



PSYCHIATRY RESIDENCY PROGRAM

HANDBOOK

2022-2023

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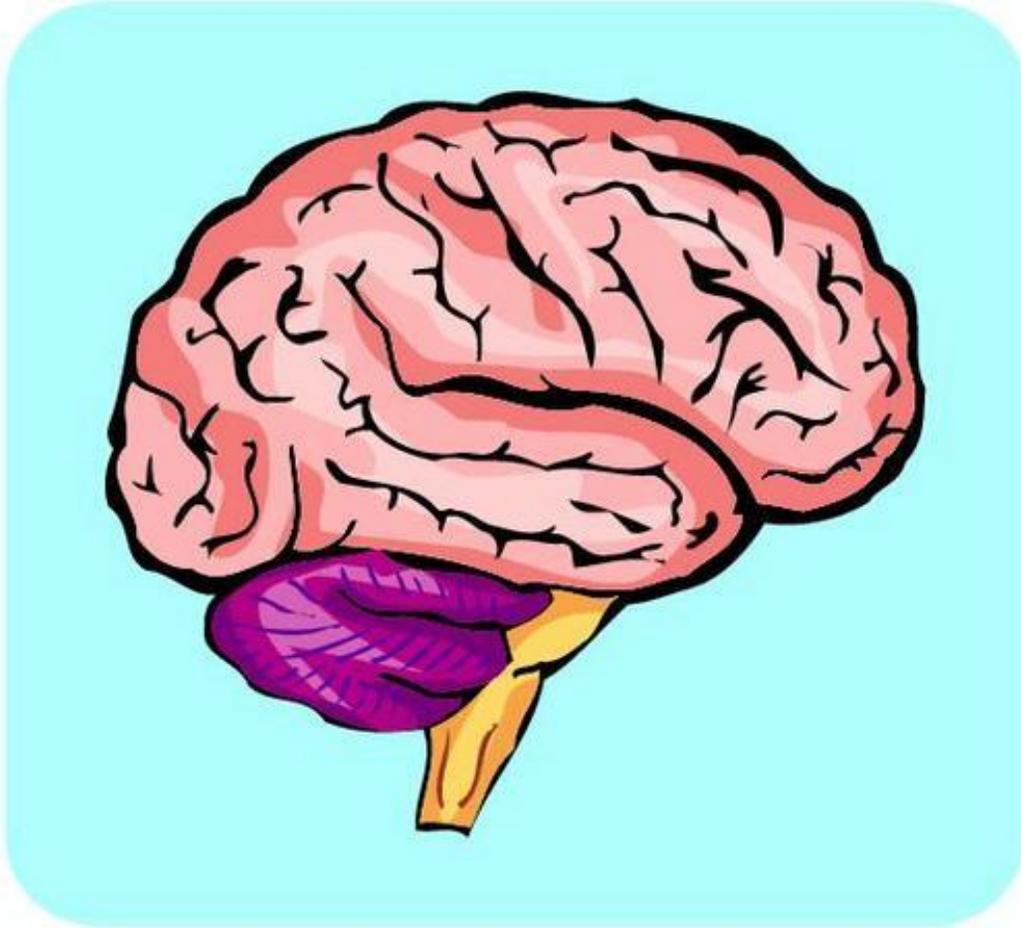
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INTRODUCTION

PROGRAM GOALS AND PHILOSOPHY

The primary goal of the Psychiatry Residency Education Program of the University of Arkansas for Medical Sciences (UAMS) is to educate physicians to become specialists in psychiatry who will meet the varying needs of the citizens of the State of Arkansas. Encompassed within this goal is the strongly held belief that psychiatry is a medical specialty; psychiatrists are physicians first and, second, experts in mental and emotional disorders.

This philosophical principle is implemented by the selection of residents who have exhibited competence in general medicine and who remain enthusiastic about their primary identity as physicians. All aspects of the educational program maintain the orientation that, as a physician/psychiatrist, one accepts the responsibility (with appropriate referral and consultation) of the diagnosis and treatment of patients from the bioscientific perspective as well as in regard to their psychosocial needs.

Consistent with the overall goal and philosophical orientation of the program is the need to provide specific educational experiences to residents who will have varying roles in the field of psychiatry. Among these roles are academic psychiatrist, public sector psychiatrist, and private practice psychiatrist.

OBJECTIVES AND CRITERIA FOR GRADUATION

Criteria for graduation include successful completion of objectives set forth in all essential teaching rotations in the Psychiatry Residency Manual. Residents must successfully complete all residency assignments for the prescribed 48 months of education as dictated by the Residency Review Committee for Psychiatry. Residents must satisfactorily demonstrate competency as defined by the ACGME and measured by the residency. This includes any mechanism for measuring competencies, 360° evaluations or any other means that the residency uses for evaluation purposes.

The training objectives for graduation are reached when a resident is viewed as a solid clinician, able to use current literature, and able to negotiate a general psychiatric practice. This includes demonstrated competency in the ACGME competency areas. The faculty on the Residency Education Committee (REC), the residency director, and the Chairman determine resident promotions.

SUMMARY OF THE CLINICAL TRAINING PROGRAM

The clinical training program progresses in a stepwise fashion. Each year's clinical experience demands mastery of the previous year. The various clinics and hospitals are complementary in nature, allowing a broad range of treatment modalities and diverse patient problems.

<u>FIRST YEAR</u>	(Internship) Clinical experiences consist of four months of primary care, two months of neurology, and six months of inpatient psychiatry.
<u>SECOND YEAR</u>	Clinical Experiences for one semester of this year consist of two months (50% time) on a Geriatric Psychiatry unit, two months (50% time) in the Substance Use Disorder Clinic, two months (50% time) on a psychiatry elective, and longitudinal child psychiatry outpatient work equal to two full-time months. In the other semester there are six weeks of night float call rotation (in two, separated three-four week blocks), six weeks of Psychiatry inpatient unit (in two, separated

three-week blocks), six weeks of Psychiatry Consultation/Liaison service, and six weeks of Psychiatry Consultation/Liaison/ER service.

PGY 2, 3, and 4 residents are assigned their own psychotherapy outpatients whom they follow in clinic on an ongoing basis one half day each week. PGY 2 residents see patients for one semester at the North Little Rock VA Hospital. PGY 3 residents see patients in the PRI Walker Family Clinic. PGY 4 residents can arrange psychotherapy at either North Little Rock VA or PRI Walker Family Clinic.

THIRD YEAR

Clinical experiences consist of 12 months of outpatient care in three distinctly different settings. The residents spend 1½ days each in a community mental health outpatient clinic, a family outpatient clinic, and a veteran's outpatient clinic

FOURTH YEAR

Regarded as a "track" year. The individual resident, with the approval of a faculty advisor and the Residency Education Committee, plans a fourth-year experience that will be consistent with long-term career goals. The Residency Education Office evaluates each resident's ECT experience individually and may require the resident to participate in more ECT training this year. The following are to be regarded as examples and not exclusive of other elective possibilities:

Academic Psychiatry - Administrative and teaching responsibilities as well as research in education. Opportunities for chief of service (ASH/VA) residents.

Administrative Psychiatry – Opportunities exist at various sites to gain experience in administrative issues.

Public Sector Psychiatry - Supervision and teaching of junior residents in a public hospital inpatient service, consultation to public agencies such as the police department, consultation to a community mental health clinic, and JCAHO compliance and policies.

Child Psychiatry - Entry into the Child Psychiatry Fellowship program at UAMS.

Private Practice Psychiatry - Primary assignment to the adult outpatient clinic; work in the Student Mental Health Service at UAMS.

Chief Resident - Serves as a faculty/resident liaison assuming some administrative and teaching duties.

Research – Opportunities are available for mentored projects in outcomes, basic, and clinical studies. See description of resident research track

**DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES
FACULTY ROSTER**

Marie Wilson Howells Professor
& Chair

Laura B. Dunn, M.D.

UNIVERSITY HOSPITAL DIVISION

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	James Clardy, M.D.
	Jeffrey Clothier, M.D.
	Jennifer Kleiner, Ph.D.
	Michael Mancino, M.D.
	Lawrence Miller, M.D.
	John Spollen, M.D.
	Greer Sullivan, M.D., M.S.P.H.
	Puru Thapa, M.D., MPH
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	Jennifer Gess, Ph.D.
	Ben Guise, M.D.
	Sufna John, Ph.D.
	Nihit Kumar, M.D.
	Shona Ray-Griffith, M.D.
	Samidha Tripathi, M.D.

	Chelsea Wakefield, Ph.D.
Assistant Professor:	Caris Fitzgerald, M.D.
	Victoria Flynn-Walden, M.D.
	Hunter Gibbs, M.D.
	Amy Grooms, M.D.
	Lewis Krain, M.D.
	Payton Lea, M.D.
	Abigail Richison, M.D.
	Scott Steele, M.D., Ph.D.
	Hannah Williams, M.D.

DIVISION OF HEALTHCARE SERVICES RESEARCH

Professor:	Geoffrey Curran, Ph.D.
	Linda Larson-Prior, Ph.D.
	JoAnn Kirchner, Ph.D.
	Richard R. Owen, M.D.
	Prasad Padala, M.D., M.S.
	Jeffrey Pyne, M.D.
Associate Professor:	Michael Cucciare, Ph.D.
	Ellen Fischer, Ph.D.
	Carolyn Greene, Ph.D.
	Teresa Hudson, Pharm.D.
Assistant Professor:	Corey Hayes, Pharm.D.
	Ronald Thompson, Jr, Ph.D.
	Melissa Zielinski, Ph.D.

DIVISION OF PEDIATRIC PSYCHIATRY

Professor Emeritus:	Patricia Youngdahl, Ph.D.
Director:	Nihit Kumar, M.D.
Professor:	Molly Gathright, M.D.
Associate Professor:	Nihit Kumar, M.D.
	Glenn Mesman, Ph.D.
Assistant Professor:	Toby Belknap, M.D.
	Natashia Bottoms, M.D.
	Srini Gokarakonda, M.D.
	Molly Lambertsen, M.D.
	Veronica Raney, M.D.

VA MENTAL HEALTH DIVISION

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Professor:	Richard Owen, M.D.
	John Spollen, M.D.
Associate Professor:	Tim A. Kimbrell, M.D.
	Eugene Kuc, M.D.
Assistant Professor:	Kelley Burrow, M.D.
	Erica Hiett, M.D.
	Sam House, M.D.
	Lewis Krain, M.D.
	Irving Kuo, M.D.
	Marie Mesidor, Ph.D.
	John Milwee, Psy.D.

	Megan Mueller, M.D.
	Brian Neukirch, M.D.
	Shanna Palmer, M.D.
	Lisa Snow, M.D.
	Jessica Stovall, M.D.
	Justin Treas, M.D., PhD
	Sidney Winford, M.D.
	Joshua Woolley, M.D.
Instructor:	Margaret Ege-Woolley, M.D.

ARKANSAS STATE HOSPITAL

Assistant Professor and Medical Director:	Steve Domon, M.D.
Assistant Professor:	Kara D. Belue, M.D.
	April Coe-Hout, Ph.D.
	Megan Edwards, Psy.D.
	Caiti Maskrey, D.O.
	Samuel Olson, D.O.
	Michelle Ransom, M.D.
	Brandon Wall, M.D.
	Martin Watts, M.D., Ph.D.
	Lindsey Wilbanks, M.D.
	Veronica Williams, M.D.
Adjunct Professor:	Blake Byrd, J.D.
	Robert Forrest, M.D.
	J. Thomas Sullivan, J.D.

CENTER FOR ADDICTION SERVICES AND TREATMENT

Professor:	Alison Oliveto, Ph.D.
	Michael Mancino, M.D.
	Ashley Acheson, Ph.D.
Associate Professor:	Merideth Addicott, Ph.D.

BRAIN IMAGING RESEARCH CENTER

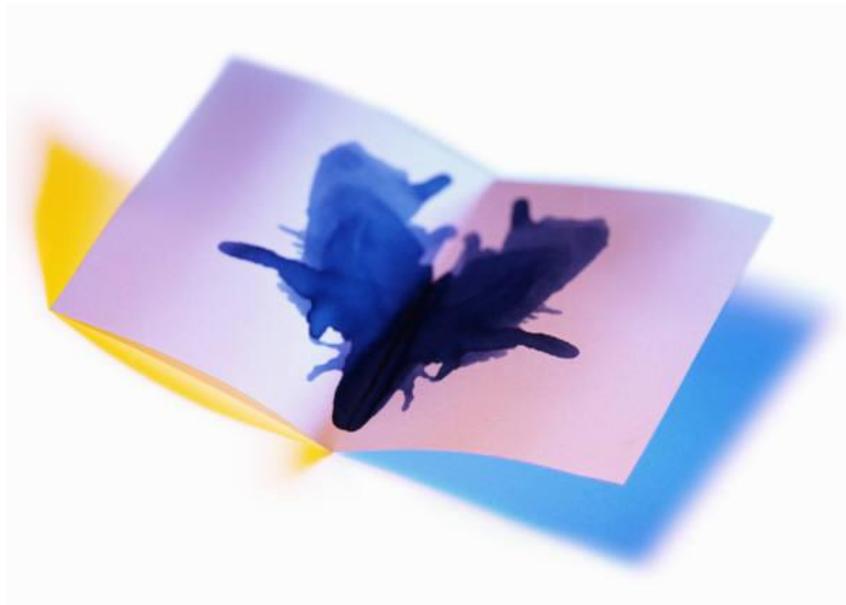
Professor:	Clint Kilts, Ph.D.
Associate Professor:	Andy James, Ph.D.
Assistant Professor:	Keith Bush, Ph.D.

RESIDENT ROSTER

Resident UAMS Mail Slot 589

PGY Year (effective 7/1/22)

Archana Adikey	ACH 1
Todd Brinkley	4
Adam Burroughs	3
Kyle Camp	ACH 1
David Catlin	3
Phillip Cowan	3
Jace Duhon	ACH 1
Karen Hall	ACH 2
Cody Halsted	3
Ann-Marie Hayre	3
Charles Hunter	2
William Hyatt	2
Erin Jefferson	3
Kiley Jones	ACH 2
Brooke Kamath	2
Nadia Khan	2
Janine Klar	1
Jacob Linna	2
Catey May-Martin	1
Mary Nance	4
Chris Parrill	1
Margaret Pickhardt	3
Alex Preston	2
Kristen Rice	1
Karina Sanders	4
Brett Shaw	ACH 2
Natasha Sra	3
Molly Tibbs	1
Wesley White	2
Kesley Winn	1
Jordyn Wolfe	2
Molly Wootten	1
Katherine Yoder	1
Rebecca Young	3



EDUCATIONAL PROGRAM

RESIDENT POLICIES

Policies of the Graduate Medical Education (GME) Committee

The policies of the GME Committee are reviewed and revised periodically. Revised policies are effective as determined by the GME Committee. All GME Committee policies can be located on the UAMS College of Medicine website <https://gme.uams.edu> . Residents are expected to be familiar with and adhere to these policies.

Criteria and Processes for Academic Actions of Reappointment, Evaluation, Promotion, and other Disciplinary Actions

In compliance with the UAMS COM GME Committee policy on Evaluation and Promotion, the following guidelines apply:

Reappointment

Educational appointments to the Psychiatry Residency program are for a term not exceeding one year. The resident agreement of appointment, which outlines the general responsibilities for the College of Medicine and for the resident, is signed at the beginning of each term of appointment. Renewal of the resident agreement of appointment for an additional term of education is the decision of the Program Director and the Department Chair. Promotion to the next level of training is dependent upon the resident performing at an acceptable level and meeting the requirements for clinical competence for that post graduate year (PGY). Please see the document, Goals and Objectives for Each Post Graduate Year, which follows this policy statement.

It is the intent of the Program to develop physicians clinically competent in the field of Psychiatry. Physicians completing the program will be eligible for certification by the American Board of Psychiatry and Neurology with an ultimate goal of a 100% pass rate on this examination.

Clinical competence requires:

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
4. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals.
5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

6. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Evaluation and Promotion

During the residency period, the above elements of clinical competence will be assessed in writing frequently by direct faculty supervisors with subsequent review by the Program Director. Evaluations by peer resident physicians, patients, nursing staff and other support staff may be included at less frequent intervals. A resident will meet with the Program Director or other designee twice a year to review results of evaluations, in-service scores, and clinical exercises. A summary of the evaluations will be reviewed and signed by the resident. The evaluations will be maintained in confidential files and only available to authorized personnel. Upon request, the resident may review his/her evaluation file at any time during the year.

Reappointment and promotion to a subsequent year of training require satisfactory ratings on these evaluations and on the recommendation of the Promotions Subcommittee of the Residency Education Committee.

A resident receiving any unsatisfactory evaluation during the year may be immediately reviewed by the Program Director and any written recommendations made to him/her may include:

1. specific corrective actions
2. repeating a rotation
3. psychological counseling
4. academic warning status or probation
5. suspension or dismissal, if prior corrective action, academic warning and/or probation has been unsuccessful.

The resident may appeal an unsatisfactory evaluation by submitting a written request to appear before the department's Promotions Subcommittee of the Residency Education Committee in a meeting called by the Program Director. The Committee will review a summary of the deficiencies of the resident, and the resident will have the opportunity to explain or refute the unsatisfactory evaluation. After review, the decision of this Committee is final.

At the completion of the residency program, the Program Director will prepare a final evaluation of the clinical competence of the resident. This evaluation will stipulate the degree to which the resident has mastered each component of clinical competence – patient care, medical knowledge, practice-based learning and

improvement, interpersonal and communication skills, professionalism, and systems-based practice. It will also include any special accommodations the resident may have had which could affect or limit the resident's scope of practice. In this evaluation the Program Director will verify that the resident "has demonstrated sufficient professional ability in Psychiatry to practice competently and without supervision". This evaluation will remain in the resident's permanent file to substantiate future judgments in hospital credentialing, board certification, agency licensing, and in the actions of other bodies.

Academic and Other Disciplinary Actions (in accordance with UAMS COM GME Policy on Disciplinary Actions)

Probation/Suspension/Dismissal

Actions of Probation/Suspension/Dismissal will follow the guidelines in the GME Committee Policy on Academic and Other Disciplinary Actions policy as follows.

1. A resident may be placed on probation by the Program Director in consultation with the Promotions Committee for reasons including, but not limited to any of the following:
 - a. failure to meet the performance standards of an individual rotation;
 - b. failure to meet the performance standards of the program;
 - c. failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions
 - d. misconduct that infringes on the principles and guidelines set forth by the training program;
 - e. documented and recurrent failure to complete medical records in a timely and appropriate manner;
 - f. when reasonably documented professional misconduct or ethical charges are brought against a resident which bear on his/her fitness to participate in the training program.
2. When a resident is placed on probation, the Program Director shall notify the resident in writing in a timely manner, usually within a week of the notification of probation. The written statement of probation will include a length of time in which the resident must correct the deficiency or problem, the specific remedial steps and the consequences of non-compliance with the remediation.
3. Based upon a resident's compliance with the remedial steps and other performance during probation, a resident may be:
 - a. continued on probation;
 - b. removed from probation;
 - c. placed on suspension; or
 - d. dismissed from the residency program.

Suspension

1. A resident may be suspended from a residency program for reasons including, but not limited, to any of the following:

- a. failure to meet the requirements of probation;
 - b. failure to meet the performance standards of the program;
 - c. failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions;
 - d. misconduct that infringes on the principles and guidelines set forth by the training program;
 - e. documented and recurrent failure to complete medical records in a timely and appropriate manner;
 - f. when reasonably documented professional misconduct or ethical charges are brought against a resident which bear on his/her fitness to participate in the training program;
 - g. when reasonably documented legal charges have been brought against a resident which bear on his/her fitness to participate in the training program;
 - h. if a resident is deemed an immediate danger to patients, himself or herself or to others;
 - i. if a resident fails to comply with the medical licensure laws of the State of Arkansas.
2. When a resident is suspended, the Program Director shall notify the resident with a written statement of suspension to include:
- a. reasons for the action;
 - b. appropriate measures to assure satisfactory resolution of the problem(s);
 - c. activities of the program in which the resident may and may not participate;
 - d. the date the suspension becomes effective;
 - e. consequences of non-compliance with the terms of the suspension;
 - f. whether or not the resident is required to spend additional time in training to compensate for the period of suspension and be eligible for certification for a full training year.

A copy of the statement of suspension shall be forwarded to the Associate Dean for Graduate Medical Education and the Director of Housestaff Records.

3. During the suspension, the resident will be placed on “administrative leave”, with or without pay as appropriate depending on the circumstances.
4. At any time during or after the suspension, the resident may be:
 - a. reinstated with no qualifications;
 - b. reinstated on probation;
 - c. continued on suspension; or
 - d. dismissed from the program.

Dismissal

1. Dismissal from a residency program may occur for reasons including, but not limited to, any of the following:
 - a. failure to meet the performance standards of the program;
 - b. failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions;
 - c. illegal conduct;

- d. unethical conduct;
 - e. performance and behavior which compromise the welfare of patients, self, or others;
 - f. failure to comply with the medical licensure laws of the State of Arkansas;
 - g. inability of the resident to pass the requisite examinations for licensure to practice medicine in the United States, if required by the individual residency program.
2. The Program Director shall contact the Vice Dean for GME and provide written documentation which led to the proposed action.
3. When performance or conduct is considered sufficiently unsatisfactory that dismissal is being considered, the Program Director shall notify the resident with a written statement to include:
 - a. reasons for the proposed action,
 - b. the appropriate measures and timeframe for satisfactory resolution of the problem(s).
4. If the situation is not improved within the timeframe, the resident will be dismissed.
5. Immediate dismissal can occur at any time without prior notification in instances of gross misconduct including, but not limited to theft of money or property; physical violence directed at an employee, visitor or patient; use of, or being under the influence of alcohol or controlled substances while on duty, patient endangerment, illegal conduct.
6. When a resident is dismissed, the Program Director shall provide the resident with a written letter of dismissal stating the reason for the action and the date the dismissal becomes effective. A copy of this letter shall be forwarded to the Vice Dean for GME and the Director of Housestaff Records.

A resident involved in the disciplinary actions of probation, suspension and dismissal has the right to appeal according to the GME Committee policy Adjudication of Resident Grievances.

<https://medicine.uams.edu/gme/wp-content/uploads/sites/4/2022/09/1.410-Adjudication-of-Resident-Fellow-Grievances.docx.pdf>

Psychiatry Residency Program

GOALS AND OBJECTIVES FOR EACH POST GRADUATE YEAR

At the completion of PGY-1 the resident must have:

Patient Care

- demonstrated the ability to perform an initial psychiatric evaluation
- demonstrated the ability to perform a mental status examination
- demonstrated the ability to diagnose and treat basic medical problems
- demonstrated the ability to diagnose and treat basic neurological problems

Medical Knowledge

- shown basic understanding of the major psychiatric diagnoses
- shown basic understanding of psychotropic medications

Practice-based Learning and Improvement

- demonstrated ability to present cases in conference review and support the clinical decisions made

Interpersonal and Communication Skills

- demonstrated ability to function in an interdisciplinary team
- demonstrated the ability to communicate effectively with patients and families

Professionalism

- demonstrated an appropriate level of professional behavior
- demonstrated a high level of ethical behavior

Systems-based Practice

- successfully completed 12 months of PGY-1 rotations

As demonstrated by:

- Supervisor evaluation
- Patient log
- PRITE
- Core didactic attendance
- Semi-annual review
- Scored Clinical Interviewing

At the completion of PGY-2 the resident must have:

Patient Care

- demonstrated the ability to perform emergency, admission, and consultation psychiatric examinations
- demonstrated the ability to perform a mental status examination, including:
 - assessment of suicide risk

- assessment of homicide risk
- cognitive evaluation
- demonstrated the ability to diagnose and treat acute psychotic agitation
- demonstrated the ability to diagnose and treat acute alcohol withdrawal
- demonstrated competence in biopsychosocial case formulation
- demonstrated the ability to perform an initial geriatric psychiatric evaluation
- demonstrated the ability to manage common psychiatric diagnoses in the geriatric population
- demonstrated the ability to perform an initial child psychiatric evaluation
- demonstrated the ability to manage common psychiatric diagnoses in the pediatric population

Medical Knowledge

- demonstrated the ability to make major psychiatric diagnoses by DSM-5 criteria
- demonstrated the appropriate use of common psychotropic medications

Practice-based Learning and Improvement

- participated in all scheduled didactics, conferences and case presentations
- demonstrated ability to utilize medical literature to inform diagnostic and treatment decisions
- demonstrated ability to present cases in a team setting, develop and support a treatment plan incorporating input and feedback from the team

Interpersonal and Communication Skills

- demonstrated the ability to function as a member of a clinical treatment team
- demonstrated the ability to communicate effectively with patients and families

Professionalism

- completed all required medical records
- demonstrated an appropriate level of professional behavior
- demonstrated a high level of ethical behavior

Systems-based Practice

- successfully completed 12 months of PGY-2 rotations
- made appropriate referrals for outpatient care
- made appropriate referrals for psychotherapy

As demonstrated by:

- | | |
|----------------------------|---------------------------------------|
| ● Supervisor evaluation | ● Patient log |
| ● Core didactic attendance | ● PRITE |
| ● Semi-annual review | ● Psychotherapy supervisor evaluation |
| | ● Scored Clinical Interviewing |

At the completion of PGY-3 the resident must have:

Patient Care

- demonstrated the ability to perform outpatient psychiatric evaluations
- demonstrated the ability to use psychotropic medications appropriately for the management of common psychiatric disorders

- demonstrated the ability to appropriately use short and long-term psychotherapies in the management of common psychiatric disorders

Medical Knowledge

- demonstrated competence in psychodynamic case formulation

Practice-based Learning and Improvement

- participated in all scheduled didactics and conferences
- demonstrated ability to review cases with supervisor and incorporate feedback and evidence from medical literature to improve treatment planning

Interpersonal and Communication Skills

- demonstrated the ability to lead a clinical treatment team
- demonstrated the ability to communicate effectively with patients and families

Professionalism

- completed all required medical records
- demonstrated an appropriate level of professional behavior
- demonstrated a high level of ethical behavior

Systems-based Practice

- successfully completed 12 months of PGY-3 rotations
- made appropriate referrals for group psychotherapy
- demonstrated the ability to manage severe mental illness in the community mental health setting and assertive community treatment setting

As demonstrated by:

- | | | |
|---------------------------------------|----------------------------|--------------------------------------|
| • Supervisor evaluation | • Core didactic attendance | • Annual clinical skills evaluations |
| • Semi-annual review | • Patient log | |
| • Psychotherapy supervisor evaluation | • PRITE | |

At graduation from the program the resident must have:

Patient Care

- demonstrated the ability to perform a comprehensive psychiatric evaluation
- demonstrated the ability to diagnose and manage psychiatric symptoms in the setting of medical illness
- demonstrated the ability to diagnose and treat common substance abuse and dependence
- demonstrated competence in medication management of common psychiatric disorders
- demonstrated development of competence in the use of supportive psychotherapy
- demonstrated development of competence in the use of cognitive psychotherapy
- demonstrated development of competence in the use of behavioral psychotherapy
- demonstrated development of competence in the use of dynamic psychotherapy
- Demonstrated development of competence in concurrent use of medications and psychotherapy

Medical Knowledge

- demonstrated competence in the use of DSM-V diagnostic criteria

Practice-based Learning and Improvement

- participated in all scheduled didactics and conferences
- demonstrated ability to review cases with supervisor and incorporate feedback and evidence from medical literature to improve treatment planning
- demonstrated the ability to function as an independent clinician

Interpersonal and Communication Skills

- demonstrated the ability to lead a clinical treatment team
- demonstrated the ability to communicate effectively with patients and families

Professionalism

- completed all required medical records
- demonstrated an appropriate level of professional behavior
- demonstrated a high level of ethical behavior
- satisfy scholarly requirement per policy

Systems-based Practice

- successfully completed 12 months of PGY-4 rotations

As demonstrated by:

- | | |
|-------------------------------------|---------------------------------------|
| • Supervisor evaluation | • Psychotherapy supervisor evaluation |
| • Semi-annual review | • Patient log |
| • Core didactic attendance | • PRITE |
| • Annual clinical skills evaluation | |

Revised 6/22/16

Addressing Resident Concerns

At times various issues resulting from miscommunication, stress, or inappropriate behavior may arise. In compliance with the UAMS COM GME Committee Policy on Addressing Concerns in a Confidential and Protected Manner, the resident should follow these guidelines to raise and resolve issues of concern in a confidential manner:

1. A resident should discuss the concern with the supervising, senior level resident or attending physician or the resident's assigned faculty advisor.
2. If the above discussion does not resolve the concern, the resident should meet with the Program Director or his/her designee.
3. If the issue cannot be resolved by the Program Director, the resident should contact a member of the Resident Council or the Associate Dean for Graduate Medical Education. Members of the Resident Council can meet with the resident and offer advice on how to resolve or handle the problem and if further steps are necessary. Based on the discussion and advice at this meeting, the resident may resolve the problem, and no further action is necessary.
4. For serious issues for which confidentiality is of the utmost importance, the resident may seek assistance directly from the Program Director, the Department Chair and/or the Associate Dean for GME.

Supervision

All residents must perform clinical duties under proper supervision. Supervision will be defined by the following classification:

- a) Direct Supervision – the supervising physician is physically present with the resident and patient.
- b) Indirect Supervision:
 - with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
 - with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

ACGME program requirements specify the following:

- a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
 - 1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

2) PGY-1 residents may progress to being supervised indirectly with direct supervision available only after demonstrating competence in:

- the ability and willingness to ask for help when indicated;
- gathering an appropriate history;
- the ability to perform an emergent psychiatric assessment; and, presenting patient findings and data accurately to a supervisor who has not seen the patient.

All primary clinical rotations (including UAMS, PRI, VA, ACH, ASH, CMHC, and NWA) utilize supervision at the level of either direct supervision or indirect supervision with direct supervision immediately available. Guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members are included in the rotation description of each rotation, and are reviewed with residents at the beginning of each rotation. Supervisors are always immediately available for the direct supervision of PGY-1s for situations involving critical clinical decision-making. We foster progressive authority and responsibility, conditional independence, and a supervisory role in patient care by

- a) using graduated levels of supervision as residents progress through the PGY1-4 years.
- b) using upper level residents to provide direct supervision to PGY-1 residents, with attending supervision available to both residents.

In addition to the clinical supervision provided at the assigned clinical sites, each resident (2nd through 4th year) is assigned a faculty psychotherapy supervisor. This provides a weekly opportunity for residents to discuss psychotherapy cases in detail and to discuss other professional issues.

PGY-2 psychotherapy supervisory assignments are for 6 months, PGY-3 and PGY-4 psychotherapy assignments are for the entire year. Residents who wish additional supervision -- especially PGY 3s who are seeing more than four patients in the Outpatient Clinic -- should see the Director of Residency Education. Psychotherapy supervisors should be contacted in early July. Residents are expected to meet with their psychotherapy supervisors weekly.

All supervisory assignments are evaluated by both supervisors and residents. (See forms in the Appendix.)

Duty Hours and Work Environment

We monitor compliance with ACGME and UAMS COM GME Committee policies on duty hours/work environment and moonlighting and, considering that the care of the patient and educational clinical duties are of the highest priority. At the time of this publication, these guidelines are:

Duty Hours

1. Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
2. Residents are provided one day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
3. Duty periods of PGY 2 and above will not exceed 24 hours of continuous duty in the hospital. If needed, a resident may stay up to an additional 4 hours to effect transitions in care. No new clinical duties will be assigned during these 4 hours.
4. In order to ensure adequate time for rest and personal activities, an 8-hour time period is provided between daily duty periods and a 14 hour time period is provided after any 24 hour duty period.
5. Residents will not be scheduled for more than 5 consecutive nights of night float.
6. These guidelines will change to meet any changes in UAMS GME or ACGME policies in duty hours.

On-Call Activities

The goal of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period.

1. In-house call:

- a. Occurs no more frequently than every third night, averaged over a four-week period.
- b. On psychiatry rotations, in-house call will occur no more frequently than every fourth night, averaged over a four week period.

2. Short/Weekend Call

Interns will be required to have *direct supervision* (resident or faculty supervisor present during patient care) until they have successfully demonstrated clinical competence as evaluated by a PGY 2, 3 or 4 supervising resident. The supervising resident will fill out a competency card on each PGY I residents' clinical encounters until said resident successfully completes ten new consults. Competency cards document a resident's ability to gather an appropriate history, perform an emergent psychiatric assessment, present findings and data accurately to a supervisor who has not seen the patient, and the willingness and ability to ask for help when indicated. See card below.

Supervising Resident:	
Supervised Resident:	
Appropriate History	Yes___ No___
Emergent Patient	Yes___ No___
Seeks Assistance When Needed	
	Yes___ No___
Complete Risk Assessment(s)	
SI	_____
HI	_____
Other	_____
Comments:	
Relevant Information Missing:	
Accurate Presentation	Yes___ No___
(as Verified by Supervisor Interview)	

After an intern has qualified to function via indirect supervision with direct supervision immediately available, call work will be divided according to the following:

- a. Interns will cover both ER's and new consults. If at any point in time, more than one (two or more) patient's waiting to be seen in either ER or new consults (all combined), the supervising resident will assist.
- b. Interns are not to get any new consults/ER patients after 7:30 pm. Supervising residents will cover the PRI pager and respond to PRI needs and direct admits. They will also cover follow-up consult issues including admissions from the floor.

Interns will be eligible to take short-call with supervision at the level of *indirect supervision with direct supervision available* after four months of the academic year and certification as above.

The resident is expected to be on duty during normal working hours, as established by each rotation, Monday through Friday. Additional duty hours include on-call duties. Night, weekend and holiday call schedules are formulated by the chief resident and depend on the specific educational rotation. Residents must be available by telephone or pager while on-call.

The Department of Psychiatry Residency Education Program is committed to promoting patient safety and resident well-being and to providing a supportive educational environment. Didactic and clinical education activities have priority in the allotment of residents' time and energy. The learning objectives of the program will not be compromised by excessive reliance on residents to fulfill service obligations. Duty hour assignments are made with the recognition that faculty and residents collectively have responsibility for the safety and welfare of patients. In compliance with the UAMS COM GME Committee policy on Resident Supervision, the following guidelines are followed for supervision of the care of patients and backup support:

1. Qualified faculty physicians supervise all patient care and their schedules are structured so that adequate supervision is available at all times.
2. Attending faculty physician supervision is provided appropriate to the skill level of the residents on the service/rotations.
3. Specific responsibilities for patient care are included in the written description of each service/rotation; this information is reviewed with the resident at the beginning of the service/rotation. In general, the chief or senior level resident oversees the lower level resident and intern. The faculty physician oversees the entire team and is available at all times in person, by telephone or beeper.
4. Rapid, reliable systems for communication with supervisory physicians are available.
5. On-call responsibilities and supervision are documented by the call schedules and are reviewed with the resident at the beginning of each service/rotation or if/when there is a change in the schedule.
6. The following procedure is followed to address fatigue of the resident:
 - a. GME Educational Resources on Fatigue can be found at:
<https://medicine.uams.edu/gme/gmeresources/fatigue-recognition-and-mitigation/>
 - b. Any faculty who notices fatigue sufficient to negatively affect the performance of a resident via their training will relieve the resident of clinical duty in consultation with the Program Director.
 - c. The Program Director will determine when the resident will return to the education program.
 - d. The Program Director will notify the attending faculty physician about these arrangements.
7. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must:
 - a. appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
 - b. document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

- c. The program director will review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Work Environment

1. **Meals:** food is available for those residents who provide 12 consecutive hours of in-house call.
2. **Call rooms:** call rooms are provided for all residents who take in-house call.
3. **Ancillary support:** adequate ancillary support for patient care is provided. Except in unusual circumstances, providing ancillary support is not the resident's responsibility except for specific educational objectives or as necessary for patient care. This is defined as, but not limited to, the following: drawing blood, obtaining EKGs, transporting patients, securing medical records, securing test results, completing forms to order tests and studies, monitoring patients after procedures.

External Moonlighting

The General Residency Program allows external clinical activity ("Moonlighting") in conjunction with GME policy 3.300.

<https://medicine.uams.edu/gme/wp-content/uploads/sites/4/2022/08/3.300-Moonlighting-Final.pdf>

External moonlighting must be done in a safe manner with the clinical and educational needs of training remaining the priority. In conjunction with the UAMS GME policy on external moonlighting, this program has the following additions/clarifications:

1. A resident must have completed the PGY 1 year and have successfully completed 3 Clinical Skills Assessments (all five sections) before engaging in any external clinical activity.
2. A resident must be in good standing within the program in order to engage in external clinical activity. This includes:
 - a. All PGY level documentation and certification requirements are up to date.
 - b. The resident must be performing at PGY level by current evaluations of the milestones, as evaluated by the CCC.
 - c. All UAMS health and safety requirements complete (TB testing, proof of vaccination, etc.).
 - d. The resident is free of UAMS disciplinary actions or residency program probation restrictions.
3. As per GME policy, residents who wish to engage in external clinical activity are responsible for obtaining/maintaining licensing, DEA registration, insurance, and credentialing independent of the UAMS institution.
4. It is the responsibility of the resident to identify, apply for, and maintain external clinical opportunities. Neither the Residency Education office nor the Chief Resident will arrange or coordinate external clinical opportunities or external call shifts. Similarly, this residency

bears no responsibility for arranging emergency coverage for a resident who is unable to fulfill scheduled external clinical responsibilities.

5. It is the responsibility of the resident to complete/maintain all necessary certification and documentation to obtain/maintain credentialing at external clinical sites. Residency Education staff will not complete, fax, or mail paperwork on behalf of the resident. In the case of paperwork that must be filled out by the Program Director or Residency Coordinator specifically (e.g. statements of clinical ability, verification of enrollment in the residency, etc.), the office will have at least 10 business days to complete such documentation.

6. Residents are required to specifically document all external duty hours. External duty hours may not exceed 10 hours per week averaged over any consecutive 4-week period and must remain in compliance with all ACGME duty hour requirements.

7. Any resident seeking approval for external clinical activity will need to demonstrate that the activity will not overlap with any residency-assigned clinical work and didactics.

This includes the following restrictions:

- a. Residents cannot engage in external clinical work during any time during scheduled Residency-assigned clinical/didactic responsibilities. This absolutely includes weekday business hours.
- b. Residents may not engage in external clinical activities during “lunch breaks” or any other point in the regular workday. Note that there is no expectation that weekday work will cease by 5PM. It is reasonable to expect residents to work later (within duty hours) based on the service demands of a rotation. Therefore, residents are discouraged from scheduling external clinical work at any time that could overlap with reasonable expectations of a residency-assigned clinical shift.
- c. At no time will a resident be excused from any residency-assigned responsibilities due to the need to get to any external clinical activity.
- d. It is the responsibility of the resident to clear his/her schedule of external clinical activities in order to be available for assigned residency call shifts.

8. Because outpatient clinics can have unexpected clinical demands in the form of emergency calls and medication refill needs, any outpatient clinical experiences need to be demonstrated to be clearly limited to off-hours. This means that the resident will need to demonstrate that another clinician is responsible for both emergency and non-emergent phone calls during regular hours. Instructing patients to contact an ED, triage nurse, or answering service is not sufficient to meet this requirement.

9. Residents may not engage in clinical activities which are outside the scope of practice of psychiatry. Exceptions may be made for residents who have formal training in another specialty prior to matriculation in the psychiatry program (e.g. completed years in another residency, etc.).

10. The Residency Education Committee has the ability to limit authorization for external clinical activity at a specific clinical site if that site is felt to represent a dangerous clinical or legal situation for a trainee. Indicators of such risk include (but are not limited to):

- a. History of multiple malpractice lawsuits involving one or more residents at that site.
- b. Clinical demands in excess of the normal standards of practice, or staffing practices that are inadequate for a safe clinical environment.
- c. Coverage demands that routinely include clinical activities outside the scope of practice of psychiatry (e.g. running ACLS codes, frequent medical issues, emergency medical triage, etc.).
- d. Compelling evidence that the clinical supervisor, or the overall culture of practice at the clinical site, is engaging in unethical/illegal clinical or business practice (e.g. billing fraud, selling prescriptions, etc.) or dangerously out of compliance with state or national requirements.

11. Residents are required to report to their supervisor and the program director when clinical and business conflicts of interest arise during residency-related clinical work.

These may include (but are not limited to):

- a. When a resident is established as a treating clinician for a patient in both residency-related and external clinical practices.
- b. Double-agency (when decisions made during residency-related work may positively or negatively impact an external clinical entity to which the resident is beholden). This includes referrals of patients from the residency-based clinical system over to a moonlighting practice.

12. Failure to remain in compliance with these regulations and the GME policy on moonlighting will result in suspension of authorization for continuing external clinical activities. Residents who fail to comply with instruction to cease external clinical activities as directed will be subject to dismissal from the program.

13. To demonstrate these requirements are met, *any external clinical experience must be approved by completing the UAMS COM GME Moonlighting Activity Request Form, Acknowledgement of Moonlighting Policy Form and Moonlighting Approval Form.* External clinical work cannot be initiated until these forms are complete and signed by the resident, Program Director and all cosigners.

Residency Education Committee/ Education Policy Committee

The Residency Education Committee shall meet once monthly to consider business relating to the Residency Education Program. The members of this committee shall include the Residency Education Director, Associate Program Director and Program Coordinator, Faculty Representatives from each of the major training sites and clinical

rotations, a resident from each respective PGY class, the Chief Resident, and the Directors of all of the subspecialty Residency Education Programs to include Child and Adolescent, Forensics, Addictions, and Geriatrics. This committee shall be responsible for planning, developing, implementing, and evaluating all

significant features of the residency program including curricular goals and objectives and the selection of residents. This committee will also specifically evaluate the residents, the teaching faculty, and the program (see below). This committee shall act as an advisory body to the Director of the Program and the Department Chair. The activities of the committee will also include, but not be limited to the following:

YEARLY RESIDENCY EDUCATION COMMITTEE CALENDAR

July

August

Report from PGY1 representative regarding the new class

September

Discuss recruitment efforts
Promotion Committee meets

October

November

Selection Committee meets

December

Confirmation of Chief Resident for new year
Selection Committee meets
Promotion Committee meets

January

Selection Committee meets

February

Selection Committee meets

March

PGY3's present proposed schedules for 4th year
Promotion Committee meets
PGY3's present Scholarly Projects (completed or planned)

April

Discussion of PRITE results and program implications
Didactic schedules for the new year

May

Finalize PGY4 schedules for new year
Rotation schedules for new PGY1 - 3s
Reminder of important upcoming dates

June

Select resident class REC representation
Discuss any new changes in rotations
Promotion Committee meets
PGY4's present final Scholarly Projects to Promotion Committee

REC meetings are held on the first Wednesday of every month from noon until 1:30.

Note:

The Promotion Committee meets quarterly of each academic year (September, December, March, and June) to discuss residents' performance, competency, and professional growth. All REC faculty members are invited to attend.

The Selection Committee meets in November, December, January, and February to evaluate and select candidates for the residency program. All REC faculty members and the Chief Resident are invited to attend these meetings.

The Program Evaluation Committee (PEC) has an Education Retreat in August. Program Evaluation of Faculty & Program (APE, Resident Anonymous Evals, Recorded Faculty Comments, PRITE results, Board Pass Rate, ACGME Resident Survey). All REC faculty members and Chief Resident are invited to attend.

All program requirements for residency training in psychiatry can be found at www.acgme.org

DOCUMENTATION OF PROCEDURES

While on inpatient units, the opportunity will arise for residents to perform procedures upon their assigned patients. Many hospitals and educational institutions require documentation of procedures performed during training to grant the privilege to perform or teach these procedures. This includes procedures such as ECT and lumbar punctures.

A permanent record of each resident's training is kept in the residency office. It is the responsibility of each resident to document procedures he or she performs for inclusion in this file.

Scholarly Project/Formal Presentation

Every resident is required to complete an academic project or scholarly work prior to graduating. This may be a clinical or educational study, review paper, quality improvement (QI) project, or academic presentation, workshop, or poster. The purpose of this requirement is for residents to demonstrate proficiency in research methodology, critical review of scientific literature, and writing/presentation skills. It is hoped these products will lead to national publications and presentations to help build their experience and CVs. Many residents will have this completed during the course of residency as they work on academic projects in line with their interests, and then present this work at national meetings. Residents who have not completed this requirement by the beginning of the PGY-4 year will be expected to do so during the PGY-4 year, as a requirement for graduation.

The timeline for the scholarly project requirement is:

March of the PGY-3 year at REC – Promotion Committee:

Submit completed or planned version of scholarly project requirement to the Promotion Committee at REC.

Resident will indicate whether they have fulfilled the Scholarly Project requirement already, and if so provide relevant documentation to the REC for review. If not, they should announce a plan for how this requirement will be completed during the PGY-4 year, including a faculty project mentor. The resident is expected to begin communicating with that mentor regularly to formulate and execute the project.

February 1 of your PGY-4 year:

Submit scholarly product for initial review by the resident's mentor. The mentor should provide feedback on whether the project meets expectations for this requirement.

May of your PGY-4 year at REC – Promotion Committee:

Submit final version of scholarly project to the Promotion Committee at REC, where it can be reviewed. The project should be submitted to the Residency Coordinator at least 3 working days prior to REC, to allow time for processing and copying for distribution at the Promotion Committee meeting. The resident will attend REC to present an overview of the project and be available for questions. Faculty present will vote to decide if the product meets the requirement for graduation.

Products which may meet this requirement prior to the PGY-4 year are academic products that have some degree of peer or expert review, and contribute to the community beyond the level of the department. This includes publication in a peer-reviewed journal, poster or workshop at a national meeting, or invited presentation outside the UAMS psychiatry department (may include Grand Rounds at another department). Didactics to junior residents within the Psychiatry Department may be considered if the content is closely monitored and approved by the faculty mentor and agreed upon by faculty vote at REC. If there is question as to the nature or quality of a “national” meeting, this must be approved by the REC beforehand. Some examples of national meetings include, but are not limited to:

APA – American Psychiatric Association

AADPRT – American Association for Directors of Psychiatry Residency Training Programs

AAP – Association for Academic Psychiatry

AACAP – American Association for Child and Adolescent Psychiatry

AAPL – American Academy of Psychiatry and the Law

AAGP – American Association for Geriatric Psychiatry

GENERAL PSYCHIATRY DIDACTICS

General Psychiatry Seminars

Essentials Series

Designed to cover the basics of psychiatry with an emphasis on psychopathology and therapeutics. The essentials series contains a series of lectures on psychopharmacology and a series of Patient Interviewing and Communication skills with fundamental interviewing skills discussed. This series is required of all PGY1 residents. Lectures will be coordinated with the [textbook], and residents will be expected to have completed assigned readings from this text prior to each didactic session.

Patient Interviewing and Communication Skills -- Serves as a course on interviewing, case presentation, and performing a psychiatric examination. It is taught in eight sessions, half in the fall and half in the spring, during the Essentials Series.

Intermediate Series I

Designed to cover areas not addressed in the Essentials Series. The biopsychosocial treatment plan begins to be more emphasized this year. Lectures will be coordinated with the [textbook], and residents will be expected to have completed assigned readings from this text prior to each didactic session. This series is required of all PGY2 residents.

Intermediate Series II

Designed to cover the major areas of general psychiatry in greater depth and to introduce residents to areas not included in the Essentials and Intermediate I series. Includes a year-long introductory course to psychotherapy. Case conferences are used to teach and ensure proficiency in the five ACGME psychotherapy competencies. This series is required of all PGY3 residents.

Advanced Series

Didactics in the PGY4 year are flexible, meant to allow senior residents to fill in gaps in knowledge from prior series and explore advanced concepts in psychiatry relating to their interests. The PGY4 class will invite content experts from the faculty and community to present specific topics of interest. The schedule will be coordinated by the chief resident.

Psychotherapy Seminars

Introduction to Psychotherapy Series -- Introduces residents to psychotherapy. This is a basic curriculum that introduces residents to fundamental psychotherapy concepts such as the therapeutic frame, transference/countertransference, and reflective listening. Required readings may be distributed by the instructor.

Core Psychotherapy Series -- Required of PGY3 and 4 residents. Designed to further develop residents' psychotherapeutic skills and knowledge. Includes interactive case conferences concentrating on the ACGME mandated psychotherapies. This is done by faculty selection of a case that illustrates specific principles and allows residents to interact in order to gain and demonstrate competency.

ESSENTIALS LECTURE SERIES TOPICS -- PGY1s

Assessment and Treatment of the Agitated Patient
Understanding UAMS Call
Overview of Psychiatry Services at ASH
Emergency Psychiatry: VA
Violence Risk Assessment
Acute Management of Substance Use Disorders
Borderline Patients in the ER
Overview of Neuropsychiatry
Suicide
AIDS
Dementia
Delirium
PTSD
ECT
Anxiety Disorders
Mood Disorders
Overview of Personality Disorders
Neurology for Psychiatrists: Neurological Exam
Psychiatry Ethics
Milestone/Competencies
Forensic Case Study
Schizophrenia Overview
Psychopharmacology: Schizophrenia and Schizoaffective Disorder
Psychopharmacology: Unipolar Depression
Psychopharmacology: Bipolar Depression
Psychopharmacology: General Anxiety & Panic Disorders
Psychopharmacology: PTSD
Psychopharmacology: OCD
Psychopharmacology: Dementia
Psychopharmacology: Agitated and Aggressive Behavior
Patient Interviewing & Communication Skills
Psychological Testing
Bio/Psycho/Social/Spiritual Formulation
Psychiatrist in the Courtroom
Overview of Psychotic Disorders
Sexual & Gender Identity Disorders
Teaching to Teach
Introduction to Forensic Psychiatry
Confidentiality and Tarasoff
Neuroimaging
Basic Cortical Exam

INTERMEDIATE I LECTURE SERIES TOPICS-- PGY2s

Long-Term Treatment and Management of CMI
Ethics
Survey of Major Therapists
Psychotherapy Seminar
Interpersonal Psychotherapy
Introduction to Consults
Sleep Disorders
Personality Disorders: Clusters A, B, and C
Neurology Case Conference
Adjustment Disorders
Schizophrenia; Epidemiology & Phenomenology
Right to Treatment/Right to Refuse Treatment
Overview of Research Opportunities
Research Seminar
Behavioral Change Secondary to Neurological Trauma
Non-Alzheimer's Dementias
Substance Use
Illicit Drug Intoxication and Withdrawal
Medical Evaluation of Psychiatric Patients
Dissociative Disorders
Cultural Competence
Cultural Influences in Mental Health
Critical Updates in Antenatal Medicine
Geriatric Psychiatry
Affective Disorders
Religion & Psychiatry
Unipolar Depression
Bipolar Disorder
Non-Verbal Communication
Factitious and Malingering Disorders in a Medical Setting
Cognitive Behavior Therapy: Practical Application
Long-Term Care
Somatoform Disorders
Delirium and Capacity
Special Considerations in the Medically Ill Patient

INTERMEDIATE II LECTURE SERIES TOPICS -- PGY3s

Teaching Seminars
Paying for Healthcare
PTSD
Psychotherapy Series
Substance Use
History of Psychiatry
Basic Law and Malpractice for Psychiatrists
Civil Competence
Confidentiality and Tarasoff
Milestone/Competences
Family Therapy: Theoretical Approaches
Family Therapy: Who's in the Therapist's Chair?
Psychiatric Malpractice
Paraphilias
Group Dynamics
Case Conferences: Supportive Therapy; Cognitive Behavioral Therapy;
 Psychopharmacology and Psychotherapy; Neurology; Psychodynamic
 Psychotherapy; Forensic
Advocacy Groups
Private Practice & Psychiatry
Finance and Regulation of a Psychiatry Practice
Advanced Interviewing for Boards
Understanding Psychiatric Literature
Opiate Use: Withdrawal and Treatment
Psychiatric Rehabilitation
Public Systems Psychiatry
Civil Commitment
Capacity to Stand Trial and Insanity Defense
Advanced Cortical Exam
Interpreting EEG's
Assessment of Malingering
Motivational Interviewing
Bio/Psycho/Social Formulation
Non-Verbal Communication

ATTENDANCE REQUIREMENT FOR DIDACTICS

Attendance at Thursday afternoon didactics and grand rounds is required. Absences must be documented on leave forms, taken as either vacation or sick leave. It is understandable that there may be rare emergent clinical issues that prevent attendance, but these should be very uncommon and must be reported to the office of education.

Sample Weekly Didactic Schedule

Thursday

2:00 - 4:00 P.M.	PGY1 RESIDENTS Essentials Lecture Series and Patient Interview Series
2:00 - 4:00 P.M.	PGY2 RESIDENTS Intermediate Lecture Series
2:00 - 4:00 P.M.	PGY3 RESIDENTS Advanced Lecture Series (Case Conferences, etc.) Introduction to Psychotherapy Series
2:00 - 4:00 P.M.	PGY4 RESIDENTS Per Resident Invitation
4:00 - 5:00 P.M.	ALL RESIDENTS Grand Rounds (2 nd & 4 th Thursday) (except during July and August)

LEARNING OBJECTIVES FOR DIDACTICS

PSYCHOPHARMACOLOGY: BIPOLAR DISORDER

Objectives

The resident will be able to:

1. Name the medications useful in the treatment of bipolar disorder.
Include agents used for both acute episodes of mania and for maintenance therapy.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with bipolar disorder, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of bipolar disorder.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of bipolar disorder and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

PSYCHOPHARMACOLOGY: AGITATED & AGGRESSIVE BEHAVIOR

Objectives

The resident will be able to:

1. Name the medications useful in the treatment of agitated and aggressive behavior, making a distinction between those used for acute therapy and those for maintenance therapy.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes produced by each of the pharmacological agents referred to above that are thought to be responsible for the positive effects of the agent.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe which individual medications referred to above should be used as first-line agents, and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
11. Describe how treatment with the above agents differs based on age of the patient.

PSYCHOPHARMACOLOGY: DEMENTIA

Objectives

The resident will be able to:

1. Name the medications useful in the treatment of dementia.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with dementia, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of dementia.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of dementia and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

PSYCHOPHARMACOLOGY: SCHIZOPHRENIA & SCHIZOAFFECTIVE DISORDER

Objectives

The resident will be able to:

1. Name the medications useful in the treatment of psychosis.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with schizophrenia and schizoaffective disorder, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of schizophrenia and schizoaffective disorder.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of schizophrenia and other psychotic disorders and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

PSYCHOPHARMACOLOGY: OCD

Objectives

The resident will be able to:

1. Name the medications useful in the treatment of OCD.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with OCD, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of OCD.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of OCD and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

PSYCHOPHARMACOLOGY: PTSD

Objectives

The resident will be able to:

1. Name the medications useful in the treatment of PTSD.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with PTSD, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of PTSD.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of PTSD and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

PSYCHOPHARMACOLOGY: GENERAL ANXIETY & PANIC DISORDER

Objectives

The resident will be able to:

1. Name the medications useful in the treatment of generalized anxiety disorder (GAD) and panic disorder.
2. Describe the most common and the most serious side effects seen with each of the medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each of the medications referred to above.
4. Describe the pathophysiological/neurochemical changes seen in patients with GAD and panic disorder, and how each of the pharmacological agents referred to above affect these processes.
5. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
6. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
7. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
8. Describe the common drug interactions seen with each of the medications referred to above.
9. State the therapeutic dose range for individual medications referred to above.
10. Describe how treatment with the above agents affects the course, prognosis and outcome of GAD and panic disorder.
11. Describe which individual medications referred to above should be used as first-line agents in the treatment of GAD and panic disorder and which are recommended (either individually or in combination) in patients who do not respond to first-line agents.
12. Describe how treatment with the above agents differs based on age of the patient.

PSYCHOPHARMACOLOGY: UNIPOLAR DEPRESSION

Objectives

The resident will be able to:

1. Name the classes of medications (based on mechanism of action) useful in the treatment of unipolar depression.
2. Describe the most common and the most serious side effects seen with each class of medications referred to above.
3. Describe the signs and symptoms of toxicity seen with each class of medications referred to above.
4. Describe the biological/neurochemical changes seen in patients with unipolar depression.
5. When given a specific name of a pharmacologic agent used in the treatment of unipolar depression, be able to identify to which class of medications (based on mechanism of action) the specific agent belongs.
6. Name any labs/diagnostic tests that should be performed prior to beginning a specific medication referred to above.
7. Name any labs/diagnostic tests that should be performed during treatment with any of the medications referred to above and how treatment should be adjusted based on the results of these tests.
8. Describe any absolute and relative contraindications to treatment with any of the pharmacologic agents referred to above.
9. Describe the common drug interactions seen with each class of medications referred to above.
10. State the therapeutic dose range for individual medications referred to above.
11. Describe how treatment with the above agents affects the course, prognosis and outcome of unipolar depression.
12. Describe which individual medications referred to above should be used as first-line agents in the treatment of unipolar depression, and which are recommended (either individually or in combination) inpatients who do not respond to first-line agents.

PSYCHIATRY ETHICS

Objectives

The resident will be able to:

1. Name the psychiatric core ethical principles. When given a description of any of these, be able to name the principle.
2. Identify the distinctions between ethics and morals.
3. Describe any sanctions that may be imposed by the APA for ethical violations.
4. Name the five categorical transgressions that psychiatrists most frequently commit.
5. Describe Tarasoff I and II and their impact on our roles as psychiatrists.
6. Describe the 3 APA guidelines for ethical practice in organized settings.
7. Name at least two sources that psychiatrists can refer to when questions regarding medical/psychiatric ethics arise.

ECT

Objectives

The resident will be able to:

1. Describe the components of a pre-ECT evaluation.
2. Describe the indications for treatment with ECT.
3. Describe any risks associated with the use of ECT, including any relative or absolute contraindications.
4. Describe any adverse effects associated with the use of ECT, including the mortality rate.
5. Describe any medications used prior to, during, or post-ECT treatment and state the purpose, dose range and possible adverse effects of these medications. Also, describe how any of these factors may vary with age.
6. Describe any pre-ECT education that should be given to patients or their families.
7. Describe the most commonly proposed theories for the mechanism of action of ECT.
8. Describe the mechanics of administering ECT, including electrode placement, length of seizure and frequency of treatments.
9. Describe the efficacy of ECT treatment, and if/how this varies with age and type of psychiatric disorder being treated.

POST-TRAUMATIC STRESS DISORDER

Objectives

The resident will be able to:

1. Describe the prevalence rate of PTSD and if/how this varies with sex, race and age.
2. Describe the most common traumatic events that lead to the development of PTSD and how these vary for men versus women.
3. Describe the risk factors for the development of PTSD and the most common comorbidities seen with this diagnosis.
4. Name the DSM-V criteria needed for a diagnosis of PTSD.
5. Identify the signs and symptoms commonly seen in a patient with PTSD.
6. Describe the neurochemical processes thought to be affected in patients with PTSD.
7. Describe the most common psychodynamic themes seen in patients with PTSD and how these might be addressed in therapy.
8. Describe any psychotherapeutic techniques that might be useful in the treatment of PTSD.
9. When given a clinical case scenario of a patient with PTSD, identify the clinical signs and target symptoms present and formulate a differential diagnosis.
10. Describe the psychopharmacological treatment options for the various symptoms of PTSD and how these work, neurochemically.
11. Describe the suicide risk for patients with PTSD.

SCHIZOPHRENIA

Objectives

The resident will be able to:

1. Describe the pathophysiological and neurochemical changes thought to be involved in patients with schizophrenia, including the basis of the major biochemical theories.
2. Describe the various etiological processes thought to be involved in the development of schizophrenia.
3. Describe the DSM-V criteria for the various types of schizophrenia.
4. When given a clinical case scenario of a patient with schizophrenia, be able to identify the signs and target symptoms that point to a diagnosis of schizophrenia and formulate a differential diagnosis.
5. Describe the course and prognosis expected for the various types of schizophrenia.
6. Name the first-line pharmacological treatment options available and describe how these are thought to work neurochemically. Be able to describe the efficacy of these treatments regarding their effect on symptoms, course and outcome.
7. Describe pharmacological treatment options available for those who do not respond to first-line agents.
8. Describe how the pharmacological treatment options referred to above differ regarding neurochemical mechanism of action, side effects and efficacy.
9. Describe if and when ECT should be pursued as a treatment option and the efficacy of this if used.
10. Describe any psychosocial factors that might affect the course and outcome of schizophrenia, and how these factors might be addressed in treatment.
11. Describe the prevalence rate of schizophrenia in the general population and how this varies sociodemographically (with age, sex, race, marital status, and socioeconomic status).
12. Name any known risk factors for the development of schizophrenia.
13. Identify the most common comorbidities seen in a patient with schizophrenia.
14. Describe the suicide risk for a patient with schizophrenia and how this varies compared to the suicide risk for other psychiatric disorders.

15. Describe any differences in treatment of an acute episode of schizophrenia versus maintenance therapy.
16. Describe any types of psychotherapy that might be useful in the treatment of schizophrenia, in conjunction with psychopharmacologic agents.

DEMENTIA

Objectives

The resident will be able to:

1. Describe how the prevalence of dementia varies with age and the various types of dementias. Also, be able to describe the most common types of dementia and how this varies by geographic location.
2. Describe the various causes of dementia, including any theories regarding the biological/neurochemical basis for the development of a particular dementia.
3. Recall any pathological and/or lab findings that may be present with each type of dementia. When given a patient with any such findings, be able to interpret these findings to formulate a differential diagnosis.
4. Name the pharmacological treatment options available for the various types of dementia, and describe any biochemical basis known as to how these agents work.
5. Describe the most expected course and prognosis of a given type of dementia, based on its cause.
6. Identify the differences between dementia and delirium, based on clinical presentation, history, and DSM-V criteria.
7. Identify psychosocial factors that need to be addressed and describe how these might affect treatment course and outcome.
8. Identify clinical signs and symptoms present in a patient that point to a diagnosis of dementia.
9. Be able to describe any bedside testing and any neuropsychological testing that may be useful in making a diagnosis of dementia, and how these results impact prognosis.

ANXIETY DISORDERS

Objectives

The resident will:

1. Be able to name the various anxiety disorders listed in the DSM-V.
2. When given the DSM-V criteria for a particular anxiety disorder, be able to name the corresponding anxiety disorder.
3. Be able to describe the prevalence rates of the various anxiety disorders among different races, cultures, and age groups. Also, be able to describe any risk factors associated with each disorder and any common comorbidities.
4. Be able to describe the pathological mechanisms and/or neurochemical systems thought to be involved with each anxiety disorder.
5. Be able to list the most common treatments, both pharmacological and non-pharmacological, for the various anxiety disorders. Also, be able to describe dosages, length of treatment course, and efficacy of each treatment.
6. Be able to describe both pharmacological and non-pharmacological treatment options for those patients that do not respond to the most common treatments.
7. When given a clinical case scenario of a patient with an anxiety disorder, be able to identify signs and target symptoms and formulate a differential diagnosis based on this information.
8. Be able to describe which psychological treatments have been proven to be more efficacious for specific anxiety disorders.
9. When given a clinical case scenario, be able to identify any psychosocial aspects that might affect treatment course and outcome.

MOOD DISORDERS

Objectives

The resident will be able to:

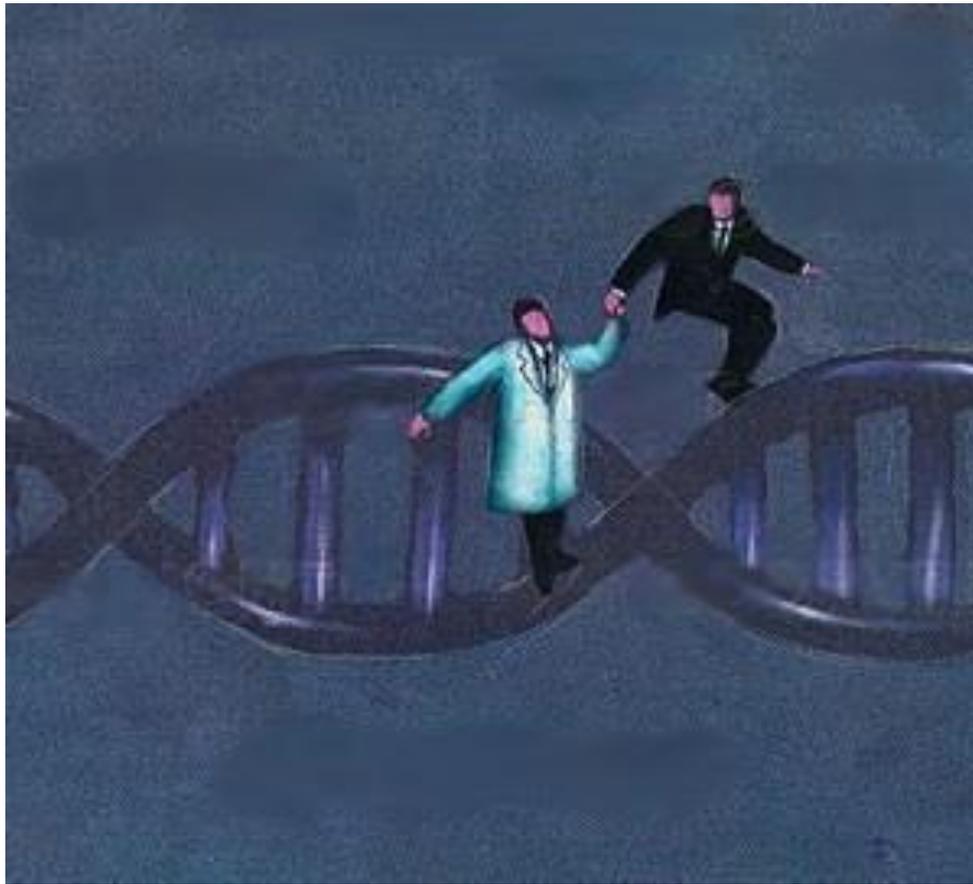
1. Name the mood disorders listed in the DSM-V.
2. When given DSM-IV criteria for a particular mood disorder, name the disorder.
3. Describe the lifetime prevalence rates of the various mood disorders listed in the DSM-IV and how these vary with age, sex and race.
4. Describe the major risk factors for development of Bipolar I Disorder and Major Depressive Disorder.
5. Describe the expected course and prognosis of the various mood disorders listed in the DSM-V.
6. Describe the most common comorbidities associated with the various mood disorders listed in the DSM-V and how these affect the course and prognosis of each.
7. Describe the pathophysiological changes and neurochemical processes thought to be affected in patients with a mood disorder.
8. Describe the various etiological theories proposed regarding the development of a mood disorder.
9. Identify the psychodynamic and other psychological theories for development of mood disorders, including the person responsible for development of that theory.
10. When given a clinical case scenario of a patient with a mood disorder, be able to identify signs and target symptoms, and formulate a differential diagnosis that includes the most likely mood disorder present in the patient presented.
11. Identify any psychosocial factors that affect course and prognosis of a mood disorder, and how these might be addressed in treatment.
12. Describe the various types of psychotherapy that might be useful in the treatment of a mood disorder.
13. Name the psychopharmacological treatment options recommended as first-line agents for the various mood disorders and those recommended for patients resistant to the first-line agents.
14. Describe the biological/neurochemical effects of the pharmacological agents referred to above, and any labs that should be followed with each.
15. Describe the role of ECT in the treatment of mood disorders, including indications for its use and its effects on course and outcome.
16. Describe the differences in treatment of an acute episode of mania or depression versus maintenance therapy for each.

17. Describe the suicide risk among the various mood disorders and how this differs from the suicide risk in other psychiatric disorders.

AUTISM SPECTRUM DISORDER

Objectives

1. Learn the DSM V diagnostic entities and diagnostic criteria for each of the Pervasive Developmental Disorders (PDDs).
2. Learn basic issues in the assessment and differential diagnosis of PDDs.
3. Become familiar with core deficits in the PDDs.
4. Understand basic treatment options for PDD.
5. Learn factors associated with outcome in PDD.



GENERAL INFORMATION

Chief Resident

Each year a resident will be selected to serve as Chief Resident of the General Program (duties begin May 1st). The function of this position is to act as liaison between the residents, the Residency Education Office, and the Department. Responsibilities of the chief resident include:

1. Creation and maintenance of the UAMS/VA call schedule. ACH call schedule will be made by the Chief Resident child and adolescent fellowship.
2. Preparation of the crash course/PGY I orientation schedule
3. Organization/planning of the Resident Retreat
4. Leadership and coordination of resident efforts during recruitment season
5. Attendance at regular Residency Education meetings
6. Leadership of weekly resident meetings
7. Assistance in the negotiation of any conflicts between residents.

It is important to note that the chief resident's role is not simply to represent the residents to the administration, but rather to facilitate the flow of information in both directions. Because this role involves very close interaction with the Chair of the department, the Residency Education Office, and the residents themselves, all of these parties will have a role in the selection of the chief resident. The procedure for selection of the chief resident is outlined below:

Second Thursday in October – Individuals interested in becoming chief resident should inform the Residency Education Director in writing or by e-mail. This will be the final deadline for declaring candidacy for chief resident. The resident candidates will meet individually with the selection committee. The Selection Committee shall consist of the Program Director, Associate Program Director, the Vice-Chair for Education, and the Chair of the Department. The selection committee will consider the qualifications required to perform the duties listed above and consider each resident's academic standing, leadership experience, and history of service to the program.

Third Thursday in November - A vote will be held during the normally scheduled resident lunch meeting to determine the resident's preference for chief resident. The structure and conduct of this meeting will include comments from the candidates and a confidential, closed ballot process will be employed. The votes will be counted by the current chief resident. The current chief resident will inform the residents of the results of the vote.

December – The Selection Committee will offer the position of Chief to one of the candidates based on the results of the candidates' interviews and the residents' vote.

Supplemental Clinical Activity

Department of Psychiatry Policy - The PRI supplemental clinical activity policy is currently being reviewed and TBA. Revisions to this policy will be made as approved by the GME office.

Call Schedule

Department of Psychiatry Policy - Night and weekend call is considered an educational responsibility. Call may be traded but cannot be bought or sold.

Emergency Resuscitation

Emergency resuscitation is provided anywhere on the UAMS campus including hospital wards by an emergency code team. The team may be summoned by dialing 686-7333 and having the hospital operator announce a code. Check victim's respiration and pulse and provide Basic Life Support (BLS) until team arrives. Advanced Cardiac Life Support (ACLS) protocols are followed by the team, and all team members must be certified ACLS Providers to participate. If you are on Internal Medicine rotation, you must complete an ACLS Provider Course before taking this call. BLS certification is required for all clinicians at the VA, and thus must be maintained throughout residency.

Grand Rounds Lecture Series

The UAMS Department of Psychiatry Grand Rounds is a weekly didactic presentation (Thursdays at 4:00 p.m.) featuring UAMS faculty or a variety of national figures in American psychiatry, as well as residents presenting case conferences, patient safety issues, or research content. Grand Rounds is an educational activity for all faculty, residents, medical students, and associated mental health workers. This speaker series is a forum that supplements the formal didactic program and provides for the dissemination of new information from medical research and/or societal issues relevant to psychiatry.

ECT

Many PGY 4s include this in their elective schedule, and all PGY 1s and 2s are required to read about ECT and attend ECT procedures on their patients while on rotations at the North Little Rock VA and at PRI. The REC requires proof that individual residents have adequate ECT experience before the planning of the fourth post-grad year. When attending ECT procedures the ECT form in the appendix should be completed and submitted to the Education Office.

Resident and Faculty Evaluation

At the end of each clinical rotation, the faculty supervisor completes a written evaluation of the resident's performance during the rotation. Each resident is asked to complete a

written evaluation of the educational aspects of the rotation, including an evaluation of the teaching abilities of faculty members.

In addition to the feedback which occurs between teacher and student, each resident meets semi-annually with the Director of Residency Education or Associate Director of Residency Education to discuss the resident's performance and educational progress. Sources of input include the evaluations done by each service chief, residents' evaluations from their instructors, information from psychotherapy supervisors, and results from the PRITE. At this time, the resident's patient log can be reviewed as well.

At quarterly Promotion Committee (faculty members of the Residency Education Committee) meetings, the residents' academic progress and professional development are discussed.

Clinical Skills Verification (CSV)

Beginning in 2012, the American Board of Psychiatry and Neurology ceased administration of an oral examination as part of the board certification process for psychiatrists. Instead, residency education programs have been directed to institute a Clinical Skills Verification exam within the four-year training program to take the place of a nationally administered certification examination.

The two organizations overseeing the implementation of the CSV process (ABPN and ACGME) have issued differing benchmarks for completion of this requirement. It is mandatory that documentation of the CSV at the program level fulfill both the ABPN and the ACGME requirements in order for our residents to graduate from the program and achieve board certification.

For purposes of the ABPN, residents must be competent to:

- Establish rapport with patients
- Effectively interview patients
- Effectively present the psychiatric evaluation information

These competencies are to be judged at the level of a practicing psychiatrist (board eligible practitioner). (Please see the enclosed ABPN publication for details and testing parameters).

For the purposes of the ACGME, competency of a resident is to be judged at a competency level commensurate with his/her PGY level. Find below the policy of the ACGME with respect to these issues:

The CSV evaluation form is designed to document both of these benchmarks. The majority of the form is to be completed per ABPN requirements (e.g. the standard of a practicing psychiatrist). Towards the end of the form is a section to document the ACGME requirements (e.g. with respect to PGY level).

Residents are required to complete one of these evaluations on each PGY I and PGY II inpatient psychiatry rotation. It is not required that a resident pass all of these

evaluations; in fact, it is expected that in the course of training most residents will fail one or more CSV. After completion of a CSV examination, the attending should complete the CSV evaluation form, which will then be given to the resident to turn into the Residency Education Office.

Three passing CSVs are required for graduation. Residents are expected to have completed this requirement by the completion of the PGY II year. If any resident has not passed three ABPN evaluations by the end of the PGY II year, a remediation plan will be designed and implemented to be approved and monitored by the Promotions Committee. PGY-III and PGY-IV residents are expected to have at least one passing CSV from each year.

ACGME Policy

1. The program must formally conduct a clinical skills examination. A required component of this assessment is an annual evaluation of the following skills:
 - (1) ability to interview patients and families;
 - (2) ability to establish an appropriate doctor/patient relationship;
 - (3) ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history;
 - (4) ability to assess mental status; and
 - (5) ability to provide a relevant formulation, differential diagnosis and provisional treatment plan.
 - (6) ability to make an organized presentation of the pertinent history, including the mental status examination.
2. Performance on all evaluations must be documented and quantified, whenever possible, and provided to the resident. When necessary, remediation opportunities must be provided.
3. In at least three evaluations with any patient type, in any clinical setting, and at any time during the program, residents must demonstrate satisfactory competence in: establishing an appropriate doctor/patient relationship, psychiatric interviewing, performing the mental status examination and case presentation. Each of the three required evaluations must be conducted by an ABPN-certified psychiatrist, and at least two of the evaluations must be conducted by different ABPN-certified psychiatrists. Satisfactory demonstration of the competencies during the three required evaluations is required prior to completing the program.

Psychotherapy Supervision

In addition to the clinical supervision provided at the assigned clinical sites, each resident (2nd through 4th year) is assigned a psychotherapy supervisor. These supervisors are full-time faculty members or respected clinicians in the community who are on the clinical faculty. They provide a weekly opportunity for residents to discuss psychotherapy cases in detail and to discuss other professional issues.

If a resident has some difficulty with the supervisory assignment, this should be discussed with the Director of the Residency Program before changes are made.

Residents who wish additional supervision -- especially PGY 3s who are seeing more than four patients in the Outpatient Clinic -- should see the Director of Residency Education. Supervisors should be contacted in early July.

All supervisory assignments are evaluated by both supervisors and residents.

Patient Safety and Quality Improvement

Clinical Case Conference Seminar

Attending/Supervisor: Jessica Coker, MD

All residents share responsibility for promoting patient safety and enhancing quality of patient care. Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. In order to promote these initiatives, residents are required to attend and/or present at monthly case conference seminars. These seminars also depend on faculty participation.

All PGY1 residents are required to lead a case conference seminar and will be assigned to a specific month at the beginning of the year. They are allowed to switch with fellow PGY1 residents for a different time. At any point in the year, if a resident or faculty member identifies a specific case or situation that would provide an opportunity to evaluate safety or quality improvement efforts, this would be presented. Ideal cases include reporting, investigating, and follow-up of adverse events, near misses, and unsafe conditions. The clinical case conference setting is designed to identify areas for improvement and promotion of safe, interprofessional, team-based care.

From the beginning of the educational year, PGY1 residents:

1. Identify any potential patient case/situation/environment that would be suitable to present during their scheduled case conference seminar
2. Discuss ideas with Dr. Jessica Coker prior to presentation who will assist in coordination and preparation of the case
3. Presentations can consist of PowerPoint slides but is not required
4. Present during scheduled time, typically a first Thursday of the month at 4 pm
5. Complete presentation evaluation form at the end of presentation

All residents are required to attend case conference seminars at scheduled times as part of their educational experience. Residents will be expected to provide feedback to the presenter, discuss aspects of the case, and provide solutions that may lead to improvement in the care and/or safety of patients and providers at UAMS.

6-Month Anonymous Evaluation of Rotations, Program, and Faculty

This evaluation allows residents anonymously to evaluate didactics, the residency program in general, the rotations on which they have served, and the faculty who have taught them over the last 6 months, either from January through June, or from July

through December. The residency director reviews all evaluations every 6 months and addresses any urgent problems. This data, in addition to feedback from the Chief Resident, is presented semi-annually at the Promotion subcommittee of the Residency Education Committee. Evaluated faculty may request copies of their evaluations after a year has passed.

Resident Transfers

Prior to accepting a resident transferred from another program, the program director will receive written verification of previous educational experiences and a competency-based performance evaluation from the previous program director. Verification will include evaluation of the professional integrity of residents transferring from one program to another, including from a general psychiatry program to a child and adolescent psychiatry program. A transferring resident's educational program will be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.

Contractual Agreement

House staff appointments are for a period not exceeding one year. A house staff agreement outlining the general mutual responsibility of the College of Medicine and house staff member is signed at the beginning of the term of service and is in effect for the full term of service (1 year). Renewal of an agreement for an additional term of service is at the discretion of the Residency.

Holidays

Official UAMS holidays are:

2022

Independence Day (Monday, July 4, 2022)

Labor Day (Monday, September 5, 2022)

Columbus Day/Indigenous Persons Day (Monday, October 10, 2022) VA only

Veteran's Day (Friday, November 11, 2022)

Thanksgiving Day Observed (Thursday, November 24, 2022)

Christmas Eve Observed (Friday, December 23, 2022)

Christmas Day Observed (Monday, December 26, 2022)

2023

New Year's Day Observed (Monday, January 2, 2023)

Martin Luther King Day (Monday, January 16, 2023)

Presidents' Day (Monday, February 20, 2023)

Memorial Day (Monday, May 29, 2023)

Juneteenth Observed (Monday June 19, 2023) VA only

Holiday on-call schedules are arranged by the Chief Resident. **ASH and VA holidays may be different.** Residents who trade holiday calls must consider the differences between UAMS and VA holidays.

LEAVE: ADMINISTRATIVE / EDUCATIONAL / ILLNESS / PROFESSIONAL

Time spent attending meetings or taking Board examinations or other examinations will not be counted as vacation if the activity is sanctioned by the home department.

Three factors govern the circumstances under which a trip to attend a professional meeting will be approved or disapproved (Leave requests must be signed by the resident's immediate supervisor(s), and the Director of the Residency Program **prior** to attending a professional meeting): (1) whether adequate coverage is maintained for patient care responsibilities, (2) the availability of travel funds, and (3) the training value of the meeting the resident proposes to attend. Forms are available in the Education Office.

If you are traveling on Departmental business which will require reimbursement from the Department, please tell the Education Office your departure and return dates, hotel information, etc., **BEFORE** you begin your trip. Upon return, all **ORIGINAL RECEIPTS** must be submitted to the Education Office. Failure to follow the above procedures could result in no reimbursement from the Department.

Effect of Leave on Completion of Training

Resident physicians are in the unique position of having a role as both students and employees. Although brief periods of leave can usually be accommodated, extended absences from the residency (fellowship) program for any reason may adversely affect both the resident's completion of the educational program on schedule and the program's responsibilities for patient care. Most specialty boards specify a minimum number of weeks of education (or training) that must be completed for a resident to receive credit for the educational (or training) time. The resident must take into account these factors when requesting extended periods of leave from the program.

Leave Policy

There are several types of leave within the program, and they must be accounted for correctly. Leave includes Annual Leave (vacation), Sick Leave, Educational Leave, and GME Leave Days. All leave balances reset on the academic year cycle (July 1 – June 30), with the exception of GME Leave Days, which are a one-time award of 5 days throughout a residents training program experience.

Leave days are considered approved upon submission to the Residency Education Office of a fully completed Request for Vacation or Sick Leave form, signed by all attendings of the services from which work will be missed. Residents who take leave without approval will be considered Away Without Leave, which will be grounds for disciplinary action.

No matter how much leave is available to a resident, residents must spend enough time on duty within a rotation for it to count as a complete rotation. In general, a resident must be on duty for 3 full weeks of a four-week rotation for that rotation to meet minimum requirements. Regardless of the length of a rotation, residents are strongly discouraged from taking more than one week of consecutive leave of any kind.

Vacation (Annual Leave)

Annual Leave represents discretionary days for residents to take vacation. Residents receive 21 days (15 work days plus weekend days) of paid Annual Leave each year. This cannot be "carried over" from one year to the next. Residents are expected to coordinate Annual Leave with the attendings and other residents on each clinical service to avoid coverage gaps. Residents are encouraged to plan their annual leave early in the academic year to avoid stacking multiple leave requests towards the end of the academic year.

Sick Leave

Department Of Psychiatry Policy

If you cannot come to work due to illness, notify the attending physician as well as the Office of Education. If you have a planned medical leave or appointment, a standard leave form should be submitted prior to the leave for planning purposes, signed by each attending whose service is affected. Sick leave may not be used for supplemental clinical activities, to supplement annual leave, to interview for jobs or fellowships, or to relocate.

Residents have 12 days of sick leave (including weekend days if scheduled to work) for medical reasons during each year of training. The sick leave cannot be "carried over" between years. Sick Leave of more than 3 consecutive days will require some form of medical documentation of need for the leave. Sick leave in excess of 12 days requires special review by the Program Director and Associate Dean of GME.

Educational Leave

Residents are encouraged to seek educational activities outside of the residency program. This may include national or regional meetings or one-time extramural educational programs. To this end, residents are afforded 5 days of Educational Leave per academic year. All requests for Educational Leave are subject to the approval of the Program Director to ensure that they are valid educational experiences. Educational leave is for special experiences and it is expected that not all days of Educational Leave will be used by each resident every year.

GME Leave Days

In addition to the annual vacation days that are given on a yearly basis, each resident or fellow will also be allotted five (5) additional leave days (GME Leave) for use by the resident or fellow at their discretion during the entirety of the individual's residency or fellowship period at UAMS. These five days do not reset at the new academic year. These five vacation days are given whether the length of the program is a one-year program or a multi-year program. These days can be used at the trainee's discretion, but are intended to provide time for interviews (for fellowships or jobs), relocating close to completion of the program, or other significant personal events.

UAMS Library

The UAMS Library is housed in the Education II Building and occupies space on three levels. To see what is available online, visit <https://library.uams.edu/>

Mailboxes

Mailboxes are located in PRI Education Suite. Please retrieve your mail at least weekly.

Name Badges

Each house officer will be furnished name badges for UAMS, VA, and ACH. It is the responsibility of each resident to renew badges as they expire during residency.

Pager Policy

All residents must have a mobile contact number so they can be quickly reached while on call and on-service. Residents use a personal cell phone for this purpose, with the understanding that this number will be posted on rosters and call schedules.

Parking

UAMS - All members of the housestaff are granted parking privileges in Parking 2 Deck with badge access. UAMS Parking Operations is located on the 2nd floor of the Distribution Center on 7th and Cottage. Office hours are 7:30 am – 4:00 pm, Monday-Friday. 501-526-7275

VA - McClellan -- UAMS lots are nearby and are suggested for residents working at the LRVA.

VA - Ft. Roots -- Parking hang tags for placement on the resident's private vehicle are furnished at the beginning of the first Ft. Roots rotation.

Arkansas State Hospital -- Parking permit will be arranged on first day of rotation.

Arkansas Children's Hospital -- Parking permit can be obtained through Jackie Jagers JagersJF@archildrens.org

Pay Schedule

House staff members are paid monthly. The stipend payment is direct deposited to the resident's bank on the last working day of the month.

Professional Liability Insurance

Each house staff physician is provided professional liability insurance when on official duty. Additional coverage may be obtained from the insurance carrier.

Tuition Discounts

U of A Tuition discounts extend to interns, residents, fellows (both house staff and post-doctoral fellows in the basic sciences). The fringe benefit also applies to members of the immediate families in the same manner that it is available to other full-time employees of UAMS.

Website

The address to access our department's website is:
<http://psychiatry.uams.edu/education/> . This site contains information on our faculty, residency program and other items of interest.

Social Media

Use of social media (Facebook, Twitter, Instagram, etc.) is at the discretion of each resident. Residents need to be aware of the implication of social media presence for an MD as different from a student or other professional. For example, posts about the workday must take special care to avoid breaches in HIPAA and confidentiality. Posts that do not break confidentiality but that speak pejoratively or judgmentally about a group of patients, region, or those sharing a diagnosis, reflect poor professional boundaries and may compromise patient care at a later date if these comments surface when caring for such an individual. In addition to issues of patient confidentiality, residents should take caution not to speculate on mental health diagnoses or treatment for individuals portrayed in the news or on social media. Residents should also be aware that personal disclosures, personal information, and photographs that are posted in the public domain may be viewed by patients, family members, and future employers. This content can affect patient care or future hiring opportunities; careful thought should be given to confidentiality settings on all social media accounts.

Resident Awards

When suitable candidates are available, residency faculty make nominations for several national awards, such as the NIMH Outstanding Resident Award and the APA Fellowship. Some of the following awards are voted upon within the Department and presented at the annual awards banquet:

William G. Reese Award: for achievement in psychiatric research as determined by a faculty residency research committee

Outstanding Care Award: to PGY1 demonstrating outstanding care of psychiatric patients as determined by a vote of the PGY1s and 2s

Lloyd Rader Outstanding Resident Teacher Award: to PGY3 or 4 demonstrating outstanding teaching of medical students/junior residents as determined by a vote of the teaching faculty

Outstanding Graduating Resident Award: to the outstanding graduating resident as determined by a vote of the teaching faculty

Resident Participation in Non-Departmental Activities/ Public Service

When engaged in nonremunerative activities in which a resident might be reasonably perceived by the public to represent UAMS or the Department of Psychiatry, advance clearance from the Office of the Residency Director is required.

Suicide of a Patient

University Hospital

The following are **UAMS** guidelines for management of the suicide of a patient under resident care.

- 1) Remember that death of the patient does not necessarily end the therapist's interaction with the patient's family. Further contact with the family should be discussed with the supervisor.
- 2) The supervisor(s) and the attending on call, and the head of the service (if different from the supervisor) should be notified immediately -- at any time of the day or night.
- 3) The University attorney and the malpractice insurance company defense attorney should be consulted by the UAMS faculty member involved.
- 4) A chart review should be arranged, involving the resident, the attending on the service, the supervisor, the residency education director, and any other staff with close involvement.
- 5) The hospital administrator should be notified.

Veterans' Administration

Instructions for Conducting Morbidity/Mortality Review (Psychological Autopsy)
EXTRACT FROM G-15, M-2, PART X, CHAPTER 4 DATED DECEMBER 11, 1989
"4.03 THE ADMINISTRATIVE PROCESSING OF SUICIDES AND SUICIDE ATTEMPTS

- a. As required by VHS&RA Supplement MP-1, a morbidity/mortality review (often termed a psychological autopsy) will be conducted whenever there is a suicide or suicide attempt. Such a review will be considered a quality assurance investigation.
- b. This morbidity/mortality review is intended to serve the following purposes:
 - (1) To determine if the care provided was indicated, appropriate, and adequately done;

- (2) To determine if, from the advantageous position of hindsight, other steps and interventions might have altered the outcome;
 - (3) To assess the adequacy of current policies and practices within the medical center or clinic, seeking to maximize safeguards and care while still promoting therapy and rehabilitation;
 - (4) To identify actions that were appropriately performed and policies and procedures that are effective; and,
 - (5) To provide a forum for the involved staff members to share their thoughts, concerns, reflections, feelings and insights concerning the incident.
- c. The mental health morbidity/mortality review should be interdisciplinary. All members of the care-providing team should participate, as should any other person who may have knowledge of the event or patient. The review should occur as soon after the event as possible or at the latest within two weeks of discovery.
- d. The Chief of the Service on which the suicide or suicide attempt occurred should appoint the chairperson for this morbidity/mortality review. The individual appointed should be someone who has not been involved with the patient and who has a mental health background and is knowledgeable in the area of suicidal behavior. If there is no eligible mental health clinician available, someone else with a knowledge of suicidal behavior should chair the review.
- e. Participation in the morbidity/mortality review process for a particular incident may vary at the discretion of the chief of the service involved. For example, in some cases participation may be restricted to staff on the unit where the incident occurred, while in other cases participation may be open to other professional staff for educational purposes. In all cases the data considered during the review process should include:
- (1) A review of the medical record, medication history, and a summary of the care provided;
 - (2) A presentation by the primary care provider of the treatment plan and its status, and a report of the patient's acceptance and compliance with the treatment plan;
 - (3) A report of the community/family influence and support factors available to the patient;
 - (4) Data on the patient's observed behavior and interactions on the ward or in the clinic;
 - (5) Reports of psychometric evaluations if performed; and,
 - (6) Reports by other staff members that may have knowledge pertinent to the incident.

- f. This data should be collected prior to the review and presented by staff directly involved in the patient's care. The chairperson should then lead a discussion in order to review and determine, retrospectively, if there were any other factors or occurrences which may have contributed to the incident and whether action can be taken to prevent further similar incidents.

- g. The findings of the morbidity/mortality review should be summarized by the chairperson in writing. This summary should be in the following format:
 - (1) A summary of the facts and events disclosed in the review;
 - (2) Conclusions regarding what occurred, why it occurred, and whether the incident could have been anticipated and avoided.
 - (3) Conclusions about appropriate measures taken by staff and policies/procedures that were effective;
 - (4) Recommendations regarding the clinical care of patients, administrative policies and procedures, environmental factors that may require alteration, and training deficiencies; and,
 - (5) A recommendation to the medical center Director that an administrative investigation be conducted if the morbidity/mortality review suggests that such an investigation is necessary."

Education Material and Travel

The Residency Office of Education encourages residents to practice self-directed learning using resources outside the formal training program. This includes use of educational materials and literature and attendance at local and national meetings. Residents who want to travel to a conference should inform the Residency Education office as soon as possible so appropriate planning can be done.

The department will support attendance at national meetings by providing a \$2,000 travel stipend to each resident. This stipend can be used to fund travel to one national meeting during the 4-year residency. It is the responsibility of the resident to follow UAMS policies regarding reimbursement including receipts for registration, meals and hotels, etc. Use of this travel stipend must be coordinated with the resident's clinical duties at the time of the conference; it is the resident's responsibility to arrange appropriate coverage on the clinical service and obtain timely approval for travel from the attending. Supported meetings include those listed below. Other suggested conferences can be submitted for approval to the residency director.

APA – American Psychiatric Association

AADPRT – American Association for Directors of Psychiatry Residency Training Programs

AAP – Association for Academic Psychiatry

AACAP – American Association for Child and Adolescent Psychiatry

AAPL – American Academy of Psychiatry and the Law

AAGP – American Association for Geriatric Psychiatry

APS – Arkansas Psychiatric Society

The Residency travel budget is limited to eight (8) \$2,000 travel stipends per year. PGY4 residents who have not yet used their stipends will have priority during each academic year. Any stipends not claimed by PGY4 residents can be used by junior (PGY1-3) residents. In order for junior residents to be able to make appropriate travel and coverage plans, PGY4 residents who intend to use their travel stipend must inform the Residency Education Office of this intent by the start of their PGY4 year (July 1). After that date, stipends will be considered unclaimed and will be distributed on a first-request basis to other residents. Note that statement of intent to use the stipend is merely a declaration of intent, and does not need to include specific travel plans or even which conference will be attended.

Funds that are not used in the above manner by the completion of residency are forfeited, and cannot be dispersed as cash pending graduation.

University Paid Travel

The Residency Education Director must approve trip before any travel arrangements can be made. A completed Education leave form must be turned in before any travel arrangements can be made.

Please check with the Residency Education Office before travelling for any updates to UAMS reimbursement & travel policies.

Travel Reimbursement Requires Itemized Receipts

Receipts are required for the following items when requesting reimbursement:

- (1) Lodging (itemized receipt). A credit card receipt is not acceptable.
- (2) Commercial Airfare (include a copy of complete itinerary showing passenger name) If booking on the Internet, print the first page of the confirmation, showing amount paid for ticket.
- (3) Train/Subway
- (4) Registration Fee
- (5) Car Rental (Enterprise Car Rental only agreement form showing amount paid)
- (6) Parking
- (7) Toll charges
- (8) Business Communication Expenses (Internet access, faxing, business telephone calls)

Airfare

- (1) Airfare may be purchased using the department T-card or personal credit card. Extension of business travel to include personal time is not allowed on the T-card.
- (2) Tickets must be purchased using major airlines or local travel agencies only. Third party sites are not allowed per UAMS policy.
- (3) All airfare tickets must be coach/economy class or the equivalent. "Main cabin" on the major airlines is allowed. No upgrades to seats or cabin are allowed (SWA Anytime, Plus, Comfort and Premium are considered upgrades).
- (4) Flights must be booked 4 weeks ahead of a scheduled conference or trip. (Psychiatry-Education requirement)

Taxi

- (1) Uber/Lyft/Taxi receipts must be itemized with the locations listed on the itemized receipts.

Lodging – Itemized Receipts are Required

- (1) Reimbursement for lodging is limited to the single room rate. If a room is occupied by more than one person, the single room rate must be noted on the receipt.

- (2) The maximum daily allowance will be limited to the Federal-per-Diem rate depending on the location for both in state and out of state travel unless a special travel circumstance exists.

Parking Fees and Toll Charges

- (1) Parking fees and toll charges for private, rental, or University owned vehicles are reimbursable and may be claimed on the Trip Reimbursement with appropriate itemized receipts attached.

Meals – Itemized Receipts are required

Reimbursement for meals is allowed ONLY in connection with overnight travel.

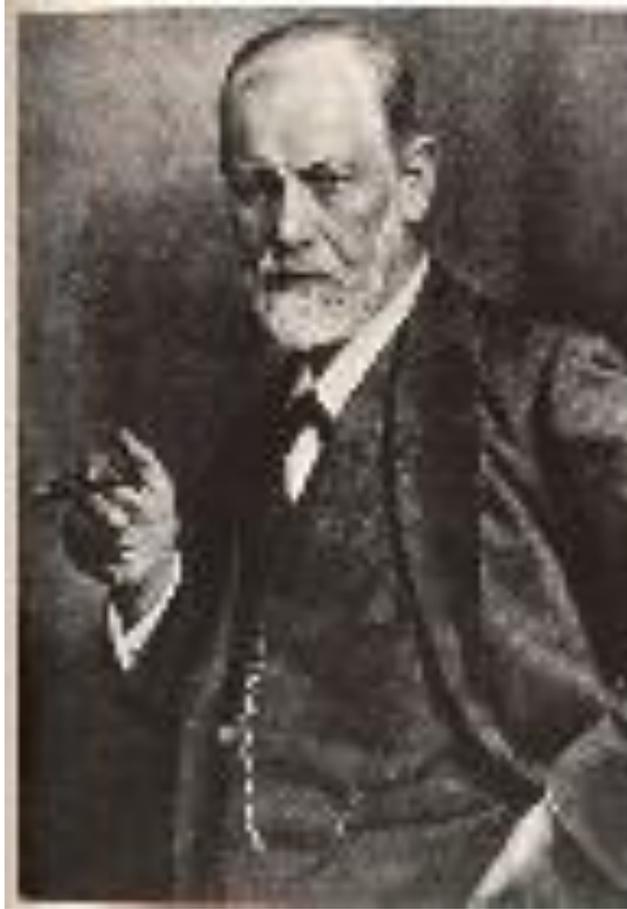
- (1) Meals are not to exceed the Federal Maximum Daily Allowance. This amount includes state and local sales tax and 15% tip. Click on the link below to find the Federal-per –Diem rates under the Quick Links tab. (<https://supplychain.uams.edu/procurement-and-travel/travel-management/>)
- (2) Meals claimed for reimbursement are to be the actual expenses incurred. Meals on the day of travel cannot exceed 75% of the per diem.
- (3) When travel is overnight, reimbursement of meals en route and from the employee's original station will be subject to the following: (for ease of calculation, note the % breakdown by each one, based on maximum per diem per day)
 - a) (15%) Breakfast may be claimed if the employee leaves their official station prior to 6:30 am.
 - b) (35%) Lunch may be claimed if the employee leaves their official station prior to 11:30 am, and when returning to home station if he/she arrives after 12:30 pm.
 - c) (50%) Dinner may be claimed if the employee leaves their official station prior to 5:00 pm; and when returning, they arrive after 6:30 pm.
- (4) Meals are not allowed within the city of the employee's official station, to include the airport located in the city of their official station.
- (5) In the event of personal time taken in conjunction with business travel, meals with only be reimbursed for the actual event dates.

The State of Arkansas allows for reimbursement of up to 15% for food tips.

Arkansas State Statue does not allow reimbursement for alcohol purchases.

Further Travel policies:

<https://supplychain.uams.edu/procurement-and-travel/travel-management/uams-admin-guide-travel-policy/>



APPENDIX

UAMS Call FAQ

Evaluation

What if I get an inappropriate consult?

Sometimes, the consulting team may not have formulated a good clinical question; talking with them may clarify the issue. In other cases, there is a good question, but the timing of the consult is not optimal (e.g. patient in the middle of a medical procedure, or a ventilated patient). If, after discussing the issue with the consulting team, you still feel the consult is inappropriate, go ahead and see the patient (remember patient care comes first) and report it to your attending and the C-L attending. Keep track of the patient's name, medical record number, resident, and attending who initiated the consult. It will be addressed at the discretion of the C-L attending.

Are we supposed to see all patients who have substance use/dependence issues?

Hospital policy #MS507 states that Psychiatry Consult and Case Coordination are *available* in such cases. It also states that the medical evaluation is to be completed and appropriate labs drawn prior to consult. Often, these are straight-forward consultations. Patients can be referred to chemical dependency treatment options; a list of numbers is kept in the Psychiatry binder in the ED. It is also an opportunity to address possible withdrawal issues.

What if I get a call from a UAMS Adult Psychiatric Clinic patient?

You must get the patient's full name, telephone number and address, in case you get disconnected or Patient is suicidal and hangs up. Having the birth date helps with identification of the patient. Then you can dictate a clinic note with the above information. The note gets signed by the CL attending and eventually will be reviewed by that patient's psychiatrist. If it is an urgent matter, you may want to notify the psychiatrist directly.

Disposition

What if a patient needs outpatient follow-up?

Patient can be given the numbers to the PRI Walker Family Clinic (526-8200) or to his/her local Community Mental Health Clinic (for Little Rock, 686-9300). Some veterans can be seen at the VA Eval Clinic (257-1000 x55719). Insured patients can also get referrals to psychiatrists on their panel. Be aware that it often takes several weeks to be able to get an appointment. In extreme cases when care is needed more urgently, you can call the UAMS Clinic the next business day and discuss with the CL attending the possibility of trying to find a more rapid appointment. There is a card in the Psychiatry folder in the ED with the names and numbers of chemical dependency treatment options.

What if a patient needs inpatient psychiatric hospitalization?

Advise the primary team that you are recommending hospitalization. They are responsible for contacting psychiatric hospitals and/or the screener. You may be asked to talk to a potential accepting MD to clarify psychiatric issues (the 'doc to doc'), and you may be able to facilitate a transfer (as with the PRI). However, it is *not* your responsibility

to make the calls for placement to write discharge orders or orders for medications, refills or PRNs.

Determine whether the patient is voluntary or not. If the patient is involuntary, check for documentation of a court ordered 7 day evaluation, 45 or 180 day commitment. If not and there are sufficient grounds for commitment, you may need to place the patient on a 72h hold. In most cases, the primary team should write the order for a 72h hold. In the ED, the nurses have the responsibility of reading the rights at UAMS. However at the VA you may have to read them their rights. Ultimately, though, it is up to you to ensure that the orders and rights are done properly and documented. It is advisable to make a copy of the signed rights. Most of the time, the UAMS C-L team will make arrangements to file the petition (or family), but in rare cases, you may be asked to do this if you are the only one who witnessed something first hand.

If applicable, be explicit about the need for sitters or for calling Psych if the patient wants to leave AMA. This type of info should be documented and personally communicated to the primary team.

What if a patient needs inpatient medical hospitalization?

Patients should be medically stabilized before being admitted to a psychiatric hospital. If there are medical issues that require hospitalization, those take precedence. If the patient is admitted to UAMS or VA, notify the next person on call or the C-L team for the respective hospitals the next business *morning* (or send an email to all of the CL team members) as the CL team will be following the patient.

Screeners

What is the screener system?

The state of AR is responsible for emergent psychiatric hospitalizations in uninsured patients, most of whom are placed at the Arkansas State Hospital (ASH). To ensure appropriate and informative admissions, ASH uses a statewide Single-Point-of-Entry (SPOE) system to screen patients for admission. The state mental health system is divided into various catchment areas depending on the patients. County of residence. For the patient's catchment area (small counties are often in the same catchment) the local mental health division (i.e., MHC) provides a screener for the patient to evaluate them in various settings such as in the hospital, jail, clinics or residential care facilities. The screeners are typically social workers who fill out the SPOE and they do have an MD backup.

What do the screeners do?

They verify that the patient needs psychiatric hospitalization and use the ASHs SPOE form regardless of placement. Screeners theoretically know a particular patient well as the patient are followed in their local MHC, and are helpful in providing information or alternative f/u. However, it is ultimately up to you and your attending to decide on the most appropriate disposition.

When should a screener be called?

Screeners should be called when a patient may be a candidate for inpatient psychiatric admission. The ED often initiates this process without Psych involvement. The sooner a screener is called, the sooner a patient is placed on the waiting list. However, if the patient is clearly intoxicated, or so medicated that an evaluation is not possible, it is reasonable to wait until the patient is assessable. For patients who are not medically stable, the screeners should be called after stabilization since a screening is only valid for 48h.

Why do the screeners ask about UDS results?

Screeners have to come out to see patients 24 hours a day 365 days a year. They want to be ensured the patient is not too intoxicated to participate in the interview. However, it is certainly possible for a patient to have a positive UDS and still be assessable, and screeners should be advised if that is the case. Sometimes, patients will require inpatient stabilization for their symptoms, regardless of whether the symptoms are primarily drug-induced or not (and it may be difficult to determine at the time). You may need to advocate for appropriate care for the patient.

What if the screener doesn't agree with my assessment?

Most conflicts can be resolved by talking to the screener. One or the other of you may have additional information that has influenced your decision. The screener may be able to offer other options that you find appropriate, such as the Crisis Stabilization Unit, day treatment, or outpatient follow-up in 1-2 days. If an agreement cannot be reached, you can involve the screener's MD backup and/or your attending. Document conversations thoroughly and tactfully.

What about patients coming from jail?

Prisoners do not have to undergo the same screening process, since the jail can serve as a point of entry into ASH. If a bed is not available, jails can provide a monitored environment for the patient called suicide watch, while s/he awaits hospitalization. Be sure to clarify whether a patient is still under custody; if they were brought from jail but have since been released, they would need a screener for ASH. Though screeners often see patients while in protective custody.

Signing Out

When should I call my attending?

During your first year, you should call your attending about each patient. Even beyond the first year, it remains a good idea. During the weekend, you should coordinate with your attending about who will round on which patients.

What should I communicate to the rest of the Psych team?

Good communication with the next resident on call on the weekends or the C-L team during the weekday is important for continuity of care. You should tell them about any new consults that have not yet been seen, as well as any patients who need to be followed. You can expect to have this same information from your colleagues.

The resident on the C-L team tries to make it clear to consultees that most inpatient are not routinely seen over the weekend. However, problems do arise. If you are called to see an inpatient already followed by the C-L team, look for the Psych evaluation under the "Consultations" section of the chart and the most recent notes under the "Progress Notes" section of the chart. Also, some patients seen by the C-L team are very unstable and need to be seen daily. You will be notified ahead of time about such patients and should make sure to pass it on to the next resident on call as well.

VA On-Call Guidelines

1. Always call the Staff Attending to check out each patient. If you cannot reach the designated attending on call, then contact Dr. Krain or any other VA attending to discuss the patient.
2. Only the ER physician or on-call psychiatry attending may accept transfers from outside ER's. The VA ER may contact you for your opinion on such transfers, but only the ER and AOD can officially accept them.
3. Only the Psychiatry Staff Attending may accept transfers to 3K from outside hospitals. (This pertains to inpatients only. Patients in ER's are considered outpatients and the ER physician accepts the patient.) Other VA's, such as Muskogee, OK, will sometimes send patients here for psychiatric care, and we have an agreement with them to often accept their veterans, barring 3K is not on diversion. Diversion is defined as the lack of inpatient psychiatric beds and is only put into action by VA Administration. Your attending or the ED staff is responsible for contacting the appropriate administrators to initiate psych diversion.
4. When you are called about patients in outside hospitals, you need to document that patient is voluntary, or that patient has a minimum 45 Day Court Order if patient is from *outside* Pulaski County. Review all court documents carefully, to ensure that they are in fact for a 45 day order. Also document that patient will be evaluated in the ER, but that the VA *does not guarantee* admission to the hospital. Therefore, whoever is transporting this patient (often law enforcement personnel), needs to stay at the VA until you have made a determination regarding admission or discharge.
5. Patients placed on 72 hour holds:
 - a. Read them their rights (forms in the Eval Conference Room). Document in your consult note that you read them their rights. Document on the original form whether or not patient signed, and that the original form was placed in patient's ER chart.
 - b. Always inform Police Officer that patient is being placed on a hold and enter a Free Text order in CPRS stating the patient is on a 72-hour hold, noting the date and time the hold was initiated. The Police will need a signed order for a 72 hour hold (on an old-fashioned paper order sheet) before they can physically prevent a patient from leaving the hospital.
 - c. It's a good idea to have the police standing nearby when you inform the patient that he/she is being placed on a hold.

6. You are responsible for the Physical Exam and Review of Systems on weekends from Friday night to Sunday. You are always responsible for aiding in the medical clearance of the patient. So, review vital signs and labs. All ER patients should be evaluated by the ER MD, and the ER MD should address any significant medical concerns. You do not have to accept a patient onto 3K if you do not think the patient is medically stable. Discuss your concerns with the ER MD. If any imaging or other testing is needed, or you recommend patient have a neurology (or other) consult, then recommend this before the patient is transported to 3K. Stress to the ER that patient needs to be medically stable for discharge before going to 3K, as there is not a readily available ICU or even IV access if patient crashes. If patient has a history of complicated alcohol withdrawal, such as being delirious even with benzodiazepine tapers, or requiring MICU care, then patient should be admitted to Medicine for detox. A sitter may be needed if patient is unable to contract for safety in the hospital.
7. Contact the Consult Resident/Attending the next day regarding any patients on Med/Surg units that need psychiatric follow-up.

RESIDENT ROTATIONS

- **Goals**
- **Resident Duties**
- **Recommended Reading Assignments**

BLOCK DIAGRAM OF ROTATION SCHEDULES

Year 1	4 Months	2 Months	6 Months
	Primary Care	Neurology	In-Patient Psychiatry

Year 2	6 Months			6 Months		
	2 Months	2 Months	2 Months	3 Months	6 Weeks	6 Weeks
	Geri. Psych 55 %	Addictions 55%	Elective 55%	Consult/Liaison/ VA ER	Night Float (2 3-wk. periods)	In-Pt. Psych
	Child Psychiatry 33%					
	½ day per week Psychotherapy 11%					

Year 3	12 Months					
	Full-time Outpatient					
	33% Community Mental Health Center/VA MHICM; 22% UAMS Adult Clinic; 33% VA Clinic					
	½ day per week Psychotherapy 11%					

Year 4	12 Months					
	Electives					
	½ day per week Psychotherapy 11%					

Fourth-Year Electives

The Fourth Year is regarded as a "track" year. The individual resident, with the approval of the Residency Education Committee, plans a fourth-year experience that will be consistent with long-term career goals. The following are to be regarded as examples and not exclusive of other possibilities:

Chief Resident – Serves as a faculty/resident liaison assuming some administrative and teaching duties.

Academic Psychiatry - Administrative and teaching responsibilities as chief resident, a research project, and outpatient clinical responsibilities associated with a subspecialty clinic (e.g., neurobehavioral).

Public Sector Psychiatry - Supervision and teaching junior residents in a public hospital inpatient service, consultation to public agencies such as the police department, and consultation to a community mental health clinic.

Child Psychiatry - Entry into the Child Psychiatry Fellowship program at UAMS/ACH.

Private Practice Psychiatry - Primary assignment to the adult outpatient clinic. Private practice activities such as billing and managing an office can be emphasized.

Educational Clinical Psychiatry – PGY 4's will be offered the opportunity to supervise PGY I Residents on short call from 4:30-8:30 up to one day each per week. The goals of this rotation is to provide for an increased level of clinical independence and a chance to teach Junior Level Residents in a clinical setting. Supervision is available through the attending on call.

Each resident has the opportunity to select a PGY-4-year faculty advisor/mentor. The year's program can then be prepared with the advisor's input and approval.

Senior electives schedules and the names of senior advisors for the PGY 4 year should be submitted to the Residency Office for approval by a date to be announced in the Spring semester of the PGY 3 year. The schedules will be presented to the Residency Education Committee for subsequent acceptance.

If residents want to make changes in their electives during the course of the year, written approval from all parties involved needs to be obtained. The Director of Residency Education will give final approval with input from the REC if needed. No change is to be made until the request is approved.

Any resident planning to work in non-UAMS-affiliated facilities must have their plans approved by the Residency Director.

PGY IV Electives Description

Please use the form that follows and describe the elective(s) that you are proposing. Consult with the supervisor of the elective for his/her input. You must submit these descriptions to the Residency Education Committee when finalizing your PGY 4 schedule. You must include the following competency discussion in the proposal.

Please include in your description of goals and objectives which of the following competencies will be included in the curriculum and how. It is not necessary to include all of these.

- a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- b. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
- c. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
- d. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
- e. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
- f. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

SELECTIVE / PGY 4 ELECTIVE DESCRIPTION

SELECTIVE / PGY 4 ELECTIVE:

ATTENDING:

TELEPHONE:

MAIL SLOT:

LOCATION:

ROTATION DESCRIPTION

GOALS AND OBJECTIVES (including competency language; see list above)

SPECIFIC DUTIES OF THE RESIDENT

SUPERVISOR'S RECOMMENDED READING MATERIALS

HOURS PER WEEK:

Direct Patient Care: _____ hours

Case Conference/Staffing: _____ hours

Supervision: _____hours

Administrative (Record Keeping): _____hours

Total Number of Hours Per Week: _____hours

Resident Academic Track

The overarching mission of the Resident Academic Track (RAT) at the University of Arkansas for Medical Sciences (UAMS) is to identify and train the next tier of academic psychiatrists. The RAT will introduce residents to academic medicine (education and/or research) so that they can make informed decisions about their career paths. In the process, RAT participants will improve their skills in observation, writing, and critical thinking, skills that will serve them well regardless of whether or not they choose a career in academics.

Many residency programs offer “research tracks” that focus on developing residents’ independent research careers. Our approach is unique in that we view “academic medicine” more broadly. In addition to those interested in research, we welcome participants who want to gain experience in other aspects of academic life, such as teaching and education, professional presentations, scholarly and critical literature reviews, and collaborative research endeavors as co-investigators. We aim to provide a progressive exposure to academic scholarship and clinical or applied research involving real world populations.

Structure of RAT. The RAT program begins in the PGY2 year. All PGY-2 RAT participants will spend ½ a day per week for a two month period on this elective rotation. RAT participants will choose to complete projects in either research or education. With the help of program leadership, they will identify an area of interest and engage one or more primary mentors to help guide them. Each RAT participant will focus on learning content relevant to their topic of interest and, with help from their mentor, build the skills needed to complete their specific project. The project will culminate in a professional presentation to the RAT Executive Committee, other residents, and guests during the weekly Psychiatry Grand Rounds. The presentation will be critically reviewed for completeness of the literature review, presentation techniques and development, and educational engagement of the resident. Residents who successfully complete the PGY 2 experience will have the opportunity to continue the experience in the PGY 3 year.

During the PGY3 year, residents will work with a mentoring team to develop goals. Each participant’s program will be tailored to these specific goals. The mentoring team will include 2-3 faculty engaged in ongoing research or education and will meet on a quarterly basis. During the PGY3 year RAT participants will have 1½ days/week devoted to their research activities for the entire year. *Of importance: this research time during the PGY3 year replaces one of the outpatient experiences that all PGY3’s are required to complete. This time is completed in the PGY4 year. For example, if a RAT trainee does not complete the VA mental health clinic in the PGY3 year, this will be completed in the PGY4 year.*

Since the PGY4 year is structured to be largely elective, the RAT participant should have the opportunity to continue his or her academic activity during the PGY 4 year. The time commitment and requirements in the 4th year will be mutually agreed upon by the resident and mentor.

Opportunities at UAMS. As noted above, the first year of the RAT program is largely exploratory. In the second year, RAT residents will further delineate their path within academic medicine. If education is of interest, RAT participants may further develop their

education skills; target groups for education might include other trainees, patients, staff, or communities. If research is of interest, RAT residents will have the chance to work with existing UAMS research programs which span clinical research to health services research. Some research strengths at UAMS include the Brain Imaging Research Center (BIRC); Center for Addiction Services and Treatment (CAST); the Women's Mental Health Program (WMHP), the Center for Implementation Science (CIS), and the Center for Mental Healthcare and Outcomes Research (CeMHOR). RAT participants can also learn more about the post-residency fellowships offered at UAMS, including clinical fellowships (child, forensics, addiction, geriatrics) and research fellowships (neuroimaging, health services research.)

Participants will have access to the formal research training offered in the T32 program associated with BIRC if applicable. Multiple other education and research training opportunities exist on the UAMS campus and mentors will assist participants in identifying and accessing appropriate learning opportunities.

Application to the RAT Program. During the PGY1 year residents will be introduced to the RAT program during their didactic sessions. Interested residents are urged to discuss their interests with Dr. Jessica Coker, Dr. Greer Sullivan, or Dr. Ben Guise, all of whom are members of the RAT Executive Committee (see below). Interested PGY1 residents will complete an application to the RAT Executive Committee. The application should include a copy of the resident's CV and a personal statement. The personal statement should include the resident's current interests within academic medicine (i.e. an experience with an attending, future career goals, interests beyond clinical practice), past and current accomplishments in education and/or research and what they hope to gain from the RAT experience. These documents should be submitted to the program coordinator by mid-December of the PGY 1 year. Interviews with the interested residents will be scheduled in January of the PGY 1 year (date TBD). The RAT committee will meet in February to make selections for the upcoming year. In addition to their personal statement and interview, this decision will be based upon each resident's clinical performance, interest in and attendance at educational activities and specific academic career goals. The residents who will participate in RAT will be announced during March of their PGY 1 year. The number of available RAT slots many vary from year to year based on the faculty's capacity to mentor participants.

RAT Executive Committee. The RAT Executive Committee is responsible for oversight of the program, review of applications, selection of participants, and monitoring of participants' progress. Residents will proceed in the program each year only after the Executive Committee approves of the resident's progress. The committee will be available to provide guidance or advice to participating residents and their mentors. This Committee consists of psychiatrists, neuroscientists, health services researchers, social scientists, and a program coordinator.

ROTATION: RESIDENT ACADEMIC TRACK (RAT)

ATTENDING: JAN “GREER” SULLIVAN, MD, PHD; JESSICA COKER, MD

TELEPHONE: 501-526-8201

MAIL SLOT: 843

LOCATION: 4th FLOOR PRI

ROTATION DESCRIPTION:

The Resident Academic Track at the University of Arkansas for Medical Sciences in Little Rock AR is a focused experience to expose residents to key concepts of an academic career. This includes but is not limited to psychometric evaluations, research design and implementation, educational techniques, critical literature review and contributions.

Specific rotations/experiences for the individual residents will be based on specific learning objectives and the previous training experience of the resident. The educational objectives of the RAT PGY II Rotation will include; 1) Brain Imaging Research Center (BIRC); 2) Center for Addiction Services and Treatment (CAST); and 3) Women’s Mental Health Program (WMHP). Competency in the various domains will undergo ongoing assessment and review.

The RAT advisory committee will review resident progress and provide input on continuation and/or re-direction. This committee consists of psychiatrists, neuroscientists, and program coordinator.

PGY-2 residents will spend two months on this rotation. Each resident is expected to complete a professional presentation for departmental Grand Rounds. The presentation will be critically reviewed for completeness of the literature review, presentation techniques and development, and educational engagement of the resident.

GOALS AND OBJECTIVES FOR PGY 2’s RESIDENTS

Psychometrics To gain exposure and training in the performance of widely utilized psychometrics evaluations in clinical research. This will include, but is not limited to, the Structured Clinical Interview for DSM-IV Axis-I Disorders (SCID), Hamilton Rating Scale for Depression (HRSD) and

Mania Rating Scale (MRS), as well as a variety of self-report measures.

Research Design

- a. To gain an understanding of the process of utilizing a clinical question and design a line of investigation to address the question. This will be accomplished by one to one and small group interactions.
- b. To establish a focus on research design and potential alternatives and confounds (i.e. critically reviewing articles and scrutinizing the design employed)

Professional Writing

- a. To develop competence in preparing a comprehensive literature search
- b. To develop the ability to critically review an article, case/case series, or utilize an existing data set in order to publish an article in a peer reviewed journal. After review of co-authors the article should be submitted within two months of completing the rotation

Mentoring and Career Development

- a. To gain an understanding of identifying a mentor depending on the resident's research and clinical interests by way of individual discussions with RAT investigators.
- b. To gain an understanding of options/opportunities in both clinical and research areas of interest for the career development of the resident.

SUPERVISOR'S RECOMMENDED READING MATERIALS

<http://www.nimh.nih.gov/health/publications/a-participants-guide-to-mental-health-clinical-research/why-do-people-choose-to-participate-in-research.shtml>

Specific articles demonstrating classic study designs

Attending will provide various journal articles for review and discussion.

Desktop access to UAMS library facilitates this process.

Handoffs

N/A due to no direct patient care.

HOURS PER WEEK

20 hours per week (4 hours per day for 2 months)

ROTATION: EVALUATION AND TREATMENT OF ACUTE PSYCHIATRIC INPATIENTS (PGY 2)

ATTENDING: MARGARET EGE-WOOLLEY, MD

TELEPHONE: 257-2847

MAIL SLOT: 116/NLR OR 3K/NLR

LOCATION: UNIT 3K NLR VA

COURSE DESCRIPTION

Unit 3K is an acute psychiatric unit with an average of 90 admissions per month and an average length of stay of 5 days. Residents on the unit will be the primary physicians for approximately 6-8 new patients per week, thus averaging a patient census of 5-7 patients. With the rapid turnaround time, residents will learn effective time management skills, rapidly stabilize acutely ill patients, and make appropriate referrals for further treatment. Working closely with a multidisciplinary treatment team is an essential component of this rotation in order to insure that patients receive appropriate and timely care in this fast paced environment. PGY-2 Residents will spend six weeks on this service. A schedule for the typical week is included below.

GOALS FOR PGY 2 RESIDENTS

1. To manifest **medical knowledge and interpersonal and communication skills (patient interviewing)** sufficient to competently evaluate common acute presentations seen in acute psychiatry.
2. To gain facility with treatment modalities for the illnesses commonly diagnosed on acute adult inpatient units, and develop **medical knowledge** with respect to the same especially psychopharmacology.
3. To develop competence in interpersonal communication skills, professionalism, and systems-based practice by working through an interdisciplinary approach to patient evaluation, treatment and follow up.
4. To demonstrate professionalism by presenting patients in a orderly, comprehensive, and timely manner and develop competence in formulating the biopsychosocial aspects of the patient's condition.
5. To develop time management skills necessary for a high volume, rapid turnover inpatient unit similar to the private practice world.

6. To learn to interact with patients and staff in a **professional** manner. (**Interpersonal and communication skills**)
7. To develop safe intervention tactics (**patient care, interpersonal and communication, professionalism**) for crisis situations of a psychotic and/or behavioral nature.
8. To gain experience within the legal system (**systems-based practice**) in initiating commitment procedures and with testifying competently in court.

OBJECTIVES FOR PGY 2 RESIDENTS

1. The resident will perform a diagnostic psychiatric interview (**patient care, communication**) on all assigned patients and will develop a differential diagnosis (**medical knowledge**) based on the interview for each patient.
2. The resident will document rationale (**patient care, medical knowledge**) for all treatments prescribed.
3. The resident will be the team leader (**communication, professionalism**) in weekly multidisciplinary staff meetings on all assigned patients and will interact informally with multidisciplinary staff on a daily basis.
4. The resident will present each patient, including a biopsychosocial formulation, to the attending, and will complete an integrated summary of assessments by all treatment disciplines within 72 hours of admission on each patient (**medical knowledge, professionalism, communication**).
5. The resident will prepare a court treatment plan, file a petition and testify in all civil commitment cases assigned.

SPECIFIC DUTIES OF ALL RESIDENTS

1. Become familiar with the electronic medical record to decrease duplication of work and to increase information gathering ability (**systems-based practice**).
2. Evaluate approximately 6 new patients per week and within 24 hours of presentation, formulate a differential diagnosis and treatment plan, and present the case in a professional manner. (**patient care, communication, professionalism, medical knowledge**)
3. Complete required documentation in a timely, thorough and **professional** manner.
4. Attend daily morning rounds. (Rounds begin at 8:30, but arrival on the unit no later than 8:00 is encouraged)

5. Attend weekly case conference (**practice-based learning**) or other educational activity and present patient or other information as assigned.
6. Have 7 hours of weekly supervision with attending.
7. Attend weekly multidisciplinary staff meetings (**communication, professionalism**) and take over increasing duties each week in this meeting.
8. Attend didactics, grand rounds weekly (**professionalism, practice-based learning**) (New patients will not be assigned during didactic and clinic times).
9. Actively participate in the education of junior medical students (**practice-based learning**) assigned to the service.
10. Contact families with the patient's consent for information and aid in follow up (**communication**).
11. Appear in court when patients are on holds and present information in a **professional** manner (**communication, systems-based practice**).

VA Inpatient Handoffs at the beginning of the shift:

All three units have a morning report at 8:30 a.m. to discuss the active inpatients and the overnight admissions. Any behavioral issues, Medicine-On-Duty (MOD) calls, or acute medical issues are discussed the treatment team with residents, MD attendings, and nursing staff present. As there is no resident that has overnight patient care responsibilities for NLRVA inpatient units, the overnight report is generated by night shift nurses who were present on the unit overnight.

VA Inpatient Handoffs at the end of the shift:

On 1H Geriatric psychiatry, residents work until noon and check out active patient issues to the unit attending before leaving. If there are ongoing issues at the end of the day, the attending will check out with the staff psychiatrist on call or the MOD as needed.

On 3K, residents work the full day. If there are ongoing or active clinical issues at the end of the day, the resident or attending will check out to the staff psychiatrist on call or to the MOD.

VA Inpatient Handoffs at the end of the rotation:

NLRVA inpatient units do not have rotating attending coverage. The same attending covers each unit year round and follows each patient throughout the hospital stay. Therefore, continuity of care is provided by the attending psychiatrist when residents rotate off the unit; the attending orients the new resident to each patient.

VA Inpatient Protocol for handling urgent issues and crises that occur between resident shifts:

The VA staff psychiatrist on call is responsible after hours for the inpatient units. During daytime hours, if there is not a resident on shift the attending psychiatrist is responsible. NLRVA also has a 24-hour on site MOD staff physician who is responsible for medical emergencies outside the scope of the practice of psychiatry.

Residents are required to contact attendings under the following circumstances:

When residents are on shift, they are expected to communicate any clinical information that changes a patient's status, location (as in unit transfers), psychiatric acuity, or medical acuity.

RECOMMENDED READING MATERIAL

Psychiatry and Law for Clinicians (Concise Guide)—Robert Simon, M.D.

The Practitioner's Guide to Psychoactive Drugs---Editors: Bassuk, Schoonover, Gelenberg

Molecular Basis of Psychiatry---Editors: S. Hyman, M.D. & E. Nester, M.D.

Electroconvulsive Therapy: A Programmed Text---J. Beyer, M.D., R. Weiner, M.D.
& M. Glenn, M.D.

HOURS PER WEEK

Direct Patient Care and Ward Work: 25 hours
Educational Conference and Staffing: 3 hours
Supervision: 7 hours
Approximate Total Hours on Ward: 32-35 hours

Please Note the following Schedule is flexible and subject to change

	Mon	Tues	Wed	Thurs	Fri	
800	Report to Unit 3K and perform any pre-round duties					
830	Morning Report and Exit Interviews					
900	Brief Daily Run-through of patient lists					
930	Patient care/supv	Patient care/supv	Staffing	Patient care/supv	Patient care/supv	
1000		CaseConf	Patient care/supv for PG-2			travel
1030						
1100						
1130						
1200	Lunch			travel/lunch	Didac 2 C&A	Lunch
1230	Patient care/supv	Patient care/supv	PG-2 UAMS Clinic PG-1 Patient Care/Supv	Res. Mtg	Patient care/supv	
100				Didac 2	Resident	
130					Lecture	
200					Patient care/supv	
230						
300						
330						
400					Grand	
430					Rounds	

ROTATION: MENTAL HEALTH CLINIC NLRVA (PGY 3)

ATTENDING: JESSICA STOVALL, MD; SIDNEY WINFORD, MD;
JOSHUA WOOLLEY, MD

TELEPHONE: 257-3166

MAIL SLOT: 116F2/NLR

LOCATION: 1L170, NLR, VA HOSPITAL

GOALS FOR PGY 3 RESIDENTS

1. To gain experience in the evaluation and management of psychiatric patients **(patient care, medical knowledge, communication)** in an outpatient setting **(systems-based practice)**
2. To gain experience in the management of psychotropic medications **(medical knowledge)** -- their side effects, mechanisms of action, drug interactions, and routine lab work required
3. To further residency education and provide experience in public speaking through preparing and presenting weekly lectures **(practice-based learning, medical knowledge, professionalism, communication)**
4. Participate in multi-disciplinary group practice focused on enhanced communication to improve clinical practice particularly in a setting with both combined and split psychotherapy experiences.

SPECIFIC DUTIES OF THE RESIDENT

1. Evaluate patient's need for psychotropic medication **(communication, medical knowledge)**.
2. Monitor patient for progress, side effects, and toxicity, making medication adjustments as necessary. **(patient care)**
3. Evaluate need for referral to other care providers, such as psychology and social work services, substance abuse treatment, or inpatient care. **(systems-based practice, communication)**

4. Participate in resident and medical student education through preparing weekly lectures based on recommended reading and review of current literature. **(practice-based learning, medical knowledge, professionalism, communication)**
5. Administrative responsibility including telephone consultation for patients, additional documentation needed for patients and handling unscheduled visits.

Handoffs at the beginning of the shift:

Documentation in the Mental Health Clinic is set up so that ideally any provider can look at the last progress note and determine what is needed. This is in the event of an unscheduled visit to the clinic, a visit to the ER, or when a new resident takes over care at the end of the rotation. Each note should be able to stand alone in the event that a new provider becomes involved in any of those situations.

Handoffs at the end of the shift:

See below for after-hours care. Again, the medical record is designed to stand alone to ensure continued care for the patient.

Handoffs at the end of the rotation:

See above.

Protocol for handling urgent issues and crises that occur between resident shifts:

On call physicians in the Emergency Department will see patients after hours. There is also a suicide hotline available 24 hours. If patients present when their regular provider is not in the clinic, the resident, the attending, or the nurse case manager handles the situation. In the event that the clinical attending or nurse case manager isn't present, the doc of the day in clinic will see the patient. As stated previously, documentation should be available to providers seeing patients in crisis

Residents are required to contact attendings under the following circumstances:

Ideally, they staff each patient with the attending in the clinic, and all new patients are interviewed by the attending. Certainly, if there is any significant change, the resident will communicate with the attending. Those patients are generally seen by the attending as well.

RECOMMENDED READING MATERIAL

Neurology for Psychiatrists – Kaufman

Textbook of Psychiatry -- Kaplan and Sadock

Essentials of Psychopharmacology – Stahl

DSM V

Manual of Clinical Psychopharmacology – Schatzberg, et al

HOURS PER WEEK

Direct Patient Care and Ward Work: 30 hours; 100% return appointments

Didactic: 1 hours

Administrative (Record Keeping): N/A

Approximate Total Hours on Ward: 8 approximately

Record keeping time will be part of direct patient care

ROTATION: ARKANSAS STATE HOSPITAL (ASH) – INPATIENT (PGY 1)

ATTENDING: LINDSEY WILBANKS, MD AND SAM OLSON, DO

TELEPHONE: 686-9423

MAIL SLOT: ASH 703

LOCATION: ASH – UNIT A

GOALS AND OBJECTIVES FOR PGY 1 RESIDENTS

1. Develop expertise in interviewing psychiatric patients. **(communication)**
2. Enhance ability in case formulation and the differential diagnosis process. **(medical knowledge)**
3. Expand knowledge base and gain practical experience in using pharmacologic agents as well as other treatment modalities in an inpatient public hospital setting. **(patient care, medical knowledge)**
4. Develop ability to lead a multidisciplinary treatment team. **(communication, professionalism, systems-based practice)**
5. Foster an empathetic approach in the treatment of the seriously mentally ill. **(professionalism)**
6. Understand patients' legal rights and commitment laws and proceedings in Arkansas and participate in the process. **(systems-based practice, patient care)**
7. Get experience in electroconvulsive therapy. **(patient care, medical knowledge)**

SPECIFIC DUTIES OF THE RESIDENT

1. Work up and implement treatment process from admission to discharge. **(patient care, medical knowledge)**
2. Run a multidisciplinary treatment team. **(communication, professionalism, systems-based practice)**
3. Supervise, monitor and teach assigned junior medical students on the unit, and deliver selected didactic lectures in the early AM didactics. **(practice-based learning, medical knowledge, professionalism, communication)**

Handoffs at the beginning of the shift:

The teaching unit at ASH is an inpatient unit and such our residents are not working in shifts. At the start of the day, the charge RN gives morning reports on every patient for the previous 24 hours or for weekends and holidays. After hours are covered by attending psychiatrists on call (MOD). If there are special concerns re a patient, the resident of attending will contact the MOD on call and brief them.

Handoffs at the end of the shift:

The teaching unit at ASH is an inpatient unit and such our residents are not working in shifts. At the start of the day, the charge RN gives morning reports on every patient for the previous 24 hours or for weekends and holidays. After hours are covered by attending psychiatrists on call (MOD). If there are special concerns re a patient, the resident of attending will contact the MOD on call and brief them.

Handoffs at the end of the rotation:

The residents write off-service notes on each patient the incoming resident will be following. In addition, we have a special formatted list of patients with most pertinent information on it which the incoming resident will receive.

Protocol for handling urgent issues and crises that occur between resident shifts:

The MOD on call.

Residents are required to contact attendings under the following circumstances:

On our Unit, the attendings are present on site all day so the resident can inform attendings about any clinical issues that may come up. Also we round on the patients almost daily discussing clinical care.

RECOMMENDED READING MATERIAL

APA Textbook of Psychiatry

Essential Psychopharmacology, by Stephen M. Stahl

Electroconvulsive Therapy: A Programmed Text, by Glenn and Weiner; American Psychiatric Press

HOURS PER WEEK

Direct Patient Care: 15 hours

Case Conference/Staffing: 8 hours

Supervision: 5 hours

Administrative (Record Keeping): 5 hours

Total Number of Hours Per Week: 33 hours

LINDSEY WILBANKS, MD – INPATIENT

A Typical Week on Unit A, ASH

MONDAY AM	7:45 - 8:15	AM Didactics - Unit A Bullpen
	8:15 - 8:45	AM Report - Unit A Report Room
	8:45 - 12:00	Master Treatment Plan/Treatment Update Ward Work
PM	1:30 – 2:30	Professor Rounds – Unit A Bullpen
	2:30 – 4:15	Ward Work
TUESDAY AM	7:45 - 8:15	AM Didactics - Unit A Bullpen
	8:15 - 8:45	AM Report - Unit A Report Room
	8:45 - 11:30	Master Treatment Plan/Treatment Update Ward Work
	11:30 – 12:30	Psychopharmacology Conference - ASH Large Conference Room
PM	1:00 – 4:15	Ward Work
WEDNESDAY AM	7:45 - 8:15	AM Didactics - Unit A Bullpen
	8:15 - 8:45	AM Report – Unit A Report Room
	8:45 - 10:30	Court Commitment Proceedings (Go to court only for your patient)
	10:00-11:30	Utilization Review (2 nd and 4 th Wed of month)
	8:45 - 12:00	Ward Work
PM	1:30 – 2:30	Didactics (schedule flexible)
	1:00 – 4:15	Ward Work /Didactics
THURSDAY AM	7:45 - 8:15	AM Didactics - Unit A Bullpen
	8:15 - 8:45	AM Report – Unit A Report Room
	8:45 - 12:00	Treatment Plan/Treatment Update Ward Work
PM	12:00 – 4:00	Resident Didactics/Lunch
	4:00 - 5:00	Departmental Grand Rounds
FRIDAY AM	7:45 - 8:15	AM Didactics - Unit A Bullpen
	8:15 - 8:45	AM Report – Unit A Report Room
	8:45 - 10:30	Court Commitment Proceedings (Go to court only for your patient)

PM	8:45 - 12:00	Ward Work
	1:30 – 2:30	Ward Work
	2:30 – 4:15	Ward Work

ROTATION: INPATIENT PSYCHIATRY UNITS – PRI (PGY 1)

ATTENDING: JESSICA COKER, MD; HUNTER GIBBS, MD; ABIGAIL RICHISON, MD

TELEPHONE: 526-8520 AND 526-8601

MAIL SLOT: 554

LOCATION: PSYCHIATRIC RESEARCH INSTITUTE (PRI)

DESCRIPTION OF THE COURSE:

The adult inpatient program at the Psychiatric Research Institute includes 30 adult beds on two separate units. The two units that residents rotate on are 6 South (6S) and 5 North (5N). These units are functionally distinct but share a common philosophy. The 6S unit cares for general, mixed gender adults for acute psychiatric illness. The 5N unit (Women’s unit) treats women with acute psychiatric illness; however, is not equipped to manage agitated patients. The average number of admissions to these units is approximately 40-50 admissions per month and an average length of stay of 4-7 days. Residents on the unit will assist the attending physicians for approximately 6-8 new patients per week; the average patient census per inpatient team is 8-10 patients. Working closely with a multidisciplinary treatment team is an essential component of this rotation in order to ensure that patients receive appropriate and timely care. PGY-1 Residents will spend 12 weeks on this service and switch units half-way through the rotation. Each resident is expected to attend all didactics and grand rounds.

GOALS FOR PGY 1 RESIDENTS

1. To manifest **medical knowledge and interpersonal and communication skills (patient interviewing)** sufficient to competently evaluate common acute presentations seen in acute psychiatry
2. To gain facility with treatment modalities for the illnesses commonly diagnosed on acute adult inpatient units, and develop **medical knowledge** with respect to the same especially psychopharmacology.

3. To develop competence in **interpersonal communication skills, professionalism, and systems-based practice** by working through an interdisciplinary approach to patient evaluation, treatment and follow up.
4. To demonstrate **professionalism** by presenting patients in an orderly, comprehensive, and timely manner and develop competence in formulating the biopsychosocial aspects of the patient's condition.
5. To develop time management skills necessary for a high volume, rapid turnover inpatient unit similar to the private practice world.
6. To learn to interact with patients and staff in a **professional** manner. **(Interpersonal and communication skills)**
7. To develop safe intervention tactics **(patient care, interpersonal and communication, professionalism)** for crisis situations of a psychotic and/or behavioral nature.
8. To gain experience within the legal system (systems-based practice) in initiating commitment procedures and with testifying competently in court.

OBJECTIVES FOR PGY 1 RESIDENTS

1. The resident will perform a diagnostic psychiatric interview **(patient care, communication)** on all assigned patients and will develop a differential diagnosis **(medical knowledge)** based on the interview for each patient.
2. The resident will document rationale **(patient care, medical knowledge)** for all treatments prescribed.
3. The resident will be the team leader **(communication, professionalism)** in daily multidisciplinary staff meetings on all assigned patients and will interact informally with multidisciplinary staff on a daily basis.
4. The resident will present each patient, including a biopsychosocial formulation, to the attending, and will complete an integrated summary of assessments by all treatment disciplines within 72 hours of admission on each patient **(medical knowledge, professionalism, communication)**.

SPECIFIC DUTIES OF THE RESIDENT

1. Become familiar with the electronic medical record to decrease duplication of work and to increase information gathering ability **(systems-based practice)**.
2. Evaluate approximately 6 new patients per week and within 24 hours of presentation, formulate a differential diagnosis and treatment plan, and present the case in a professional manner. **(patient care, communication, professionalism, medical knowledge)**
3. Complete required documentation in a timely, thorough and **professional** manner.

4. Attend daily rounds.
5. Attend case conference (**practice-based learning**) or other educational activity and present patient or other information as assigned.
6. Have 7+ hours of weekly supervision with attending.
7. Attend weekly multidisciplinary staff meetings (**communication, professionalism**) and take over increasing duties each week in this meeting.
8. Attend didactics, grand rounds (**professionalism, practice-based learning**). (New patients will not be assigned during didactic and clinic times).
9. Actively participate in the education of junior medical students (**practice-based learning**) assigned to the service.
10. Contact families with the patient's consent for information and aid in follow up (**communication**).
11. Appear in court when patients are on holds and present information in a professional manner (**communication, systems-based practice**).

Handoffs

On Friday afternoon when the weekend census is known, please send an email with checkout to the attendings on call for the weekend as well as Drs. Coker and Gibbs. Having a structured handoff format is helpful. Please use the following and resist the urge to give a full synopsis for each patient. Simplicity is key:

Room Number – Patient Last Name – Diagnoses. Legal status. History of violence toward staff (vs no history). Ongoing changes in care planned over the weekend. "To-do" items.

The charge nurse will send a PRI Shift Report to include unit acuity at the end of each 12-hour shift.

Protocol for handling urgent issues and crises that occur between resident shifts:

On call physicians.

Residents are required to contact attendings under the following circumstances:

After seeing patients the resident discusses each with the attending and the attending sees every patient the resident sees during duty hours. After hours all patients are checked out by phone to the attending on call.

HOURS PER WEEK

Direct Patient Care and Ward Work: 25 hours

Educational Conference and Staffing: 3 hours

Supervision: 7 hours

Approximate Total Hours on Ward: 32-35 hours

ROTATION: CHILD AND ADOLESCENT PSYCHIATRY (PGY2)

ATTENDING: TOBY BELKNAP, MD; SRINI GOKARAKONDA, MD; NIHIT KUMAR, MD; VERONICA RANEY, MD; MOLLY LAMBERTSEN, MD

TELEPHONE: 364-5150

MAIL SLOT: ACH 654

LOCATION: CHILD STUDY CENTER
1210 WOLFE STREET, LITTLE ROCK, AR 72202

GOALS AND OBJECTIVES FOR PGY2 RESIDENTS

To gain knowledge and experience about the evaluation and treatment of psychiatric disorders in children and adolescents within the family/relationship context.

ROTATION DESCRIPTION FOR PGY 2 RESIDENTS

This is a required 6-month rotation occurring in the second year. Faculty/Staff consists of child psychiatrists, psychologists, social workers, and case managers. Residents participate in the assessment and treatment of children and adolescents in an outpatient clinic setting two half days per week and on the pediatric consultation liaison service one half day per week. During this rotation, residents will obtain adequate **knowledge** and skill to diagnose children, adolescents and families, determine psychiatric services necessary (**systems-based practice**), and provide, when indicated, comprehensive care. Residents will conduct thorough psychiatric evaluations (**communication**), medication management (**medical knowledge**), individual therapy (**medical knowledge, communication**), family therapy, and be introduced to aspects of play therapy while in the outpatient clinic. Residents will also develop the skills to evaluate and manage children in a general medical/surgical hospital with emotional and behavioral disorders

(systems-based practice). They will work collaboratively with physicians, nurses, and other mental health professions while providing assessment and treatment for patients in the emergency room and medical/surgical inpatient services **(communication, professionalism)**. It is required that each case be discussed with and supervised by a faculty member **(practice-based learning)**. A faculty child and adolescent psychiatrist is always available for supervision. Residents will also attend a one hour lecture each week that is specific for topics related to child and adolescent development and psychopathology **(practice-based learning)**.

1. Perform new evaluations of children and adolescents and their families. **(patient care, medical knowledge, communication)**
2. Participate in ongoing medication management of children and adolescents. **(patient care, medical knowledge)**
3. Begin developing an area of psychotherapeutic expertise, and initiate treatment in this area. **(medical knowledge, communication)**
4. Develop skills in working with experts in other disciplines. **(systems-based practice, communication)**

The maximum caseload for each resident in the outpatient clinic is to perform one new patient assessment (two hours) each day and follow-up care for two outpatients in 30 minute visits. For the one-half day of hospital based consultation the average number of consults per day is 2.

Individual Supervision is provided for on a case by case basis as it is a requirement that all outpatient and consultation assessments and follow-up visits be discussed with faculty.

Residents will also select a topic pertaining to child and adolescent psychiatry and present a one hour lecture to their peers and a faculty member during their six month rotation.

There are child psychiatry fellows on the child diagnostic unit at PRI, Arkansas State Hospital adolescent inpatient unit, and at Arkansas Children's Hospital consultation/ER service. There are handoff needs in all of these settings. On the inpatient units, the attendings cover the services at night. Residents have no night responsibilities on these units. Handoffs on the inpatient units are basically given with morning report. On the consultation/emergency room service at ACH, residents and fellows use an e-mailed handoff sheet as well as verbal reports from one shift to the next. The e-mailed handoff sheet is also forwarded to the attending physician. In that way the fellow, resident, and attending are all aware of situations both in the emergency room and on the floor at ACH.

Outpatients in crisis are handled in various ways. They may be asked to come to the clinic and be seen in an emergency slot. Depending upon the nature of the crisis, the patient may be referred to the ACH emergency room or some other emergency room depending upon his/her distance from Little Rock. The outpatient in crisis may also be seen by his or her physician in the clinic on an urgent basis.

After hours, outpatients are directed to call either the attending psychiatrist on call or present to the nearest emergency room.

Handoffs at the beginning of the shift:

As mentioned above, on inpatient units the transition is by morning report. On the consultation/emergency room service, transition is by electronic communication and, possibly, verbal communication as well.

Handoffs at the end of the shift:

As stated above, on the consultation and emergency services, the attending child psychiatrist who is on call may be verbally told of potential issues on the inpatient units or on the consultation/emergency service.

Handoffs at the end of the rotation:

None of the services are resident dependent. The inpatient, outpatient, and emergency/consultation services all have attending physicians. Therefore, end of rotation issues are not a problem

Protocol for handling urgent issues and crises that occur between resident shifts:

As stated above, there is always a child psychiatrist attending physician on call at night and on weekends

Residents are required to contact attendings under the following circumstances:

For the emergency room/consultation service, each patient seen by the resident or fellow must be checked out telephonically with the attending who is on at night or on weekends.

RECOMMENDED READING MATERIAL

Child and Adolescent Psychiatry--A Comprehensive Textbook by Melvin Lewis, MD

Pediatric Neuropsychiatry – by C. Edward Coffey, Roger A. Brumback

Concise Guide to Child and Adolescent Psychiatry- Third Edition, by Mina K Dulcan, MD, D. Richard Martini, MD and MaryBeth Lake, MD. American Psychiatric Publishing, Inc.

HOURS PER WEEK

Direct Patient Care: 9 hours

Consultation Liaison Teaching Rounds: 1 hour

Didactic: 1 hours

Administrative (Record Keeping): 2 hours

Total Number of Hours Per Week: 13 hours approximately

ROTATION: PSYCHIATRIC CONSULTATION SERVICE -- UNIVERSITY HOSPITAL (PGY 2)

ATTENDING: AMY GROOMS, MD; SAMIDHA TRIPATHI, MD; BEN GUISE, MD; PAYTON LEA, MD

TELEPHONE: 526-8428 & 526-8150

MAIL SLOT: 554

LOCATION: UNIVERSITY HOSPITAL

GOALS FOR PGY 2 RESIDENTS

1. To understand the manner in which psychiatric illness can present in med/surg services. **(medical knowledge)**
2. To understand the psychological impact of illness on patients and be able to identify their coping skills and resources. **(medical knowledge)** It is essential to assess the degree to which a patient is adapting to the severe stress of hospitalization and medical illness.
3. To increase understanding of neuropsychiatric illnesses. **(medical knowledge)**
4. To be familiar with treatment modalities appropriate for medically ill patients. **(medical knowledge, patient care)**
5. To understand the consultation process and the techniques, responsibilities, and limitations of the consultant role. **(systems-based practice, communication, professionalism)**
6. To promote liaison relationships with medical, surgical, and emergency medicine services. **(communication, professionalism, systems-based practice)**
7. To demonstrate a variety of interventions and therapies relevant to medically ill patients, including time-effective psychotherapy, somatic therapies, behavioral techniques, liaison methods, and multidisciplinary team approaches.

OBJECTIVES FOR PGY 2 RESIDENTS

Skills:

1. Interview patients in a variety of settings within the general hospital. **(patient care, communication)**

2. Evaluate for psychopathology in patients with concomitant medical conditions. **(medical knowledge, communication)**
3. Learn to present a case in a concise and efficient manner. This involves describing the reason for the consult, the current medical issues requiring inpatient medical care, and the psychiatric symptoms that generated the consult questions. It is also critical to provide past psychiatric, medical, family, social and substance abuse history, current vitals and meds, relevant labs and diagnostic imaging as well as a complete mental status exam including a mmse.
4. Perform a neuropsychiatric examination. **(medical knowledge, communication)**
This may include a MMSE, neurological exam, an HIV dementia scale and tests designed to assess particular domains of CNS functioning such as the go, no go test, Trails A and B, test for apraxia, agnosia etc.
5. Gather data from appropriate collateral sources. On CL it is often necessary to talk to family members, friends, AA sponsors, roommates, parole officers and o/p physicians caring for the patient. **(communication, professionalism)**
6. Understand the role of medical illness and its treatments in the patient's psychiatric symptoms. **(medical knowledge, patient care)**
7. Understand the role of the patient's psychiatric symptoms on his/her medical illness and its treatments. **(medical knowledge, patient care)**
8. Recognize emotional responses from the patient, staff, and consultant. **(communication, professionalism, systems-based practice)**
9. Make recommendations about somatic treatments and appreciate concerns about physiologic effects, contraindications, drug interactions, and dosing in the medically ill. **(medical knowledge, patient care)**
10. Make recommendations about and provide psychoeducation, brief psychotherapy, and behavioral management techniques. **(communication, professionalism)**
11. Write a useful consultation note. **(communication, professionalism, patient care)**
12. Maintain communication with the consultees and define ongoing needs. **(professionalism, communication)**
13. Monitor the patient's course during hospitalization and provide continuing input as indicated.
14. Participate as a member of a multidisciplinary team to optimize patient care. **(systems-based practice, communication)**
15. Understand local resources for follow-up and be able to make appropriate referrals. **(systems-based practice, communication)**
16. Efficiently triage cases to manage clinical urgency and time pressure.
17. Proactively seek supervision when facing emergent issues.
18. Recognize when attending to attending discussion is needed to resolve consultant/consultee conflict.

KNOWLEDGE

1. Resident will become knowledgeable about the following essential topics in consultation psychiatry (**medical knowledge**):

Adjustment Disorders
Aggression/Impulsivity
AIDS/HIV Disease
Alcohol and Drug Abuse in the General Medical Setting (including withdrawal states)
Anxiety in the General Medical Setting
Determination of Capacity and other Forensic Issues in C-L Psychiatry
Coping with Illness
Death, Dying, and Bereavement
Delirium/Agitation
Dementia in the General Medical Setting
Depression in the General Medical Setting
Factitious Disorders and Malingering
Pain
Personality Disorders in the General Medical Setting
Psychiatric Issues Related to Pregnancy
Psychiatric Manifestations of Medical and Neurologic Illness
Psychological Factors Affecting Medical Conditions
Psycho-Oncology
Psychopharmacology of the Medically Ill (including drug interactions)
Psychotherapy of the Medically Ill
Somatoform Disorders
Suicide
Transplantation Psychiatry
Traumatic Brain Injury

2. Resident will be expected to explore several areas of interest in depth. (**practice-based learning**)

SPECIFIC DUTIES OF THE RESIDENT

1. Resident is responsible for overseeing the management of the University Hospital Psychiatric Consultation team, which may include of 3rd and 4th year medical students, Neurology interns, and/or Family Medicine residents. (**patient care, medical knowledge, professionalism, communication, system-based practice**)

2. Respond to consultation requests and complete the pertinent paperwork in a timely manner, communicating directly with the consultees as indicated.
(professionalism, communication)
3. Follow up patients remaining in the hospital. **(patient care)**
4. Attend daily rounds.
5. Participate actively in weekly supervision. **(practice-based learning)**
6. Participate in weekly combined psychiatric consultation services conference.
(practice-based learning)
7. Teach medical students and rotating residents. **(professionalism, communication, practice-based learning)**
8. Complete documentation and billing as designated by service requirements in a thorough and timely manner.

Handoff

Handoff notes are entered for each patient under the "handoff" tab in Epic. The CL resident, on-call resident, and weekend team should check under this tab to see what needs to be done for each patient.

It is IMPERATIVE that EVERY patient that was seen after hours (short call or overnight) with plan to be followed by the psychiatric CL team be added to the CL psychiatry list in EPIC (every resident should have access to this list).

Protocol for handling urgent issues and crises that occur between resident shifts:

On call physicians respond to these events.

Residents are required to contact attendings under the following circumstances:

After seeing patients, the resident discusses each one with the attending and the attending sees every patient the resident sees during duty hours. After hours, all patients are checked out by phone to the attending on call.

RECOMMENDED READING MATERIAL

Readings maintained at the UAMS library. <https://library.uams.edu/>

The Massachusetts General Handbook of General Hospital Psychiatry. Available on Clinical Key

Levenson, James L (Ed) (2005) Textbook of Psychosomatic Medicine

Wise MG and Rundell JR (Eds). (2002). The American Psychiatric Press Textbook of Consultation-Liaison Psychiatry: Psychiatry in the Medically Ill, 2nd Edition.

Yudofsky SC and Hales RE (Eds). (2002). The American Psychiatric Publishing Textbook of Neuropsychiatry and Clinical Neurosciences, 4th Edition.

Teaching Consultation-Liaison Psychotherapy: Assessment of Adaptation to Medical and Surgical Illness, Jonathan J. Hunter, M.D., F.R.C.P.(C.)Robert G. Maunder, M.D., F.R.C.P. (C.), Mona Gupta, M.D., F.R.C.P. (C.) Academic Psychiatry, 31:5, September-October 2007

HOURS PER WEEK

Direct Patient Care: 25-30 hours

Case Conference/staffing: 5-10 hours

Didactic: 1 hours

Individual Supervision: 1 hour

Administrative: 5 hours

Total Hours: 45 (excludes clinic, other supervision, other didactics)

ROTATION: SUBSTANCE USE DISORDER CLINIC (PGY 2)

ATTENDING: JUSTIN TREAS, MD; LISA SNOW, MD

TELEPHONE: 501-257-3184

MAIL SLOT: VA SLOT 704, 116E/NLR

LOCATION: SPECIAL TREATMENT SECTION, BUILDING 170, NLR VA

GOALS AND OBJECTIVES FOR PGY 2 RESIDENTS

1. Learning to work within an interdisciplinary team. **(professionalism, communication, system-based practice)**
2. Managing comorbid psychiatric and medical conditions. **(medical knowledge)**
3. Working with families (as available). **(professionalism, communication)**
4. Addressing the unique issues and problems of substance-abusing patients and their families. **(medical knowledge, systems-based practice)**
5. Exploring issues of specific sub-populations (e.g., minorities, geriatric populations, etc.). **(medical knowledge)**
6. Using neuropsychological testing, laboratory testing, and diagnostic procedures when appropriate. **(medical knowledge, communication)**
7. Training in the use of various psychotherapies and pharmacotherapies in this population. **(patient care, medical knowledge)**
8. Training in the use of buprenorphine, acamprosate, naltrexone and nicotine replacement therapies. **(medical knowledge)**
9. Studying unique issues involved in cocaine addiction, phencyclidine dependence, volatile hydrocarbon inhalant abuse, etc. **(medical knowledge)**
10. Developing an understanding and familiarity with rational criteria for different levels of care and patient transfer across levels of care. **(patient care, systems-based practice, communication, professionalism)**

SPECIFIC DUTIES OF THE RESIDENT

The rotation was patterned after the "Model Curriculum for Alcohol and Drug Abuse Training and Experience During the Adult Psychiatry Residency," by J.A. Halikas ([The American Journal on Addictions](#), 1(3):222-229, 1992). Halikas suggested that the required resident rotation should last a minimum of 2 months and occur some time in PGY-2.

Clinical elements on this rotation include:

1. Comprehensive psychiatric assessments of substance-abusing patients. **(medical knowledge, communication)**
2. Direct patient management responsibility of psychiatric issues. **(patient care, professionalism)**
3. Functioning as part of a multidisciplinary treatment team. **(communication, professionalism, systems-based practice)**
4. Participation in group therapy. **(medical knowledge, communication)**
5. Participation in Alcoholics Anonymous groups. **(medical knowledge, professionalism, communication)**
6. Contact with community resources (including a halfway house and a methadone clinic). **(systems-based practice, communication)**

Interactive teaching techniques for this rotation include having the residents evaluate the strengths and weaknesses of various group leaders when they observe group therapy because this "actualizes" their understanding of group therapy techniques and tenets. In addition, the residents are asked to evaluate the impact of pending or recent organizational changes because this may increase their appreciation of organizational issues and how these relate to patient care and the interdisciplinary team.

Handoffs at the beginning of the shift:

In the anti-craving clinic where residents see patients, each morning residents are given a schedule of patients for the clinic. The resident also meets individually with the attending each morning to discuss any expected difficult patients/education. Each patient is checked out to the attending in the clinic after the resident has evaluated them. The attending covers anytime the resident is not present.

Handoffs at the end of the shift:

Each clinic day, the resident has a 30-minute window after the last patient to get caught up on any documentation or to handle unforeseen difficulties (with the attending present). If the resident is not able to complete evaluations/treatment by the end of the morning, all work is checked out to the attending to complete/follow up. The attending covers all clinical duties the rest of the day and will update the resident the following morning with any new information.

Handoffs at the end of the rotation::

At the end of the rotation, the attending is up to date on all current patients and relays any needed information to the next resident during the orientation days.

Protocol for handling urgent issues and crises that occur between resident shifts:

The attending in the clinic is responsible for all urgent or crisis issues even if the resident is present. The resident may assist with evaluation/crisis intervention – but only while being supervised by the attending in the clinic. After hours, if the attending is not contacted directly, there is a psychiatrist on call for the hospital that covers any questions or problems.

Residents are required to contact attendings under the following circumstances:

During or directly after each patient encounter, the treatment plan is discussed and supervision is provided by the attending.

RECOMMENDED READING MATERIAL

As particular patient issues arise, related sentinel articles will be distributed for discussion.

HOURS PER WEEK

Direct Patient Care: 12 hours

Groups: 2

Case Conference/Staffing: 1

Supervision: 2.5 hour

Administrative (Record Keeping): 2.5 hours

Total Number of Hours Per Week: 20

ROTATION: WALKER FAMILY CLINIC (PGY 3)

ATTENDING: JEFF CLOTHIER, MD; VICKI FLYNN-WALDEN, MD; BEN GUISE, MD; PAYTON LEA, MD; SCOTT STEELE, MD AND SAMIDHA TRIPATHI, MD

TELEPHONE: 501-526-8200

MAIL SLOT: 568

LOCATION: PSYCHIATRIC RESEARCH INSTITUTE

GOALS AND OBJECTIVES FOR PGY 3 RESIDENTS

1. To participate in a multidisciplinary, group practice managing the evaluation and treatment of a wide variety of mental illnesses and conditions in a late adolescent, adult, and geriatric population. **(patient care, medical knowledge, systems-based practice)**
2. To experience the management of serious and acute mental illnesses and emotional crises in an outpatient setting. **(patient care, medical knowledge)**
3. To design treatment plans using the appropriate combinations of psychopharmacology, psychotherapies, behavioral techniques, social services, and medical consultation. **(systems-based practice, medical knowledge, communication)**
4. To orchestrate patient care in the context of institutional structures and economic constraints imposed by various insurance structures. **(systems-based practice)**
5. To concentrate on "time conscious" psychotherapies during the rotation. **(professionalism, patient care)**
6. To participate in continuous clinical improvements using disease-specific outcomes assessment tools. **(practice-based learning)**

SPECIFIC DUTIES OF THE RESIDENT

1. The clinic is best viewed as a private practice opportunity for the rotating resident **(patient care)**. Managing confidentiality, flexibly meeting the needs of different patients, proactively seeking supervision, coordinating care, and record keeping and billing, are critical skills to be mastered. **(professionalism)**.
2. New patients evaluated by the resident will remain in the resident's care throughout the rotation. Treatment plans will address the individual patient's needs and may involve the participation of non-psychiatrist, mental health providers. Residents will be expected to provide a comprehensive and integrated assessment of patients' needs with respect to diagnostic/biological, psychological and social issues. Creating and conducting groups; experiencing couples and family therapy; and exposure to behavioral techniques will be encouraged. A thorough diagnostic assessment and

attention to target symptoms will guide the prudent use of psychopharmacology.
(systems-based practice, medical knowledge, patient care)

3. The clinic practice will be guided by evidence based medicine and an enduring commitment to understand and respect patients as unique human beings.
(systems-based practice, medical knowledge, patient care).

Handoffs at the beginning of the shift:

This does not generally occur on the outpatient service. However, communication via e-mail, telephone, or note in the medical record is done if a patient is seen in the hospital (between resident who saw them in the hospital and their outpatient provider)

Handoffs at the end of the shift:

This does not generally occur on the outpatient service. If a patient of the resident in clinic notified the resident of plans to present to the ER, the resident will call or e-mail the resident(s) on call.

Handoffs at the end of the rotation:

About 3 months or more before the end of the outpatient rotation, the resident should be preparing the patient for an upcoming change in care. It is not often known which resident will be taking over the care of a specific patient, so the clinic notes should document clearly the patient's diagnosis, treatment, and ideas of possible next steps. If the patient is particularly complicated, the current resident should notify the upcoming resident of any major factors.

Protocol for handling urgent issues and crises that occur between resident shifts:

The nurse and call center team handle issues up front. If it is an issue that requires urgent attention, the attending in clinic that day will handle the crisis.

Residents are required to contact attendings under the following circumstances:

Residents are required to check-out a patient's history and plan face-to-face with each new diagnostic evaluation. They also are required to have an attending co-sign each progress note. The attendings are readily available for urgent questions at any time during clinic hours.

RECOMMENDED READING MATERIAL

Residents are encouraged to use the electronic resources.
Psychiatryonline.com accessed via the UAMS library system.

Manual of Clinical Psychopharmacology

Textbook of Psychotherapeutic Treatments

The American Psychiatric Publishing Textbook of Psychiatry
The DSM V and its handbook of Differential Diagnosis

The Perspectives of Psychiatry by McHugh and Slavney

Psychodynamic Psychiatry in Clinical Practice by Gabbard

Persuasion and Healing by Jerome Frank

A more comprehensive reading list will be presented at the time of the rotation.

HOURS PER WEEK

Direct Patient Care: 10 hours

Groups Supervision: 1 hour

Individual Supervision: 1 hour

ROTATION: CONSULTATION-LIAISON SERVICE / LR VAMC (PGY 2)

ATTENDING: DOUGLAS PROVAZNIK, MD

TELEPHONE: 501-257-6604

MAIL SLOT: 116T/LR

LOCATION: LRVA EMERGENCY ROOM

GOALS AND OBJECTIVES FOR PGY 2 RESIDENTS

1. To learn about the various psychiatric syndromes that most commonly present in a medical setting. **(medical knowledge)**
2. To learn about the various psychiatric treatment modalities utilized in a medical setting. **(patient care, medical knowledge)**
3. To gain knowledge of the consultation process and learn ways to communicate effectively with other professional staff. **(communication, systems-based practice)**
4. To become familiar with psychological and social factors that contribute to somatic illness. **(medical knowledge)**
5. To gain knowledge about the medico-legal and the ethical issues surrounding capacity and competency. **(medical knowledge, systems-based)**

SPECIFIC DUTIES OF THE RESIDENT

1. Evaluate new consultations daily on medical/surgical wards (approximately 40/month).
2. Attend rounds daily.
3. Follow up consultations and confer with staff and family members daily.
4. Assist with transfers to acute psychiatry/STS as needed.
5. Assist with follow-up MHC appointments as appropriate.
6. Attend conferences as scheduled.
7. Supervision weekly.

Handoffs at the beginning of the shift:

The VA Hospital uses an electronic medical record system called CPRS. As the permanent attending physician for the C/L Service, I am automatically flagged on each patient that receives a consult either in the emergency room or in the hospital. Every morning when I log on, I review all of the consults overnight from both the ER and the hospital medical floors.

Handoffs at the end of the shift:

At the end of every note, I have listed the following statement: "Please page me with any questions during business hours. After business hours or during the weekend, please page the psychiatrist on call for behavioral emergencies." If there is a patient that needs follow-up overnight, I page the resident on call before I leave to explain the situation.

Handoffs at the end of the rotation:

My rotation does not end. I am there as a permanent faculty member whether the resident is present or not. If the resident is not present, for leave of absence, educational duties, or psychotherapy, I carry the resident's pager in addition to my own.

Protocol for handling urgent issues and crises that occur between resident shifts:

The psychiatry resident is the first page for psychiatric emergencies after hours. There is an attending on call after business hours, on weekends, and during the holidays for supervision.

Residents are required to contact attendings under the following circumstances:

Residents are required to communicate clinical information after each patient contact. I discourage the presentation of multiple patients at once.

RECOMMENDED READING MATERIAL

Manual of Psychiatric Medicine (2005) -- Editors: Wyszynski and Wyszynski

Clinical Neurology for Psychiatrists (2007) – Editor: Kaufman

Patients' Competence to Consent to Treatment: Appelbaum P. S. N Engl J Med. 2007 Nov 1;357(18):1834-40.

Additional selected readings from attendings

HOURS PER WEEK

Direct Patient Care: 28 hours

Case Conference/Staffing: 1 hour

Supervision: 5-10 hours

Administrative (Record Keeping): 5 hours

Total Number of Hours Per Week: 39 hours (excluding didactic, clinic, other supervision)

ROTATION: GERIATRIC PSYCHIATRY (PGY 2)

ATTENDING: LEWIS KRAIN, MD

TELEPHONE: 501-257-3146

MAIL SLOT: 116A/NLR

LOCATION: NLRVA

GOALS AND OBJECTIVES FOR PGY 2 RESIDENTS

1. Develop competency in the assessment and management of common psychiatric diagnoses associated with geriatric patients, especially depression, dementia, and delirium, as well as the medical issues that can present with behavioral symptoms (**medical knowledge, patient care**).
2. Develop competency in the management of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older patients, and understand how care of these illnesses changes through the lifespan (**medical knowledge, patient care**).
3. Develop competency interviewing older patients, and understand how to communicate and establish rapport with patients with cognitive and sensory impairments. Demonstrate empathy and sensitivity to the medical, social, and psychologic challenges aging patients face (**patient care, interpersonal communication**).
4. Demonstrate ability to utilize a multi-disciplinary approach to managing mental health issues in older patients, both on the regular treatment team (e.g. social work, nursing, occupational therapy) and in interactions with consulting services (e.g. geriatric medicine, neurology, PM&R, etc) , including a respectful and altruistic attitude towards non-MD staff members (**systems-based practice, communication, professionalism**).
5. Develop competency in communicating with families in order to obtain collateral information and coordinate care. This includes the ability to use family meetings to obtain information, convey medical recommendations, and steer treatment planning (**systems-based practice, communication, professionalism**).
6. Learn to advocate for older patients in terms of accessing resources within and beyond the VA medical center, as well as to optimize independent function of older patients by addressing active social and safety issues common in older patients, such as ability to drive, obtaining in-home assistance, and avoiding elder abuse/neglect. (**professionalism, systems based practice**)
7. Understand the etiology and neurobiology of dementia and delirium, using required readings as well as self-guided study based on cases admitted to the inpatient unit (**medical knowledge, practice-based learning**)
8. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses, and should be able to serve as an effective leader of the multi-disciplinary team by the end of the rotation (**practice-based learning, systems-based practice, professionalism, patient care**).

SPECIFIC DUTIES OF THE RESIDENT

1. This is a half-time rotation. Residents are expected to be available for patient care and supervision between 8am and noon every weekday. Residents are expected to respond promptly to calls and pages from unit staff. Residents are expected to complete documentation thoroughly and in a timely manner (**professionalism**).
2. Residents are responsible for initial assessment of new patients admitted to the unit. This includes physical exam, review of systems, and patient history, as well as admitting orders.
3. Residents are responsible for ongoing daily care of inpatients on the geriatric psychiatry unit, including daily interviews and assessments. Residents are responsible for entering appropriate orders into CPRS and charting progress notes as needed.
4. Residents are expected to be present for rounds/ treatment team meetings. These meetings occur daily at 8:30am.
5. Residents are expected to be present for all family meetings, provided these meetings are scheduled before noon
6. Residents who have patients treated with ECT may be asked to be present to assist the attending with this procedure (which may begin before 8am).

Handoffs at the beginning of the shift:

All VA inpatient units have a morning report at 8:30 a.m. to discuss the active inpatients and the overnight admissions. Any behavioral issues, Medicine-On-Duty (MOD) calls, or acute medical issues are discussed the treatment team with residents, MD attendings, and nursing staff present. As there is no resident that has overnight patient care responsibilities for NLRVA inpatient units, the overnight report is generated by night shift nurses who were present on the unit overnight.

Handoffs at the end of the shift:

On 1H Geriatric psychiatry rotations, residents work until noon and check out active patient issues to the unit attending before leaving. If there are ongoing issues at the end of the day, the attending will check out with the staff psychiatrist on call or the MOD as needed.

On 3K, residents work the full day. If there are ongoing or active clinical issues at the end of the day, the resident or attending will check out to the staff psychiatrist on call or to the MOD.

Handoffs at the end of the rotation:

NLRVA inpatient units do not have rotating attending coverage. The same attending covers each unit year round and follows each patient throughout the hospital stay. Therefore, continuity of care is provided by the attending psychiatrist when residents rotate off the unit; the attending orients the new resident to each patient.

Protocol for handling urgent issues and crises that occur between resident shifts:

The VA staff psychiatrist on call is responsible after hours for the inpatient units. During daytime hours, if there is not a resident on shift the attending psychiatrist is responsible. NLRVA also has a 24-hour on site MOD staff physician who is responsible for medical emergencies outside the scope of the practice of psychiatry.

Residents are required to contact attendings under the following circumstances:

When residents are on shift, they are expected to communicate any clinical information that changes a patient's status, location (as in unit transfers), psychiatric acuity, or medical acuity.

RECOMMENDED READING MATERIAL

Reading materials will be provided based upon the clinical cases present on the unit at any given time.

HOURS PER WEEK

Direct Patient Care: 10 hours

Groups: 0

Case Conference/Staffing: 3 hours

Supervision: 2 hours

Record Keeping: 5 hours

Total hours per week: 20

ROTATION: VA MHICM / OUTREACH PROGRAM (PGY 3)

ATTENDING: KELLEY BURROW, MD

TELEPHONE: 501-257-2331

MAIL SLOT: 116 F1/NLR

LOCATION: NLR VA

DESCRIPTION OF COURSE:

The MHICM / Outreach program at the Central Arkansas Veterans Healthcare System in North Little Rock, AR provides intensive community case management services to Veterans diagnosed with severe, persistent mental illness. The program is designed to assist Veterans who are high users of inpatient mental health services and are unable to function in a community living situation without intensive support. The MHICM/Outreach team consists of a psychiatrist, RN program manager, and case management team made up of RNs and social workers.

Residents on the rotation will work closely with the multidisciplinary treatment team in order to insure patients receive appropriate care. PGY-3 Residents will spend 6 months on this service. Each resident is expected to attend all didactics and grand rounds.

GOALS AND OBJECTIVES FOR PGY 3 RESIDENTS

1. To manifest **medical knowledge and interpersonal and communication skills (patient interviewing)** sufficient to competently evaluate common acute presentations seen in this particular patient population.
2. To gain facility with treatment modalities available for treating the severely and persistently mentally ill in the community, and develop **medical knowledge** with respect to the same, especially psychopharmacology.
3. To develop competence in **interpersonal communication skills, professionalism, and systems-based practice** by working through an interdisciplinary approach to patient evaluation, treatment and follow up.
4. To gain an understanding of what the continuous and comprehensive treatment of this patient population involves with particular attention to the work of non-MD staff (i.e. case managers). (**systems-based practice, communication**)
5. To develop safe intervention tactics (**patient care, interpersonal and communication, professionalism**) for crisis situations of a psychotic and/or behavioral nature in the outpatient setting.

SPECIFIC DUTIES OF THE RESIDENT

1. Residents will become familiar with the electronic medical record to decrease duplication of work and to increase information gathering ability (**systems-based practice**).

2. Residents will attend multidisciplinary team meetings one half day per week for six months while they are on the rotation and participate with MHICM/Outreach staff in discussions of patients within the program. (**communication, professionalism, patient care, system-based practice**)
3. Residents will spend time with case managers as he/she performs clinical duties with patients in order to appreciate the issues involved with intensive case management. (**systems-based practice, communication**)
4. Complete required documentation in a timely, thorough and **professional** manner.
5. Attend didactics, grand rounds (**professionalism, practice-based learning**).
6. Residents will attend a 60-minute group supervision with the MD during which time they will discuss various cases and other clinical aspects of their experience with MHICM/Outreach. (**practice-based learning**)
7. Actively participate in the education of junior medical students (**practice-based learning**) assigned to the service.

Handoffs at the beginning of the shift:

Residents have no specific patient care obligations on this rotation. Attendings are responsible for all care

Handoffs at the end of the shift:

Residents have no specific patient care obligations on this rotation. Attendings are responsible for all care.

Handoffs at the end of the rotation:

Since residents are only there one half-day per week, they may see patients in the clinic but do not carry a case load. The service attending is the primary provider for all of the MHICM/Outreach patients.

Protocol for handling urgent issues and crises that occur between resident shifts:

The MHICM/Outreach attending is responsible. The Veterans are seen on an outpatient basis. After hours, Veterans can be seen in the ED.

Residents are required to contact attendings under the following circumstances:

Residents are required to communicate with the attending after patient contact which is typically at medication management visits.

RECOMMENDED READING MATERIAL

The residents are encouraged to read contemporary sources in respected Journals as they relate to specific patients. Desktop access to UAMS/VA library facilitates this.

Assertive Community Treatment of Persons with Severe Mental Illness —Leonard I. Stein

HOURS PER WEEK

Direct Patient Care: 3 hours

Case Conference/Staffing: 1 hours

Supervision: 1 hours

Total hours per week: 4 hours

ROTATION: THE CENTERS ADULT OUTPATIENT CLINIC (PGY 3)
ATTENDING: CYDNEY GRANT, DO
TELEPHONE: 501-660-6893
MAIL SLOT:
LOCATION: 1521 MERRILL DR., SUITE D-220 LITTLE ROCK, AR 72212

GOALS AND OBJECTIVES FOR PGY 3 RESIDENTS

1. To gain experience in the diagnosis and treatment of psychotic, mood, anxiety, trauma, and personality disorders in an outpatient community mental health center (CMHC) (**patient care, medical knowledge, communication, systems-based practice**)
2. To gain experience working in a team setting along with therapists, nurses and case managers while being personally responsible for the management of each patient's psychotropic medications (**medical knowledge**)
3. To interact with fellow residents and the attending(s) in an educational environment that fosters continued learning through self-development and weekly small group discussions (**practice-based learning, medical knowledge, professionalism, communication**)

SPECIFIC DUTIES OF THE RESIDENT

1. Evaluate and diagnose new patients and make recommendations which will be used to formulate the treatment plan (**medical knowledge**)
2. Manage specific patients for one year as the primary medication management physician making necessary adjustments under the supervision of an attending (**patient care**)
3. When necessary, refer patients to group or individual therapy, day programs, case management, care coordination or inpatient services (**systems-based practice, communication**)
4. Participate in weekly small group discussions with fellow residents and attendings relevant to the care of patients in the public psychiatry setting (**practice-based learning, medical knowledge, professionalism, communication**)

Handoffs at the beginning of the shift:

Residents on the CMHC rotation work at The Centers Adult Outpatient Clinic. The Centers maintains a 24/7 crisis line, the number to which is available online, on the front door of the clinic, on appointment cards, and other Centers' literature. The crisis line is answered by emergency services staff during the business day and by on-call staff nights and weekends. These trained professionals triage calls including directing patients to area ERs if necessary. If a resident physician's patient utilizes the crisis line, the crisis staff should email the resident physician and/or attending alerting them of the call and the plan for follow up.

Crisis line: 501-666-8686 and select option 0

Handoffs at the end of the shift:

Residents treat patients in an outpatient setting so in general there is no need for a handoff. Residents may leave after all patients are seen, notes are done and the attending is notified. Resident patients who have appointments near the end of the day and present in crisis are seen by the resident for assessment, safety planning and triage. If a resident feels hospital admission is necessary, the patient may be transported to the ER by MEMS, RCF staff, or a family member depending on the situation. The attending is notified and is available for assistance. Additionally, clinic security is available if needed. The resident is responsible for completing an Acute/AWOL note and printing the Face Sheet and other information for MEMS as requested.

Handoffs at the end of the rotation:

Patients of The Centers resident clinic are typically seen every one to four months depending on diagnosis, medication regimen, length of time in treatment, etc. Outgoing residents will prepare their patients for termination in an empathetic manner over the last quarter of the year. Because notes are written at every encounter, a direct handoff is not necessary. However, if a patient requires close follow up or a resident has concerns about treatment (labs, refills, court orders, etc.) the attending will be notified and will follow up until the patient is transitioned to their new resident. Specific patient information will be given to new residents by attendings. Outgoing residents may also choose to communicate with incoming residents about specific patient care issues in a HIPAA-compliant manner.

Protocol for handling urgent issues and crises that occur between resident shifts:

The Centers attendings and therapists will address urgent medication issues and crises as they come up on days in which residents are not in clinic. Routine issues such as refill requests will be addressed by the residents during scheduled clinic. Additionally, The Centers maintains a 24-hour crisis line and provides screenings for indigent patients who present to ERs.

General Information:

The Centers Adult Outpatient Clinic (OP West) hours are 8am – 5pm. Didactics are held on Tuesdays and Wednesdays from 8:00am – 8:30am. Patient care occurs from 8:30am – 11:30am (8:30am - 11:00am on Tuesdays to accommodate Psychopharmacology Conference at ASH) and 1:00pm - 4:30pm. Scheduled administrative time may be given depending on need. Residents are required to staff all psychiatric evaluations (PDAs) with an attending. Medication management appointments may be staffed as needed. At least one attending is always available during resident clinic hours. Residents should consult the attendings when they have questions about medication, safety or treatment. The Centers' email is encrypted for the body of the email, but not the subject line. Therefore, PHI is not used in the subject line.

RECOMMENDED READING MATERIAL

Neurology for Psychiatrists -- Kaufman

Textbook of Psychiatry -- Kaplan and Sadock

Essentials of Psychopharmacology – Stahl

HOURS PER WEEK

Direct Patient Care: 9 hours

Didactic: 1.5 hours

Administrative (Record Keeping): 2 hours

Individual Supervision: 1 hour

ROTATION: PSYCHOTHERAPY CLINIC

ATTENDING: NLRVA: LEWIS KRAIN, MD; MEGAN MUELLER, MD

WALKER FAMILY CLINIC: VICKI FLYNN, MD, MEDICAL DIRECTOR;
BEN GUISE, MD; CHELSEA WAKEFIELD, PHD; SCOTT STEELE, MD;
BRIAN KIRKPATRICK, MD; SAMIDHA TRIPATHI, MD

TELEPHONE: UAMS: 501-526-8200

MAIL SLOT: NLRVA: Slot 116A UAMS: 554

LOCATION: North Little Rock VA Mental Health Clinic; UAMS Walker Family
Clinic

DESCRIPTION OF COURSE:

This rotation provides psychotherapy training for residents. Residents spend one half-day per week for six months in the PGY 2 year, and one half-day per week throughout the PGY 3 and PGY 4 years. During this half-day residents are expected to see outpatient psychotherapy cases with the supervision of experienced therapists (who may be psychiatrists, psychologists, or social workers). Residents are expected to carry a caseload of 2-3 psychotherapy cases at a time. Residents are expected to develop proficiency in psychodynamic psychotherapy, cognitive behavior therapy, and supportive therapy, in both brief and long-term formats. This clinical rotation is intended to be supplemented by the core didactics on psychotherapy (see didactics), as well as readings assigned by the supervisor.

GOALS AND OBJECTIVES FOR PGY 3 RESIDENTS

1. Develop expertise in taking a complete biopsychosocial assessment of an outpatient in order to evaluate him/her for suitability to participate in psychotherapy and to select the type of psychotherapy best suited for each individual patient (**Interpersonal Skills and Communication; Patient Care**).
2. Demonstrate understanding of the basic concepts and application of psychodynamic, cognitive, behavioral, and supportive therapy including standardized techniques used in the delivery of these therapies (**Patient Care; Medical Knowledge**).
3. Develop competency in the identification of key concepts in the therapeutic relationship including transference, countertransference, resistance, and avoidance. (**Interpersonal Skills and Communication; Patient Care; Practice-Based Learning**)
4. Develop competency in maintaining structural aspects of the therapeutic framework and maintenance of treatment boundaries (**Professionalism; Systems-Based Practice**)
5. Understand and maintain the role of therapist within the clinic as an adjunctive treatment provider distinct from the primary psychiatrist. Prevent splitting or role diffusion between the treatment team (e.g. avoid prescribing medications different from those chosen by the primary prescribing physician). (Systems-based Practice; Professionalism)
6. Maintain an attitude of respect, altruism, and empathy towards patients of varying

backgrounds irrespective of differences of gender, culture, race, socio-economic status, etc (Patient Care; Professionalism)

SPECIFIC DUTIES OF THE RESIDENT

1. Contact assigned psychotherapy supervisor promptly after assignment to set up a regular time for supervision.
2. Receive case assignments from the supervisor (or other clinic personnel). Contact these patients promptly to schedule weekly therapy.
3. See psychotherapy patients promptly when scheduled. Follow all clinic policies regarding scheduling, documentation, and cancellations.
4. Record process notes as directed by the supervisor (may be written or audio recorded).
5. Complete assigned readings and homework as directed by the supervisor.
6. Understand that although the psychotherapy is not the primary clinic contact for the patient, that the resident has an obligation to assess safety and stability of the patient, and contact the patients primary clinician if there are acute safety issues.

HOURS PER WEEK

Direct Patient Care: 3 hours

Supervision: 1 hour

Approximate Total Hours: 4 hours

UAMS COM Department of Pediatrics
General Pediatric Outpatient Rotation
Goals and Objectives

Name of Rotation: Circle of Friends Teaching Clinic Rotation, Arkansas Children’s Hospital

Overall Goals:

To develop the skills to perform age specific health promotion with respect to screening, prevention, education, growth and development, in the General pediatric clinic using appropriate tools.

To evaluate and manage signs and symptoms of common pediatric illness presenting in the ambulatory clinic with efficient and effective use of relevant and up-to-date literature and community resources.

Competency	Objectives / Expectations/Outcomes		
	PGY 1 / Intern	PGY 2	PGY 3
Patient Care	<p>Demonstrate competence in gathering appropriate history about the presenting medical problem from the patient and their family.</p> <p>Perform complete and accurate physical examination in all patients.</p> <p>Develop skills in performing a family centered health supervision interview, developmental surveillance and school performance monitoring.</p> <p>Demonstrate the skills to utilize Reach out and Read guidelines and educating parents on the benefits of the program for the patient.</p> <p>Critically observe the interaction between parent and the infant/child/ adolescent and offer appropriate guidance when required.</p> <p>Review age appropriate immunizations with the family and recommend additional immunizations using nationally standardized schedules.</p> <p>Identify multiple services available in the clinic like Lactation consultants, Car seat program specialist,</p>	<p>Demonstrate independence, and ability to provide patient centered care that is developmentally age appropriate, compassionate, culturally acceptable and effective.</p> <p>Utilize and apply common diagnostic tests and imaging studies appropriately in the outpatient setting.</p> <p>Familiarize and employ the common treatments and techniques in the outpatient setting like: Administration of nebulized medication, Oxygen delivery systems, application of splints, injury and wound care.</p> <p>Set priorities and develop effective plans for common problems.</p> <p>Perform usual procedures with minimal or no supervision.</p>	<p>Demonstrate the ability to analyze and investigate a complex medical patient, organize appropriate consultation with various specialists and formulate a comprehensive patient specific treatment plan.</p> <p>Demonstrate competence in effective communication with families with respect to critical conversation.</p> <p>Demonstrate ability in counseling about various vaccinations with regards to adverse effects and alleviating any misconceptions based on literature and research.</p> <p>Develop skills in administering age appropriate vaccinations.</p> <p>Supervise interns during usual procedures and function as a team leader.</p>

	<p>Respiratory therapist, Nutritionist, Social worker and Interpreter services.</p> <p>Perform common procedures like Lumbar puncture, Incision and drainage under supervision.</p>		
Medical Knowledge	<p>Understand the basic concepts about the process of providing health supervision (screening, prevention, education, growth and development and nutrition) and implement these at well child visits.</p> <p>Identify the age specific recommended guidelines (AAP, Bright futures) and learn to discuss the rationale for these.</p> <p>Recognize the signs and symptoms of common pediatric illness (Otitis Media, UTI, Gastroenteritis etc) and know the recommended evidence-based management and treatment guidelines.</p> <p>Develop appropriate set of differential diagnosis to the presenting signs and symptoms and possess the basic fund of knowledge needed to initiate plans and counsel patients and families.</p>	<p>Understand the scope of established and evolving biomedical, clinical, epidemiological and social-behavioral knowledge needed by a pediatrician.</p> <p>Demonstrate understanding of common diagnostic tests and imaging studies used in outpatient setting.</p> <p>Possess the basic knowledge of evidence-based decision making and appropriately seek and use consultation.</p>	<p>Demonstrate a continued commitment to acquiring a broad base of knowledge needed in the care of children in the continuity and general ambulatory settings.</p>
PBLI	<p>Identify and select various available medical resources relevant for the rotation like AAP practice guidelines, Up to Date.</p> <p>Identify strengths, deficiencies in one's knowledge and outline strategies for self learning.</p> <p>Develop a logical and systematic clinical approach to the care of outpatients.</p> <p>Learn to adapt principles of evidence-based decision-making and problem solving</p>	<p>Access and apply medical information efficiently and learn to evaluate it critically.</p> <p>Demonstrate knowledge skills and attitudes needed for continuous self assessment and become a self directed and motivated learner.</p> <p>Interpret the available clinical information and learn to summarize and discuss it with the patients, families and other health care professionals.</p> <p>Complete the required online learning modules and tests.</p>	<p>Demonstrate use of scientific methods and evidence to investigate, evaluate and improve one's patient care practice independently.</p> <p>Prioritize treatment options and recommend evidence based treatments.</p> <p>Demonstrate the ability to engage and teach residents and students providing in depth evidence based discussions in a clear and concise manner.</p> <p>Complete the required online learning modules and tests.</p>

	<p>Complete the required online learning modules and tests.</p> <p>Present case based discussions during morning report.</p>	<p>Present discussions on various topics during morning report.</p>	<p>Present discussions on various topics during morning report</p>
SBP	<p>Learn about patient care resources and the health care system.</p> <p>Understand the concept of multidisciplinary team and its role in health care delivery.</p> <p>Effectively work with the multidisciplinary team to deliver quality care and enhance patient safety.</p>	<p>Identify logistical barriers to the provision of health care (financial, social, environmental, insurance systems, language and cultural) and discuss strategies to overcome these for specific families.</p> <p>Recognize cost and utilization issues of diagnostic tests and their proper application.</p> <p>Effectively coordinates multiple systems to provide care that is timely, safe, effective and efficient.</p>	<p>Understand the key aspects of outpatient health care system, including cost control, billing and reimbursement.</p> <p>When providing outpatient care consider cost and resource allocation without compromising quality of care.</p> <p>Learn to organize resources in the most challenging medically complex cases and advocate for patients within the context of health care system.</p>

CAVHS Adult Neurology Outpatient (PGY 1)
Clinic Rotation Curriculum for Psychiatry Residents Rev. 12/01/2012

Summary Description of Rotation

The ACGME mandates that all Psychiatry residents must have two months of Neurology. The Psychiatry Resident rotation at the CAVHS is predominately an outpatient clinic rotation. During this rotation, the resident will participate in VA Neurology Clinics, including general neurology clinic, a procedure clinic, MS clinic, Epilepsy clinic, Movement Disorders clinic, ALS clinic, and Neuromuscular/EMG clinic weekly. The resident will also respond to emergent consultations the two half-days that the Neurology Inpatient residents are in continuity clinic. Completion of high quality, effective medical record notes for all patients seen by the resident in a timely fashion (within 24 hours) is emphasized. Failure to complete notes within 7 days may result in being locked out of CPRS. Repetitive noncompliance with this requirement will be viewed as unprofessional behavior. Copying and pasting is discouraged, although templates may be used.

The resident will not be required to take neurology call. Most residents will have some free time during this rotation. It is expected that this time will be utilized for individual study.

Educational Goals Summary

1. To provide an experience that will allow the resident to achieve competence in the assessment and management of acute and chronic neurological diseases of the central and /or peripheral nervous system managed on an outpatient basis.
2. To provide an experience that will allow the resident to achieve competence in performing outpatient consultations regarding acute and chronic neurological symptoms occurring as a complication of other disease states.
3. To learn the indications for ordering and interpreting ancillary and laboratory studies, including neuroimaging, neurosonology, lumbar puncture, EEG and EMG.
4. To provide training and supervision that allows development of professionalism necessary to become an effective physician, including honesty, communication, proper interaction with patient, peers and ancillary staff, and proper referral of patients to provide appropriate provisions of care.
5. To provide training and supervision in completion of urgent neurologic consultations and the performance of common outpatient neurological procedures.
6. To develop expertise in performing common outpatient neurologic procedures, including lumbar puncture, GON block, trigger point injection.

Assessment Summary

Resident performance will be assessed in the six core competencies:

1. Patient Care (PC)
2. Medical Knowledge (MK)
3. Interpersonal and Communication Skills (ICS)
4. Practice Based Learning and Improvement (PBLI)
5. Professionalism (P)
6. Systems Based Practice (SBP)

At the end of each rotation, the resident should receive and/or complete the following assessments:

1. Verbal feedback from Attending Physician(s).
2. Written assessment of performance in the six core competencies.
3. Opportunity for anonymous resident assessment of Attending Physician(s).

Summary of Expectations

The resident is responsible for the initial consultation, as well as the formulation of differential diagnosis and initial management plan. The resident is expected to develop competency in evaluation of subspecialty patients and the performance of common neurologic procedures. The resident is expected to be supervised by Faculty for every case. Completion of medical records in a timely fashion is expected.

Duty Hours

Neurology strictly adheres to the duty hour limits mandated by the ACGME; for PGY-1 residents:

1. Duty hours must be limited to 80 hours per week, averaged over a four-week period.
2. Residents are provided with 1 day in 7 free from all educational and clinical responsibilities, on average.
3. A 10-hour time period is provided between all daily duty periods and after in-house call.
4. Continuous call must not exceed 16 hours.

Rotation Orientation

Orientation is the responsibility of the CAVHS Chief of Neurology. This document should be provided at the beginning of this rotation.

Supervision

Each continuity clinic has 1-2 Attending Faculty Neurologists, and each subspecialty clinic has an Attending Faculty Neurologist. The Attending Faculty Neurology physician will supervise all residents during the clinics.

Mix of Diseases

Residents will meet the goals and objectives of the rotation through the identification, diagnosis, appropriate testing, management, and treatment of the following broad categories of neurological diseases:

- A. Cerebrovascular disease
- B. Demyelinative disease
- C. Disorders of balance and dizziness
- D. Disorders of higher cognitive function and communication (the dementias and aphasia)
- E. Movement disorders
- F. States of altered consciousness
- G. Headache
- H. Spinal disorders and pain (neck and low back)
- I. Neoplasms of the central nervous system
- J. Disorders of muscle and the neuromuscular junction
- K. Disorders of peripheral nerve
- L. Epilepsy
- M. Central nervous system infections
- N. Nutritional diseases of the nervous system

Patient Characteristics

Patients are referred to the outpatient Neurology clinic by the Emergency Department, other services, outside physicians, or as Neurology inpatients requiring neurological follow-up.

Patients with chronic neurological disorders are followed, as needed, in the continuity clinic,

although residents should discharge patients with chronic stable problems to the care of their PCP. Adult patients of various ethnic and socioeconomic backgrounds, with acute and chronic neurological disorders, will be encountered during the rotation.

Procedural Skill Acquisition

Neurological skills include perfecting the technique of careful history-taking as it applies to the neurological patient, as well as the application of a carefully-performed neurological examination. In addition, opportunities to perform lumbar puncture for spinal fluid analysis are available for the trainee to perfect his/her skills. In addition, Residents acquire skills in the performance of occipital nerve block, trigger point injections. Finally, acquiring knowledge of interpretive skills and familiarity with neuroimaging studies such as CT scans, MRI studies, etc. is essential.

Conferences:

The outpatient neurology clinic rotation is associated with numerous departmental clinical conferences directed at patient management, the treatment of neurological emergencies, and general didactic reviews. Attendance is recommended. A schedule of these conferences is distributed weekly.

Resources:

AAN Patient Care & Practice Management.

AAN Practice Guidelines.

Up-to-Date (can be accessed through the UAMS library web site. <https://library.uams.edu/>)

Recommended Text – Yudofsky SC and Hales RE. The APA Textbook of Psychiatry

PATIENT CARE

VA Neurology Clinic Rotation (PGY-1) - Patient Care		
Objectives	Teaching Methods	Assessment Strategy
To become proficient in managing outpatients with chronic neurological symptoms including patients with mental status change, headache, dizziness, dementia, stroke, MS, epilepsy, syncope, movement disorders, spine pain & neuromuscular symptoms.	Direct Patient Care Supervised procedures Performance feedback Conferences Independent study	Faculty rotation rating & evaluation PRITE Program Director semi-yearly review
Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgment.	Direct Patient Care Supervised procedures Performance feedback Conferences Independent study	Faculty rotation rating & evaluation PRITE Program Director semi-yearly review
Perform comprehensive neurologic outpatient consultations.	Direct Patient Care Supervised procedures Performance feedback Conferences	Faculty rotation rating & evaluation PRITE Program Director semi-yearly review
Demonstrate technical skills in performing lumbar punctures, occipital nerve blocks, & other outpatient procedures.	Staff instruction & supervision Independent study	Faculty rotation rating & evaluation

MEDICAL KNOWLEDGE

VA Neurology Clinic Rotation (PGY-1) - Medical Knowledge		
Objectives	Teaching Methods	Assessment Strategy
Describe the underlying pathophysiology, presenting signs and symptoms and common treatment protocols for non-acute cerebrovascular disease.	Direct Patient Care Performance feedback Conferences	Faculty rotation rating & evaluation PRITE Program Director semi-yearly review
Demonstrate an investigatory and analytic thinking approach to a patient with new onset seizure and the management of chronic epilepsy.	Direct Patient Care Performance feedback Conferences, including Grand Rounds Independent study	Faculty rotation rating & evaluation PRITE Program Director semi-yearly review
Critically evaluate and judiciously apply the latest knowledge to the care of patients with acute and chronic degenerative neurologic problems, including dementia, movement disorders, MS and neuromuscular disorders.	Direct Patient Care Supervised procedures Performance feedback Conferences, including Grand Rounds Independent study	Faculty rotation rating & evaluation PRITE Program Director semi-yearly review
Develop an approach to investigating and verifying new knowledge needed to care for patients.	Direct Patient Care Performance feedback Conferences, including Grand Rounds Independent study	Faculty rotation rating & evaluation PRITE Program Director semi-yearly review
Describe the foundational principles and management of subacute & chronic encephalopathies.	Direct Patient Care Performance feedback Conferences, including Grand Rounds Independent study	Faculty rotation rating & evaluation PRITE Program Director semi-yearly review

INTERPERSONAL AND COMMUNICATION

VA Neurology Clinic Rotation (PGY-1) - Interpersonal and Communication		
Objectives	Teaching Methods	Assessment Strategy
Present cases verbally and in writing in a logical and coherent manner.	Direct Patient Care Performance feedback	Faculty rotation rating & evaluation Program Director semi-yearly review
Clearly describe a diagnostic and/or a therapeutic plan to patients, families, and consulting physicians.	Direct Patient Care Performance feedback	Faculty rotation rating & evaluation Program Director semi-yearly review
Provide distressing news to patients and families clearly and compassionately.	Direct Patient Care Performance feedback	Faculty rotation rating & evaluation Program Director semi-yearly review
Develop effective strategies for interacting with "stressed" or angry patients and or families.	Direct Patient Care Performance feedback	Faculty rotation rating & evaluation Program Director semi-yearly review
Listen to and evaluate the contributions of other members of the healthcare team, and work together as an effective team member.	Direct Patient Care Performance feedback	Faculty rotation rating & evaluation Program Director semi-yearly review

PRACTICE BASED LEARNING AND IMPROVEMENT

VA Neurology Clinic Rotation (PGY-1) Practice Based Learning and Improvement		
Objectives	Teaching Methods	Assessment Strategy
Critical review and record of difficult and interesting cases.	Direct Patient Care Performance feedback Teaching conferences	Self assessment Faculty rotation rating & evaluation Case log (encouraged)
Use appropriate computer databases and online educational materials to assist in "real time" medical decision making.	Direct Patient Care Performance feedback Teaching conferences	Self assessment Faculty rotation rating & evaluation Case log (encouraged)
Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.	Direct Patient Care Performance feedback Teaching conferences	Self assessment Faculty rotation rating & evaluation Case log (encouraged)
Facilitate the learning of medical students.	Direct Patient Care Performance feedback	Self assessment Faculty rotation rating & evaluation Case log (encouraged)
Demonstrate and teach medical students to access medical information on their patient for record review as well as online information/medical databases to assist in their evaluations of patients	Direct Patient Care Performance feedback	Self assessment Faculty rotation rating & evaluation Case log (encouraged)

PROFESSIONALISM

VA Neurology Clinic Rotation (PGY-1) Professionalism		
Objectives	Teaching Methods	Assessment Strategy
Interact responsibly with patients, families and co-workers taking into consideration age, disability, culture and gender issues.	Self assessment Faculty rotation rating & evaluation Program Director semi-yearly review	Self assessment Faculty rotation rating & evaluation Program Director semi-yearly review
Demonstrate appropriate use of the EMR in regards to patient respect and confidentiality as well as understanding the scope and limits of patient confidentiality.	Direct Patient Care Performance feedback EMR training Online HIPAA training	Self assessment Faculty rotation rating & evaluation Program Director semi-yearly review
Understand the scope and limits of living wills and DNR status.	Direct Patient Care Performance feedback	Self assessment Faculty rotation rating & evaluation Program Director semi-yearly review
Evaluate a patient's capacity to make informed decisions and factors that would limit patient autonomy.	Direct Patient Care Performance feedback	Self assessment Faculty rotation rating & evaluation Program Director semi-yearly review
Complete medical records effectively and in a timely fashion, in compliance with VA regulations.	Direct Patient Care Performance feedback	Faculty rotation rating & evaluation Program Director semi-yearly review

SYSTEM BASED PRACTICE

VA Neurology Clinic Rotation (PGY-1) System Based Practice		
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Objectives	Teaching Methods	Assessment Strategy
Advocate for patients when dealing with resource allocation issues and complex payer systems problems.	Direct Patient Care Clinical Teaching Interaction with SW Performance feedback	Self assessment Faculty rotation rating & evaluation
Access quality allied health care and social services resources as they apply to patients with neurological disorders/disabilities.	Direct Patient Care Clinical Teaching Interaction with SW Performance feedback	Self assessment Faculty rotation rating & evaluation
Practice high quality cost effective medical care across all practice venues.	Direct Patient Care Clinical Teaching Interaction with SW Performance feedback	Self assessment Faculty rotation rating & evaluation
Understand how their patient care and professional practices affect other health professionals, organizations and society.	Direct Patient Care Clinical Teaching Interaction with SW Performance feedback	Self assessment Faculty rotation rating & evaluation

COMPETENCIES

At its February 1999 meeting, the ACGME endorsed general competencies for residents in the areas of:

- patient care,
- medical knowledge,
- practice-based learning and improvement,
- interpersonal and communication skills,
- professionalism, and
- systems-based practice.

Identification of general competencies is the first step in a long-term effort designed to emphasize educational outcome assessment in residency programs and in the accreditation process. During the next several years, the ACGME's Residency Review and Institutional Review Committees will incorporate the general competencies into their Requirements. The following statements will be used as a basis for future Requirements language. If you have any questions, comments and other requests for assistance, please address them to outcomes@acgme.org.

ACGME GENERAL COMPETENCIES Vers. 1.3 (9.28.99)

The residency program must require its residents to develop the competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the competencies.

PATIENT CARE

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

- communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- gather essential and accurate information about their patients
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- develop and carry out patient management plans
- counsel and educate patients and their families
- use information technology to support patient care decisions and patient education
- perform competently all medical and invasive procedures considered essential for the area of practice
- provide health care services aimed at preventing health problems or maintaining health
- work with health care professionals, including those from other disciplines, to provide patient-focused care

MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline

PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- obtain and use information about their own population of patients and the larger population from which their patients are drawn
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- use information technology to manage information, access on-line medical information; and support their own education
- facilitate the learning of students and other health care professionals

INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.

Residents are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- work effectively with others as a member or leader of a health care team or other professional group

PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society
- that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

SYSTEMS-BASED PRACTICE

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities
- know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

<http://www.acgme.org>/<http://www.acgme.org/>
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Date of Treatment	Demographic Information	Indication for ECT	Lead Placement and Settings (pulse width, frequency, duration, amps)	Special considerations and/or Complications
Ex: 8/1/18	SJ 39 F	MDD, treatment refractory	BLBT, 0.5/40/4/800	

To be completed by attending ECT psychiatrist:

- | | | |
|--|-----|----|
| Does this resident demonstrate understanding of the indications for ECT? | Yes | No |
| Does this resident demonstrate understanding of contraindications for ECT? | Yes | No |
| Does this resident demonstrate skills needed to perform pre-ECT work-up? | Yes | No |
| Does this resident demonstrate appropriate ECT technique? | Yes | No |
| Is this resident skilled in monitoring adverse effects of ECT? | Yes | No |
| Is this resident skilled in post-ECT follow-up? | Yes | No |
| Does this resident understand possible complications of ECT? | Yes | No |

Signature of Resident

Date

Signature of ECT Psychiatrist

Date

APPROVED FOR SUBMISSION INTO RESIDENT'S PERMANENT FILE

Signature of Psychiatry Residency Director Date

Request for Planned Sick Leave

Sick Leave is not to be used to supplement Annual or Education Leave

Resident: _____ Date: _____
(Print Name)

I request _____ days. Leave Date(s): _____

Does this request include more than 3 days of sick leave?: YES NO

Sick Leave greater than 3 consecutive days requires documentation of medical need for the leave.

Rotation Responsibilities:

_____ has agreed to cover my rotation assignment and my supervisor has this information.

Call Schedule Responsibilities:

_____ I am not on call.

_____ will be on call in my place and I have notified the Chief Resident.

Outpatient Responsibilities (PGY 2, 3, 4):

_____ I have notified the clinic scheduler.

_____ I have informed my patients as appropriate.

_____ has agreed to cover my out-patient needs
(Psychotherapy patient calls, clinic patient calls, etc).

Approval of request:

_____ Date: _____
(Supervisor's(s') Signature(s))

(Supervisor's(s') Name(s) PRINTED)

Adult Outpatient Clinic Signature (**PGY 3, 4**)

Return completed form to Janis Cockmon

Signature of Residency Program Director or Designee

Request for Vacation and Education Leave

Resident: _____ Date: _____
(Print Name)

I request _____ days. Leave Date(s): _____

<u>Type of Leave</u>	<u>Total days of leave taken/submitted before this request</u>	
_____ Vacation	_____	
_____ Educational leave	_____	_____ Name of Conference, Exam, etc.

Does this request bring total leave on this rotation to more than 5 days in a month? YES NO
Leave greater than 5 days in a calendar month is not permitted in most circumstances

Rotation Responsibilities:

_____ has agreed to cover my rotation assignment and my supervisor has this information.

Call Schedule Responsibilities:

_____ I am not on call.

_____ will be on call in my place and I have notified the Chief Resident.

Outpatient Responsibilities (PGY 2, 3, 4):

_____ I have notified the clinic scheduler.

_____ I have informed my patients as appropriate.

_____ has agreed to cover my out-patient needs (Psychotherapy patient calls, clinic patient calls, etc).

Approval of request:

_____ Date: _____
(Supervisor's(s') Signature(s))

(Supervisor's(s') Name(s) PRINTED)

Adult Outpatient Clinic Signature (PGY 3, 4)

Return completed form to Janis Cockmon

Signature of Residency Program Director or Designee

ANONYMOUS RESIDENT RATING

Site _____ Supervisor _____

1 one of the worst – in the lower 20%ile	2 below average	3 average – between the 35 th & 65 th %ile	4 above average (but not in top 20%ile)	5 top 20%
---	-----------------------	---	--	--------------

Please especially comment on any extreme ratings (1 or 5).

1. Compared to other sites, the overall learning experience was:

_____ 1 2 3 4 5 _____

Comments:

2. Educational time (quality and quantity) spent with faculty was:

_____ 1 2 3 4 5 _____

Comments:

3. The educational experience provided by the patient population was:

_____ 1 2 3 4 5 _____

Comments:

4. Supervision of your work (patient care and nonclinical matters) was:

_____ 1 2 3 4 5 _____

Comments:

5. This rotation provided stimulation for me to learn on my own as well as on the spot:

_____ 1 2 3 4 5 _____

Comments:

6. My primary supervisor's teaching was:

_____ 1 2 3 4 5 _____

Comments:

7. Did I have a total of at least 1 hour average individual supervision on site per week?

Yes No

8. My work-related stress level at this site compared to other sites was:

1 high (highest 20%)	2 above average	3 average	4 below average	5 Low (lowest 20%)
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ANONYMOUS RESIDENT RATING

RESIDENCY PROGRAM (not any individual faculty member)

1 Seldom	2 Only sometimes	3 Often	4 Usually	5 Very nearly always
-------------	---------------------	------------	--------------	----------------------------

Please especially comment on any extreme ratings (1 or 5).

1. Does it seem that the residency has fairness as a goal?

_____ 1 2 3 4 5

Comments:

2. Are you treated with respect in the residency?

_____ 1 2 3 4 5

Comments:

3. Is the ratio of work to education proportioned in a way to encourage your professional development?

_____ 1 2 3 4 5

Comments:

4. Do you feel free to ask questions about the residency and/or UAMS policies?

_____ 1 2 3 4 5

Comments:

5. Do you feel the evaluations residents complete are considered in residency planning?

_____ 1 2 3 4 5

Comments:

6. Are you being taught what you need to know?

SEMI-ANNUAL REVIEW TOPICS

Name:
Reviewer:
Date:

1. Comment on evaluations.
2. Comment on PRITE scores.
3. How are things going? Stress level, satisfaction with educational and professional development, etc.
4. Ask for feedback about the faculty.
5. Ask for feedback about the program.
6. Ask about study habits/reading list.
7. What has been your psychotherapy experience thus far? (#'s, length, types of therapies) (supportive, dynamic, CBT, psychotherapy & psychopharm)
8. Research & career interests

SEMI-ANNUAL EVALUATION FORM

_____ PD/APD _____ met on _____
with _____ M.D. and reviewed the resident's
satisfactory unsatisfactory
progress in the Psychiatry Residency Education Program.

SEMI-ANNUAL REVIEW

Resident Name: _____ Date: _____ Year in Training: _____

ACGME Requirements:	Months Completed	MILESTONES			
Primary Care	4 months	PC1		SBP 1	
Neurology	2 months	PC2		SBP 2	
Inpatient Psychiatry	6 months	PC3		SBP 3	
Emergency Psychiatry	1 month	PC4		SBP 4	
Outpatient Psychiatry	12 months	PC5		PBL1	
Geriatric Psychiatry	1 month	MK1		PBL2	
Chemical Dependency	1 month	MK2		PBL3	
Child and Adolescent	2 months	MK3		PROF1	
Consultation-Liaison	2 months	MK4		PROF2	
Forensic Psychiatry	experience	MK5		ICS1	
ECT	experience	MK 6		ICS2	
NOTE:					
Additional Program Requirements:		PC = Patient Care; MK = Medical Knowledge; SBP = Systems Based Practice; PBL = Practice Based Learning; PROF = Professionalism; ICS = Interpersonal Communication Skills;			
Lecture Attendance:					
CSV Evaluations:					
		PRITE		%tile	
		Psychiatry			
		Neurology			
		Needs Review			
		Review Complete?			

1. Are you functioning at a level commensurate with your year of training? **Y or N** (circle one)

2. What are your strengths with respect to the practice of psychiatry?

3. What are your weaknesses with respect to the practice of psychiatry?

4. How do you plan to address these issues?

5. General Comments: _____

Residency Training Director: _____

Date: _____

DIDACTIC EVALUATION FORM

PRESENTATION EVALUATED: _____ DATE: _____

This questionnaire gives you the opportunity to provide feedback on various aspects of didactic activities. This information will be used to guide scheduling of presentations in the future. Please answer all questions, if applicable, and make appropriate comments.

Circle a number under each column that best describes your degree of agreement or disagreement with each statement.

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
This presentation provided material beneficial to you. (applied to patient care)	1	2	3	4	5

This presentation was appropriate to your education level.	1	2	3	4	5

The material was presented in a stimulating manner.	1	2	3	4	5

This presentation should be given to future residents.	1	2	3	4	5

The material should be given to future residents by the same presenter.	1	2	3	4	5

The presenter was knowledgeable about the subject material.	1	2	3	4	5

Questions were allowed and answered appropriately.	1	2	3	4	5

An appropriate amount of time was provided for the topic.	1	2	3	4	5

Handout materials were helpful.	1	2	3	4	5

COMMENTS:

YOUR RESIDENT YEAR: _____

Return form to LaTanya Poole, UAMS Slot 589

360 Comprehensive Multi-Rater Evaluation

Resident: _____ Evaluator(s) _____
 PGY Level : _____ Discipline: _____
 Rotation: _____ Date: _____

To provide an effective residency experience, it is important to systematically evaluate residents' professional performance from a variety of perspectives (eg. patient, attending doctor, nurse, other health care professional, peer and self). Your feedback is critical to understanding how residents develop professional skills, and how residency programs can be made more effective. In particular, your written comments will serve to extend the information that you provide on the checklist. Your comments and feedback are completely anonymous and confidential.

Please take a few minutes to respond to the following, **360 Comprehensive Multi-Rater Evaluation**, which measures five of the six ACGME competencies. Base your responses on how you think the resident **generally performed** his or her duties over the past rotation

THIS RESIDENT GENERALLY:

Strongly Disagree Disagree Neutral Agree Strongly Agree

INTERPERSONAL AND COMMUNICATION SKILLS

Encourages the patient to ask questions	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					
Communicates well with other members of the treatment team	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					

PRACTICE-BASED LEARNING AND IMPROVEMENT

Responds to feedback receptively	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					
Acknowledges the limits of own medical knowledge as appropriate	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					
Demonstrates willingness to share knowledge and information in teaching others	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					

PROFESSIONALISM

Maintains confidentiality	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					
Makes ethically sound judgments regarding patient care	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					
Respects the roles of health care staff in patient care	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					
Responds to requests, including pages, in a helpful and prompt manner	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					

SYSTEMS-BASED PRACTICE

Advocates for quality patient care and optimal patient care systems	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					
Uses consultations and referrals effectively	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					
Advocates for patient safety	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					

PATIENT CARE

Gathers essential and accurate information about patients	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					
Develops and carries out appropriate management plans	1	2	3	4	5
<hr style="border-top: 1px dashed black;"/>					

Adequately counsels and educates patients and their families

1	2	3	4	5
---	---	---	---	---

Displays sensitivity and individualizes care for diverse populations

1	2	3	4	5
---	---	---	---	---

During the past year, I have worked with this resident

1	2	3	4	5
---	---	---	---	---

Comments extend and explain the numerical ratings on the survey. Comments also provide more specific information for resident feedback.

Comments:

ABPN CLINICAL SKILLS VERIFICATION FORM (CSV v. 1)

Resident: _____ PGY: _____ Date: _____ Examiner: _____

OVERALL GRADE		Fail	Pass								
INTERVIEW STYLE											
1.	Opening and closing	Awkward strategies	1	2	3	4	5	6	7	8	Appropriate strategies
2.	Informational cues	Ignored leads	1	2	3	4	5	6	7	8	Followed leads
3.	Affective cues	Ignored	1	2	3	4	5	6	7	8	Explored appropriately
4.	Communication style	Insensitivity interfered with data collection	1	2	3	4	5	6	7	8	Adequate language and cultural sensitivity
5.	Questioning techniques	Abrupt and forced choice questions	1	2	3	4	5	6	7	8	Open-ended but appropriately structured
6.	Control and direction of interview	Scattered and fragmented questions	1	2	3	4	5	6	7	8	Developed cohesive interview
Average score for Interview Style: _____											
SUBSTANCE OF INTERVIEW											
7.	Presenting problems and history of present illness	Inadequately obtained or too vague	1	2	3	4	5	6	7	8	Obtained adequate data
8.	Past history:	Ignored major issues	1	2	3	4	5	6	7	8	Gathered relevant data in at least brief form
	Psychiatric	Ignored major issues	1	2	3	4	5	6	7	8	Gathered relevant data in at least brief form
	Family	Ignored major issues	1	2	3	4	5	6	7	8	Gathered relevant data in at least brief form
	Medical	Ignored major issues	1	2	3	4	5	6	7	8	Gathered relevant data in at least brief form
	Social/educational/occupational	Ignored major issues	1	2	3	4	5	6	7	8	Gathered relevant data in at least brief form
	Developmental	Ignored major issues	1	2	3	4	5	6	7	8	Gathered relevant data in at least brief form
9.	History of drug and alcohol abuse	Ignored or too limited	1	2	3	4	5	6	7	8	Sensitively gathered
10.	Assessment of suicidal risk	Ignored or too limited	1	2	3	4	5	6	7	8	Sensitively explored
11.	Assessment of homicidal risk	Ignored or too limited	1	2	3	4	5	6	7	8	Sensitively explored
12.	Mental status examination	Omitted or too limited	1	2	3	4	5	6	7	8	Organized approach and performed appropriately
Average score for Substance of Interview: _____											
CASE PRESENTATION											
13.	Summary of important data	Disorganized	1	2	3	4	5	6	7	8	Presented concisely and coherently
14.	Mental status exam	Incomplete	1	2	3	4	5	6	7	8	Accurately summarized
15.	Emergency issues:	Ignored	1	2	3	4	5	6	7	8	Considered
	Suicide	Ignored	1	2	3	4	5	6	7	8	Considered
	Violence/abuse	Ignored	1	2	3	4	5	6	7	8	Considered
	Drugs/alcohol	Ignored	1	2	3	4	5	6	7	8	Considered
16.	Recognition of need for additional history and collateral information	Absent or no rationale	1	2	3	4	5	6	7	8	Appropriate
Average score for Case Presentation: _____											

GME Moonlighting Policy

(Moonlighting Application is on the following 3 pages)

Policy:

<https://medicine.uams.edu/gme/wp-content/uploads/sites/4/2022/08/3.300-Moonlighting-Final.pdf>

UAMS COM GME Moonlighting Activity Request Form

Academic Year _____

Instructions for Completing Request:

1. Please complete the entire form. Any missing information could delay approval.
2. Please obtain all required signatures and initial and sign where indicated.
3. Please submit completed form to askgme@uams.edu.
4. Please wait for email of approval from GME before agreeing to work any moonlighting shifts. You are not approved to moonlight until you receive this form signed by the DIO.

Personal Information

Housestaff Name _____ PGY Level _____ Training Program _____

Are you a US Citizen _____ If not, what is your Visa status? _____

H1B Visa Holders, please contact askimmigration@uams.edu before engaging in any supplemental clinical activities. Please attach immigration documentation if supplemental clinical activities are allowable.

Medical License Number _____

Issue Date _____ Expiration Date _____

Federal DEA Number

Issue Date _____ Expiration Date _____

Moonlighting Information

Moonlighting: Internal or External

Separate from my duties as a housestaff officer at UAMS, I request to be employed for the academic year July 1, _____ to June 30, _____ at the following location.

Approval is granted for 12 months or less during a single academic year (July 1 – June 30)

Location:

Administrative Contact Name:

Administrative Contact Phone Number and Email:

Description of Moonlighting Activities:

Average number of hours/week residents/fellows will participate in this activity: Average number of times/week residents/fellows will participate in this activity:

Responsibilities of Resident/Fellow:

Funding sources for moonlighting:

Acknowledgement of Moonlighting Policy

Please initial after each of the following statements.

I understand that moonlighting activities are prohibited during regular UAMS work hours, as defined by my Program Director and/or Department Chair. Additionally, I understand that this activity will not be credited toward my current training program requirements. _____

I understand in requesting approval for any moonlighting activity, my performance will be monitored for the effect moonlighting activities have upon patient care responsibilities and education performance related to ACGME requirements, and if the moonlighting activities adversely affect either of these areas of care or learning, then permission to moonlight may be withdrawn. _____

I understand that time spent in internal/external moonlighting activities must be counted toward the 80-hour Maximum Weekly Limit, as required by the ACGME. _____

I understand that I am responsible for accurately recording all work hours including regular duty, moonlighting, and supplemental clinical activity hours in my institution's work hour tracking mechanism. Failure to do so could result in corrective action and suspension of moonlighting privileges. ____

I agree to submit another form should the moonlighting location, activity, or hours given on this form change. _____

I acknowledge that violation of the Moonlighting Policy constitutes a breach of the House Staff Agreement between UAMS Medical Center and myself and may lead to Corrective Action. _____

I have obtained a malpractice insurance policy that will cover the moonlighting activity being performed outside of my training program. _____

I understand that should I have a professional liability claim while moonlighting, I will notify the UAMS Director, Insurance and Claims Management within 30 days of notice. _____

Resident/Fellow Signature:

Name _____ Signature _____ Date _____

Moonlighting Approval

With this signature, I:

- 1) approve this moonlighting activity request;
- 2) agree to monitor this housestaff officer for educational effect of this activity;
- 3) agree to monitor proper recording of work hours for this activity; and
- 4) agree to withdraw approval if necessary.

Program Director:

Name_____Signature_____Date_____

I have reviewed and approved this request:

Department Business Administrator:

Name_____Signature_____Date_____

Department Chair:

Name_____Signature_____Date_____

Director, Insurance and Claims Management:

Name_____Signature_____Date_____

Vice Dean for GME:

Name_____Signature_____Date_____

Psychiatry Milestones 2.0

PC1. Psychiatric Evaluation
<i>A: General interview skills B: Collateral information gathering and use C: Safety assessment D: Use of clinician's emotional response</i>
PC2. Psychiatric Formulation and Differential Diagnosis
<i>A: Organizes and summarizes findings and generates differential diagnosis B: Identifies contributing factors and contextual features and creates a formulation</i>
PC3. Treatment Planning and Management
<i>A: Creates treatment plan B: Manages patient crises, recognizing need for supervision when indicated C: Monitors and revises treatment when indicated</i>
PC4. Psychotherapy. Refers to 1) the practice and delivery of psychotherapies, including psychodynamic, cognitive-behavioral, and supportive therapies; 2) exposure to couples, family, and group therapies; and 3) integrating psychotherapy with psychopharmacology
<i>A: Empathy and process B: Boundaries C: The alliance and provision of psychotherapies D: Seeking and providing psychotherapy supervision</i>
PC5. Somatic. Therapies Somatic therapies including psychopharmacology, electroconvulsive therapy (ECT), and emerging neuromodulation therapies
<i>A: Using psychopharmacologic agents in treatment B: Education of patient about medications C: Monitoring of patient response to treatment and adjusting accordingly D: Other somatic treatments</i>
PC6. Patient Care 6: Clinical Consultation
MK1. Development through the life cycle (including the impact of psychopathology on the trajectory of development and development on the expression of psychopathology)
<i>A: Knowledge of human development B: Knowledge of pathological and environmental influences on development C: Incorporation of developmental concepts in understanding</i>
MK2. Psychopathology. Includes knowledge of diagnostic criteria, epidemiology, pathophysiology, course of illness, co-morbidities, and differential diagnosis of psychiatric disorders, including substance use disorders and presentation of psychiatric disorders across the life cycle and in diverse patient populations (e.g., different cultures, families, genders, sexual orientation, ethnicity, etc.)
<i>A: Knowledge to identify and treat psychiatric conditions B: Knowledge to assess risk and determine level of care C: Knowledge at the interface of psychiatry and the rest of medicine</i>
MK3. Clinical Neuroscience. Includes knowledge of neurology, neuropsychiatry, neurodiagnostic testing, and relevant neuroscience and their application in clinical settings
<i>A: Neurodiagnostic testing B: Neuropsychological testing C: Neuropsychiatric co-morbidity D: Neurobiology E: Applied neuroscience</i>
MK4. Psychotherapy Refers to knowledge regarding: 1) individual psychotherapies, including but not limited to psychodynamic, cognitive-behavioral, and supportive therapies; 2) couples, family, and group therapies; and, 3) integrating psychotherapy and psychopharmacology
<i>A: Knowledge of psychotherapy: theories B: Knowledge of psychotherapy: practice C: Knowledge of psychotherapy: evidence base</i>

SBP1. Patient Safety and the Health care Team
<i>A: Medical errors and improvement activities B: Communication and patient safety C: Regulatory and educational activities related to patient safety</i>
SBP2. Resource Management (may include diagnostics, medications, level of care, other treatment providers, access to community assistance)
<i>A: Costs of care and resource management</i>
SBP3. Community-Based Care
<i>A: Community-based programs B: Self-help groups C: Prevention D: Recovery and rehabilitation</i>
PBL1. Development and execution of lifelong learning through constant self-evaluation, including critical evaluation of research and clinical evidence
<i>A: Self-Assessment and self-Improvement B: Evidence in the clinical workflow</i>
PBL2. Formal practice-based quality improvement based on established and accepted methodologies
<i>A: Specific quality improvement project B: Quality improvement didactic knowledge</i>
PROF1. Compassion, integrity, respect for others, sensitivity to diverse patient populations, adherence to ethical principles
<i>A: Compassion, reflection, sensitivity to diversity B: Ethics</i>
PROF2. Accountability to self, patients, colleagues, and the profession
<i>A: Fatigue management and work balance B: Professional behavior and participation in professional community C: Ownership of patient care</i>
PROF3. Well-Being
ICS1. Relationship development and conflict management with patients, families, colleagues, and members of the health care team
<i>A: Relationship with patients B: Conflict management C: Team-based care</i>
ICS2. Information sharing and record keeping
<i>A: Accurate and effective communication with health care team B: Effective communications with patients C: Maintaining professional boundaries in communication D: Knowledge of factors which compromise communication</i>
ICS3. Communication within Health Care Systems

PC = Patient Care; MK = Medical Knowledge; SBP = Systems Based Practice; PBL = Practice Based Learning; PROF = Professionalism; ICS = Interpersonal Communication Skills