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INTRODUCTION AND TRAINING PHILOSOPHY

The internship training program is based on a scientist practitioner model of education and training. Within this model, we aim to train students who will make contributions to the field of psychology and to general human welfare, either in the scientific domain, the practice domain or both. Graduates recognize that psychological practice is based on the science of psychology, which is influenced by the professional practice of psychology. Throughout the training year, interns are exposed to and work with faculty who serve as scientist-practitioner role models, as well as faculty who have adopted a more exclusively practitioner role. We believe that this exposure to a variety of role models provides the best real-world clinical training, as well as exposure to the excitement and challenge of integrating scientific inquiry with clinical practice.

The internship program consists of supervised clinical training experiences that are sequential, cumulative, and graded in complexity. The delivery of direct clinical services occurs in the context of individual and, at times, additional group supervision. The assumption of clinical responsibilities is a gradual process, which occurs as both supervisor and trainee judge that the trainee is ready for additional opportunities. Clinical and supervisory experiences are supplemented by a year-long, weekly didactic series that deals with ethics and professional behavior, Colorado jurisprudence, multicultural approaches to assessment/diagnosis, health services psychology, consultation, supervision, and psychological interventions. Strategies for working in the public health services psychology sector are an additional focus.

We believe in the importance of developing a repertoire of diverse assessment/intervention strategies suitable to the diverse client needs of the populations that we serve. The major objectives of the internship program are to prepare the intern, through supervised clinical training and didactic instruction, to function as a professional psychologist, and to practice competently in applied areas of assessment/diagnosis, consultation, and intervention/treatment. It is important for trainees to develop attitudes and practices for ongoing professional development though an appreciation of the importance of remaining current with the evolving body of clinical and scientific knowledge relevant to their work and through an understanding of the importance of ongoing communication with fellow professionals.
Program Organization

The Psychology Internship Training Program at the University of Colorado School of Medicine was established in 1952 and has been continuously APA accredited since 1956. The internship program moved to its new academic home in the Dept. of Family Medicine in 2012 under Chairman Frank deGruy, MD, MSFM. The CU School of Medicine on the Anschutz Medical Campus is home to 85 psychologists who hold faculty appointments in the departments of Family Medicine, Pediatrics, Medicine, Neurosurgery, and Psychiatry. The rich training opportunities in the psychology internship program are the result of interdisciplinary and multi-institutional collaborative efforts that include faculty members from the School of Public Health, other CU system institutions, including the University of Colorado at Boulder, and the National Jewish Health Center. A number of clinical volunteer faculty members also contribute to the service, teaching, and scholarly missions of the School of Medicine through their dedication to the psychology internship program. All psychologists with primary supervisory responsibilities are graduates of APA accredited internships. The Internship Program is administered under the direction of Audrey Blakeley-Smith, Ph.D.

Core Training Faculty in the Clinical Psychology Internship Program are as follows:

Abbie Beacham, Ph.D.          Kim Driscoll, Ph.D.
Adria Pearson-Mauro, Ph.D.     Laura Martin, MD
Alex Reed, Psy.D., MPH         Laura Santerre-Lemmon, Ph.D.
Alyssa Olland, Ph.D.           Lauren Tolle, Ph.D.
Audrey Blakeley-Smith, Ph.D.   Lisa Meltzer, Ph.D.
Benjamin Brewer, Psy.D.        Michael Greher, Ph.D.
Brian Hoyt, Ph.D.              Michelle Sarche, Ph.D.
Bruce Pennington, Ph.D.        Nomita Chhabildas, Ph.D.
Candace Fleming, Ph.D.         Nuri Reyes, Ph.D.
Christopher Domen, Ph.D.       Rebecca Richey, Ph.D.
Dana Steidtmann, Ph.D.         Richard Martinez, M.D.
Deb Seymour, Psy.D.            Rick Kamins, Ph.D.
Harlan Austin, Ph.D., CP       Samuel Hubley, Ph.D.
Jack Edinger, Ph.D.            Scott Cypers, Ph.D.
Johanna Sturhahn Stratton, Ph.D. Shandra Brown Levey, Ph.D.
Jonathan Muther, Ph.D.         Steven A. Rosenberg, Ph.D.
Josette G. Harris, Ph.D.       Yaira Oquendo-Figueroa, Ph.D.
Judy Reaven, Ph.D.             Yajaira Johnson-Esparza, Ph.D.
Predoctoral
Psychology Internship - Major Rotations

Major rotations correspond to the specialty tracks to which an individual applies. Major rotations average 24-30 hours per week for 12 months. For the 2017-2018 training year we will offer three specialty tracks as listed below. Applicants may apply for only one track.

Because this training has a specialty emphasis, applicants who show promise of a career focus in the specialty area will be given priority. Evidence of prior experience in and commitment to the specialty area will be weighed heavily in evaluating applicant credentials.

- A.F. Williams, Primary Care Psychology
- CeDAR
- JFK, Developmental Disabilities
- Salud Family Health Centers, Primary Care Psychology
This major rotation of the psychology internship program provides interns with opportunities to learn aspects of working as a psychologist in primary care settings. The primary practice site is A.F Williams Family Medicine Center, a Level III NCQA Patient Centered Medical Home that serves patients of all ages, including adults, children, infants, pregnant women and seniors. The clinic patients are from a variety of ethnic, religious and socio-economic backgrounds and we consider this diversity to be one of our greatest strengths as a training site for multiple health care disciplines. The clinic is run by the University of Colorado Hospital and has been in existence for over 35 years. Behavioral health has been an integral part of the A.F. Williams practice for over 2 decades.

Multidisciplinary Work: A.F. Williams Family Medicine Center is a primary training site for Family Medicine residents as well as clinical pharmacy students, nurse practitioner students, physician assistant students, psychology graduate students, and medical students. Our multidisciplinary team also includes care managers, a social worker, and tele-psychiatry consultants. This provides numerous opportunities for psychology interns to work collaboratively on a multidisciplinary team.

Goals of the Primary Care Psychology Track:
The overarching goal of the primary care psychology major rotation is to train psychologists to provide a full range of clinical primary care psychology services as key members of multi-disciplinary healthcare teams, develop an array of interprofessional competencies, and become leaders in this growing area of healthcare. Specific goals include developing core competencies of primary care psychology such as providing consultations to patients and providers, participating in multidisciplinary care teams, providing brief individual therapy services, becoming skilled with warm hand offs and co-consultations, providing diagnostic clarification and brief assessment, providing in-patient consultation, providing group interventions, and assisting with population-based care initiatives. As a unique aspect of the primary care psychology training experience, interns will participate in many facets of medical student and resident education. We provide many opportunities for interns to become familiar with the varied roles that psychologists can have in medical education and will participate in the training of physicians in communications skills at both the graduate and undergraduate levels.

Outpatient Experience:

Interns will engage in the provision of primary care psychology services in collaboration with attending psychologists, family physicians, psychiatrists, care managers, psychiatric nurse practitioners, physician assistants, RN’s, MA’s, social workers, medical students, residents, graduate psychology students, and pharmacy students. These services may include:

1. Consultation regarding behavioral health questions and presenting problems
2. Consulting with physicians about patient care, mental health and health behavior change
3. Provision of team based care
4. Teaching and supporting patient self-management skills
5. Facilitation of health-related support groups
6. Individual patient assessment and intervention
7. Health promotion/disease prevention interventions
8. Psychological screening and assessments
9. Home Visits with a multidisciplinary team
10. Opportunities to supervise psychology practicum students and engage in supervision of supervision

Interns will contribute to the education and training of medical students and medical residents via:

1. Collaborative care/clinical teaching
2. Small group teaching
3. Coaching physicians in techniques of health behavior change
4. Video recording of clinic visits
5. Medical precepting (supervision of psychosocial aspects of medical care)
6. Hospital rounds

Interns may potentially participate in ongoing research and/or program development in community based medicine with options including:
1. Serving on grant writing teams
2. Participation in clinical home visits
3. Participation in practice based research working groups
4. Focal study of a selected underserved population

Interns will master a primary care psychology curriculum through:
1. Direct patient care in the primary care setting
2. Selected readings
3. Attending lecture and seminar series
4. Participation in medical school education activities, including Family Medicine, Rural Health and Psychiatry Grand Rounds

Participation in daily supervision

**Inpatient Experience:**
Interns will work collaboratively with family medicine residents and attending providers within a consultation-liaison structure to best care for patients during in-patient hospitalizations. In particular, services such as mental health screening, brief mental health interventions, health behavior change interventions, family meetings, and discharge plans are engaged effectively in this team format. Interns will observe these interactions, act independently, and receive supervision during this learning experience. Inpatient experiences are typically \( \frac{1}{2} \) day per week.

**Theoretical Approaches:**
The rotation supervisors are well versed in evidence-based approaches to interventions in primary care, medical specialty, and traditional mental health settings. Trainees can expect to gain exposure to and expertise in behavioral activation, cognitive behavioral therapy, dialectical behavior therapy, mindfulness-based cognitive therapy, acceptance and commitment therapy, and health behavior change assessment and intervention.

**Population of Clients:**
Our patient population includes insured and underinsured patients from a large variety of ethnic and socio-economic backgrounds. It also includes refugees from Africa, Iraq, Iran, Russia and South East Asia, medical students, residents, and medical school faculty.

**Supervision:**
The intern will receive a minimum of 2 hours of supervision per week. Some of this supervision is individual and some will be completed as part of a precepting model where you will have the opportunity to work with supervisors with patients individually and learn from how they work and then discuss approaches to best serve those patients before and after encounters.

**Supervisors:**
**Shandra Brown Levey, PhD** – Primary Internship Supervisor- Director of Behavioral Health Integration
**Alex Reed, PsyD, MPH** – Supervising Psychologist- Director of Behavioral Health Education
**Joanna Stratton, PhD** – Supervising Psychologist – Primary Inpatient Psychology Supervisor
The Center for Dependency, Addiction, and Rehabilitation (CeDAR)

The Center for Dependency, Addiction, and Rehabilitation (CeDAR) is a 30 day residential, extended care, and outpatient treatment center for individuals with addictive disorders, specializing in treatment of individuals who are dually diagnosed with both psychiatric and substance abuse problems. Our patients often also have acute or chronic medical illnesses that further impact their treatment. CeDAR emphasizes a bio-psycho-social-spiritual approach to treating addictions, and provides opportunities for training in treatment of these disorders in individual, group, spiritual, and family-oriented modalities.

**Goals of the Training Rotation**
- Provide training in treatment of substance abuse disorders in a residential setting and along the continuum of care to the outpatient level.
- Emphasize collaboration with other members of a multi-disciplinary team.
- Perform psychological testing and neuropsychological screening as a part of multi-disciplinary evaluation.
- Identify and make recommendations for further assessment or treatment of cognitive disorders related to addiction.
- Become experienced in family-oriented interventions to address the chronic disease of addiction.
- Introduce trainees to Twelve Step programs and the use of these techniques in wider practice.

**Objectives of the Training Rotation**
- The psychology trainee will be trained in the administration and interpretation of psychological testing in patients with substance dependence and cognitive disorders.
- The psychology trainee will be trained in the treatment of addictive disorders in both individual and group modalities.
- The psychology trainee will participate in weekly interdisciplinary team meetings that include physicians, nurses, addiction counselors, family counselors, and spiritual counselors.
- The psychology intern will gain experience in developing individualized treatment plans that address the biological, psychological, social, and Twelve Step components of addictive and psychiatric illnesses as well as become familiar with ASAM placement criteria.

**Specific Training Activities**

**Required Activities**

**Psychological and Neuropsychological Assessments:** The intern will perform and interpret psychological testing for diagnostically difficult patients with co-occurring psychiatric, addictive, and cognitive disorders. The intern will be expected to perform a minimum of two and maximum of five assessments each month. These assessments may include intelligence testing, personality testing, and/or brief neuropsychological batteries.

**Group Therapy:** The intern will co-facilitate one process or psychoeducational group related to addiction, depending on the intern’s personal interests and schedules. The groups include: Intensive Outpatient Group, Men’s Group, Women’s Group, Coping Skills Group, Co-Occurring Disorders Group, etc.

**Multi-Disciplinary Treatment Planning:** The intern will attend the weekly multi-disciplinary treatment planning meeting to learn about treatment issues for individual patients and gain experience in working within a larger team. This meeting occurs on Thursdays at 1:00 p.m.

**Optional Activities**
As time and individual interests permit, interns will be given the opportunity to work more closely with patients in providing individual therapy in a variety of modalities including cognitive-behavioral therapies,
individual coaching of dialectical-behavioral techniques, supportive therapies, insight oriented therapy, biofeedback, and mindfulness based therapies. Opportunities also exist for more in depth training in the Twelve Step and family oriented treatments for addiction.

**Optional Courses**
Ongoing weekly seminars offered by the Addiction faculty are available on a variety of addiction related topics. These “Lunch and Learn” opportunities occur on Tuesday’s at 12:00.

**Supervision:** The intern will receive 3 hours of individual supervision per week. Supervision will be focused on intern professional development, and will be facilitated by a licensed psychologist.

**Theoretical Approaches**
The staff members at CeDAR integrate a Twelve Step Facilitation model of addiction treatment with a more traditional medical model for treatment of psychiatric and addictive disorders. Cognitive-behavioral approaches, mindfulness work, and biofeedback all also employed. As each patient receives an individualized treatment plan, opportunities exist to work in a variety of clinical approaches in both individual and group modalities.

**Supervisors:**

**Harlan Austin, Ph.D., LP, CC-AASP:** Dr. Austin is a licensed psychologist and has specialty training in addiction treatment, performance psychology, and psychological assessment. As psychologist for CeDAR, Dr. Austin provides psychological testing, group therapy, individual therapy, pain management, and biofeedback. Dr. Austin uses CBT and Mindfulness based approaches in his work with patients. Dr. Austin also serves as an Adjoint Instructor for the University of Colorado School of Medicine, Department of Psychiatry.

**Laura Martin, M.D., DFAPA and ABAM Diplomate, Medical Director:** Dr. Martin serves as CeDAR’s medical director and is a board-certified addiction psychiatrist. She is an Assistant Professor within the Department of Psychiatry's Division of Psychopharmacology at University of Denver School of Medicine. Dr. Martin has lectured extensively, authored numerous articles in peer reviewed journals, and has been an investigator on research grants studying the effects of nicotine in the brain and tobacco cessation. She is also a member of the Colorado Psychiatric Society and the American Psychiatric Association.
JFK Developmental Disabilities

University Center of Excellence in Developmental Disabilities Rotation

JFK Partners is a University Center of Excellence in Developmental Disabilities (UCEDD) for interdisciplinary training in developmental disabilities. It offers training to graduate and postgraduate trainees from a number of health, mental health, and educational disciplines in the complex needs of children with developmental disabilities, particularly as their needs interact with family, school and community.

Professional disciplines represented at JFK include developmental pediatrics, child psychiatry, clinical psychology, social work, speech and language pathology, occupational therapy, and special education. JFK is affiliated with Developmental Pediatrics at Children’s Hospital Colorado. JFK is also actively involved with community agencies to address the needs of persons with developmental disabilities. Faculty at JFK hold appointments in the Department of Psychiatry and Pediatrics.

The JFK Autism and Developmental Disabilities Clinic, a component of Developmental Pediatrics/JFK Partners, provides a variety of interdisciplinary clinical services to persons of all ages. The Clinic provides a full range of clinical services, including disciplinary and interdisciplinary evaluations, consultation, therapies, and clinical research activities.

Goals of the Developmental Disabilities Track

JFK Partners is a university based interdisciplinary training program with a commitment to the following goals for psychology trainees:

1. Teach trainees about the needs and strengths of persons with developmental disabilities and their families.
2. Teach trainees a variety of specialized clinical skills for assisting persons with developmental disabilities, including psychological assessment, psychotherapy and consultation.
3. Teach trainees to work in an integrated fashion with members of an interdisciplinary clinical team.
4. Foster development of leadership skills and scholarly activities related to the field of developmental disabilities.
5. Introduce trainees to values involving inclusion, family and individually centered care, diversity, advocacy, and self-determination for persons with developmental disabilities.

Objectives:

1. The psychology intern will learn to administer (or gain mastery with) a variety of cognitive, academic and adaptive assessments for individuals with developmental disabilities, including autism spectrum disorder, across the life span.
2. The psychology intern will learn to administer (or gain mastery with) gold standard autism assessment measures with individuals across the life span.
3. The psychology intern will learn the basic tenets of positive behavioral interventions and use these strategies (where appropriate) to:
   • design teaching and educational strategies for persons with developmental disabilities to develop new skills
   • to design positively based interventions to address problem behaviors, based on functional assessment for persons with developmental disabilities.
4. The psychology intern will learn to assess the complex co-occurring psychiatric needs of individuals with autism spectrum disorder/intellectual disabilities, as well as deliver interventions (individual, group, family, and consultative).
5. The psychology intern will co-facilitate group therapy for children with autism spectrum disorder. The intern will receive training on Facing Your Fears – a group therapy program for managing anxiety in children with ASD.

6. The psychology intern will work together as a team member with members from other disciplines, including pediatrics, social work, occupational therapy, speech/language pathology and child psychiatry to evaluate and treat persons with developmental disabilities, and to provide comprehensive oral and written feedback to family members.

7. The psychology intern will complete a scholarly project in collaboration with a supervisor on a topic related to ASD/developmental disabilities.

**Required Training Activities:**
Facing Your Fears (CBT group intervention for treating anxiety in youth with ASD): The intern will co-facilitate at least one Facing Your Fears group.

**Optional activities:**
Developmental Pediatrics Research Didactic: The intern may participate in this monthly seminar focused on conducting research related to developmental disabilities. This group also generates ideas for new research projects and presents findings from ongoing studies of its various members.

**Additional Courses:**
There are a variety of seminars, courses, and lectures provided by the UCEDD as a whole and available to any of the trainees.

**Theoretical:**
Although there is not a single theoretical approach that is utilized exclusively, a major philosophy of JFK Partners is to promote culturally responsive, family focused interventions in inclusive settings. There is an emphasis on child neuropsychology, as it pertains to autism and other developmental disorders, both in the research programs and in the clinical practice of the center. Cognitive-behavioral approaches, along with a developmental orientation and family systems perspective are the main ways of understanding persons with developmental disabilities and their families. Each intern also becomes quite familiar with positive behavioral approaches for behavioral growth and change.

**Types of Clinical Approaches**
Interdisciplinary and disciplinary diagnostic services
- School and community consultation
- Positive behavioral methods for skill building and behavior management
- Cognitive/behavioral therapy groups
- Family-centered consultation and advocacy
- Child and adult individual psychotherapy

**Population of Clients**
The people referred to JFK Partners are of all ages, from infancy to adulthood, with a diagnosis (or a question of a diagnosis) of a developmental disability. There is a particular focus on the diagnosis and treatment of people with autistic spectrum disorder. JFK Partners serves people with disabilities throughout the Rocky Mountain region, both urban and rural settings, from all ethnic groups and from all income levels.

**Supervision:**
The intern receives supervision for all clinical activities, including psychological assessment, psychotherapy and consultation. Three psychology faculty members are on site at JFK Partners.
**Assessment supervision** is shared by several primary faculty supervisors. The intern will be supervised for 6 months by two different supervisors. Supervision for assessments averages 1 ½ - 2 hours per evaluation, not including live supervision during the assessment itself. Supervision covers preparation for the assessment, review and interpretation of data, and written and oral reporting.

**Psychotherapy supervision** is generally provided by one supervisor for the entire year, 1 ½ hours per week. Live supervision and supervision by videotape are also important components of the supervision. Each intern may participate in a psychotherapy group supervision.

**Supervisors:**


**Judy Reaven, PhD** (Clinical Psychology, University of Missouri-Columbia, 1985). Areas of expertise/interest: the co-occurrence of anxiety symptoms and other mental health conditions in children and adolescents with ASD; cognitive-behavioral interventions with children/adolescents with ASD.


Updated: 6/29/18
Salud Family Health Centers
Primary Care Psychology (Bilingual Spanish Required)

Plan de Salud del Valle, Inc. (Salud) is a federally qualified health center that provides quality, comprehensive primary health services to residents of a defined catchment area in Northeastern Colorado, covering parts of Weld, Boulder, Adams, Larimer, Morgan and Logan Counties. Salud aims to improve the overall health of the communities it serves by reducing barriers to health care, including ability to pay, transportation, and language. Salud provides health care services without regard to age, sex, or disease process. Salud has a firm commitment to provide care to all people, and does not turn patients away based on finances, insurance coverage, or ability to pay. Patients seen include those of all ages and with all presenting problems, including a broad range of psychiatric and medical diagnoses. Salud is committed to an integrated care model including full dental services, placing mental health practitioners in all of the clinics, and utilizing patient educators to support the medical staff with diabetes and weight management (including nutrition) and tobacco cessation.

Salud has established that services will be provided:
•To migrant and seasonal farm workers and the poor and near-poor populations as the priority clientele.
•With cultural and linguistic understanding and sensitivity.
•With programs designed to eliminate or reduce the barriers to health care through the establishment of a network of clinics and provision of outreach and transportation services.
•With financial charges based on ability to pay through the utilization of income and size of family as key factors in a sliding-fee scale.
•With mechanisms through which quality secondary and tertiary health care can be obtained.
•With the ultimate goal of significantly improving health status of Salud’s population.

Given Salud’s population, it is strongly recommended that interns are either fluent or proficient in Spanish.

Goals of the Training Rotation
1. To educate trainees about the psychological and medical functioning of patients who are cared for in primary care settings
2. To teach trainees how to conduct health and behavior evaluations within a primary care medical center
3. To teach trainees how to collaborate within a multidisciplinary team
4. To teach collaborative care approaches in primary care
5. To teach psychology interns to provide primary care psychology services to rural, Latino, migrant farm worker, refugee and underserved or disadvantaged populations.

Objectives:
1. The psychology trainee will be trained to administer health and behavior evaluations to assess for mental and behavioral health problems
2. The psychology trainee will participate in weekly interdisciplinary team meetings that include physicians, nurses, and psychologists when/if possible
3. The psychology trainee will provide mental health screenings and arrange for appropriate follow-up care as needed
4. The psychology trainee will attend monthly case conferences and presentations and will provide one formal case conference OR one presentation during the six months of the rotation if possible
5. The psychology trainee will be trained to provide differential diagnosis to inform medication management and psychotherapeutic treatment.
**Required Training Activities**
Interns will engage in the provision of primary care psychology services in collaboration with physicians, nurse practitioners, physician assistants, other behavioral health providers, care managers, and clinical pharmacists. These services will include:

- **Psychosocial Screenings**: Provided universally to patients of all ages, aimed at identifying and addressing various psychiatric and psychosocial needs.
- **Consultation**: Consultation services as requested by medical providers, including, but not limited to, providing differential diagnosis, supportive counseling, crisis intervention and safety planning, referrals, and resources.
- **Follow-up during Medical Visits**: Appropriate follow-up care provided to identify patients including, but not limited to, psychoeducation, skills building, other brief interventions, motivational interviewing, self-management skills, and solution-focused therapy.
- **Psychotherapy**: Brief individual, family, group psychotherapy; approximately 8-12 patients per week.
- **Formal Psychological Assessment**: Provided as requested by patient and/or treating care team, including cognitive, personality, ADHD, and neuropsychological screenings, for children and adults, in English and in Spanish. Interns will master a primary care psychology curriculum through:
  - Direct patient care
  - Selected readings
  - Participation in site-specific monthly didactics/case conference with other members of the psychology training program two times per month specifically on Tuesdays morning
  - Weekly individual supervision
  - Supervised participation on a primary care team, including a minor rotation at the AF Williams Family Medicine Center

**Additional Training Opportunities:**
Group psychotherapy: Interns will have opportunities to co-facilitate groups consistent with clinic needs and intern interests.

Testing & Assessment: Interns will have opportunities to provide psychological and intellectual functioning testing batteries.

Additional supervision: Interns with a strong interest can request additional supervision from behavioral health providers with specific expertise in different areas as long it is approved by clinical supervisor

**Theoretical Approach:**
Salud utilizes a biopsychosocial model of treatment for patients. Supervisors are well-versed in evidence-based approaches in primary care and traditional mental health settings. We seek to view the patient’s presenting problems by understanding how medical, psychological, and social problems are interconnected and influence one another.

**Supervision:**
The intern will receive supervision for all aspects of treatment and assessment activities.

**Supervisors:**
**Jonathan Muther, Ph.D.** (Counseling Psychology, University of Denver, 2011). Vice President of Medical Services. Jonathan Muther, Ph.D. Dr. Muther is currently the Vice President of Medical Services at Salud Family Health Centers, a large FQHC system providing behavioral health services in 13 clinics. He is also a Senior Clinical Instructor at the University of Colorado School of Medicine, Department of Family Medicine, and Behavioral Health Clinical Integration Advisor with the Eugene S. Farley Health Policy Center. His specialty area is Integrated Primary Care Psychology and he is involved in direct patient care, training and supervision, program development and evaluation, as well as advocacy for healthcare policy change. His primary areas of interest is working with those traditionally underserved by existing systems.
and working with the Spanish-speaking population. He is committed to providing treatment and program
development to address life stress and the full spectrum of mental disorders, behavioral interventions for
physical illnesses, and evaluating health outcomes. Additional areas of research and clinical interest include
integrated primary care and team-based approaches to care, provision of supervision and training to
bilingual psychology trainees, child/adolescent therapy, and acculturation discrepancies within Latina/o
families.

**Yaira Oquendo-Figueroa, Ph.D.** (Clinical Psychology, Ponce Health Sciences University, 2014). Director
of Training for Behavioral Health. Primary area of interest is providing supervision for native Spanish-
speakers students and training in cultural competence. Additional areas of research and clinical interest
include primary care psychology, management of chronic conditions, sexuality and aging. The theoretical
approach is Cognitive-Behavioral and third generation theoretical orientations.

**Yajaira Johnson-Esparza, Ph.D.** (Clinical Psychology, University of New Mexico, 2015). Medication
Assisted Treatment Program Director. Primary area of interest is working with underserved and Spanish-
speaking immigrant populations providing clinical intervention and assessment. Additional areas of research
and clinical interest include health disparities, acculturative stress, effect of sociocultural/sociopolitical
factors on health, and integrated primary care psychology. Theoretical approach is cognitive-behavioral.
Predoctoral
Psychology Internship - Minor Rotations

Minor rotations average 12 hours per week. Minor rotations allow interns to acquire additional training in areas of interest to them. Interns in consultation with their advisors typically select two clinical minor rotations. Upon recommendation of the training committee, an intern may be placed year-long in a rotation in order to achieve competencies for graduation. If a minor rotation supervisor is not available on any specified training day and specifically cancels the rotation for that day, the intern is to report to their major rotation instead.

- Adult Behavioral Sleep Medicine
- Adult Neuropsychology Service
- Attention, Behavior and Learning Lab
- Burn Intensive Care Unit
- Child Learning Disability and Neuropsychology Clinic
- Integrated Behavioral Health and Primary Care: Boulder
- Integrated Behavioral Health and Primary Care: Westminster
- Johnson Depression Center Outpatient Psychotherapy
- Johnson Depression Center: Anxiety Specific Rotation
- Pediatric Behavioral Sleep Medicine
- Psychosocial Oncology
- The Women’s Integrated Services in Health (WISH)
- Type 1 Diabetes Minor Rotation
The UCH Neuropsychology Clinic within the Department of Neurosurgery sees a wide variety of patients with acute and chronic medical and neurologic disease. The neuropsychology minor rotation follows the Houston Conference Guidelines for Education and Training in Neuropsychology. As such, the experience is intended to provide the intern with exposure to the field of neuropsychology, building upon the individual’s prior experience and training in neuropsychology. The rotation is not structured to prepare the intern for independent practice as a neuropsychologist and is not intended to be fellowship training at the internship level. Individuals interested in the minor rotation will be required to demonstrate basic proficiencies in neuropsychological assessment prior to acceptance into the minor rotation.

Goals of the Training Rotation
- To educate trainees about the cognitive and psychological functioning of patients with chronic medical or neurologic disease.
- To teach trainees the administration and interpretation of a brief neuropsychological assessment battery.
- To teach trainees to communicate neuropsychological test results to patients and referring physicians.

Objectives of the Training Rotation
- The psychology trainee will be trained to administer and score a standardized neuropsychological assessment battery that includes measures of intellectual functioning, attention and information processing speed, executive functioning, learning and memory, language skills, visuospatial skills, and motor functioning. Brief psychological screening measures for depression and anxiety will also be administered.
- The psychology trainee will learn to administer a detailed neuro-medical interview with a specific focus on prior medical and neurologic illness, head injury, medication use, academic functioning and learning difficulties, social and occupational functioning, substance abuse, and psychiatric history.
- The psychology trainee will learn to document and communicate relevant behavioral observations from the neuropsychological assessment.
- The psychology trainee will learn to write a concise interpretative neuropsychological report that includes background information, behavioral observations, neuropsychological and psychological test results, as well as summary and treatment recommendations.
- The psychology trainee will participate in feedback sessions with individual patients regarding neuropsychological test results, including summary and recommendations.

Required Training Activities
- **Neuropsychological assessments:** Each intern will receive basic training in the administration, scoring, interpretation, and reporting of the neuropsychological
assessment. Time devoted to each activity will vary as a function of the intern’s experience, but each intern will be expected to independently complete two full neuropsychological assessments (including administration scoring, interpretation, report writing, and feedback) by the end of the six-month rotation.

- **Supervision:** Each intern will be supervised by faculty and staff in the UCH Neuropsychology Clinic in all aspects of their training. Weekly supervision meetings with faculty will serve as a forum to learn about general neuropsychological assessment issues, specific aspects of medical or neurologic illness relevant to patients the intern has seen, interpretation of neuropsychological test data, and communication of test results.

- **Feedback sessions:** The intern will be supervised in the feedback of neuropsychological test results and recommendations to individual patients.

- **Theoretical Approaches**
  - The UCH Neuropsychology Clinic aims to provide assessment of brain function in a diverse patient population with neurological (e.g., dementia, epilepsy, brain tumor, traumatic brain injury) disease or injury. Neuropsychological assessment batteries are tailored to the individual needs of the patient and the referral question.

- **Population of Clients**
  - The UCH Neuropsychology Clinic serves adults over the age of 18 with a wide variety of medical and neurologic illnesses. Referrals are received from throughout the University of Colorado clinics and University of Colorado Hospital, particularly those in neurosurgery and neurology, as well as community physicians.

- **Supervisor**
  - Christopher Domen, PhD [CHRISTOPHER.DOMEN@UCDENVER.EDU](mailto:CHRISTOPHER.DOMEN@UCDENVER.EDU)
  - Michael R. Greher, PhD, ABPP-CN [MICHAEL.GREHER@UCDENVER.EDU](mailto:MICHAEL.GREHER@UCDENVER.EDU)
  - Brian D. Hoyt, PhD, ABPP-CN [BRIAN.HOYT@UCDENVER.EDU](mailto:BRIAN.HOYT@UCDENVER.EDU)
The Attention, Behavior, and Learning (ABL) Clinic in the Department of Psychology at the University of Colorado, Boulder provides affordable, comprehensive evaluations for children and adolescents in Boulder and surrounding communities. The program specializes in assessment of learning differences, attention problems, and other cognitive, emotional, or behavioral difficulties. We offer a limited number of scholarship slots so that we are able to serve a diverse group of families. Our goal is to better understand each child's needs and strengths, as well as the needs of their family, in order to help with strategies and recommendations for meeting a child's needs, and helping them successfully move forward in school and in life.

- **Goals of the Training Rotation**
  - Goals of this rotation include a greater understanding of common childhood disorders, including etiology, trajectory, and empirically supported treatments. Interns will also develop increased proficiency in administration of psychological and neuropsychological tests with children. Participants will also gain skills in integrating and presenting complex feedback information to parents, as well as synthesizing key information in comprehensive reports.

- **Required Training Activities**
  - Required activities include performing evaluations of the type described above, giving case presentations at the ABL case conferences, participating in discussions of others’ cases, jointly providing feedback to parents about evaluation results, developing specific intervention plans, becoming knowledgeable about specific community resources and relevant legal issues, and writing reports. Students will also be expected to do some readings about various disorders affecting cognitive performance.
  - It is required that interns work on either Tuesday, Wednesday, or Thursday. Thursdays are ideal as case conference meetings will be some Thursdays from 12 to 2 pm.

- **Optional Training Activities**
  - Optional activities include further readings and participation in research activities. Students who enter with some previous training in neuropsychology may participate in more comprehensive neuropsychological evaluations.

- **Theoretical Approaches**
  - There is a close integration of research and practice in this clinic, and the overall theoretical perspective derives from developmental cognitive neuroscience and behavioral and molecular genetics. So, there is a considerable emphasis on understanding the genetic and environmental risk and protective factors that have shaped the development of the client’s cognitive and psychosocial profile, and on empirically-supported treatments for helping to optimize the client’s development.

- **Types of Clinical Approaches**
  - Clinical activities include individual evaluation, development of skill in relating to school personnel both for information gathering as well as to facilitate subsequent intervention, and providing education to parents and school personnel regarding the nature of a child’s difficulties.
• Population of Clients
  o Clients seen at this clinic are referred from the community, frequently by pediatricians, psychiatrists, tutors, and psychologists. The age range of clients is approximately age 5 through college-age.

**Nomita Chhabildas, Ph.D.** is a licensed clinical psychologist and director of the Attention, Behavior, and Learning Clinic at the University of Colorado, Boulder. She graduated with a PhD in clinical psychology from the University of Denver in 2003 under the mentorship of Dr. Bruce Pennington. She received a 3-year training grant (National Research Service Award Predoctoral Fellowship) through the National Institute of Mental Health for research on Attention Deficit Hyperactivity Disorder. In collaboration with Dr. Erik Willcutt, Dr. Chhabildas was also awarded funding for 11 consecutive years to provide psychoeducational evaluations for low-income families through the Attention, Behavior, and Learning Clinic.
Barbara Davis Center
Type 1 Diabetes Minor Rotation

The type 1 diabetes minor rotation provides interns the opportunity to gain knowledge of and skills in the diagnosis and treatment of psychological disorders in children with type 1 diabetes. Interns will evaluate and treat young children, children and adolescents, and young adults, and in some cases their parents with a variety of presenting complaints. These include adjustment to new onset type 1 diabetes, grief, anxiety (fear of hypoglycemia), depression, and nonadherence.

Patients seen in the type 1 diabetes minor rotation also commonly have co-morbid medical (e.g., thyroid, celiac disease). Interns are responsible for interviewing patients, formulating diagnoses, creating treatment plans, and providing follow-up care.

Goals/Objectives of the Training Program

The type 1 diabetes minor rotation is offered through the University of Colorado School of Medicine in the Department of Pediatrics at the Barbara Davis Center for Diabetes. The primary objective of this program is to teach interns how to evaluate, diagnose, and treat psychological disorders in patients with type 1 diabetes. At the completion of this rotation, trainees will be able to:

1. Conduct diagnostic evaluations in the context of the child’s family, medical, social, and developmental history.
2. Formulate differential diagnoses based on presenting concerns and history.
3. Develop and implement behavioral treatment plans.

Through this rotation trainees will have the opportunity to participate in:

- New Onset Diabetes Classes (Wednesdays)
- Fellows Seminar, Barbara Davis Center Grand Rounds, Social Work Staffing Conference (Tuesdays)
- Depression, Suicide, and Fear of Hypoglycemia Screenings.
- Reviewing the primary research literature demonstrating the validity and application of behavioral interventions in type 1 diabetes.
- Clinical research opportunities.

Specific Training Activities

Required Activities
This rotation occurs on an agreed upon day between the supervisor and the trainee. Hours may vary based on patients’ schedules (e.g., need to be seen for outpatient therapy outside of school hours.)

Outpatient Therapy: Interns will carry a caseload of 4-5 outpatient therapy cases. Interns will be responsible for conducting the clinical intake interview. Differential diagnoses and treatment recommendations will be determined together with the supervisor. Use of telemedicine is an option for patients who are not able to travel to the Barbara Davis Center because of distance.

Depression, Suicide, and Fear of Hypoglycemia Screenings: The Barbara Davis Center annually screens
pediatric patients with type 1 diabetes for depressive symptoms, suicidal ideations, and fear of hypoglycemia during routine diabetes clinic visits. When clinical elevations of depressive symptoms or anxiety associated with hypoglycemia, or if suicidal ideations are endorsed, then the intern will evaluate the patient using a standardized assessment approach. In cases of suicidal endorsement of any degree, the intern will consult with the supervisor to develop an intervention plan prior to the patient leaving the Barbara Davis Center.

**Clinical Research Project:** Interns will choose a clinically based research project during the type 1 diabetes minor rotation. As part of this opportunity, the intern may choose to implement interventions as part of NIH-funded research studies. In addition, it is expected that the trainee will have a completed project at the end of the rotation (e.g., be prepared to present a poster at a professional meeting, or be an author on an original research article).

**Documentation:** Interns are expected to complete all suicide assessment notes prior to leaving the Barbara Davis Center. All draft of all other notes must be completed within 48 hours or receipt by email from the supervisor.

**Theoretical Approaches**
The primary theoretical treatment approach used in the Type 1 Diabetes Minor Rotation is cognitive-behavioral. There are a number of well-validated and efficacious cognitive-behavioral interventions for nonadherence to the type 1 diabetes treatment regimen, as well other psychological disorders (e.g. depression, anxiety). However, case conceptualization is based in the biopsychosocial model with the child’s environment (e.g., parenting practices, school) taken into context.

**Types of Clinical Approaches**
Clinical activities include diagnostic interviews, standardized screenings for depression, suicide, and fear of hypoglycemia, as well as the development and implementation of interventions.

**Population of Clients**
Patients seen in the Barbara Davis Center range in age from infancy to young adults. The majority of patients seen have private insurance, although Medicaid patients are also seen.

**Supervision**
Interns will receive regular supervision for at least one hour every week. This includes live supervision during patient evaluations, as well as before and after diagnostic intake sessions to help formulate clinical hypotheses and treatment plans for new patients, and discuss next steps for follow-up and ongoing patients. In addition, professional development and clinical research supervision will be provided as needed.

**Kimberly A. Driscoll, Ph.D.** is the supervisor for this rotation. Dr. Driscoll is an Associate Professor of Pediatrics with a dual appointment in Family Medicine at the University of Colorado School of Medicine. She received her B.A. from Miami University, and her M.S. and Ph.D. in clinical psychology from Florida State University. She completed her internship in child and pediatric psychology at Children’s Hospitals and Clinics of Minnesota and her fellowship in child behavior and nutrition at Cincinnati Children’s Hospital Medical Center.
The Adult Behavioral Sleep Medicine is offered through the Sleep Medicine Section of the Division of Pulmonary, Critical Care and Sleep Medicine, Department of Medicine at National Jewish Health. The Sleep Medicine Program at NJH is the oldest and most comprehensive sleep medicine program in the Denver region. The minor rotation provides interns the opportunity to gain knowledge and skills in the diagnosis and treatment of physiological and behavioral sleep disorders. Interns will evaluate and treat patients with a variety of presenting sleep complaints under the supervision of a licensed clinical psychologist, Jack Edinger, Ph.D., C.B.S.M.

Goals of training rotation

- The primary goal of this minor rotation is to teach interns how to evaluate, diagnose, and treat sleep disorders using evidence-based evaluations and therapies.
- Learn how to work within a multidisciplinary sleep medicine team
- Obtain knowledge of a wide variety of sleep disorders and apply that knowledge to differentially diagnosing and treating patients
- Proficiency in cognitive-behavioral therapy for insomnia

Objectives of Training Rotation

- To learn about basic sleep promoting mechanisms
- To learn about the range of sleep disorders encountered in sleep medicine practice
- To learn how to prepare comprehensive assessment reports for a range of patients with various types of sleep disorders.
- To learn how to administer cognitive behavioral insomnia therapy
- To learn other behavioral sleep medicine techniques including imagery rehearsal for nightmares, graded exposure treatment of CPAP related claustrophobia, methods for aiding patients discontinue sleep medications, and treatment strategies for circadian rhythm sleep/wake disorders.

Required Training Activities

- Interns are required to attend one day a week (8am-5pm) at the Sleep Medicine clinic. Sleep Medicine clinics are held on Mondays at the main campus of National Jewish Health and on Wednesdays at the Highlands Ranch location. On a typical day, 2-4 new patient evaluations are completed and 8-10 follow-up patients are seen.
- Interns will see patients jointly with Dr. Edinger to evaluate and diagnose patient’s sleep complaints. Interns are responsible writing the diagnostic report for new patient evaluations.
- Interns will also be involved in the follow-up treatment of patients, which is brief and lasts between 1-6 sessions. Follow-up treatment is conducted using empirically-based treatments, which commonly involves cognitive-behavioral therapy for insomnia.
Optional Training

- If the intern has an interest and time available, there is opportunity to get involved in insomnia research being conducted by Dr. Edinger.

Population of Clients

- A wide variety of patients are seen at the Adult Sleep Medicine clinic, including a range of sleep disorders, patient demographics, and co-morbid medical and psychiatric conditions. We treat patients with the following sleep disorders: circadian rhythm disorders, excessive sleepiness, insomnia, narcolepsy, obstructive sleep apnea, parasomnias, periodic limb movement disorder, and restless leg syndrome. We also see patients from a wide range of backgrounds, including socioeconomic, race/ethnicity, and education.

Supervision

Interns will be provided didactic materials (selected readings) to help them learn about basic sleep mechanisms, the range of sleep disorders likely to be encountered on the rotation and methods of sleep disorder diagnosis. In addition, Dr. Edinger provides interns one-on-one discussion to aid them in their case conceptualization and treatment planning abilities. Much of the experience involves modeling as interns will have ample opportunity to observe Dr. Edinger performing assessment interviews and therapeutic interventions with various patient types.

Supervisor

Dr. Edinger is a licensed clinical psychologist who is certified in behavioral sleep medicine by the American Board of Sleep Medicine. He has been involved in the field of sleep medicine since 1982 and had published some of the first case series studies of what has become current day cognitive behavioral insomnia therapy. He has research and clinical interests in the nature, classification and management of insomnia disorders. His basic research interestpertain to developing understanding of the causative and perpetuating mechanisms involved in insomnia as well as ascertaining effective methods for documenting the daytime impairments associated with this condition. He also has interest in ascertaining new methods for classifying or subtyping insomnia and identifying reliable insomnia phenotypes. Finally he has interest in developing and improving our current insomnia management strategies. His research has been supported by grant funding from the National Institutes of Health, the Department of Veterans Affairs and Industry.
The Pediatric Behavioral Sleep Medicine minor rotation provides interns the opportunity to gain knowledge of and skills in the diagnosis and treatment of both physiological and behavioral sleep disorders. Interns will evaluate and treat patients ages 6 months through college age with a variety of presenting sleep complaints. This includes difficulties falling asleep, multiple nighttime awakenings, poor or unrefreshing sleep, a delayed or shifted sleep schedule, and/or unexplained daytime sleepiness.

Patients seen in the Pediatric Behavioral Sleep Clinic also commonly have co-morbid medical (e.g., atopic dermatitis, asthma) or psychiatric (e.g., autism spectrum disorder, anxiety) disorders. Interns are responsible interviewing patients, formulating diagnoses, creating treatment plans, and providing follow-up care. In addition, interns will have the opportunity to participate in a professional project related to pediatric sleep.

Goals/Objectives of the Training Program
The Pediatric Behavioral Sleep Medicine minor rotation is offered through the Department of Pediatrics and Division of Pediatric Behavioral Health at National Jewish Health. The primary objective of this program is to teach interns how to evaluate, diagnose, and treat pediatric sleep disorders. At the completion of this rotation, trainees will be able to:

5. Conduct a developmentally appropriate sleep evaluation, focusing on a child’s sleep, medical, and developmental history
6. Formulate differential diagnoses based on presenting concerns and history
7. Develop and implement behavioral treatment plans for the most common presenting pediatric behavioral sleep issues (e.g., bedtime problems and night wakings, insomnia)
8. Dictate clinical evaluations

Through this rotation trainees will have the opportunity to participate in:

6. Professional pediatric psychosocial meetings and case presentations within the Division of Pediatric Behavioral Health (Wednesdays)
7. Department of Pediatrics clinical and research conference focused on children with medical conditions (Thursdays)
8. Reviewing the primary research literature demonstrating the validity and application of behavioral interventions for common pediatric sleep disorders
9. Clinical research opportunities

Specific Training Activities
Required Activities
This rotation occurs on Wednesdays or Thursdays from 9 a.m. to 5 p.m. at National Jewish Health.

Pediatric Behavioral Sleep Clinic: Interns will attend the Pediatric Behavioral Sleep Clinic on Wednesdays from 12:30-4:30 p.m. or on Thursdays from 1:00 to 4:30. Interns will see a mix of new and follow-up patients each week. After an initial training/observation period, interns will be responsible for conducting the clinical intake interview. Differential diagnoses and treatment recommendations will be determined together with the
supervisor (who will be present during the clinic).

**Professional Meetings:** On Wednesdays, interns will attend the weekly Division of Pediatric Behavioral Health meeting where professional issues (e.g., patient care, billing, scheduling) are discussed (9-10 a.m.). As members of the division give regular case presentations, the intern will also be required to give one case presentation at the end of the rotation. On Thursdays, interns will attend the weekly Department of Pediatrics case conference where clinical issues related to children with respiratory and allergic diseases are presented.

**Professional Project:** Interns will choose a clinically based project to work on each week while at National Jewish Health (Wednesday or Thursday mornings). Although the time spent on this project is limited to the training time at NJH, it is expected that the trainee will have a completed project at the end of the rotation (e.g., be prepared to present a poster at a professional meeting, or be an author on a case report, review chapter, or original research article).

**Follow-Up Patient Care:** Interns will be given an active confidential voice mail number where patients can call in with an update in between follow-up visits. Interns will be responsible for checking this voice mail daily and returning patient calls within 24 hours.

**Documentation:** Interns are expected to dictate their clinic notes prior to leaving NJH, as well as edit and return their clinic letters to the supervisor within 48 hours or receipt by email.

**Optional Activities**

**Sleep Medicine Journal Club:** This monthly journal club, sponsored by the Division of Sleep Medicine at National Jewish Health, meets on the first Tuesday of the month from 12:30-1:30 p.m. to review recently published articles in the field of sleep medicine. Interns have the option of attending and/or presenting at journal club.

**Sleep Medicine Grand Rounds:** This weekly didactic, sponsored by the Division of Sleep Medicine at National Jewish Health, covers clinical and research topics on physiological and behavioral sleep issues. Grand rounds are Tuesdays from 1:30-2:30 p.m.

**Adult Behavioral Sleep Medicine Clinic:** Interns may have the opportunity to observe this clinic which focuses on the diagnosis and treatment of primary and co-morbid insomnia in adults (clinic sessions on Mondays and Wednesdays).

**Parent Sleep Group:** Interns have the opportunity to attend and co-lead a parent sleep support group (every other Thursday from 11 a.m. to 12 p.m.) for parents of children with severe asthma and atopic dermatitis participating in the day hospital program at NJH.

**Theoretical Approaches**

The primary theoretical treatment approach utilized in the Pediatric Behavioral Sleep Clinic is behavioral. There are a number of well-validated and efficacious behavioral interventions for pediatric sleep, in particular for bedtime problems and night wakings. Interventions are typically brief (1-2 follow-up visits with an additional 1-2 brief phone calls) and problem focused.
Evaluations are also approached from a systemic perspective, as a significant portion of pediatric behavioral sleep issues are related to interactions with the child’s environment (e.g., parenting practices, school anxiety). Finally, because sleep changes significantly over development, a developmental framework is also applied to the presenting issues and treatment approaches.

**Types of Clinical Approaches**
Clinical activities include diagnostic interviews, as well as the development and implementation of brief interventions.

**Population of Clients**
Patients seen in the Pediatric Behavioral Sleep Clinic range in age from 6 months to college age. Patients are referred by community primary care providers, National Jewish pediatrics, and National Jewish sleep physicians. A significant number of patients also self-refer. The majority of patients seen have private insurance, although Medicaid patients are also seen.

**Supervision**
Interns will receive regular supervision for at least one hour every week. This includes live supervision during patient evaluations, as well as before and after the clinic to help formulate clinical hypotheses and treatment plans for new patients, and discuss next steps for follow-up and ongoing patients. In addition, professional development and project supervision will be provided as needed.

**Lisa J. Meltzer, Ph.D.** is the supervisor for this rotation. Dr. Meltzer is an Associate Professor of Pediatrics at National Jewish Health and Family Medicine at the University of Colorado School of Medicine. She is board certified in Behavioral Sleep Medicine by the American Academy of Sleep Medicine. She received her B.A. from Pomona College, and her M.S. and Ph.D. from the University of Florida’s Clinical and Health Psychology program. She completed her internship in Pediatric Psychology and her fellowship in Pediatric Behavioral Sleep Medicine at the Children’s Hospital of Philadelphia.
Interns participating in a minor rotation through the University of Colorado School of Medicine Department of Psychiatry Consult Service will have exposure to a variety of clinical settings and experiences that align with an interest in health service psychology. The scope of the psychiatry consult service spans all of the inpatient medical services in the University of Colorado Hospital. A licensed psychologist is a member of this team and is designated to the Burn Intensive Care Unit (BICU) and Transplant Center. Typically, patients are admitted to the hospital for treatment of medical conditions requiring burn specialty care and may have co-occurring psychiatric concerns that affect their medical care. These psychiatric concerns may be present prior to the patient’s admission to the hospital or may arise during the patient’s stay. The consult team consists of a rotating group of department of psychiatry faculty, or attendings, as well as medical students, psychiatry residents, and psychiatry fellows. The patient’s medical team requests the services of the consult team when there is a psychiatric concern and the team will conduct an evaluation, make treatment recommendations, provide psychological services, and follow up with the patient as needed.

**Goals of the Training Rotation**
- Experience in the role of a psychologist on a multidisciplinary medical team
- Collaborate and liaison with multidisciplinary team
- Gain knowledge about burn care, trauma evaluations, and early intervention
- Develop treatment plans appropriate for inpatient medical settings

**Objectives of the Training Rotation**
- Interns will learn consultation and liaison skills for working with a multidisciplinary team
- Gain competence in completing psychosomatic assessments and develop treatment plans
- Use appropriate, evidence-based interventions for patients in intensive care
- Learn best practices in participating as a member of a multidisciplinary medical team

**Specific Training Activities**
- Health Behavior and Psychological assessments: Semi-structured intake assessments to develop treatment plans and administer interventions
- Psychotherapy: Conduct psychotherapy for intensive care patients. Typically for patients who have significant injuries which may require months of care
- Treatment team meetings: Participate as an integral member of multidisciplinary rounds. Interns will coordinate with a team of surgeons, occupational therapists, physical therapists, and others to provide care to patients.

**Theoretical Approaches**
Interns are welcome to develop their own approaches using evidence based practices. Typical situations which arise on the BICU call for solution focused interventions, trauma focused therapy, and systems focused care.

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Burn Intensive Care Unit  
University of Colorado Hospital
Types of Clinical Approaches
- Brief and long-term psychotherapy
- Adult individual psychotherapy
- Couples & Family psychotherapy
- Psychoeducation and Multidisciplinary

Population of Clients
Patients on the BICU represent a diverse group of adult patients that may include those with addiction, experiencing homelessness, and generally are representative of the Denver population.

Supervision
Weekly supervision is provided to the intern for initial assessments, brief intervention, and psychotherapy. Supervision is conducted using a developmental approach so that the intern’s specific training needs are met. Interns begin by shadowing for orientation and then incrementally advance to a preceptor model. At least one hour of scheduled supervision is provided weekly to discuss cases and process one’s experiences.

Supervisor
Tyler Branagan, Ph.D. (Florida State University, 2017) is the primary psychologist with the Department of Psychiatry’s consultation and liaison service. His primary focus is psychosomatic assessment and intervention in Burn Intensive Care and Transplant Services.
Child Learning Disability and Neuropsychology Clinic
University of Colorado Department of Psychology
University of Denver Interdisciplinary Developmental Cognitive Neuroscience

This is a diagnostic clinic at the University of Denver to which children and adolescents are referred because of concerns about possible learning disorders, including dyslexia, ADHD, speech/language disorders, intellectual disability, or broader neuropsychological problems related to certain medical (e.g., genetic disorders, brain injury, perinatal problems) or mental health concerns (e.g., mood and anxiety disorders).

This Clinic is part of Dr. Bruce Pennington’s Developmental Neuropsychology Center which studies the etiology and neuropsychology of learning disorders. This Center is part of the Department of Psychology and the interdisciplinary Developmental Cognitive Neuroscience program at the University of Denver (DU), which Dr. Pennington heads.

Goals of the Training Rotation
- Goals of this rotation are for students to develop a clear theoretical understanding of a range of common difficulties affecting children’s cognitive performance, how to evaluate a child for the presence of such problems, how to effectively convey this information to parents and schools, and how to develop appropriate intervention plans.

Required Training Activities
- Required activities include performing evaluations of the type described above, giving case presentations at the weekly Clinic case conference, participating in discussions of others’ cases, jointly (with Dr. Laura Santerre-Lemmon) providing feedback to parents about evaluation results, developing specific intervention plans, becoming knowledgeable about specific community resources and relevant legal issues, and writing reports. Students will also be expected to do some readings about various disorders affecting cognitive performance.
- Interns must attend the Clinic case conference on Wednesdays, 12:00 to 2:00 PM.

Optional Training Activities
- Optional activities include further readings, participation in research activities, and use of learning resources of the Center, such as neuroanatomy and genetics software instruction programs and a DVD library of patients with different developmental disabilities. Students who enter with some previous training in neuropsychology may participate in more comprehensive neuropsychological evaluations.

Theoretical Approaches
- There is a close integration of research and practice in this clinic, and the overall theoretical perspective derives from developmental cognitive neuroscience and behavioral and molecular genetics. So, there is a considerable emphasis on understanding the genetic and environmental risk and protective factors that have shaped the development of the client’s cognitive and psychosocial profile, and on empirically-supported treatments for helping to optimize the client’s development.

Types of Clinical Approaches
- Clinical activities include individual evaluation, development of skill in relating to school personnel both for information gathering as well as to facilitate subsequent intervention, and providing education to parents and school personnel regarding the nature of a child’s difficulties.
Population of Clients
- Clients seen at this clinic are referred from the community, frequently by pediatricians, psychiatrists, tutors, and psychologists. The age range of clients is approximately age 5 through college-age.

Supervisors
- Laura Santerre-Lemmon, Ph.D. LAURA.SANTERRE-LEMMON@DU.EDU
- Bruce F. Pennington, Ph.D. BPENNING@PSY.DU.EDU
The Integrated Behavioral Health and Primary Care minor rotation at the University Family Medicine Boulder (UFMB) Clinic provides interns the opportunity to function as an integral member of an interdisciplinary team to provide whole-person, patient-centered behavioral health and primary care. UFMB is a Level III NCQA Patient Centered Medical Home that serves patients of all ages, including infants, children, adolescents, adults, pregnant women and seniors.

Within this model, clinical psychology interns serve as behavioral health providers (BHPs) who function as consultants to primary care providers (PCPs) and patients by providing brief (15-45 minutes) consultations and short-term episodes of psychotherapy (5-6 visits). Focusing on brief consultation and psychotherapy allows BHPs to be available for other important administrative tasks (e.g., developing registries, implementing quality improvement and research initiatives, and working with clinic leadership to obtain federal and local reimbursement designations) and clinical functions (e.g., precepting, point-of-care interventions, and conducting shared medical appointments with PCPs). Though it can be tempting to function as the “in-house psychotherapist” due to the high need for mental and behavioral health interventions, providing brief episodes of care allows BHPs to function as an integral member of the primary care team as opposed to a “co-located” therapist (i.e., co-location involves providing psychotherapy only in the same location, but with little engagement within the clinic otherwise).

Goals/Objectives of the Training Program
The UFMB Minor Rotation is offered through the Department of Family Medicine at The University of Colorado School of Medicine. The primary objective of this program is to teach interns how to function as BHPs within primary care settings. At the completion of this rotation, trainees will be able to:

1. Rapidly conduct functional assessments of patient’s presenting problems to identify short- and long-term goals that align with patients’ values and PCP’s referral requests.
2. Provide appropriate levels of care to all patients ranging from 1-time consultations to brief episodes of psychotherapy/behavioral health interventions to coordinating outpatient mental health care.
3. Describe the rationale, process, and results of a quality improvement initiative within UFMB.

Specific Training Activities
Required Activities
This rotation may occur Tuesday, Wednesday, Thursday or Friday from 9 a.m. to 5 p.m. at the UFMB clinic.

Behavioral Health Clinic: Interns will see a mix of new and follow-up patients each week. After an initial training/observation period (2-4 weeks), interns will be responsible for conducting the initial consultation, developing an appropriate treatment plan in collaboration with the patient, and coordinating care inside and outside of the clinic. Differential diagnoses and treatment recommendations will be determined together with the supervisor (who will be present during the clinic).

Professional Meetings: On the 3rd Thursday, interns will attend the monthly Behavioral Health Taskforce Meeting where professional issues (e.g., patient care, billing, scheduling) are discussed (2-3 p.m.). As members of the division give regular case presentations, the intern will also be required to give one case presentation at the end of the rotation.

Professional Project: Interns will choose a clinically-based, quality improvement project to work on each week while at UFMB. Projects will be informed by a needs assessment with UFMB leadership and in collaboration with the site supervisor. Although the time spent on this project is limited to the training time at UFMB, it is expected that the trainee will have a completed project at the end of the rotation. Potential projects include establishing or maintaining a registry, implementing universal screening protocols, developing self-help materials for a defined population, implementing a new clinical service, strengthening
community ties with local outpatient providers, data evaluation, developing interprofessional education initiatives, etc.

**Documentation:** Interns are expected to complete their clinic notes prior to leaving UFMB. Extensions are granted under extenuating circumstances and with advanced notice and must be completed by the end of the week at the absolute latest.

**Theoretical Approaches**
The primary theoretical treatment approach at the UFMB is eclectic with an emphasis on Cognitive Behavior Therapy, Behavioral Activation (BA), Motivational Interviewing, Mindfulness-Based Cognitive Therapy, and Acceptance and Commitment Therapy. Initial consultations emphasize a case conceptualization that highlights the relationships between a patient’s life context, experience, and symptoms/behavior. Subsequent visits include evidence-based interventions based on collaborative decision-making between patients, trainees, and the clinical supervisor (see Figure 1 for BA example).

<table>
<thead>
<tr>
<th>TRIGGERS (What happened?)</th>
<th>EXPERIENCE (How do I feel?)</th>
<th>BEHAVIORS (What do I do?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid 20s - Diagnosed with type II diabetes, didn’t take it serious Late 20s/early 30s - Worsening type II diabetes Late 30s - Poorly controlled type II diabetes</td>
<td>Minor tingling in feet, no pain. Mood generally okay, but increasingly irritable. Tingling turns into pain, frustrated with pain. Severe neuropathic pain and depression. Difficulty standing for more than 5-10 minutes. Low mood, feels worthless and guilty.</td>
<td>No major lifestyle changes, work through the tingling “Muscling” through pain + long recovery periods Stopped working, less time with family and friends. More time watching TV and taking naps.</td>
</tr>
</tbody>
</table>

Figure 1. BA Case “Map”
Short-term consequences = distraction from pain and depression, small bit of immediate “relief”

Long-term consequences = no improvement with pain or depression, increased guilt, new problems

**Potential Interventions** = MI to clarify motivation/commitment to learning new skills; ACT to clarify values; BA to increase frequency of value-consistent behavior; mindfulness to accept pain.

**Population of Clients**
Patients at the UFMB Clinic most commonly present with depression, anxiety, PTSD, adjustment disorder, marital dissatisfaction, parenting difficulties, substance use, weight loss, and management of chronic pain and other chronic diseases. A large proportion of patients are affiliated with the University of Colorado Boulder as students, staff, and faculty or have employee-sponsored or private health insurance.

**Supervision**
Interns receive regular supervision for at least one hour every week. This includes live supervision during patient consultations, as well as before and after the clinic to help formulate clinical hypotheses and treatment plans for new patients, and discuss next steps for follow-up and ongoing patients. Interns will also receive a minimum of 2 formal clinical evaluations, once at the beginning of the rotation and once halfway through the rotation. In addition, professional development and project supervision will be provided as needed.

**Supervisor:**

**Vanessa Rollins, Ph.D.** is the supervisor for this rotation. Dr. Rollins is an Assistant Professor of Family Medicine at the University of Colorado School of Medicine. She received a B.S. from University of Colorado, Boulder, M.A. from University of Colorado, Denver, and Ph.D. from University of Denver. She completed internship in clinical psychology at University of Texas Health Science Center, San Antonio. She has a background in inpatient psychiatry, integrated primary care, and medical residency education, and has supervised psychology learners at all levels of training. She has an interest in practice-based research and social determinants of health, and is the behavioral health section editor for FPIN’s *Evidence Based Practice* publication.
Integrated Behavioral Health:
Westminster Location

The Integrated Behavioral Health and Primary Care minor rotation at the University of Colorado Family Medicine Westminster (UCFMW) Clinic provides interns the opportunity to work as part of a multidisciplinary team in providing whole-person, patient-centered integrated primary care. UCFMW is a Level III NCQA Patient Centered Medical Home that serves patients of all ages.

Within this model, clinical psychology interns serve as behavioral health providers (BHPs) who provide a range of services including: brief consultation, assessment, triage to appropriate levels of behavioral health treatment or care management, and brief therapy (5-6 visits). Interns also have the opportunity to work on new or existing clinical transformation or quality improvement projects, participate in grant writing, or participate in additional avenues to integrate behavioral health into primary care (shared or group visits, warm hand-offs, etc.).

Goals and Objectives:
The UCFMW Minor Rotation is offered through the Department of Family Medicine at The University of Colorado School of Medicine. The primary objective of this program is to teach interns how to function as BHPs within primary care settings. At the completion of this rotation, trainees will be able to:

1. Rapidly conduct functional assessments of patients’ presenting problems to identify short- and long-term goals that align with patients’ values and PCP’s referral requests.
2. Provide appropriate levels of care to all patients ranging from 1-time consultations to brief episodes of psychotherapy/behavioral health interventions to coordinating outpatient mental health care.
3. Describe the rationale, process, and results of a quality improvement initiative within UCFMW.

Theoretical Approach:
The rotation supervisor is well versed in evidence-based approaches to interventions in primary care, medical specialty, and traditional mental health settings. Trainees can expect to gain exposure to and expertise in behavioral activation, cognitive behavioral therapy, dialectical behavior therapy, mindfulness-based cognitive therapy, acceptance and commitment therapy, and health behavior change assessment and intervention.

Population of Clients:
Our patient population includes insured and underinsured patients from a large variety of ethnic and socio-economic backgrounds.

Supervision:
The intern will receive a minimum of 1 hour of supervision per week. Some of this supervision is individual and some will be completed as part of a precepting model where you will have the opportunity to work with
the supervisor with patients individually and learn from how they work and then discuss approaches to best serve those patients before and after encounters.

**Supervisor:**

**Lauren W. Tolle, Ph.D.** (University of Nevada, Reno – 2010). Dr. Tolle is a clinical psychologist and Senior Instructor with the University Of Colorado School Of Medicine, Department of Family Medicine. Dr. Tolle received her B.A. from Creighton University, a M.A. in Applied Health Psychology from Northern Arizona University, and an M.A. and Ph.D. in Clinical Psychology from the University of Nevada, Reno. Dr. Tolle completed her pre-doctoral internship and postdoctoral fellowship at the University Of Colorado School Of Medicine. Dr. Tolle’s clinical background is in third-wave behavioral therapies, behavioral, and cognitive behavioral therapy. Dr. Tolle’s research background is in primary care psychology, development and program evaluation of integrated primary care programs and services.

**Integrated Behavioral Health:**

**The Women’s Integrated Services in Health (WISH)**

This rotation gives interns the opportunity to develop skill in integrated healthcare practice with a specialty population. Interns will be providing services to women, ages 13-end of life in a dynamic, fast-paced, and energetic setting. Interns will provide assessments, triage patients to long-term care, and provide brief, focused treatment to women addressing a variety of concerns such as: depression, anxiety, eating disorders, trauma, difficulty with adherence to medical treatment, substance use disorder, grief, and pain.

The Women’s Integrated Services in Health (WISH) clinic is housed in the University of Colorado Hospital, Anschutz Outpatient pavilion. All patients of integrated care services are primary care patients of the WISH clinic. The WISH clinic providers are a diverse, multidisciplinary team comprised of seven physicians, one nurse practitioner, two nurses, one pharmacologist, 11 medical assistants, and one psychologist. Patients are referred to integrated care services by their physician, who initiates the referral and engages the psychologist. Electronic health records (EPIC) are used within the clinic and greater hospital system.

**Learning Objectives:**

The primary objective of this program is to teach interns how to assess, triage, and treat women through integrated healthcare treatment in primary care. At the end of the rotation, interns will have honed their skill in:

1. Providing warm hand-offs and co-consults with physicians
2. Brief assessment of mental health disorders
3. Patient triage to long-term behavioral healthcare treatment
4. Behavioral health consultation in primary care
5. Use of modalities of brief psychotherapy
6. Education around integrated healthcare for other healthcare professionals

**Through this rotation, interns will have the opportunity to:**

1. Attend WISH rounds
2. Attend WISH staff and faculty meetings (clinical)
3. Consult with multidisciplinary team members
4. Provide education for other healthcare professionals

Specific Training Activities:
1. Initial Assessment: Interns will meet with patients through warm hand-offs and co-consults to provide brief assessments of mental health pathology and functioning. Assessments include: PHQ9, GAD7, PC-PTSD, MoCA, and others.
2. Triage: After assessing the patient’s pathology/functioning, interns will learn to triage patients effectively. Determining the appropriate level of behavioral healthcare care for patients, finding adequate referral sources, and initiating continuation of care are skills the intern will build.
3. Behavioral health consultation in primary care: Interns will also learn the structure, focus, and implementation of effective consultation in primary care.
4. Effective use of evidence-based brief treatment modalities: Interns will learn to use ACT, CBT, MI, behavioral activation, and mindfulness interventions in primary care.
5. Education around integrated healthcare for other professionals: This is a new placement, and the intern will have many opportunities to educate physicians, nurses, medical assistants, and other healthcare professionals around mental health and integrated care workflows.

Types of Patients and Cases:
All-female patient population who are generally struggling with depression (including postpartum depression), anxiety (including postpartum anxiety), trauma-related disorders, drug and alcohol use, weight loss, parenting difficulties, and chronic pain. Many of the women who attend this clinic are students, staff and faculty of the University of Colorado at Anschutz/University of Colorado Hospital/Children's Hospital and have private health insurance

Theoretical Orientation:
The primary theoretical orientation at WISH focuses on empirically-based interventions for integrated healthcare treatment, such as ACT, CBT, motivational interviewing, behavioral activation, and mindfulness interventions.

Supervision:
Interns will receive precepting supervision as well as one hour per week of face-to-face supervision with Dr.Rebecca Richey. When consulting with a patient, the intern will be asked to perform an assessment of the patient’s mental health pathology and functioning, and to deduce a plan to address the prominent concerns. The intern will then meet with Dr. Richey to present the findings and the plan. Dr. Richey will then accompany the intern into the room with the patient (providing precepting supervision) as the plan is carried out. Finally, Dr. Richey and the intern will debrief after each patient. The intern will also receive one hour per week of dedicated face-to-face supervision time.

Supervisor:
Dr. Rebecca Richey is a Licensed Clinical Psychologist, a Licensed Clinical Social Worker, and a Certified Addiction’s Counselor as well as an Accredited Clinical Supervisor. She received her doctorate in Psychology from the University of Indianapolis, and moved to Colorado for her
postdoctoral fellowship at the University of Colorado at Anschutz’s Wellness Leadership Institute. She has expertise in psychological assessment, women’s wellness, and health psychology. She is the current President of the Colorado Psychological Association.

**Johnson Depression Center**

**Anxiety Specific Rotation**

This rotation allows for interns to gain experience conducting outpatient psychotherapy focused on anxiety disorders across the developmental spectrum (ages 3 to 93). Interns will be trained in an anxiety specific model and learn how to apply that model across the developmental spectrum. Interns will also learn how to provide this model across different modalities including individual therapy, group therapy, couples therapy, tele-health, family therapy, and intensive 3 day Bootcamps.

Of note, Bootcamps and groups typically happen after hours or on weekends so if you are interested in this rotation please note that there will be a need to work some night hours and weekends to learn this model across different modalities.

This rotation is housed in the Johnson Depression Center (JDC), a specialty center for mood and anxiety disorders. The intern will be part of the FAMILY team and have additional opportunities to interact and shadow psychiatrists, other psychologists, and LCSW’s who focus their work on children, youth, and families.

**Goals and Objectives**

The anxiety specific minor rotation is offered through the University of Colorado School of Medicine in the Johnson Depression Center. The primary objective of this program is to teach interns how to evaluate, diagnose, and treat anxiety disorders, and implement a CBT / exposure based model for anxiety related issues. At the completion of this rotation, trainees will be able to:

1. Conduct anxiety specific diagnostic evaluations of psychological conditions taking into account psychosocial and medical factors
2. Develop exposure based conceptualizations
3. Implement an evidence-based psychotherapy for anxiety disorders across different contexts and developmental ages
4. Document clinical visits

Through this rotation trainees will have the opportunity to:

1. Attend JDC Monthly Didactic
2. Attend FAMILY specific meetings focused on children, youth, and families
3. Attend JDC Weekly Team Meetings
4. Consult with multidisciplinary members of care team
5. Watch anxiety specific therapy delivery and then to provide this model across different developmental ages

**Initial Evaluations**
Interns will be responsible for conducting clinic intakes, which includes a review of intake questionnaires, diagnostic interviewing and assessment of relevant psychosocial and medical factors. They will learn anxiety specific measures by different ages and how to quickly incorporate into larger clinical evaluations

**Outpatient**
Interns will carry a caseload of 4-6 individual anxiety specific cases. Client visits are typically 50-60 minutes. Interns will also be requested to join anxiety groups and boot camps when possible.

**Documentation**
Interns are expected to complete documentation for initial evaluations within 1 week and all other documentation within 48 hours of client visits.

**Theoretical Approach**
Interns will get trained in a specific CBT approach with a focus on developing appropriate exposures around anxiety

**Population of Clients**
Clients seen at the JDC range from early childhood to older adults. Due to the clinic specialization in mood and anxiety disorders, the JDC attracts many clients with treatment-resistant mood and anxiety difficulties. Although some clients use private insurance or Medicare, many clients pay for their JDC treatment out-of-pocket. Due to logistical issues with insurance billing, Interns will only see self-pay patients.

**Supervision**
Interns will receive supervision with a Licensed Psychologist for at least one hour every week. Supervision will typically focus on formulating diagnoses, case conceptualizations and treatment plans, discussing next steps for follow-up and ongoing patients, discussing issues of professional development and other relevant issues as needed.

**Supervisors**
**Scott Cypers, PhD**, is a licensed psychologist whose primary clinical and research interests focus on anxiety and stress related issues. Dr Cypers has worked for the past 13 years in various clinical roles including Director of Anxiety and Stress Programs at Children’s Hospital Colorado, Psychologist working with active duty military at Buckley Mental Health, as well as working for many universities in student health services in various roles. At each place he has worked, Dr. Cypers has built innovative programs to address the range of mental health issues, most notably in the areas of stress, anxiety, and promoting help seeking behaviors.

**Aimee Sullivan, PhD**, is a licensed clinical psychologist and senior instructor in the School of Medicine. While in Ann Arbor, she worked with Dr. Catherine Lord at the University of Michigan.
Autism and Communication Disorders Center, and Dr. Israel Liberzon at the U of M Psychiatry Affective Neuroimaging Lab. She earned her doctorate in Clinical Psychology with Dr. David Miklowitz at the University of Colorado Boulder, and completed her predoctoral clinical internship at UCLA.

She has taught undergraduate and graduate courses at University of Colorado Boulder and University of Denver Graduate School of Professional Psychology. At the Helen and Arthur E. Johnson Depression Center, she uses evidence-based psychotherapies to work with children and adults with mood and anxiety symptoms, and has a special interest in using Family-Focused Therapy to treat bipolar disorders. Current research interests are focused on the role of family variables in the development and course of early-onset bipolar disorders.
This rotation allows for interns to gain experience conducting outpatient psychotherapy. Interns will conduct intake evaluations, develop case conceptualizations and treatment plans and implement evidence-based psychotherapies. Most psychotherapy will be individual but the possibility for assisting with groups may be available.

This rotation is housed in the Johnson Depression Center (JDC), a specialty center for mood and anxiety disorders. Thus, many JDC clients are experiencing symptoms of depression, Bipolar Disorder, trauma and/or anxiety disorders. However, other presenting issues may include eating disorder symptoms, grief and adjustment difficulties. The JDC includes an active telehealth program and so opportunities to see clients via secure video conferencing may be available. In addition, the JDC staff includes Psychiatrists and Psychiatric Nurse Practitioners. Thus, Interns have the opportunity to observe and consult regarding psychiatric medication evaluations and management, if interested.

Goals and Objectives of the Training Program: The outpatient psychotherapy minor rotation is offered through the University of Colorado School of Medicine in the Johnson Depression Center. The primary objective of this program is to teach interns how to evaluate, diagnose, and treat psychological disorders, form case conceptualizations and implement evidence-based psychotherapies with adults. At the completion of this rotation, trainees will be able to:

1. Conduct diagnostic evaluations of psychological conditions taking into account psychosocial and medical factors
2. Develop psychotherapy case conceptualizations
3. Implement evidence-based psychotherapies for mood and anxiety disorders
4. Document clinical visits

Through this rotation trainees will have the opportunity to:

1. Attend JDC Monthly Didactic
2. Attend JDC Weekly Team Meetings
3. Consult with multidisciplinary members of care team

Specific Training Activities:

Initial Evaluations: Interns will be responsible for conducting clinic intakes, which includes a review of intake questionnaires, diagnostic interviewing and assessment of relevant psychosocial and medical factors.

Outpatient Therapy: Interns will carry a caseload of 4-6 individual outpatient psychotherapy cases. Client visits are typically 50-60 minutes. Differential diagnoses, treatment formulation and treatment plan will be developed and refined over time in collaboration with the supervisor. Telehealth psychotherapy may be an option for patients in some cases.

Documentation: Interns are expected to complete documentation for initial evaluations within 1 week and all other documentation within 48 hours of client visits.

Theoretical Approaches:
Evidence-based psychotherapies are emphasized in the JDC. Depending on a client’s presenting concern and diagnosis and the Intern’s interest, approaches may include elements of Cognitive-Behavioral Therapy,
Behavioral Activation, Acceptance and Commitment Therapy, Dialectical Behavior Therapy, Motivational Interviewing and Family Focused Therapy for Bipolar Disorder. The use of psychosocial and CBT-based case conceptualization is used to integrate components of these various evidence-based treatments into a treatment plan.

*Types of Clinical Approaches:*
Clinical activities include diagnostic interviews, standardized screenings for depression, and conducting evidence-based psychotherapies individually and in groups.

*Population of Clients:*
Clients seen at the JDC range from early childhood to older adults. Due to the clinic specialization in mood and anxiety disorders, the JDC attracts many clients with treatment-resistant mood and anxiety difficulties. Although some clients use private insurance or Medicare, many clients pay for their JDC treatment out-of-pocket. Due to logistical issues with insurance billing, Interns will only see self-pay patients.

*Supervision:*
Interns will receive supervision with a Licensed Psychologist for at least one hour every week. Supervision will typically focus on formulating diagnoses, case conceptualizations and treatment plans, discussing next steps for follow-up and ongoing patients, discussing issues of professional development and other relevant issues as needed.

*Supervisors:*
**Dana Steidtmann, PhD** is a supervisor for this rotation. Dr. Steidtmann is a clinical psychologist and Senior Instructor in the Department of Family Medicine at the University of Colorado School of Medicine. She uses evidence-based psychotherapies to work with adults experiencing depression, anxiety, stress and related difficulties. Dr. Steidtmann also provides psychotherapy for couples. Her research interests focus on strategies for making mental health treatments more effective, accessible and affordable.

Dr. Steidtmann received an undergraduate degree from the University of Wyoming and a PhD from the University of Kansas. She completed fellowship training at Stanford University where her research focused on enhancing the effectiveness of treatment for chronic depression and improving health care affordability.

**Adria Pearson-Mauro, PhD** is a supervisor for this rotation. Dr. Pearson-Mauro is a clinical psychologist and Assistant Professor in the Departments of Family Medicine and Psychiatry at the University of Colorado School of Medicine. Her clinical practice includes adults with a broad array of psychiatric diagnoses. She has specialty training in treating complex and severe mental health problems. Her clinical approach utilizes evidence-based cognitive behavioral therapy approaches, including CBT for anxiety and mood disorders, Acceptance and Commitment Therapy and Dialectical Behavior Therapy (DBT).

Dr. Pearson-Mauro holds a PhD in clinical psychology from the University of Nevada, Reno and completed her internship and residency in psychosocial rehabilitation and recovery at the VA Long Beach Healthcare system. Her research focus is treatment development and outcome using Acceptance and Commitment Therapy.
Psychosocial Oncology
The University of Colorado Hospital (UCH)

- Support to family members and caregivers and co-lead support groups, as appropriate. Psychotherapy will be provided in outpatient and inpatient settings, as needed.
- Educational activities: The intern will participate in weekly inpatient or outpatient multidisciplinary meetings. The intern will attend weekly supervision sessions. The intern will attend weekly educational seminars offered on Tuesdays or Fridays. During the rotation, the intern will present an in- service to the medical staff and/or patients on a topic of interest.
- Additional Opportunities: Interns are encouraged to identify additional goals of their training.
- Opportunities exist to participate in a small research study; shadow the Palliative Care team; shadow an oncology social worker, nurse, or nurse practitioner; and program development and evaluation.

Theoretical Approaches
The range of issues and problems that arise for patients and their family members when faced with a serious, life-threatening illness often requires eclectic therapeutic approaches. In general, the goal is to promote healthy adaptation to the illness and optimal functioning of the patient and family. Cognitive-behavioral, existential, biopsychosocial and family systems theoretical approaches are commonly used to conceptualize and treat patients.

Types of Clinical Approaches
- Brief and long-term psychotherapy
- Adult individual psychotherapy
- Couples & Family psychotherapy
- Group psychotherapy
- Supportive psychotherapy
- Psychoeducation and Multidisciplinary

Population of Clients
Adults referred to the UCCCC have a diagnosis of cancer, which vary in type and stage (severity) of disease. The program attracts and treats patients from a range of ages, ethnic and racial backgrounds, socioeconomic statuses, and from rural and urban settings in Colorado and the Rocky Mountain region.

Supervisors:

Ben Brewer, Psy.D. (University of Denver, 2008) is the director of clinical psychology services for the department of hematology and investigator at the University of Colorado Cancer Center. Dr. Brewer has expertise in team based care, evidence-based assessment, and psychological intervention (e.g., CBT, existential and meaning making techniques) for patients with cancer.

Elissa Kolva, Ph.D. (Fordham University Graduate School of Arts and Sciences, 2014) is a licensed psychologist and Assistant Professor in the Division of Medical Oncology. She is a clinical provider in the Medical Oncology Psychology Clinic. Dr. Kolva’s clinical interests include the provision of empirically supported psychotherapy to reduce distress and improve quality of life for patients with cancer. Her research interests include the assessment of psychological distress, medical decision-making capacity, and psychological issues in advanced cancer. She is an active member of the University of Colorado Cancer Center and the Colorado Clinical and Translational Sciences Institute.
University of Colorado, School of Medicine  
Department of Family Medicine, Psychology Internship  

Other Learning Experiences  
and Specialized Professional  
Development  

Required Seminars  
Didactics are held every Monday throughout the year. Most seminars are offered in blocks of 6 to 10 weeks, with the exception of Psychologist as Leader, which meets throughout the year. Additional required seminars are as follows:  
- Competency and the Law (Richard Martinez, M.D.)  
- Outcomes Oriented Psychotherapy (Rick Kamins Ph.D.)  
- Multicultural Seminar (Fernand Lubuguin, Ph.D.)  

Psychologist as Educator  
Deb Seymour, Psy.D.  

Each intern from A.F. Williams and Salud is required to select a Psychologist as Educator track. Interns from J.F.K. Partners can elect to select a track, with permission from JFK supervisors (Drs. Judy Reaven and Audrey Blakeley-Smith). **The purpose of the Psychologist as Educator track is to expose psychology interns to aspects of medical education that can become part of their careers as health care professionals. It is an experiential curriculum that will provide interns an opportunity to work as facilitator/teachers at the UCSOM and to expose them to an interdisciplinary leadership role that is well suited for psychologists.**  

Psychologists are generally not trained to see themselves as medical or health services providers. Thus, they may be slower to develop professional identities that include being a health care services provider. In order to support the primary care health services identity development of our psychology interns, we have created three new learning opportunities for interns. Interns will select one of the three opportunities to complete over the course of the training year. These include opportunities for interns to:  
1. Teach in two required courses on the UCSOM campus—Foundations of Doctoring course and the Inter-professional Education course;  
2. Participate in service learning activities (e.g., oral health clinics) with the interdisciplinary track at UCSOM for service to the urban underserved; or  
3. Participate in a week-long interdisciplinary rural immersion trip that is hosted by the School of Medicine’s interdisciplinary rural health training track and the Colorado Area Health Education Consortium (AHEC).  

**The Foundations of Doctoring Curriculum (FDC).** The FDC is a three-year curriculum required of all students admitted to UCSOM. It prepares students to be outstanding physicians who will care for our diverse society. It contains the curriculum for physical examination, clinical reasoning, medical communication skills and early clinical experience in preceptor sites in the Front Range area of Colorado. Psychology interns would have the opportunity to be facilitators for the communication skills training portion of this course which involves standardized patients and
personalized coaching for all first and second year medical students.

The Inter-professional Education course (IPE). The IPE is the largest course taught at the UCSOM. It brings students from schools of nursing, medicine, pharmacy, physical therapy, physician assistant and dentistry together 16 times per year for learning about health care and interdisciplinary work in a team based learning (TBL) format. Over 400 students per year participate in this course. The goal of the campus wide IPE course is to improve population health, quality of care, and reduce health care costs through the creation of a patient-centered, collaborative practice-ready workforce with competencies in team work and collaboration, values and ethics, quality and safety in patient care and interdisciplinary practice.

Initial discussions with IPE course leadership about interns’ participation in these interdisciplinary classes lead to the discovery that the level of training that psychology interns have upon entering internship makes them much more likely to grow and learn by becoming teacher/facilitators of these classes than participants. Thus, UCSOM and the IPE campus leadership agreed that our interns will be trained in the TBL model along with interdisciplinary faculty throughout the medical campus, oriented to the curriculum, and serve as facilitators for the year long course. This opportunity will allow interns to not only engage in a large, campus wide interdisciplinary course, but also to take on leadership roles in which they will practice, receive feedback, and supervision on both teaching and facilitation skills.

Interdisciplinary immersion learning experiences. Other options that our trainees may choose from include participating in community based immersion experiences that are offered through the elective interdisciplinary ‘track system’ at the UCSOM. The ‘track system’ is a longitudinal system of training that medical, nursing and physician assistant students may apply to at the time of matriculation to the University of Colorado. The CUSOM sponsors tracks that specialize in the care of urban underserved populations and the care of rural populations. As part of this course work, students participate in community based learning experiences including foot care clinics at homeless shelters, free oral health care fairs at Salud, and a weeklong immersion in a rural Colorado community. These experiences are supervised by physicians, nurses and psychologists, but are lead and carried out by interdisciplinary teams of trainees. These options would be open to our interns as well as our graduate level psychology trainees.

Psychologists as Leaders in Healthcare
Shandra Brown Levey, Ph.D.

All interns will participate in our leadership development mentoring series. Through this, interns will meet with mentors once a month for approximately an hour and a half to learn about healthcare policy, practice transformation, and leadership.

Primary Care Psychology interns with major rotations at Salud or AF Williams will take lessons back to their major rotation primary supervisors for further discussion regarding opportunities for direct application and implementation of principles and lessons learned for on the ground implementation. Throughout the year, Salud and AF Williams interns will meet with mentors and primary supervisors, select a track of focus, and discuss progress regarding implementation options and observations for leadership principles at their major rotation sites which will culminate in a project to be presented at the end of the year. This project is required for Salud and AF Williams interns, but optional for JFK interns and at the discretion of Drs. Reaven and Blakeley-Smith.
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<thead>
<tr>
<th>Track</th>
<th>Mentor</th>
<th>Description</th>
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<tbody>
<tr>
<td>Leadership</td>
<td>Dr. deGruy</td>
<td>Highlight the importance of flexibility, adaptability, learning, and innovation to promote effective psychologist leaders.</td>
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<tr>
<td>Healthcare Policy</td>
<td>Dr. Green</td>
<td>Review how healthcare policies influence clinical care processes and how these policies influence behavioral health.</td>
</tr>
<tr>
<td>Practice Transformation</td>
<td>Dr. Knierim</td>
<td>Provide an overview of how innovative care delivery features are integrated into real-world clinics to improve patient care.</td>
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**Primary Care Leadership Track.** Dr. deGruy will help support interns’ understanding of the role of psychologists in leadership. Clinics are complex, adaptive systems, and successful leadership must be understood in the context of such complex adaptive systems. Flexibility, adaptability, learning, and continuous innovation must be exercised for a complex adaptive system to achieve success (deGruy, 2015). Dr. deGruy will facilitate a deepening of understanding of Complexity Leadership Theory (Uhl-Bien, Marion, & McKelvey, 2007), its application, and how interns can use this theory to enhance leadership capacity and success throughout their career.

**Healthcare Policy Track.** Dr. Larry Green will help support interns’ understanding of healthcare policy. Dr. Green is the founding director of The Robert Graham Center for Policy Studies in Family Medicine and Primary Care, which opened in 1999 in Washington, D.C., with the mission of bringing a family medicine perspective to health policy deliberations in the nation’s capital. Dr. Green was an architect of the Future of Family Medicine project (FFM) initiated in 2002 by the leadership of seven national family medicine organizations. Recognizing fundamental flaws in the fragmented U.S. health care system and the potential of an integrative approach, the FFM project developed a strategy to transform healthcare to meet the needs of people and society in a changing environment and outlined a model of care based on the concept of a patient-centered medical home. Dr. Green will foster a deepening understanding of the role of psychologists in healthcare, and policy change at the local, state, and national levels.

**Practice Transformation Track.** Dr. Kyle Knierim will meet with interns to support their understanding of the role of psychologists in practice transformation. The American Psychological Association has identified practice transformation activities as an area where psychologists could bring enormous knowledge and skill given the high quality training in quantitative and qualitative research methods, effective communication, and knowledge of evidence-based interventions. Practice transformation refer to formalized quality improvement initiatives where particularly relevant topics include patient care and safety, protocol design, and obtaining appropriate and reliable payment for services. The goal of these training activities is to motivate healthcare professionals to undertake the challenges of practice transformation and to engage in state and national practice transformation activities.

**Required Grand Rounds**

*Interns must attend either Psychiatry, Child Psychiatry or Family Medicine Grand Rounds, unless there is a direct conflict with major or minor rotation on-site requirements*

Psychiatry Grand Rounds  
2nd, 3rd & 4th Wednesdays, 12:10 to 1:15
AMC, Shore Auditorium Nighthorse Campbell Building

Family Medicine Grand Rounds

Child Psychiatry Grand Rounds
   Tuesdays, 12:00 to 1:00,
   The Children’s Hospital Denver Seminar Room

**Optional Seminars**

Optional seminars meet as follows. Some seminars include psychiatry residents and psychology interns and may have space limitations.

Key Concepts in Developmental Disabilities (Joy Browne, Ph.D.)*
   Mondays, 8:30-11:30 (tentative) – Meets 12 times

Leadership Dialogs, JFK Partners – (Kathy Kennedy, Ph.D.)*

Biological Basis of Psychiatric and Neurological Disorders
   Tuesday and Thursday (TBA) Jason Tregellas, Ph.D.
   Research Complex 1 North 7th Floor Conference Room

* Required for JFK Interns

**Optional Grand Rounds**

Behavioral Neurology & Neuropsychiatry Grand Rounds
   1st Wednesday, 1:00 to 2:00 pm. – Academic Building One, Room 6101

Geriatrics Grand Rounds
   1st 3rd & 5th Thursdays, 7:30 to 8:30 a.m. – Hensel Phelps Auditorium East, Research Complex 1

Neurology Grand Rounds
   Wednesdays, , RC-1 North, Hensel Phelps Auditorium - East, 1st floor, Room P18-1000

Hospital Wide Ethics Rounds
   2nd Thursday, noon-1:00, AOP 2005-2006

**Research Groups and Meetings**

Developmental Psychobiology Research Group
   2nd and 4th Tuesdays, 10:00 to 11:45
Perinatal Vulnerability Research Group
   4th Tuesday, 8:15 to 10:00, The Children’s Hospital Mountain View Room (Randy Ross, M.D.)

Perinatal Research Group
   2nd & 4th Tuesday, 9:00 to 10:00, The Children’s Hospital, Castle Rock Video Room

Prevention Studies Research Group
   2nd & 4th Tuesday, 1:00 to 3:00, The Children’s Hospital, Denver Seminar Room

Developmental Disabilities Research Group
   2nd Tuesday, 8:30 to 10:00, Locations vary

DPRG Biannual Retreat
   Colorado mid-May (to be announced)
School of Medicine
Policy and Procedures

Professionalism Code of Conduct
Sexual Harassment Policy and Procedures
Risk Management
CHANGES TO THE “PROFESSIONALISM MISSION STATEMENT” (RULES OF THE SCHOOL OF MEDICINE)
Revised: January 6, 2014

PROFESSIONALISM CODE OF CONDUCT

A climate of respect, civility and cooperation is essential to achieving excellence in clinical care, education, research, and university and community service. Therefore, the School of Medicine places the highest priority on professional behaviors.

Expected Faculty Conduct

In all educational, clinical, research and administrative activities, faculty are expected to demonstrate the core attitudes and behaviors that reflect the ideals of professionalism. Under the umbrella of professionalism lies an extended set of responsibilities, including: civil and courteous behavior; respect for learners, teachers, supporting staff and professional colleagues; and open and honest communication.

At all times, faculty will demonstrate respect for, and sensitivity to, all aspects of diversity, including: age; culture; disabilities; ethnicity; gender; language; political beliefs; religious and spiritual beliefs; sexual orientation; and socioeconomic status.

In all interactions with patients and their families, faculty are expected to adhere to the ideals of the profession of medicine. These include, but are not limited to: compassion; respect for patients’ privacy, autonomy and dignity; altruism in patient care and in the pursuit and application of knowledge; empathy; accountability; punctuality; and respect for diversity.

Teaching and mentoring are special privileges, and it is implicit that being a good teacher includes being a model of professional conduct for all learners, staff, colleagues and patients and their families. Unique elements of professionalism in this setting include: respect for all learners, including students, residents and clinical and post-doctoral fellows; humility; effective listening; active engagement in the teaching and mentoring process; and providing respectful and timely feedback.

Faculty members are also expected to exhibit the characteristics of good academic and institutional citizenship. This includes maintaining a high level of scientific or clinical competence and demonstrating a dedication to life-long learning. Faculty must adhere to the highest standards of academic honesty and integrity. For example, truthfulness and accuracy are essential elements in medical and scientific writings, in representations of effort and in medical record documentation. Additionally, faculty members are expected to critically analyze, and avoid, activities that suggest a conflict of interest with their roles as administrators, clinicians, scientists or educators.

Consistent with the principles outlined above, all SOM faculty members are expected to:

Professional Responsibilities and Accountability

- Demonstrate behaviors that convey compassion, respect, empathy, caring and tolerance in
all interactions with learners, patients and families, professional colleagues and staff.

☐ For health care professionals, uphold the primacy of patient welfare, always having the patient’s best interests at heart.

☐ Demonstrate accountability to patients, families, learners, professional colleagues and society by maintaining scientific, clinical and educational competence appropriate to one’s role as a faculty member.

☐ Provide, accept and respond appropriately to constructive feedback and evaluations, in order to provide high quality clinical care and educational excellence.

☐ Recognize and respond appropriately to behavior by others that is disrespectful, disruptive or unprofessional.

☐ Demonstrate sensitivity and respect for learners,’ co-workers’ and patients’ ethnic, racial and cultural differences.

☐ Demonstrate professionalism through appropriate dress, grooming and behavior.

☐ Maintain appropriate confidentiality.

Additional Professional Responsibilities as a Teacher

☐ Appropriately prepare for, and actively engage in, all assigned teaching and mentoring responsibilities.

☐ Treat all learners with understanding, dignity, respect and tolerance.

☐ Evaluate learners equitably and fairly, using only criteria that reflect the learner’s performance, as measured by standards applied uniformly to all learners in the course or other learning activity, except where differentiation is required or permitted in the case of students with disabilities.

Additional Professional Responsibilities as a Member of the Academic Community

☐ Evaluate the performance of others equitably and fairly, and without prejudice, harassment or intimidation, ensuring that such evaluations are based solely on criteria that reflect professional competence.

☐ Uphold the principles of academic honesty, including truthfulness and accuracy in medical and scientific research and writing.

☐ Understand and comply with University, School of Medicine, hospital and other policies governing conflicts-of-interest, performance reviews, credentialing and other matters.

☐ Recognize and manage conflicts-of-interest.

Unacceptable Faculty Conduct

Unprofessional behaviors have no place in any educational, research, administrative or patient care environment and will not be tolerated. Within the healthcare environment, unprofessional and disruptive behaviors interfere not only with learning, but also with communication and trust among health care team members; thus, such behaviors threaten healthcare quality and patient safety.

Unprofessional behaviors include: disruptive behaviors; actions, words or behaviors that a learner, colleague, co-worker or patient would reasonably consider to be humiliating or demeaning; passive disrespect (including dismissive treatment of others); academic dishonesty (including falsification or fabrication of data or the misappropriation of the writings, research or findings of others); and discrimination against any learner, patient, co-worker or other individual on political grounds or for reasons of race, ethnicity, religion, gender, sexual orientation or any other illegal or arbitrary reasons. Disruptive behaviors include: verbal attacks or outbursts;
profane language; bullying; throwing or breaking things; boundary violations; and comments that are personal, rude, disrespectful, threatening or belittling. Insulting or insensitive comments, jokes or behaviors directed toward learners’, colleagues’ or co-workers’ age, culture, disabilities, ethnicity, gender, language, political beliefs, physical appearance, religious or spiritual beliefs, sexual orientation or socioeconomic status also will not be tolerated.

Finally, faculty members may not assign a lower grade, write a poor evaluation, threaten, harass or otherwise retaliate against any learner because he or she has reported, in good faith, a violation of this faculty professionalism code.

Violations of this Professionalism Code

Although these qualities and behaviors may be more difficult to evaluate than research, scholarship, teaching and other traditional measures of academic performance, they are critical to the missions of the School of Medicine. Therefore, serious or repeated violations of these professionalism standards will be taken into account by department chairs and evaluation committees during performance reviews and at the time promotion or tenure decisions are made. Faculty members whose conduct departs from these precepts may also be expected to undergo professionalism or communication remediation, prescribed by the faculty member’s department chair, the President or Director of a hospital medical staff or the Dean of the School of Medicine. In addition, serious or repeated violations of these professionalism standards may give rise to other disciplinary actions, which may include removal from patient care or teaching environments, suspension or termination of employment.
Policy Title: Sexual Harassment Policy and Procedures

APS Number: 5014

APS Functional Area: HUMAN RESOURCES

Brief Description: This policy defines sexual harassment and related terms and the procedures and processes for reporting and investigating allegations of policy violations.

Effective: July 20, 2012 (Updated 11/29/2012)

Approved by: President Bruce D. Benson

Responsible University Officer: Vice President, Employee and Information Services

Responsible Office: Office of the Vice President, Employee and Information Services

Policy Contact: Office of the Vice President, Employee and Information Services

Supersedes: Sexual Harassment Policy and Procedures, July 1, 2009

Last Reviewed/Updated: July 20, 2012

Applies to: All Campuses

Reason for Policy: This policy defines sexual harassment and related terms and the procedures and processes for reporting and investigating allegations of policy violations.

I. INTRODUCTION
Regent Policy 2-J, adopted on June 23, 2003, established that consistent with the Laws of the Regents, Article 10, Non-Discrimination, the University will not tolerate acts of sexual harassment or related retaliation against or by any employee or student in its educational programs and activities.

II. POLICY STATEMENT
The University of Colorado is committed to maintaining a positive learning, working and living environment. The University does not discriminate on the basis of race, color, national origin, sex, age, disability, creed, religion, sexual orientation, or veteran status in admission and access to, and treatment and employment in, its educational programs and activities. (Regent Law, Article 10). In pursuit of these goals, the University will not tolerate acts of sexual harassment or related retaliation against or by any employee or student.

This policy (1) provides a general definition of sexual harassment and related retaliation; (2) prohibits sexual harassment and related retaliation; and (3) sets out procedures to follow when a member of the University community believes a violation of the policy has occurred. It also is a violation of this policy for anyone acting knowingly or recklessly either to make a false complaint of sexual harassment or to provide false information regarding a complaint.

Robust discussion and debate are fundamental to the life of the University. Consequently, this policy shall be interpreted in a manner that is consistent with academic freedom as defined in Regent Law, Article 5 D, last amended 10/10/02.

It is intended that individuals who violate this policy be disciplined or subjected to corrective action, up to and including termination or expulsion.
III. DEFINITIONS

**Appointing authority** - an appointing authority is the individual with the authority or delegated authority to make ultimate personnel decisions concerning a particular employee.

**Disciplinary authority** - a disciplinary authority is the individual who has the authority or delegated authority to impose discipline upon a particular employee or student.

**Supervisor** - A supervisor is anyone who has the authority to hire, promote, discipline, evaluate, grade or direct faculty, staff, or students.

**Complainant** - a complainant is a person who is subject to alleged sexual harassment.

**Respondent** - a respondent is a person whose alleged conduct is the subject of a complaint.

**Sexual harassment** - Sexual harassment consists of interaction between individuals of the same or opposite sex that is characterized by unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when: (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment, living conditions and/or educational evaluation; (2) submission to or rejection of such conduct by an individual is used as the basis for tangible employment or educational decisions affecting such individual; or (3) such conduct has the purpose or effect of unreasonably interfering with an individual’s work or academic performance or creating an intimidating, hostile, or offensive working or educational environment.

**Hostile environment sexual harassment:** (described in subpart (3) above) is unwelcome sexual conduct that is sufficiently severe or pervasive that it alters the conditions of education or employment and creates an environment that a reasonable person would find intimidating, hostile or offensive. The determination of whether an environment is “hostile” must be based on all of the circumstances. These circumstances could include the frequency of the conduct, its severity, and whether it is threatening or humiliating. Examples which may be policy violations include the following: an instructor suggests that a higher grade might be given to a student if the student submits to sexual advances; a supervisor implicitly or explicitly threatens termination if a subordinate refuses the supervisor’s sexual advances; and a student repeatedly follows an instructor around campus and sends sexually explicit messages to the instructor's voicemail or email.

**Retaliation:** Retaliation is prohibited by this Policy. To be considered retaliation, a causal connection is required between a materially adverse action and the act of (1) reporting an allegation of sexual harassment; or (2) participating in support of an investigation of sexual harassment. A materially adverse action is one that would dissuade a reasonable person from reporting an allegation of sexual harassment, or participating in support of an investigation of an allegation of sexual harassment. A determination of whether an action is materially adverse is made on a case by case basis. Students and employees who believe they have been retaliated against because of testifying, assisting or participating in a proceeding, investigation, or hearing relating to an allegation of sexual harassment, should meet with and seek the advice of their campus sexual harassment officer, whose responsibilities include handling retaliation.

IV. POLICIES AND PROCEDURES

A. Obligation to Report

In order to take appropriate corrective action, the University must be aware of sexual harassment or related retaliation. Therefore, anyone who believes that s/he has experienced or witnessed sexual harassment or related retaliation should promptly report such behavior to a campus sexual harassment officer (see campus Appendix discussed below) or any supervisor (see section B below).

B. Supervisor’s Obligation to Report

Any supervisor who experiences, witnesses or receives a written or oral report or complaint of sexual harassment or related retaliation shall promptly report it to a campus sexual harassment officer. This section of the policy does not
obligate a supervisor who is required by the supervisor's profession and University responsibilities to keep certain communications confidential (e.g., a professional counselor or ombudsperson) to report confidential communications received while performing those University responsibilities. Each campus shall have an appendix to this policy designating the supervisory positions that qualify under this exception.

C. Investigation Process

1. Reports or complaints under this policy shall be addressed and resolved as promptly as practicable after the complaint or report is made. Ordinarily, investigations shall be concluded and reports submitted to the standing review committee no later than 60 days following the receipt of a complaint. Ordinarily, the final report shall be sent to the Chancellor or President no later than 30 days after the committee's receipt of the draft report of the investigation.

   It is the responsibility of the sexual harassment officer(s) to determine the most appropriate means for addressing the report or complaint. Options include, but are not limited to: 1) investigating the report or complaint in accordance with paragraph C.3. below; 2) with the agreement of the parties, attempting to resolve the report or complaint through a form of alternative dispute resolution (e.g., mediation); or 3) determining that the facts of the complaint or report, even if true, would not constitute a violation of this policy.

   The campus sexual harassment officer(s) may designate another individual (either from within the University, including an administrator, or from outside the University) to conduct or assist with the investigation or to manage an alternative dispute resolution process. Outside investigators shall have training, qualifications and experience as will, in the judgment of the sexual harassment officer, facilitate the investigation. Anyone designated to address an allegation must adhere to the requirements of this policy and confer with the sexual harassment officer(s) about his or her progress. (See campus appendix for a list of resources for further assistance or additional information.)

2. All reports or complaints shall be made as promptly as feasible after the occurrence. (A delay in reporting may be reasonable under some circumstances, as determined on a case-by-case basis. An unreasonable delay in reporting, however, is an appropriate consideration in evaluating the merits of a complaint or report.)

3. If an investigation is conducted: The complainant and the respondent shall have the right to:
   
   a. Receive written notice of the report or complaint, including a statement of the allegations, as soon after the commencement of the investigation as is practicable and to the extent permitted by law;
   
   b. Present relevant information to the investigator(s); and
   
   c. Receive, at the conclusion of the investigation and appropriate review, a copy of the investigator's report, to the extent permitted by law.

4. The Chancellor, the respondent's appointing authority and the respondent's supervisor shall be notified that an investigation is taking place. The sexual harassment officer shall advise the respondent's appointing authority whether the respondent should be relieved of any supervisory or evaluative authority during the investigation and review. If the respondent's appointing authority declines to follow the recommendation of the sexual harassment officer, s/he shall send a letter explaining the decision to the Chancellor with a copy to the sexual harassment officer.

5. At the conclusion of an investigation, the investigator shall prepare a written report which shall include a statement of factual findings and a determination of whether this policy has been violated. The report shall be presented for review to the standing review committee.
6. The standing review committee shall consist of employees who have received appropriate training regarding implementation of this policy.

7. The standing review committee may consult with the investigator, consult with the parties, request that further investigation be done by the same or another investigator, or request that the investigation be conducted again by another investigator. The standing review committee may adopt the investigator's report as its own or may prepare a separate report based on the findings of the investigation. The standing review committee may not, however, conduct its own investigation or hearing. Once the standing review committee has completed its review, the investigator shall send the final report to the complainant and the respondent, to the extent permitted by law.

The report also shall be sent to the Chancellor, or, in the case of System Administration\(^1\), to the President. If a Chancellor is the respondent or complainant, the report shall be sent to the President. If the President or the Secretary of the Board of Regents is the respondent or complainant, the report shall be sent to the Board of Regents.

D. Reporting Process

1a. If a policy violation is found, the report(s) shall be sent to the disciplinary authority for the individual found to have violated the policy, and the disciplinary authority must initiate a disciplinary process against that individual. The disciplinary authority shall have access to the records of the investigation. If disciplinary action is not taken, the appointing authority and the Chancellor, or in the case of System Administration, the President, shall be notified accordingly.

1b. Following a finding of violation of the policy, the disciplinary authority shall forward to the sexual harassment officer and to the Chancellor, or in the case of System Administration, the President, a statement of the action taken against an individual for violation of this policy.

1c. If a policy violation is not found, the appointing authority and the Chancellor, or in the case of System Administration, the President, shall be notified accordingly.

2. The sexual harassment officer shall advise the complainant and respondent of the resolution of any investigation conducted under this policy.

3. A copy of the investigator's written report as approved by the standing review committee, shall be provided to: 1) the complainant; 2) the respondent; and 3) the respondent's appointing authority.

4. In all cases, the sexual harassment officer shall retain the investigator's report, as approved by the standing review committee, for a minimum of three (3) years or for as long as any administrative or legal action arising out of the complaint is pending.

5. All records of sexual harassment reports and investigations shall be considered confidential and shall not be disclosed publicly except to the extent required by law.

6. Complaints Involving Two or More Campuses: When an alleged policy violation involves more than one campus, the complaint shall be handled by the campus with disciplinary authority over the respondent. The campus responsible for the investigation may request the involvement or cooperation of any other affected campus and should advise appropriate officials of the affected campus of the progress and results of the investigation.

7. Complaints By and Against University Employees and Students Arising in an Affiliated Entity: University employees and students sometimes work or study at the worksite or program of another organization affiliated with the University. When a policy violation is alleged by or against University employees or students in those
circumstances, the complaint shall be handled as provided in the affiliation agreement between the University and the other entity. In the absence of an affiliation agreement or a provision addressing this issue, the University may, in its discretion, choose to 1) conduct its own investigation, 2) conduct a joint investigation with the affiliated entity, 3) defer to the findings of an investigation by the affiliated entity where the University has reviewed the investigation process and is satisfied that it was fairly conducted, or 4) use the investigation and findings of the affiliated entity as a basis for further investigation.

E. No Limitations on Existing Authority

No provision of this policy shall be construed as a limitation on the authority of a disciplinary authority under applicable policies and procedures to initiate disciplinary action. If an individual is disciplined for conduct that also violates this policy, the conduct and the discipline imposed shall be reported to a campus sexual harassment officer. If an investigation is conducted under this policy and no policy violation is found, that fact does not prevent discipline of the respondent for inappropriate or unprofessional conduct under other applicable policies and procedures.

F. Information and Education

The President's Office shall provide an annual report documenting: (1) the number of reports or complaints of policy violations; (2) the categories (i.e., student, employee, or other) and sexes of the parties involved; (3) the number of policy violations found; and (4) examples of sanctions imposed for policy violations.

Each campus shall broadly disseminate this policy, distribute a list of resources available on the campus to respond to concerns of sexual harassment and related retaliation, maintain the campus appendix to the sexual harassment policy, and develop and present appropriate educational programs. Each campus shall maintain information about these efforts, including a record of how the policy is distributed and the names of individuals attending training programs.

V. RELATED POLICIES, PROCEDURES, FORMS, GUIDELINES, AND OTHER RESOURCES

A. Administrative Policy Statement, "Conflict of Interest in Cases of Amorous Relationships," provides that an amorous relationship between an employee and a student or between two employees constitutes a conflict of interest when one of the individuals has direct evaluative authority over the other and requires that the direct evaluative authority must be eliminated.

B. For related complaint, grievance or disciplinary processes, refer to Regent Policies 5. H. Faculty Senate Grievance Process and 5. I. Faculty Dismissal for Cause Process (for faculty), State Personnel Board Rules (for classified employees), and campus student disciplinary policies and procedures (for students).

C. Frequently Asked Questions (FAQs)

D. Campus Appendices
   1. Boulder
   2. Colorado Springs
   3. Denver

VI. HISTORY

Correction: 11/29/2012 correction to strike Section IV.G. which was not shown in final version for July 20, 2012.

Supersedes: Sexual Harassment Policy and Procedures, Jul 1, 2009
Supersedes: Sexual Harassment Policy and Procedures, July 1, 2003
Supersedes: University Policy on Sexual Harassment, November 14, 1996

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VII. KEY WORDS

| regent, law, article 10, sexual, harassment, 2-I, discrimination, retaliation, race, color, national origin, gender, sex, age, disability, creed, religion, sexual orientation, veteran, hostile, working, environment, conduct, offensive. |

1 For the purposes of this policy, System Administration includes the Office of the Secretary of the Board of Regents and the Department of Internal Audit.
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What to Include: The informed consent discussion should include the following five sections: (1) nature, purpose and benefits of the procedure; (2) risks of the procedure; (3) alternate treatments (if any); (4) benefits and risks of alternative treatments; and (5) possible outcome or risks if no treatment is given. While it is not possible to list every risk of every surgical procedure, the physician should discuss the statistically significant four or five most likely potential complications including common potential risks such as infections, blood loss and scarring. Additionally, any serious risk of the procedure, no matter how uncommon, such as death, permanent disfigurement, or brain damage should be discussed. Detailed information about the informed consent process also is available in the PRM Office. The above information should be presented to the patient in a caring, but objective, manner. A consent that is obtained through exaggeration, misrepresentation, intimidation or the like is invalid and may be the basis for a medical malpractice claim.

Documentation: It is unnecessary to list each risk in the documentation of the discussion. One way to document is to enter a notation in the chart stating “nature, alternatives and risks of procedure discussed and patient understands and agrees to procedure.” Any particularly important risk that warrants discussion should be mentioned, such as “explained risks, with emphasis on ....” If an interpreter is used during the discussion, the interpreter’s name should be indicated clearly in the charting note and on the consent form.

Forms: The hospital consent form must always be completed to verify that an informed consent has been obtained. Informed Consent is a process of communication with a patient regarding the risk and benefit of a planned procedure. The form is required to document the procedure. The form alone can never be considered an informed consent. Signature of a witness, other than the physician, is only necessary during telephone and verbal consents.

Emergency: An informed consent is not necessary in a medical emergency when (1) the patient is not able or competent to give consent; (2) has not previously withheld consent for the planned procedure; and (3) a relative, guardian or other authorized person or agent is unavailable to give consent. The chart notes should clearly document the situation. A Certified of Emergency form must be signed by the physician and the administrator on call (see Administrative Policy I-3). (NOTE: This does not apply to the Emergency Department.)

Refusing Treatment: A competent adult patient has the right to refuse treatment. If the Resident feels the treatment is essential to prevent serious deterioration or death, they can recommend that involved family members or friends speak to the patient regarding the benefits of the treatment. If the Resident feels that the patient is confused about the recommended treatment, a psychiatric consult may be requested. However, it must be emphasized that a competent adult patient can legally refuse treatment, regardless of the opinions of family, friends, or the healthcare team. If after consent is requested, and the patient refuses the recommended course of treatment, documentation is critical. It is important to specifically note in the medical record the patient’s understanding of the benefits of the recommended treatment and the risk/results of refusing treatment. (Also see Informed Consent Policy, UCH Administrative Policy I-3, for more detailed information; when at CU Denver institutions, reference their specific policies.)
**Adults:** An adult (18 years of age or older) may consent to treatment (exception: Medicaid requirement for sterilization is 21 years of age). The person must be mentally competent and must not have recently received anesthetiic sedation. A mentally challenged person is not necessarily incompetent, but an individual should be able to understand the information. This is a judgment made in good faith by the physician. If unsure about a person’s competency level, obtain a second opinion and document the decision process in the medical record.

**Minors:** A minor (under 18 years of age) may consent to treatment in any of the situations described below, except sterilization:

1. Emancipated (15 years of age or older)
2. Legally married
3. Seeking pregnancy testing, birth control or abortion
4. Treatment of EtOh and drug abuse (unless intoxicated)
5. Treatment of venereal disease
6. Mental health services (15 years of age or older)
7. Treatment of HIV
8. Abuse
9. Children of minors
10. On active duty with the U.S. Armed Forces

**Methods of Obtaining Consent**
Written Consent: Written consent on the appropriate form should be obtained whenever possible. However, if it is not possible to obtain written informed consent, consent may be obtained by one of the following less satisfactory methods.

Verbal Consent: Although verbal consent is valid, it may be difficult to prove. This is the reason that written consent should be obtained whenever possible. Verbal consents should be witnessed by two individuals (the physician and one other person) and documented in the medical record. Immediate steps should be taken to procure confirmation in writing.

Telephone Consent: Consent by telephone must be witnessed and documented in the medical record indicating the exact time and nature of the consent given. Telephone consents must be witnessed by two individuals (the physician and one other person). Immediate steps should be taken to procure confirmation in writing.

**Consent Policies**
Role of Non-Physicians: If a hospital employee finds that a patient does not understand the pertinent elements of the scheduled procedure, or the patient indicates a change of mind, the physician must be notified immediately.

Copies: While the original consent form should always be kept in the medical record, a legible copy is adequate.
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Duration: A consent is considered valid and in effect until either (1) the patient has revoked the consent (which may be done at any time); (2) 30 days have elapsed; or (3) there are changed circumstances which would significantly affect the nature of or risks of the procedure. For example, when a patient has been admitted for a specific course of treatment including a specific operation, but while studying the patient several days elapse and the anticipated operation/procedure changes, the physician should obtain a new informed consent.

Abbreviations: It is in the hospital’s best interest to avoid the use of abbreviations on consent forms. Only abbreviations that are considered common knowledge to both the patient and physician may be used.

Medications and the Consent Process: For a consent to be valid, it must be obtained from a competent patient. Competency is defined to mean an ability to understand the nature and consequences of what one is asked to consent. If medication was given prior to the consent process and if such medication might affect a patient’s ability to comprehend the situation, then it becomes the physician’s responsibility to determine competency to consent.

Telephone Consent: Consent for treatment should be obtained by telephone only if the person(s) having legal capacity to consent for the patient is not otherwise available. If a physician obtains a consent by telephone, a hospital staff witness should listen in on the telephoning of the consenting process. The physician must alert the patient/representative that a third party is on the line. The verification by the witness must be documented on the consent form.

Patient Unable to Sign: In the event a patient is physically unable to write his name, his mark must be obtained. This is done by a UCH staff member first printing the patient’s name in full and then having the person place their ‘X’ beneath it. Two persons should witness the patient place his or her mark on the consent.

Malpractice Insurance Coverage
Professional malpractice refers to an event where a patient is injured as a result of medical negligence. Specifically, malpractice is present when (1) there is an act or failure to act which is below the “standard of care,” and (2) this act or failure to act results in a personal injury to the patient. The PRM staff seeks to identify such situations when they arise and take early intervention to avoid the filing of a lawsuit. However, if a suit is filed and the Resident is involved in the case, he/she will be covered by the University’s self-insurance program in accordance with the following sections.
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**Self-Insurance Program:** Professional liability “malpractice” coverage for Residents is provided through the University of Colorado’s Self-Insurance and Risk Management Trust. The University of Colorado became self-insured under the Trust for Medical Malpractice June 23, 1976. To administer the medical self-insurance trust fund, the University has established a Professional Risk Management Program. Coverage is provided on an occurrence basis. Therefore, Residents are covered for acts within the course and scope of employment even if a claim or lawsuit is brought for that occurrence after leaving the employment of the University. To ensure protection when on rotation at another hospital, the University enters into affiliation service agreements with these facilities.

It is recommended that Residents always wear the CU ID badge, identify themselves as an employee of the CU and sign, as such, in the medical record while rendering care to patients at other institutions. Moonlighting, by definition, is not an approved activity and deemed to be outside the course and scope of University of Colorado employment. Contact the PRM Department at 303-724-7475 for questions on coverage.

**Attorneys**
Contact Professional Risk Management: Do not enter into conversations with attorneys regarding patient care matters without first checking with the Professional Risk Management Office. Revealing sensitive patient care information to unknown individuals — regardless of whom they say they are — can constitute a breach of patient confidentiality. Furthermore, answering questions from a patient’s attorney out of context and without the guidance of well-informed and capable legal counsel can be against the Resident’s interest and that of CU Denver. Check with the PRM Office to determine whether the attorney is an appointed University employee or agent.

On the other hand, once the PRM Office has confirmed that an attorney is a University agent, complete cooperation is very important. Since the Resident’s attorney will need help to understand the often complex issues surrounding the medical care in question, a close attorney-client working relationship is essential. Never hesitate to reveal circumstances that may seem negative (when in a private conference with a University attorney only), for only with a complete understanding of the facts can legal counsel effectively defend the Resident.

**Depositions:** If contacted regarding a deposition as a result of a University assignment, the Resident should notify the PRM Office as soon as possible. Most depositions can be conducted at a convenient time and place. If appropriate, an attorney will be available to brief the Resident on testifying or will accompany the Resident to the deposition to protect their interests and those of the University.

A deposition is one of several means provided by Colorado law for taking testimony under oath. Depositions serve several purposes. Without using expensive court time, they allow the attorneys to “discover” knowledge regarding a case. They commit testimony given under oath. Depositions give the attorneys for both sides an opportunity to evaluate the impression the Resident would make on a jury. Finally, they preserve the testimony if the Resident cannot be present at a trial.
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**Expert Witness Testimony:** If a Resident is not an involved witness or a defendant in a case and is asked to testify, it will likely be as an expert witness. Serving as an expert witness in a case is strictly voluntary. The Resident is entitled to an expert witness fee if asked to provide an expert opinion regarding a patient's care in which, they or a Resident as no involvement. Fees should be negotiated with the attorney according to what the Resident's time is worth. When asked to testify as an expert witness for a University lawsuit, fees must be approved by University counsel and the PRM Office. The mechanism for payment is also arranged through these offices.

When considering testifying as an expert, it is the Resident’s professional responsibility to ensure that there is no conflict of interest, and to determine that the Resident’s background gives adequate qualification. Before considering rendering an opinion as an expert witness in a case, the Resident should verify that it does not adversely affect another University of Colorado employee.

**Legal Documents**

**Subpoena:** A subpoena is an order of a court or an authorized agency commanding the person subpoenaed to appear as a witness.

**Subpoena Duces Tecum:** A subpoena duces tecum requires the person subpoenaed to produce records or documents officially under their control at a specified time and place. If the subpoena duces tecum is for the patient’s medical record, direct the server to the Medical Records Department.

**Notice of Claim:** Within 182 days after the discovery of an injury attributable to a public entity and employee, a written notice must be filed which states the following: the name and address of the claimant and that of their attorney, if any; a concise statement of the factual basis of the claim, including the date, time, place and circumstances of the act, omission, or event complained of; the name and address of any public employee involved, if known; a concise statement of the nature and extent of the injury; and a statement of the amount of monetary damages sought. A “Notice of Claim” must be filed with the University of Colorado when one of its employees is involved. The PRM Office will investigate all Notices of Claim involving patient care by CU physicians and other employees.

**Summons and Complaint:** A Summons and Complaint is a notice to a defendant and the initial pleading by a plaintiff in a civil court action. The complaint details the various allegations of misconduct by the defendant and the request for monetary compensation.

**Notify Professional Risk Management:** Upon receipt of any legal correspondence from patients, attorneys or courts, or Department of Regulatory Agencies (DORA); notify
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the Office of University Counsel, 303-315-6617, or Professional Risk Management, 303-724-RISK (7475), immediately. As certain legal documents must be responded to within a statutory time limit, our immediate receipt of legal correspondence is imperative. Failure to respond on time may result in default judgments, the issuance of a bench warrant, or other sanctions entered against the Resident and/or the University. Please record the exact date and time of receiving a document and bring the original to the Office of University Counsel, School of Medicine, Room 1660.

Who Accepts: Before accepting a legal document, determine whether it names a Resident specifically or whether it names another individual and/or CU or University of Colorado Hospital. If the legal document names the individual Resident specifically, the Resident must accept it. If the legal document names an individual in the department, accept it only if previously authorized to do so. If someone other than the person named accepts a legal document, it then becomes the responsibility of the acceptor to promptly deliver the legal document. It is important to emphasize that no employee should accept a legal document unless specifically authorized to do so or the individual is specifically named.

Withholding/Withdrawing Life Support
University of Colorado Hospital has a policy for withholding or withdrawing life support measures which is available in the Administrative Policy and Procedures Manual. (Patients treated at an affiliated hospital are governed by the affiliated hospital’s policy.) Every patient has the right to make informed decisions regarding their medical treatment, including the withholding or withdrawal of life support. These options should be discussed with each patient who may require life support as a component of their treatment. In the case of incompetent patients, other sources of authority for treatment decisions include living wills, durable powers of attorney, court-appointed guardians and next of kin.

Addressing the issue of life support with patients and families in advance of the need for life support will help avoid confusion and difficult ethical decisions when the need for life support arises. Healthcare providers who disagree with a patient’s or family’s decision regarding life support should transfer the patient or arrange for care by another provider.

More information is available in the Administrative Policy and Procedures Manual. Also, the hospital chaplain can assist in addressing issues of life support with patients. Another source of assistance for providers faced with life support decisions is the Hospital Ethics Committee.

Colorado Medical Treatment Decision Act: The Colorado Medical Treatment Decision Act allows competent adult patients to declare in writing that their physician withhold or withdraw life sustaining procedures ‘in the event of a terminal condition.’ The written declaration, called a “Declaration as to Medical or Surgical Treatment,” should follow the statutorily prescribed form and wording, and be properly executed. Consult the PRM Office or Office of University Counsel for more information or approval of documents.
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BrainDeath: In general, when an individual is pronounced dead by determining the individual has sustained an irreversible cessation of all functions of the entire brain, including the brainstem, and that determination has been independently confirmed by a second physician, life support should be discontinued. Consultation with the appropriate attending physician is required. The pronouncement of brain death is a medical act that does not require the consent of a patient’s relative, guardian or other legally authorized person or agency.

Documentation
Avoiding Liability: The patient’s medical record almost always becomes the primary source of evidence throughout a malpractice action. As the memories of the plaintiff and defendants can be faulty, selective, or both, courts must rely upon the medical record as the primary account of what actually transpired. Therefore, it is very important to document all relevant and appropriate information regarding a patient’s health care in the chart. Further, it should be done legibly. A plaintiff’s attorney may be convinced to take on even the most marginal of cases if the medical records are incomplete and/or poorly written.

What to Document: Facts; dates and times; patient’s condition; treatment recommended; treatment provided; noncompliance with recommended treatment, prescriptions; appointments; “no shows”; all prescriptions and refills; evidence of informed consent; sources of information, if other than the patient; rationale for any unusual type of care; complications, mishaps, or unusual occurrences; significant discussions with patient or family; worries or concerns expressed by patient or family; brief record of complaints about the quality of care from the patient or family and response; responses to entries by others that require action by the provider.

Reasons the patient needs to be in an acute care hospital; reasons for transfer from one facility to another such as availability of services; an accurate and complete discharge assessment after discussion with discharge planning; comments on test results which indicate the need for continued care or changes in treatment plans; the reason for admission for a procedure usually done as an outpatient; the severity of the patient’s condition and limits of activity; specific diagnosis (e.g., rather than anemia, define the type of anemia); tests pertinent to diagnosis update and completeness; differential diagnosis at time of admission (rule-outs); pending lab results and the reason they are needed for continued hospitalization; attempts at outpatient treatment prior to admission and reason for admission thereafter; facts that make a patient’s discharge or transfer unacceptable.

What NOT to Document: Risk prevention activities; anything about an occurrence report; matters which have legal implications but have no value to patient care; an entry requiring action by a Resident or other staff unless they are certain it will take place; disagreement with another entry when there is a reasonable explanation; opinions regarding the actions of other staff; statements blaming the hospital or economic factors; statements regarding care rendered by other healthcare providers; disapproval or a negative value judgment of the patient; self-serving statements; changes or additions to previous entries after a claim is filed.
Beliefs that the patient should not be in the hospital; comments about DRGs, PROs, or administration, utilization, or discharge planning staff; unjustified social or administrative reasons for continued stay; patient’s reluctance to be discharged unless accompanied by justifiable reasons and plans to resolve problems.

**Increasing Reimbursement:** Lack of documentation or poor documentation can cause denial of payments to the hospital in many instances. Good documentation, which reveals the appropriateness of admission and the need for continued acute stay, not only increases the likelihood of reimbursement, it facilitates communication between providers and increases the quality of care.

**Change to Entries:** Never change an entry in the medical record. Doing so is a sure way to destroy the defense of an otherwise defensible case. It also may be fraud. By the time a claim is filed, a plaintiff’s attorney most likely will have a copy of the record.

Residents may make corrections in everyday charting by drawing a single line through an erroneous entry, thereby leaving the entry legible. Date and sign the correction in the margin. If needed, add an explanation of the correct entry in the next available area. Never use correcting fluid or completely mark over an entry. In the electronic medical record (EMR), Residents may make corrections in everyday charting by composing an addendum. Never remove information or pages from the chart once they have become part of the official record.

**Written Orders:** Good documentation is the most valuable tool in preventing and minimizing liability; it requires that a Resident’s request for ancillary services, such as x-ray and lab, always be in writing or ordered electronically in the EMR. While a telephone call may help expedite an x-ray or lab request, the initial request should be documented by the appropriate mechanism. Not only will this improve the process of obtaining services, but also from a liability standpoint it is always easier to defend an incorrect document than no document.

**Occurrence Reports**
The *Occurrence Report* is an important communication tool used by the PRM Department. It allows the entire CU Denver staff to provide confidential notification of any situation involving injury or potential injury to a patient, or any event that may contribute to liability problems in the future. Reports allow the PRM Department to proceed with early intervention by following up on significant reports.

UCH has implemented an online system of reporting Patient Occurrences using a product called Safety Intelligence (SI). Access to this online system is available on most UCH unit computers. Any Medical Staff member who suspects an actual or potential patient occurrence enters a report electronically via SI. In accordance with UCH policy, events are to be reported within 3 days. Events involving great potential or actual risk, or those which are reportable to regulatory agencies are reported immediately via SI and a telephone call.
Risk Management Guide

to Professional Risk Management at 303-724-RISK (7475). When clinical services are provided at affiliate hospitals, a phone report would be required because the online system pertains to UCH locations only.

When a patient injury has occurred, contact the PRM Department immediately at 303-724-RISK (7475). (Voice mail is utilized during off-business hours to receive reports.)

Reportable Occurrences: These include unexpected/unexplained deaths; patients who are away from the hospital without being discharged and without notifying their providers (AWOL); unplanned removal or injury to an organ during surgery; hospital acquired infections or trauma (falls, hit by equipment, etc.); significant adverse drug reaction; medication errors; equipment failures; actions by abusive patients or staff; and any occurrences that cause an angry reaction by patient or family member.

Occurrence Reports should never be used for disciplinary action, photocopied, mentioned or included in the medical record, posted in a public area, discussed with anyone other than PRM staff or their legal representatives. Employee injuries should be reported on an Employee Occurrence Form and sent to the Employee Health Services (Mail Stop B-213).

Visitor injuries should be reported to Security at 720-848-7777 and by filling out the Visitor Occurrence Report on the hub (http://hub.uch.edu/) and faxed to 720-848-5501.

Nosocomial Infections should also be reported to the Infection Control Department.

Interdepartmental Problem/Incident Form

Questions often arise regarding when to use an Interdepartmental Incident Form as opposed to a Patient Occurrence Report. Always report a patient’s injury to PRM on the Patient Occurrence Report. An Interdepartmental Incident Form is appropriate for situations that are potentially harmful in a general way to patients, visitors, employees or the hospital. Frequent or ongoing delays in service, frequent policy violations or any physical hazards are some examples. An Interdepartmental Incident Form generally cites system or operational problems and other overall issues affecting quality of care, while an Occurrence Report addresses a specific occurrence involving a specific patient or visitor.

The Interdepartmental Incident Form, with the problem identified, is forwarded to the involved department(s) for evaluation of the problem and the department’s response is then sent to the reporting department. Therefore, it is imperative that it be completed legibly. If the Resident includes their name and location, the response will be forwarded personally to them. Data from the forms are intended for presentation to appropriate committees. Interdepartmental Incident Forms are available on all nursing units.
Risk Management Guide

Patient Problems and Concerns
Medical Records and X-Rays: If patients need a copy of their charts, refer them to Health Information Management at 720-848-1031. If patients desire copies of x-rays, refer them to the Radiology File Room at 720-848-1105. There will be a charge. Charts and x-ray films involving lawsuits are placed in secure storage by custodians upon notification by Professional Risk Management. When outside requests or subpoenas for charts and x-ray files are received on claim records, the custodian should contact PRM before releasing the records. If there is a suggestion of legal action against the University when an outside request is received, notify Professional Risk Management.

Bills and Charges: Avoid offering to reduce or eliminate charges or saying that insurance will be accepted as payment in full. If a patient is questioning a charge or desires an explanation of their bill, refer them to the Patient Services Office at 720-848-8800 for hospital bills and University Physicians, Inc. at 303-493-7000 for physician bills. When a patient resists payment and alleges that the quality of care was below standard, the PRM Office should be notified. A physician has no authority to reduce hospital charges, and most patients do not realize that professional fees and hospital charges are separately generated and charged. Often when a complication in treatment arises, whether it is within the standard of care or not, a provider is tempted to offer a reduction of charges. If professional fees are waived or reduced, it should be made clear that this will not affect hospital charges. Contact Professional Risk Management before making such arrangements.

Property: Patients/families should be advised on admission not to keep valuables with them while in the hospital. If necessary, they can be stored in the safe in Admissions. If loss or damage to property of a patient is known or alleged, the circumstances are to be reported to 720-848-7777.

Complaints: Patient complaints should be forwarded to the patient representative unless they involve quality of care or potential liability issues. The patient representative also handles complaints that require immediate/same-day action. If patients want to file a complaint, do not discourage them. Direct complaints to the patient representative at 720-848-5277.

Abusive and Uncooperative Patients: When a patient is being abusive or uncooperative, contact PRM to help determine the best course of action. Fully document inappropriate behaviors and all discussions with the patient regarding them. Especially note the progression of warnings and attempts to safeguard the health and safety of the patient and other patients and staff. Remember not to express value judgments in the medical record; stick to the facts.

Reporting Responsibilities
Child and Elder Abuse: Colorado law requires University of Colorado Hospital healthcare personnel to report suspected cases of abuse or neglect of children or dependent adults. The law also prohibits any civil or criminal action against healthcare personnel for fulfilling reporting responsibilities. The possibility of abuse should be considered when any of
Risk Management Guide

the following conditions are present: 1) there is no explanation for the injury; several explanations, or the explanation given is not compatible with the patient’s age and injury; 2) multiple or recurrent injuries; 3) delay in seeking medical treatment; 4) nonorganic failure to thrive; 5) medical or physical neglect; 6) a child is dead on arrival; 7) severe emotional damage due to the home situation; 8) any suggestion of sexual assault or inappropriate confinement; and/or 9) direct beatings or unexplained bruises or welts. Further, in the case of dependent adults, staff should be suspicious of cuts, freezing, lacerations, punctures, bone fractures, dislocations, sprains, burns, scalding, internal injuries, or over medication.

If abuse is suspected or case consultation is desired, please refer to Hospital Policy on suspected Child Abuse (P-10) for reporting requirements and consultation services.

Reportable Deaths to the Coroner: Government regulations (§ 30-10-606(1), C.R.S.) require the immediate reporting of the following deaths to the coroner for investigation:

1) any death within 24 hours of arrival at the hospital;
2) from external violence, unexplained cause, or under suspicious circumstances;
3) where no physician is in attendance, or where, although in attendance, the physician is unable to certify the cause of death;
4) from thermal, chemical, or radiation injury;
5) from criminal abortion, including any situation where such abortion may have been self-induced;
6) from a disease which may be hazardous or contagious or which may constitute a threat to the health of the general public;
7) while in the custody of law enforcement official or while incarcerated in a public institution;
8) when the death was sudden and happened to a person who was in good health; or
9) from an industrial accident.

More information, including explanation and comments on certain types of deaths which have been difficult to evaluate, is available from the PRM Office. To report a coroner’s case, call 303-659-1027. If in doubt, call the coroner.

Reportable Injuries to Law Enforcement Agencies: The Emergency Department is responsible for reporting the treatment of certain types of cases to the CU Denver Police Department which will notify the appropriate law enforcement agencies. Identification of such cases is the responsibility of Emergency Department personnel who must notify CU Denver Police Department when such cases appear for treatment. Reporting is not necessary if police accompany the patient to the Emergency Department or if reliable information is available that police were at the scene of the incident/accident.

Types of Reportable Incidents/Accidents Include:
1) Suspected cases of child abuse or neglect (must be reported either to county social services or local law enforcement (required by § 12-36-135, C.R.S.).
Risk Management Guide

2) Injuries involving bullet wounds, gunshot wounds, powder burns or any other injuries arising from the discharge of a firearm, or any injury caused by a knife, an ice pick, or any other sharp or pointed instrument which the physician believes to have been intentionally inflicted upon a person, or any other injury which he or she has reason to believe involves a criminal act (required by § 19-3-304, C.R.S.).

Reports should be filed with the police in the jurisdiction where the incident/accident occurred and the Aurora Police Department. Notify CU Denver Police and they will call the appropriate jurisdiction.

3) Rape: When directed to do so by the responsible physician or AT THE VICTIM’S REQUEST, notify the appropriate law enforcement jurisdiction (ex: Denver Police Department or Aurora Police Department).

4) Attempted suicide: When directed to do so by the responsible physician, report to the appropriate law enforcement jurisdiction (ex: Denver Police Department or Aurora Police Department).
University of Colorado School of Medicine
Department of Family Medicine Psychology
Internship Program

Policy on Due Process for Intern Evaluation and Grievances

This document provides guidelines for the evaluation of interns, grievance procedures, and the management of problematic performance or conduct. These guidelines are consistent with accreditation standards of the American Psychological Association and the policies of the University of Colorado. These guidelines emphasize due process and assure fairness in the program's decisions about interns, and they provide avenues of appeal that allow interns to file grievances and dispute program decisions.

THE EVALUATION PROCESS

The Psychology Internship Program assesses each intern's performance on a continuing basis. On a quarterly basis, supervisors provide written evaluations and meet with the intern to discuss the assessments and offer recommendations. After meeting, the supervisor and intern sign the written evaluation and forward it to the intern's Advisor, who reviews all of the evaluations with the intern. The Advisor summarizes the evaluations and forwards the evaluations and a brief written summary to the Training Director. The Training Committee meets quarterly to assess progress of all interns.

COMMUNICATION WITH INTERNS' HOME GRADUATE PROGRAMS

The Training Director communicates with each intern's sponsoring graduate program about the intern's activities and progress. Mid-year, the home graduate program receives information about the intern's training activities. At the end of the internship year, the home program receives a summary of the evaluation, indicating whether the intern has successfully completed the internship. At any time that problems arise casting doubt on an intern's ability to successfully complete the internship, the Training Director will inform the sponsoring graduate program. The home program will be encouraged to provide input to assist in resolving the problems.

DEFINITION OF PROBLEMATIC PERFORMANCE AND/OR CONDUCT

The program defines problematic performance and problematic conduct as follows. Problematic performance and/or problematic conduct are present when there is interference in professional functioning that renders the intern: unable and/or unwilling to acquire and integrate professional standards into their repertoire of professional behavior; unable to acquire professional skills that reach an acceptable level of competency; or unable to control personal stress that leads to dysfunctional emotional reactions or behaviors that disrupt professional functioning.
Guiding Principles to Ensure Due Process

The following principles serve to ensure that decisions made by the training program about interns are not arbitrary or personally based. These principles ensure that the intern is provided ongoing and meaningful feedback, opportunities for remediation, and information about appeals procedures.

- Presenting interns with written documentation of the program's expectations related to professional and personal functioning
- Stipulating the procedures for evaluation, including when and how evaluations will be conducted
- Articulating the various procedures and actions involved in making decisions regarding problem behaviors
- Communicating with interns early and often about how to address problem behaviors
- Instituting a remediation plan for identified inadequacies (including the competency domain(s) in which performance is not adequate), target behaviors, expectations for acceptable performance, steps for remediation, supervisors’ responsibilities, time frame for expected remediation, and consequences of not rectifying the inadequacies.
- Providing a written procedure to the intern that describes how the intern may appeal the program's action
- Ensuring that interns have sufficient time to respond to any action taken by the program.
- Using input from multiple professional sources when making decisions or recommendations regarding the intern's performance.
- Documenting, in writing and to all relevant parties, the action taken by the program and its rationale. Interns and faculty will sign any written action and evaluation.

Formally Addressing Performance Problems

This section addresses the sequence of supervisory actions to be taken when performance problems are identified. Attention is paid to remediation strategies that may be used to address these problems. Finally, there is a discussion of formal grievance procedures.

Supervisory Actions

If competence problems are noted by an intern’s supervisor, the following procedures will be initiated:

- The intern's supervisor(s) will meet with the intern’s Advisor and the Training Director to discuss the problem and determine what action needs to be taken.
- The intern will be notified, in writing, that such a review is occurring and will have the opportunity to provide an oral or written statement.
- In discussing the problem and the intern's response, the Training Director may adopt any one or more of the following methods or may take any other appropriate action.
  - Issue a verbal warning to the intern that emphasizes the need to engage in recommended amelioration strategies in order to alter the competence concern (as opposed to problem). No written record of this action is kept.
o Issue a "Performance Notice" which formally indicates that the faculty is aware of and concerned with the intern’s performance, that the problem has been brought to the attention of the intern, that the faculty will work with the Intern to specify the steps necessary to rectify the competence problems, and that the behaviors are not significant enough to warrant serious action. Remediation strategies described below should be implemented at this time. A signed copy of the Remediation Plan will be kept in the intern’s file, as will the Performance Notice.

o Issue a “Probation Notice” which defines a relationship such that the faculty actively and systematically monitors, for a specific length of time, the degree to which the intern addresses, changes and/or otherwise improves the problem behavior. The intern must be provided with a written statement that includes: a description of the actual problem behaviors, the specific recommendations for rectifying the problem, the time frame for the probation during which the problem is expected to be ameliorated, and the procedures designed to ascertain whether the problem has been appropriately rectified. Additional remediation strategies must be implemented at this time. A signed copy of the Probation Notice and the revised Remediation Plan will be kept in the intern’s file.

o Take no further action and inform all parties of this decision.

- The Training Director will then meet with the intern to review the action taken. If placed on probation, the intern may choose to accept the conditions or may challenge the decision. The procedures for challenging the decision are presented below (see Procedures for Appeal by an Intern).

- Once the Performance Notice or Probation Notice is issued by the Training Director, it is expected that the intern’s performance will be reviewed no later than the next formal evaluation period or, in the case of probation, no later than the time limits identified in the probation statement. If the problem has been rectified to the satisfaction of the faculty, the intern and other appropriate individuals will be informed and no further action will be taken.

- If it is determined that the conditions for revoking the probation status have not been met, the faculty may take any of the following actions:
  
  o Continue the probation for a specific time period, with written notice to the intern of ongoing steps that must be taken to ameliorate the problem in the specified time frame.
  
  o Issue a written “Suspension Notice” stating that the intern is not allowed to continue engaging in certain professional activities until there is evidence that the behavior in question has improved.
  
  o Issue a written “Warning Notice” stating that if the problem behavior does not change, the intern will not meet criteria for internship graduation.
  
  o Issue a written “Termination Notice” that the intern will be terminated from the internship program as of the date specified in the notice.

When a combination of the aforementioned interventions do not, after a reasonable time period, rectify the problem, or when the trainee seems unable or unwilling to alter their behavior, the training program may need to take more formal action, including such actions as:
• Communicating to the intern that he or she has not successfully completed the internship, with the possibility of continuing an additional year.
• Terminating the intern from the training program. This includes issuing of a “Termination Notice.” This information will be communicated to the intern’s graduate school faculty.

Remediation Strategies
It is important to have meaningful ways to address performance problems once they have been identified. The training program therefore, in conjunction with the intern, will formulate strategies for remediation of such problems and will implement such strategies and procedures.

Several possible and perhaps concurrent courses of action designed to remediate problems include, but are not limited to, the following. These remediation strategies may also be used when addressing competence concerns as well. All of these remediation strategies need to be appropriately documented and implemented in ways that are consistent with due process procedures.

• Increasing supervision, either with the same or other supervisors.
• Changing the format, emphasis, and/or focus of supervision.
• Strongly recommending personal therapy (the Training Director and other faculty have lists of therapists willing to work with Interns at a reduced rate).
• Reducing the intern’s clinical or other workload or modifying their schedule in other ways.
• Requiring specific academic coursework or independent study.
• Recommending, when appropriate, a leave of absence and/or a second internship.
• Recommending and assisting in implementing a career shift for the intern.

Grievances Initiated by Interns
Situations may arise in which an intern has a complaint or grievance against a faculty member, staff member, other trainee, or the program itself, and in which the intern wishes to file a formal grievance if he/she feels that the informal grievance process has not effectively resolved the situations. The following steps are intended to provide the intern with a means to resolve perceived conflicts that cannot be resolved by informal means. The program leadership will do its best to ensure that interns who pursue grievances in good faith will not experience adverse personal or professional consequences. Nothing here precludes attempted resolution of difficulties by adjudication at a clinic, hospital, or university level.

• Prior to filing a formal grievance, the intern should raise the issue with the supervisor, staff member, other trainee, intern’s Advisor or Training Director in an effort to resolve the problem.
• If the matter cannot be resolved, if it is inappropriate to raise the matter with the other individual, or if the intern fears potential repercussions, the issue should be brought to the attention of the intern’s Advisor or Training Director. If the Training Director is involved in the grievance or is unavailable, the issue should be raised with the intern’s Advisor, who may function as the Director in responding to the complaint.
• The intern’s Advisor or Training Director will initially attempt to mediate the complaint between the parties involved.
• If the intern’s Advisor or Training Director can not resolve the matter, the intern’s Advisor or Training Director will choose a faculty member, agreeable to the intern, and request that
individual mediate the matter. Written material will be sought from both parties.

- If mediation fails, the Training Director will convene a Review Panel within 30 days of receiving the written complaint. The panel will consist of the Director, two faculty members selected by the Director, and two faculty members selected by the intern. Any party involved in the dispute may not serve on the panel. The Review Panel will review all written materials (from the intern, other party, mediation). A review hearing will be conducted, chaired by the Training Director, in which evidence is heard. All parties in the dispute retain the right to be present at the hearing, to hear all facts, and to dispute any evidence or claims presented. Within 15 days of the completion of the review hearing, the Review Panel files a written report, including any recommendations for further action. Decisions made by the Review Panel will be made by majority vote of the five panel members. The intern is informed of the recommendations by the Training Director and receives a copy of the panel report. Recommendations of the Review Panel are forwarded to the appropriate University, Clinic, or Hospital administrator for review and response. It is the responsibility of the Training Director to follow-up on the response to these recommendations.

**Procedures for Appeal by an Intern**

Interns who wish to contest supervisory actions and decisions must submit a written challenge to the Training Director within 15 days of receipt of the faculty decision. Failure to submit a written challenge within 15 days will be taken as assent to the supervisory actions and decisions. Once a written challenge is received, the following steps will occur:

- The Training Director will convene a Review Panel consisting of the Director, the intern’s Advisor and one faculty member selected by the Director, and two faculty members selected by the Intern.
- A review hearing will be conducted, chaired by the Training Director, in which evidence is heard from the faculty supervisor, who has the right to be present at the hearing. The intern retains the right to be present at the hearing, to hear all facts, and to dispute or explain his or her behavior.
- Within 15 days of the completion of the review hearing, the Review Panel files a written report, including any recommendations for further action. Decisions made by the Review Panel will be made by majority vote of the five panel members. The intern is informed of the recommendations by the Training Director and through receipt of a copy of the panel report.
- If the Review Panel finds in favor of the intern, no further action against the intern is taken. The Training Director will consult with the intern’s Advisor and the intern’s major and minor rotation supervisors concerning the decision.
- If the Review Panel finds in favor of the faculty supervisor, the original supervisory action is implemented.
- The Review Panel may, at its discretion, find neither in favor of the supervisor nor the intern. It may instead modify the original supervisory action or issue and implement its own action. In this instance, the Training Director will consult with both the faculty supervisory and the intern concerning the decision.
- Decisions of the Review Panel may be appealed to the Chair of the Department of Family Medicine that employs the intern. A further appeal may be directed to the Senior Associate Dean
for Clinical Affairs (or designee) of the University of Colorado School of Medicine. The decision of the Dean is final.
Intern name: 

Rotation: 

Major or Minor Rotation 

Dates of rotation: 

Supervisor/s: 

Assessment Methods used (check all that apply)

<table>
<thead>
<tr>
<th>Direct Observation</th>
<th>Review of Written Work</th>
<th>Discussion of Clinical Interaction</th>
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<tbody>
<tr>
<td>Video tape</td>
<td>Review of Raw Test Data</td>
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<tr>
<td>Audiotape</td>
<td>Review of Process Notes</td>
<td>Feedback from other staff</td>
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<tr>
<td>Case Presentation</td>
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COMPETENCY STANDARDS

Use the following scale to make ratings in all areas listed below that are applicable to the intern’s training on this rotation. **It is expected that most interns will progress from 2 - 4 over the course of the training year. The following is required:**

End of first quarter, intern must have an average of 2 or better within each domain

End of second quarter, intern must have an average of 3 or better within each domain

End of third quarter, intern must have an average 3 or better within each domain

End of fourth quarter, intern must have an average 4 or better within each domain

1 **Development lags expectations, remedial action required**
Trainee exhibits basic knowledge, skills, and abilities, but requires remedial training and direction in specific areas of weakness and/or lack of prior experience. Direct observation and modeling may be required for certain clinical activities. Scores in this range may require a remediation plan and always trigger a review by Training Director and Training Committee.

2 **Development lags expectations, address within supervision**
Trainee exhibits basic knowledge, skills, and abilities, but requires close supervision for unfamiliar clinical activities and/or novel circumstances. Direct observation and modeling may be required for new experiences.

3 **Developing as expected towards basic competency; requires regular supervision**
Trainee generalizes knowledge, skills, and abilities across clinical activities and settings. Can engage in routine clinical activities with minimal structure, but may need closer supervision for more complex situations. Direct observation and modeling is rarely required.

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<tr>
<th>4</th>
<th>Achieved basic competency; supervision is needed only for non-routine cases</th>
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<tr>
<td></td>
<td>Trainee consistently integrates knowledge, skills, and abilities into all aspects of professional service-delivery. Able to engage in less familiar clinical activities, and function proactively and independently in most contexts. Prepared for entry level practice and professional licensure.</td>
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<th>5</th>
<th>Achieved advanced competency; comparable to independent practice</th>
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<tr>
<td></td>
<td>Trainee is ready for independent practice and can handle complex situations with minimal consultation. Sound critical thinking/judgment evident overall.</td>
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### COMPETENCY 1: RESEARCH COMPETENCY

Trainees need to demonstrate the substantially independent ability to critically evaluate and disseminate research or other scholarly activities (case conference, presentations, publications) at the local (including the host institution), regional, or national level. Program evaluation projects that involve the analysis of data are considered research.

<table>
<thead>
<tr>
<th>Evaluation Period</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>1</td>
<td>Demonstrates knowledge of readings in seminars and case conferences</td>
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<tr>
<td>2</td>
<td>Integrates scientific knowledge during supervision and case conferences</td>
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<td>3</td>
<td>Applies knowledge and understanding of scientific findings into clinical care</td>
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<tr>
<td>4</td>
<td>Disseminate research through presentation at case conferences, seminars, and in supervision</td>
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**Average**

### COMPETENCY 2: ETHICAL AND LEGAL STANDARDS COMPETENCY

Trainees respond professionally in increasingly complex situation with greater degree of independence across levels of training, including knowledge and in accordance with APA Code and relevant laws, regulations, rules, policies, standards, and guidelines.

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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>1</td>
<td>Demonstrates understanding of the Ethical Guidelines through their conversations in supervision, approach to ethical dilemmas in patient care and contributions to case conferences and seminars.</td>
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<td>2</td>
<td>Recognizes ethical dilemmas as they arise, and applies ethical decision-</td>
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### COMPETENCY 3: INDIVIDUAL AND CULTURAL DIVERSITY COMPETENCY

Trainees must demonstrate the ability to conduct all professional activities with sensitivity to human diversity, including the ability to deliver high quality services to an increasingly diverse population. They demonstrate knowledge, awareness, sensitivity and skills when working with diverse individuals and communities who embody a variety of cultural and personal background and characteristics.

Cultural and individual differences and diversity is defined as including, but not limited to, age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation, and socioeconomic status.

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<tr>
<th>Self-Awareness</th>
<th>Evaluation Period</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tr>
<td>1</td>
<td>Demonstrates understanding of the ways in which their own life and background affects their perceptions of and work with patients from a wide range of backgrounds</td>
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<td>2</td>
<td>Demonstrates understanding that diversity applies to a broad range of categories including, but not limited to, race; religion; ethnicity; age; sexual orientation, identity and expression; socioeconomic status; geographic origin; type of family; etc.</td>
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<td>3</td>
<td>Addresses these issues as a means of facilitating treatment when it is necessary to do so</td>
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<tr>
<td>4</td>
<td>Recognizes when their patients or families are responding to them based on such differences (e.g. when it might be interfering with the formation of a therapeutic alliance) and addresses these concerns</td>
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**Patient Life Experience**
| 1 | Is familiar with important aspects of the lives of their patients – e.g. the degree to which poverty might affect a patient’s ability to attend therapy on a regular basis |
| 2 | Provides referrals to community resources that might be more consistent with their patients’ “world view” than psychological services (e.g., supports patient in accessing a religious leader with power in the community). |
| 3 | Evaluates the treatments he/she is using in the context of their applicability to the population he/she is seeing |
| 4 | Is conversant with literature and research that helps them evaluate the applicability of their therapy techniques to the population they are seeing. |

**Application of Cultural Knowledge**

| 1 | Questions their patients and families in a non-threatening way about aspects of their lives that he/she does not understand |
| 2 | Follows appropriate boundaries when children or families ask about their background or personal life |
| 3 | Addresses issues of cultural difference especially when such differences are interfering with clinical care |
| 4 | Demonstrates cultural competence during supervision and case presentations |
| 5 | Incorporates relevant literature addressing issues of diversity including as it pertains to interpreting psychological testing |
| 6 | Chooses tests appropriate to the population he/she is testing |
| 7 | Interprets psychological test in the context of relevant issues of diversity |

**COMPETENCY 4: PROFESSIONAL VALUES, ATTITUDES AND BEHAVIORS**

Demonstrate maturing professional identities and senses of themselves as “Psychologists” and awareness of and receptivity in areas needing further development
### Professional Responsibility

<table>
<thead>
<tr>
<th>Evaluation Period</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is well prepared for supervisory meeting and uses supervision effectively</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Takes initiative to meet the needs of patient and families.</td>
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<tr>
<td>3</td>
<td>Effectively engages with staff and clinical team members.</td>
<td></td>
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<tr>
<td>4</td>
<td>Completes all assigned tasks (e.g., progress notes, reports) in a timely manner</td>
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<tr>
<td>5</td>
<td>Sets work priorities appropriately and independently</td>
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<tr>
<td>6</td>
<td>Responsibly adheres to institution policies (e.g., leave, dress code, etc.)</td>
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</tbody>
</table>

### Use of Reflective Practice, Self-Assessment, and Self-Care in Professional Development

<p>| | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Actively engages in self-reflection regarding performance and interactions with staff and patients</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Is open and non-defensive in accepting feedback</td>
<td></td>
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<td></td>
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<tr>
<td>3</td>
<td>Exhibits awareness of professional and personal barriers to professional development and engages in self-care</td>
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</tbody>
</table>

### Average

**COMPETENCY 5: COMMUNICATION AND INTERPERSONAL SKILLS**

Develop effective communication skills and the ability to perform and maintain successful professional relationships

### Multi-disciplinary Collaboration

<table>
<thead>
<tr>
<th>Evaluation Period</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Collaborates effectively as a member of a team and with other disciplines/health professionals</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Communicates effectively, both orally and in writing</td>
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</tbody>
</table>

### Interpersonal Skills

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<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Relates to patients, colleagues, supervisors, and other health professionals</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>Demonstrates the ability to work collaboratively</td>
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<tr>
<td>3</td>
<td>Handles differences with staff and clinical team members tactfully and effectively</td>
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<tr>
<td>4</td>
<td>Maintains appropriate boundaries with patients</td>
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</tbody>
</table>

**COMPETENCY 6: ASSESSMENT COMPETENCY**

Trainees develop competence in evidence-based psychological assessment with a variety of diagnoses, problems and needs

<table>
<thead>
<tr>
<th>Evaluation Period</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diagnostic interviewing skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Selects and applies assessment methods supported by the empirical literature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Administration/scoring of psychological assessment instruments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Interpretation of psychological tests and case conceptualization</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5</td>
<td>Assesses risk for harm to self and others</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>Clarity and conciseness of report writing</td>
<td></td>
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<td></td>
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<tr>
<td>7</td>
<td>Integration of behavioral observations, historical data, medical records and other non-test based information</td>
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<td></td>
<td></td>
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<tr>
<td>8</td>
<td>Formulates appropriate recommendations</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>Communication of results (e.g., to patient, family members, other professionals)</td>
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</tbody>
</table>

**COMPETENCY 7: INTERVENTION COMPETENCY**

Demonstrate competence in evidence-based interventions consistent with a variety of diagnoses, problems and needs and across a range of therapeutic orientations, techniques, and approaches

**Formulation of a Treatment Plan**

<table>
<thead>
<tr>
<th>Evaluation Period</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Establishes and maintains an effective therapeutic alliance</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Formulates useful case conceptualization</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Formulates specific treatment recommendations based on their case conceptualization</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Implementation and Monitoring of a Treatment Plan

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Effective and flexible adaptation and application of therapeutic strategies</td>
</tr>
<tr>
<td>2</td>
<td>Awareness and use of current literature and research in intervention</td>
</tr>
<tr>
<td>3</td>
<td>Monitors or evaluates progress of intervention using appropriate measures or methods</td>
</tr>
<tr>
<td>4</td>
<td>Formulate changes in treatment as necessary</td>
</tr>
</tbody>
</table>

**Average**

### COMPETENCY 8: SUPERVISION

The supervision broad competency domain is completed by an adjunctive evaluation by the supervision seminar instructor. Supervision related items vis a vis clinical work are evaluated in other broad competency domains in this evaluation.

<table>
<thead>
<tr>
<th>Evaluation Period</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demonstrates knowledge of supervision models and research</td>
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<tr>
<td>2</td>
<td>Demonstrates beginning to intermediate competence as a supervisor of practicum students</td>
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<tr>
<td>3</td>
<td>Acts as a mentor to practicum students</td>
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<tr>
<td>4</td>
<td>Acts as a professional role model with practicum students and maintains responsibility/accountability for activities overseen as an intern supervisor</td>
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</tbody>
</table>

**Average**

### COMPETENCY 9: CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS
Consultation and interprofessional/interdisciplinary skills are reflected in the intentional collaboration of professionals in health service with other individuals or groups to address a problem, seek or share knowledge, or promote effectiveness in professional activities. Demonstrate knowledge applying this knowledge in direct or simulated consultation with individuals and their families, other health care professionals, interprofessional groups, or systems related to health and behavior.

<table>
<thead>
<tr>
<th>Evaluation Period</th>
<th>1</th>
<th>2</th>
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<th>4</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Conducts consultation with skill and knowledge</td>
<td></td>
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<tr>
<td>2</td>
<td>Maintains a climate of mutual respect and shared values in regards to interprofessional practice. This includes appreciation and integration of contributions and perspectives of other professions.</td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Use knowledge of one’s own role and those of other professions to appropriately assess and address (i.e., coordinate) the healthcare needs of patients and populations served.</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of illness</td>
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<td>Average</td>
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</tbody>
</table>

Please provide a summary of the intern’s strengths and weaknesses. In particular, please address all ratings of 2 or lower.

| Please check one of the following | The intern HAS successfully met the above competency goals. We have reviewed this evaluation. |
The intern HAS successfully met the above competency goals, yet would benefit from additional steps to ensure continued growth in some areas of relative weakness. This evaluation has been reviewed and the Director of Training has been notified. The Training Director will discuss these areas with this Intern and in collaboration with the supervisors, come up with a training plan that will augment the Intern’s training experience to further develop these areas of relative weakness. This will be written in memo form, signed by Supervisor, Training Director and Intern and placed in Intern’s file. **It does not indicate** that the Intern is on formal remediation. If this box is checked as part of the final evaluation, the memo outlining the training plan will be shared with the supervisors on the Intern’s next rotations.

The intern HAS NOT successfully met the above competency goals. Remedial steps will be necessary as outlined in the Due Process section of the Psychology Training Policy.

*Please have all parties sign and date:*

<table>
<thead>
<tr>
<th>Supervisor</th>
<th>Date</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Supervisor</th>
<th>Date</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Director of Training</th>
<th>Date</th>
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</table>

*I have received a full explanation of this evaluation. I understand that my signature does not necessarily indicate my agreement.*

<table>
<thead>
<tr>
<th>Intern</th>
<th>Date</th>
</tr>
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<tbody>
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</tbody>
</table>
The Ancora Imparo* Award

Established by: 2008-2009 intern cohort

Annually Awarded: To a teacher, supervisor, mentor, or advisor for outstanding and inspirational contributions to intern training

Awarded By: Graduating intern cohort

Presented at: Annual Graduation

Nomination Process: Initiated at the end of third quarter of internship year by intern cohort

Eligibility: Any professional, regardless of discipline, who is involved in the teaching, supervision, mentoring, or advising of one or more interns

Nomination Criteria: 1) Models a professional identity characterized by integrity and lifelong learning
2) Displays an engaging and motivational teaching approach
3) Encourages one or more interns to integrate a broad definition of multiculturalism into the practice of psychology
4) Not the previous year’s recipient (i.e., no one may receive the award two years in a row)

Selection Process: 1) Any number of individuals can be nominated by interns
2) Intern cohort discusses nominations with respect to nomination criteria and retains individuals who meet criteria
3) Each intern places an anonymous vote for one retained individual into a “hat”
4) Votes are tallied to determine recipient
5) In case of a tie, only the tied individuals should be included in a new vote (e.g., if three nominees were initially voted on and two of them tied for most number of votes, only those two should be included in a new vote)
6) In the event of a tie following a new vote, multiple recipients may be named

Recipient Recognition: Name engraved on traveling annual recipient award plaque, to be displayed by recipient during the subsequent internship year

*translation from Latin = I am still learning.
# Holiday Schedule

## Fiscal Year

### 2018-2019

**Anschutz Medical Campus Holiday schedule**

Units specifically serving the Anschutz Medical Campus and its colleges, schools and clinics will observe the following holidays:

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Date</th>
<th>UCH &amp; Clinics</th>
<th>CU Anschutz</th>
<th>CU Medicine</th>
<th>CHCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Years Day</td>
<td>Mon, Jan 1, 2018</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Martin Luther King Day *</td>
<td>Mon, Jan 15, 2018</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Presidents Day</td>
<td>Mon, Feb 19, 2018</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Memorial Day</td>
<td>Mon, May 28, 2018</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Independence Day</td>
<td>Wed, Jul 4, 2018</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Labor Day</td>
<td>Mon, Sep 3, 2018</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Columbus Day</td>
<td>Mon, Oct 8, 2018</td>
<td></td>
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<tr>
<td>Veterans Day</td>
<td>Mon, Nov 12, 2018</td>
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<tr>
<td>Thanksgiving Day</td>
<td>Thurs, Nov 22, 2018</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Day after Thanksgiving *</td>
<td>Fri, Nov 23, 2018</td>
<td>X</td>
<td>X</td>
<td></td>
<td>&lt;option to close&gt;</td>
</tr>
<tr>
<td>Christmas Eve</td>
<td>Mon, Dec. 24, 2018</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Christmas Day</td>
<td>Tues, Dec 25, 2018</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Day after Christmas</td>
<td>Wed, Dec 26, 2018</td>
<td></td>
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<td></td>
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<tr>
<td>New Year’s Day</td>
<td>Tues, Jan 1, 2019</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

X – Indicates closure
Helpful links

Administrative offices: http://www.ucdenver.edu/about/contact/Pages/Admin-offices.aspx

Directory: https://directory.ucdenver.edu/

Office of Professionalism:
http://www.ucdenver.edu/academics/colleges/medicalschool/facultyAffairs/Pages/FacultyProfessionalism.aspx

IT Help Desk: http://www.ucdenver.edu/about/departments/ITS/CustomerCare/Pages/HelpDesk.aspx

Library- Health Sciences: http://hslibrary.ucdenver.edu/

Map of AMC Campus: http://www.ucdenver.edu/anschutz/about/Documents/maps/anschutzguide.pdf

Ombuds Office: http://www.ucdenver.edu/about/departments/OmbudsOffice/Pages/OmbudsOffice.aspx

School of Medicine: http://www.ucdenver.edu/academics/colleges/medicalschool/Pages/somWelcome.aspx

Updated: 9/9/2014
LEAVE POLICY

Sick Leave
Five sick days are allowed. Leaves of absence are granted as needed when approved by the Internship Director. Interns are encouraged to seek medical attention as necessary so that they may best serve their patients and attend to assigned duties. Sick leave may not be used in lieu of vacation, and such substitution is strictly prohibited.

Vacation
Interns are granted 10 business days for paid vacation in addition to university vacation days. Interns are expected to use vacation leave for interviews. Leave should be scheduled as far in advance as possible to maintain compliance with duty hours and clinic schedules. Before starting leave, an intern must have completed all patient medical records in the hospitals and clinic. Leave is not permitted the last two weeks of internship as this period is a time in which interns should be wrapping up all clinical work.
EXPENSE REIMBURSEMENT

Setting up your profile online for the Concur Travel & Expense system. The instructions follow below:

You will need to set up your Concur Travel & Expense profile. This will allow you to enter all of your information once (including frequent flyer and hotel traveler programs), which will eliminate the need to provide it every time you travel. In addition, it will allow you to delegate a travel arranger, who will be able to book trips for you. To set up your Concur travel profile, navigate to the Concur Travel system:

1. Log in to the myCU portal (https://portal.prod.cu.edu/UCDAccessFedAuthLogin.html)
2. Click on the “Quick links” orange circle icon on the right
3. Click on the “Concur Travel & Expense” to open the Concur system
4. Click on the “Profile” upper right corner then the “Profile Settings”
5. Fill out as much as possible. The following is what is required to allow you to book travel:
   a. Name as it appears on government-issued ID
   b. Employee ID, supervisor, email address c. One contact phone number
   d. Gender
   e. Date of birth
6. Left side panel under Expense Settings, select “Expense Delegates”
   a. Click “Add an Assistant”.
   b. Click “Add” type Lyon and search for Jesse S Lyon (might be under Jessica S Lyon) then select add.
   c. Make sure Jesse “Can Prepare” and “Can Review Receipts”
   d. Most important part hit “SAVE”

Once all this has been completed, you are ready to go.
How to sign up for mandatory online training classes:

To sign up for the mandatory HIPAA, Sexual Discrimination, and Computer security classes online, you will need to follow the link below,

https://my.cu.edu/tag.66b81c62cabc699.render.userLayoutRootNode.up?up_root=root&up_sparam=activeTab&activeTab=1

Or search My.cu.edu

This link takes you to the My CU portal where you can access important personal information such as your pay, your leave, and your trainings.

Once you have logged in click on the tab that says “My Training” and follow the link that says CU
A new web page will pop up bringing you to the University’s training options. Select the “Catalog” option on the left hand side. This will allow you to see all the headings for which certain trainings are categorized by and you can continue to search for whatever training classes you may need. For your HIPAA training, select the first option: University of Colorado-Courses. As shown below.

This will populate drop down selections. Select HIPAA and launch this class.

Once you have completed your HIPAA training you will need to begin your Sexual Discrimination portion. Go back to the Catalog section and click the same University of Colorado drop down. Scroll down to the Human Resources section and launch the Discrimination and Harassment training.
Follow the same steps as previous in the Catalog section. Here you will scroll down to Information Security and launch the Information Security and Privacy Awareness training.