abuse – Patient & Family Services (#563)

REASON FOR POLICY

1. To protect patients and families from abuse and ensure that Arizona Revised Statute (ARS) 13-3620 is followed.

DEFINITION(S)

Practitioner: A physician (MD or DO), allied health practitioner (e.g., nurse practitioner (NP), certified registered nurse anesthetist (CRNA), etc.), dentist (DDS), oral surgeon (DMD), doctor of podiatric medicine (DPM), or other clinician privileged to provide certain care and services and perform or initiate certain treatments or procedures, without direction or supervision, in accordance with the law and PCH Medical Staff Bylaws.

POLICY

1. PCH employees notify a social worker immediately if abuse is suspected.

PROCEDURE(S)

<i>Responsibility:</i>	<i>Action:</i>
PCH Employees	<ol style="list-style-type: none">1. Notify a social worker immediately or contact the Forensic Social Worker directly, if abuse is suspected. (Criteria for the identification of possible abuse are listed in Appendix A.)2. Document interactions between the patient and family that may be pertinent. Documentation should be objective, factual, and descriptive.3. Cooperate with authorities as indicated.
Social Worker	<ol style="list-style-type: none">1. Refer to SW policy, Child Sexual Abuse-Patient and Family Services (#563).2. Assesses the case and consults with appropriate members of the medical team to obtain key information necessary to make a valid and thorough report.3. Interviews the legally authorized representative, separately if possible and normally identifies:<ol style="list-style-type: none">A. Family dynamics; demographics.B. Other children in the home and their ages.C. Information to clarify if the injuries are compatible with incident account provided.D. Delays in seeking medical treatment.E. History of incident inconsistent with the child's developmental age and abilities.F. Relevant stressors in the family.G. History of drugs, ETOH, domestic violence, mental illness, etc.H. Forms of discipline used by legally authorized representative(s).I. Legally authorized representative's history of suspected non-accidental trauma (as victims).J. History of previous CPS involvement.K. Legally authorized representative's understanding of the current situation, their affect, attitude, etc.L. Caregivers of the child.M. Other pertinent information needed to clarify the suspected event.

4. Interviews the child(ren) when possible, except in cases of suspected sexual abuse.
5. Contacts the PCH Forensics provider and the County Attorney as needed.
6. Contacts Child Protective Services (CPS) and law enforcement as appropriate to file a verbal referral (written report within 72 hours of verbal report).
7. Informs Hospital Security Command Center of patient that has been referred to CPS and the child is placed at a high risk status for potential abduction.
8. Discusses the CPS referral with the legally authorized representative when the social worker assesses this as appropriate.
9. Facilitates the investigation of the case by serving as liaison between the investigating agencies and the hospital by:
 - A. Coordinating the flow of information between the hospital staff and CPS as necessary.
 - B. Assisting CPS and Law Enforcement with obtaining copies of the medical record and/or photographs.
 - C. Supplying CPS with the attending physician's name and contact information.
 - D. Informing the CPS worker of the patient's progress, important new information in the medical record and the plan of discharge.
10. Keeps the child's legally authorized representative apprised of the discharge plan.
11. Ensures that all appropriate court documents are obtained from the CPS worker and placed in the medical record (e.g., petition for temporary custody; notice of removal forms).
12. Facilitates the discharge plans made by CPS and documents the disposition plans in the medical record, to include appropriate names, phone numbers, etc.
13. Informs the healthcare team of the destination of the child at discharge.
14. Documents observations of the interactions with the patient/family that may be pertinent to the case.
15. Notify the appropriate authorities and coordinate efforts with Child Protective Services (CPS), law enforcement, and legal authorities.
16. Conduct interviews and collect appropriate data.
17. Contact the Forensic Team to initiate a consult.
18. Facilitate necessary photographs through the police department.
19. Notify the legally authorized representative that a report was made, as appropriate.

Practitioner

1. Document the following on the patient care record:
 - A. Relevant social risk factors for abuse.
 - B. Family explanation of injury.
 - C. Developmental age of the child.
 - D. Statements made by child regarding injuries.

2. Suspected victims of sexual abuse are not interviewed, as these children are questioned by a Forensic interviewer.
3. Ensure that social work is involved.
4. Follow up with social work to verify the appropriate agencies are involved.

The Emergency Department Social Worker will assume the responsibility of the Forensic Social Worker for cases that are evaluated at night. Handoff communication is provided to the Forensic Social Worker for follow-up the next day.

KEYNOTES / ADDITIONAL INFORMATION

1. Arizona Law (A.R.S. § 13-3620) imposes a reporting obligation on health care providers whose observation or examination of a minor or vulnerable person discloses reasonable grounds to believe that the minor or vulnerable person is a victim of injury, sexual abuse, assault, neglect, molestation or exploitation that appears to have been inflicted upon the minor or vulnerable person by other than accidental means or which cannot be explained by the available medical history.
2. Reportable events are not limited to, but may include:
 - A. Infliction of physical harm
 - B. Sexual acts by an adult upon a minor or other vulnerable person
 - C. Infliction of psychological harm (verbal or emotional abuse)
 - D. Exploitation of a minor
 - E. Physical neglect
 - F. Deprivation or omission of necessary medical treatment surgical care
 - G. Deprivation or omission of necessary nutrition with the intent to cause or allow the death of a minor.
 - H. Unreasonable confinement
 - I. Deprivation of shelter, heating, cooling, or other services necessary to maintain minimum physical and mental health.
 - J. Substance exposure to a newborn as evidenced by toxicity in the mother or newborn.
3. A child with a history or exam suspicious for abuse, neglect, sexual abuse, or intentional poisoning requires a complete evaluation by the Forensic Team.
4. Report cases to Child Protective Services of children hospitalized as the result of a motor vehicle accident in which the child was unrestrained or the driver was impaired.
5. Information is strictly confidential. No information is released or shared with uninvolved parties.

REFERENCE(S)

1. Ariz.Rev.Stat13-3620 (last updated 8/1/07)
2. Nancy D. Kellogg and the Committee on Child Abuse and Neglect (2007). Evaluation of Suspected Child Physical Abuse. *Pediatrics* 119;1232-1241.
3. Jenny, C., Hymel, K.P., Ritzen, A., Reinert, S.E., Hay, T.C. Analysis of Missed Cases of Abusive Head Trauma. *JAMA* 1999; 281;621-626.
4. National Association of Children's Hospitals and Related Institutions (2006). Defining the Children's Hospital's Role in Child Maltreatment. Alexandria, VA: National Association of Children's Hospital and Related Institutions.

Policy Information/History:	
Manual:	<i>ADMINISTRATIVE</i>
Dates Created/Reviewed/Revised:	<i>3/99, 9/99, 1/02, 2/04, 11/04, 4/07, 4/11</i>
Policy Owner:	<i>TRAUMA DEPARTMENT / Melissa Twomey</i>

APPENDIX A

Criteria:

The investigation and management of possible abuse is a complex situation requiring professional observation, assessment, judgment and discretion. Reports are based upon first-hand observations and evaluation only. It is only necessary to report data suggesting abuse, not to prove that abuse has occurred. Certain criteria are used in combination to help identify cases in which there is a possibility that abuse may have occurred:

1. Social
 - A. Family stress related to financial pressures, marital discord, drug/ETOH abuse, domestic violence, housing issues, etc.
 - B. Family history of involvement with CPS or law enforcement
 - C. History of mental illness, including post-partum depression
 - D. Family history of abuse
2. Past Medical History
 - A. Lack of routine/timely well-child checkups, immunization delay, and frequent visits to emergency room for injuries
 - B. Chronic illness, developmental delay, complicated birth or severe neonatal illness
 - C. Developmental difficulties including feeding, toilet training, colic, or sleep
3. Physical Examination
 - A. There is no history of trauma to explain injuries
 - B. Explanation is not consistent with:
 - (1) Degree of injury
 - (2) Type of injury
 - (3) Age of injury
 - (4) Child's development
 - C. Burns, bites, and fractures are often suspicious, especially in children less than 2 years of age
 - D. Bruises located on buttocks, trunk, back, mouth, ears, and proximal extremities are often suspicious
 - E. Pattern markings raise suspicion for non-accidental trauma (belt marks, slap marks, shoe print, cigarette burns)
 - F. Genital injuries are always concerning for abuse. The procedure is as follows:
 1. If not reported to our Social Work department, any questions or suspicion of child abuse or neglect will be reported to Child Protective Services at the CPS Hotline 1 (888) 767-2445.
 2. Any questions regarding whether to report will be resolved by:

- a. Discussions with Clinical Supervisor
- b. Phone consultation with the Child Protective Services (CPS) worker. **Be sure to obtain and record the name of CPS worker for chart progress note.**
- c. Discussion with Director of Training

3. Details of report as well as when and to whom report was made is to be documented clearly for patient's medical record.

Child Abuse or Neglect:

The hospital and individual patient care personnel in the hospital must report all suspected cases of non-accidental injury, sexual abuse/assault and severe physical neglect to the appropriate authorities.

The primary aim of this policy is to protect patients. This policy is mandated by Arizona State Statutes.

The individual hospital professional has no option in the matter of reporting such cases for investigation. Reporting in good faith frees the hospital or individual from any liability if the report proves to be unfounded. On the other hand, willful failure to report opens the hospital and individual professional in the hospital to criminal or civil prosecution.

There is **NO** exception to this policy.

Reporting of Sexual Activities Between Minors:

- I. INVOLUNTARY SEXUAL ACTIVITY is always reported.
- II. INCESTUOUS SEXUAL ACTIVITY is always reported.
- III. VOLUNTARY SEXUAL ACTIVITY

This guide was designed to assist mandated reporters with appropriate reporting actions when encountering situations of sexual activity between minors (17 years old and under) and between minors and adults.

Office of General Counsel

2008

January 25,

When Are PCH Providers Subject to Mandatory Reporting of Sexual Conduct?

A PCH health care provider¹ who has a reasonable basis for believing that a minor patient has been

involved in sexual conduct must report such conduct to either law enforcement or Child Protective Services, as explained below, unless an exception applies.

Specifically, the following **must be reported**:

- Sexual activity between a minor younger than 14 years of age with a partner who is 14 years of age or older.ⁱⁱ
- Sexual activity between a minor who is 15, 16 or 17 years of age with a partner who is 18 years of age or older (“Adult”).ⁱⁱⁱ
 - Example: Minor who is 17 years of age with an Adult who is 19 years of age.

The following meet an exception and **should not be reported**:

- Consensual, non-abusive, non-coercive sexual contact with the breast, oral sexual contact or sexual intercourse involving minors who are both between the ages of 14-17 years old.^{iv}
 - Examples: Minors who are both 14 years of age; Minors who are 15 and 17 years of age.
- Minor of any age with his/her legal spouse.

To Whom Should PCH Providers Report?

In the case of a reportable event, the PCH Provider must report or cause a report to be made to a law enforcement officer, unless the report concerns a person who has care, custody or control of the minor, in which case the report shall be made to Child Protective Services.^v The person must make the report immediately by telephone or in person, and also file a written report within 72 hours of the oral report.^{vi}

What Should PCH Providers Report?

The written report should contain: (1) the names and addresses of the minor and his or her parents or persons having custody of the minor, if known; (2) the minor’s age and the nature and extent of the evidence; and (3) any other information that might be helpful.

If you have any questions about this guidance or need further information, please contact Carmen Neuberger, General Counsel, 602-933-5463, or Bhavi Shah, Assistant General Counsel

ⁱ The mandatory reporting requirements imposes the duty to report on health care providers, such as psychologists, physicians, physicians’ assistants, behavioral health professionals, nurses, counselors and social workers who develop the reasonable belief in the course of treating a patient. See A.R.S. § 13-3620(A)(1).

ⁱⁱ The Arizona statutes do not address the situation of sexual activity amongst minors who are both 13 years of age or younger. In these instances, if the sexual activity is consensual, non-abusive and non-coercive, you should consult with Child Protective Services.

ⁱⁱⁱ Arizona provides a statutory defense to prosecution if the victim is fifteen, sixteen or seventeen years of age and the defendant is under nineteen years of age or attending high school and is no more than twenty-four months older than the victim and the conduct is consensual.

^{iv} A.R.S. § 13-3620(B).

^v A.R.S. § 13-3620(F).

^{vi} A.R.S § 13-3620(D).

Disclaimer: This guidance is not a substitute for legal advice and is provided for general informational purpose only. Please contact the PCH Office of General Counsel for specific questions or issues.

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PCH Office of General Counsel
January 25, 2008

Medical Neglect:

Medical neglect is defined as parent's not assisting their child, or providing access to needed medicine or needed medical appointments to care for the medical needs of their child. Medical neglect reports should be made with consultation of the medical team who can define if the lack of medical care or follow-up is serious enough to warrant a medical neglect report.

HIGH RISK/SUICIDAL PATIENTS

High-Risk Emotional Illness: Inpatient Population

When hospital, clinical or medical staff become aware of a patient who is high-risk, or has allegedly attempted suicide, or has a known history of being dangerous to self or to others, a consultation by a staff psychologist or attending psychiatrist is **MANDATORY** at the earliest appropriate time.

I. Admission with History of Suicide/High-Risk Emotionally Unstable:

Patients who are being considered for hospitalization for a medical condition and who are known to have a history of being high risk emotionally unstable, or a danger to themselves or others, must be evaluated prior to or upon admission by a staff psychologist or attending psychiatrist.

- A. An attending physician must make phone contact with the staff psychologist or attending psychiatrist to discuss the appropriateness of admission or transfer.
- B. The mental health consultant will make a recommendation as to the level of observation required for the patient's safety.

II. Suicide/High-Risk Emotionally Unstable Admission:

Patients who have allegedly attempted suicide or are high-risk emotionally ill may be admitted to the Pediatric Intensive Care Unit (PICU), provided that their condition justifies that level of care. They may be admitted, provided that acute medical/surgical services other than psychiatric/psychological services are required.

An attending physician must order a consultation by a staff psychologist or psychiatrist at the earliest appropriate time.

III. Current Patient with a History of Suicide, High-Risk Emotionally Unstable or Demonstrating Such Behavior:

Patients who are currently in the hospital and are discovered during the course of hospitalization to have a history of being a danger to themselves or to others, or who demonstrate such behavior while in the hospital, must be evaluated on an emergency basis by a staff psychologist or attending psychiatrist to determine the level of observation required, and the danger to self or others.

- A. An attending physician must order a consultation by a staff psychologist or attending psychiatrist at the earliest appropriate time.
- B. If the child is evaluated to be a current danger to self or others, a secure situation must be provided for the patient until the acute medical/surgical episode is over and/or the attending physician can arrange a transfer to a psychiatric facility. Speak with your supervisor immediately as a 24-hour sitter must be ordered in the medical record. The patient's nurse and attending physician should immediately be made aware of the need for constant monitoring.
- C. Inform the patient that someone will need to go through their belongings to ascertain their safety. Ask the patient's nurse or trustworthy parents to immediately search their belongings (pockets, purse, inside shoes) for anything that can be of danger to the patient (e.g., small mirror, belt, pills). Also, inform the parents to refrain from leaving their belongings in the room for patient safety (e.g., they could have Tylenol or their own medication in their purse).
- D. Even if the patient is awaiting transfer to a psychiatric inpatient facility, inform the parents of the need to provide an even safer home environment. Ropes, guns, and medications (including insulin, Motrin or Tylenol) should be removed or placed in a securely locked location. Simply hiding these items from children and adolescents is not an option.

Suicide/High-Risk Emotional Issues - Outpatient Treatment

When the hospital, clinic or medical staff become aware of a patient who is high risk emotionally ill or has allegedly attempted suicide or has a known history of being dangerous to self or others, a consultation by a staff psychologist or attending psychiatrist is **MANDATORY** at the earliest appropriate time.

Any child being treated for a medical condition in the PCH clinic who is suspected to be a danger to self or to others, or is high-risk emotionally ill, must be evaluated by a staff psychologist or attending psychiatrist **before** being discharged from the clinic, unless the child is admitted to the Hospital. If the child is admitted to the Hospital for medical reasons, then the above inpatient safety precautions must be followed. If not admitted, the following will apply.

- A. If the child is assessed to be at current risk:
 - 1. Call Security and/or Phoenix Police Department for assistance.
 - 2. Directly observe patient and provide a safe environment until patient can be transported to the Emergency Department (ED)
 - 3. Psychology/Psychiatry Departments
If after office hours, the on-call psychiatrist must be contacted through the PCH operator.
- B. If inpatient admission is necessary for a child under age 12, Phoenix Children's Hospital Biobehavioral Unit may be contacted for availability and appropriateness of referral to their unit at this time (602-546-5515).

- C. If an inpatient admission is necessary for a child over age 12, their insurance company will be asked which hospital would be appropriate and to request coverage of ambulance service (if required).

Transportation Services: -APIPA transportation 1-800-348-4058 option 1 and then 2
or 1-888-700-6822
-SW Ambulance 602-267-8991

Please see below for a listing of psychiatric resources.

- E. If the child is assessed to be at no immediate risk, then the child and family will be referred, when appropriate, to outpatient mental health services if child does not have a current provider.
- F. Increased frequency of psychological sessions are necessary if there are concerns related to endangerment, but patient is not hospitalized due to not being an immediate danger to self.

Suicide/High-Risk Emotional Illness - Non-patient Treatment

When the hospital, clinic or medical staff becomes aware of a non-patient who is high-risk emotionally unstable or has allegedly attempted suicide, a consultation by a staff psychologist or attending psychiatrist is recommended at the earliest appropriate time.

Any non-patient visiting PCH who is discovered or suspected to be a danger to themselves or to others, or is high-risk emotionally unstable, must be evaluated by a staff psychologist or attending psychiatrist.

A. Involved hospital staff must contact:

1. Call Security and/or Phoenix Police Department for assistance.
2. Directly observe patient and provide a safe environment until patient can be transported to the Emergency Department (ED)
3. Psychology/Psychiatry Departments
If after office hours, the on-call psychiatrist must be contacted through the PCH operator.

B. Security and the Psychology/Psychiatry consultant will establish a plan based on information received.

C. The high-risk non-patient will be interviewed by the consultant or on-call psychiatrist to assess the level of risk.

D. If the non-patient is assessed to be a current risk, then he/she will be referred to an appropriate facility.

E. If no immediate risk to the non-patient is assessed, then the non-patient will be referred, when appropriate, to outpatient mental health services.

Protocol for Emergency Psychiatric Services - Children

The Division of Behavioral Medicine staff may receive phone calls to “evaluate” children, both patients and visitors, who potentially require emergency psychiatric services. This is especially true when such persons may require hospitalization because of suicide risk. When a member of the Psychology staff encounters such a situation, the following procedures should be followed.

1. Call Security and/or Phoenix Police Department for assistance.
2. Directly observe patient and provide a safe environment until patient can be transported to the Emergency Department (ED)

Biobehavioral Crisis Hotlines for Children and Youth

Maricopa County:

Banner Behavioral Health – 602-254-HELP (4357) or 1-800-254-HELP (4357)

24-hour helpline; crisis service 24-hour emergency assessments. www.bannerhealth.com

Empact – SPC 480-784-1500 24 hour hotline and crisis services and mobile crisis intervention services; serving Maricopa and Pinal County www.empact-spc.com

Teen Lifeline, Inc. 602-248-TEEN (8336) or 1-800-248-TEEN (8336)
www.teenlifeline.org

Magellan- 602-222-9444 or 1-800-631-1314 24 hour crisis and Rapid Response Mobile Team
www.magellanhealth.com

Outlying Areas:

Cenpatico 1-866-495-6735 crisis hotline for Pinal, Yuma, Gila and LaPaz Counties

CPSA 1-800-771-9889 Pima, Cochise, Graham, Greenlee, Santa Cruz Counties

Gila River 1-800-259-2449 Gila River Reservation crisis hotline

NARBHA 1-800-640-2123 Coconino, Apache, Mohave, Navajo (other than reservation), and Yavapai Counties

Navajo Nation 1-928-871-7945 or 1-928-657-8004 Navajo reservation

Pascua Yaqui 1-521-591-7206 Pascua Yaqui Reservation crisis hotline

Show Low 1-928-537-2951 24 hour emergency hotline

Psychiatric Resources

Maricopa County

Aurora Behavioral Health System 623-344-4400
6015 W Peoria Avenue
Glendale, AZ 85302

Banner Help Line 602-254-HELP (4357)
Scottsdale, AZ
13-17 year olds

Phoenix Children's hospital 602-546-5515
Biobehavioral Unit
1919 E. Thomas Rd
Phoenix, AZ 85016
12 and under; Under 140 lbs.

St. Luke's 602-251-8535
1800 E. Van Buren St.
Phoenix, AZ 85006
5-17 year olds

Magellan 602-222-9444
Rapid Response Crisis Mobile Team for AHCCCS patients

Outside Maricopa County

Flagstaff Medical Center 1-928-213-6300
Behavioral Health
1200 N. Beaver Street
Flagstaff, AZ 86001
12-17 year olds

Sonora Behavioral Health 1-520-469-8700
6050 N. Corona Rd. #3
Tucson, AZ 85704

Transportation Services: -APIPA transportation 1-800-348-4058 option 1 and then 2
or 1-888-700-6822
-SW Ambulance 602-267-8991

PATIENT RIGHTS

The Department of Behavioral Medicine shall observe the list of patient rights as set forth in the Hospital Administrative Manual. In addition, the Department shall observe patient rights and therapist responsibilities specific to the provision of psychological services in order to promote the opportunity for patients to receive care that respects their human dignity.

The list of patient rights in psychotherapy will be prominently posted in the Waiting Area of the offices of the Department of Behavioral Medicine. They will be reviewed as part of the Orientation process of each new staff member.

Confidentiality

It is the policy of the Department of Behavioral Medicine to have specific guidelines to protect patient rights and confidentiality especially pertaining to his/her care in accordance with our policy for Medical Records.

All requests for release of psychological therapy, consultations, assessments and evaluations are submitted to Medical Records. These are then forwarded to the provider of services for release. The student/intern should discuss all release of records requests with their supervisor to make the final decision regarding whether or not to release the information requested. He/she edits any materials released to preserve patient confidentiality and protection, and returns the edited copy to Medical Records for release. Medical Records as well as the service provider ensures that a "Release of Information" is obtained and documented.

Right of Minor to Consent

Office of General Counsel January 25, 2008

Under What Instances Can a Minor Provide Consent under Arizona Law?

As a general rule, a child under the age of eighteen may not consent to her own healthcare, except in the circumstances listed below. The Arizona Legislature has identified these circumstances as important enough to shift the right to consent from the parents to the minor. The health care provider should carefully document the circumstances and the basis for the exception in the medical record. The health care provider should determine whether it is possible to obtain the minor's agreement to involve the parent or guardian in treatment decisions, and should document the minor's agreement to involve the parent, if granted.

A minor can consent to health care in the following circumstances (list is not all-inclusive):

- Minor parent consenting for child's medical care if minor parent has mental and emotional capacity to give appropriate consent.⁷
- Minors requiring emergency medical care, such as serious disease, injury or drug abuse or to save a life, after reasonably diligent efforts are made to locate and obtain consent of parent or guardian without delaying or compromising any necessary emergency medical care.⁸
- Emancipated minors⁹ who can prove that: 1) a court or the Department of Economic Security ("DES") has determined that the minor is emancipated (obtain court emancipation order or administrative ruling);

2) the minor's parents have relinquished parental rights; or 3) the minor is financially independent and has established a residence separate from the parents with parental consent.¹⁰

- Minors who are lawfully married. For minors who have been lawfully married, annulment or dissolution does not affect adult status. Obtain marriage certificate in non-emergency cases.¹¹
- Homeless minors who live apart from their parents and lack a fixed and regular nighttime residence or whose primary residence is either a supervised shelter designed to provide temporary accommodations, a halfway house or a place not designed for or ordinarily used for sleeping by humans."¹²
- Minors in military service.¹³
- Minors who are veterans or a spouse of a veteran.¹⁴
- Minors who may have contracted a venereal disease may consent to the furnishing of hospital or medical care related to the diagnosis or treatment of such disease.¹⁵
- Minors, upon diagnosis of a licensed physician or a registered nurse practitioner, to be found under the influence of a dangerous drug or narcotic, including withdrawal symptoms, may be considered an emergency case and the minor is considered to have provided consent to treatment for that condition (age 12 or older).¹⁶
- Minors who are victims of sexual assault (age 12 or older).¹⁷

- Minors seeking HIV testing if understands nature and consequences of the test.¹⁸
- Minors seeking contraception/prenatal care (age 12 or older; preferable to ask minor for permission to obtain parental consent; provider must notify parent over minor's objection *only* if failure to inform parent could seriously jeopardize the health of the minor).¹⁹

If you have any questions about this guidance or need further information, please contact Carmen Neuberger, General Counsel, 602-546-7762, or Bhavi Shah, Assistant General Counsel, 602-546-1966. Thank you.

⁷ A.R.S. § 36-2271(A)-(B).

⁸ A.R.S. § 44-133.

⁹ The Arizona Legislature has not defined what constitutes an “emancipated” minor. Health care providers should proceed with caution and consult with legal counsel before treating a minor who claims to be an emancipated minor.

¹⁰ A.R.S. § 44-132(A).

¹¹ A.R.S. §§ 44-131(A), 44-132(A).

¹² A.R.S. § 44-132(A).

¹³ *Tencza v. Aetna Casualty & Surety Co.*, 111 Ariz. 226, 527 P.2d

97, 99 (Ariz. 1974).

¹⁴ A.R.S. § 44-131(B).

¹⁵ A.R.S. § 44-132.01.

¹⁶ A.R.S. § 44-133.01.

¹⁷ A.R.S. § 13-1413.

¹⁸ A.R.S. §§ 36-661(2), 36-663.

¹⁹ See *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977).

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Medical Records Access by Patient or Representative

Under Arizona law, the patient or the parent/guardian generally has the right to inspect or receive copies of the Medical Record. Medical Records Department will be responsible for responding to all requests for patient access to the Medical Record. Requests received elsewhere will be referred directly to the Medical Records Department. This request should then be forwarded to the service provider.

For a patient or representative to have access to the Medical Records, requests must be submitted in writing and must provide sufficient information to identify the patient. A hospital form is available from Medical Records to facilitate a request.

When a request to review or receive copies of a chart has been received by PCH, the records will be reviewed prior to permitting inspection or providing copies to ensure the following:

1. Integrity of the record.
2. Completeness of the record.
3. Removal of any portion of the record relating to someone other than the patient.
4. Removal of any information furnished in confidence by someone other than the patient or by the patient in the event of parent/guardian review.
5. Appropriateness of request of minor patients.
6. Consideration of possible adverse determination on records of minor patients, psychiatric/psychology records, or alcohol/drug abuse records.

In allowing access to a patient's record, reasonable effort to establish the identity of the patient or patient's representative will be made prior to beginning of inspection or provision of copies. Persons requesting access as guardians or conservators of the person must present evidence of appointment.

Written Request for Release of Information

- A. The Medical Records Department shall honor a written request for the release of information only if such request is on an approved hospital form or on any other document which generally satisfies these criteria:
 1. States name of patient whose records are requested.
 2. Is signed and dated in ink by one of the following:
 - a. The patient. A patient who is a minor may sign an authorization for the release of medical information only if such information was obtained by the Hospital in the course of furnishing services to which the minor could have lawfully consented.
 - b. The parent or legal representative of the patient, if the patient is a minor. The relationship to the patient must be stated.
 3. States that consent is given to PCH.
 4. States the name or function of the person or entity authorized to receive the medical information.

5. Identification or portion of record to be inspected or copied.
 - B. In general, information on a patient not currently in-house is released only during office hours of the Medical Records Department. The Nursing Supervisor may make exceptions to this policy (Refer to Policy 13.6).
 - C. The request is to be filed in the patient's medical record
-