UNLV School of Medicine
Psychiatry Residency

Policy and Procedure Handbook
For Residents

Revised 6/29/2018

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General Competencies of Residency Training

The objectives are similar among all programs. The means by which the objectives are achieved will vary. Achievement of objectives will be time sensitive; namely, that only a limited number can be addressed over time, in sequence. Programs shall evaluate and qualitate the degree to which residents understands and/or practice the following:

For Patient Care:

- The performance of patient history and physical examinations, particularly interviewing techniques
- The technical skills required by the program
- Deductive reasoning in the management of patients
- Constructing meaningful management plans
- Techniques related to counseling, instructing and teaching patients about their clinical condition
- Health promotion and maintenance and disease prevention
- Responsibilities as a collaborative member of the health care team

For Medical Knowledge:

- Core factual medical knowledge, illness/disease based
- Analytic and deductive reasoning
- Applications of basic science

For Practice Based Learning:

- Use of scientific evidence: evidence based medicine and outcome of practice as a guide to standards of care development, i.e., best practices
- Self-evaluation of practice experience
- Statistical methods
- Use of informational technology
- Interaction with others in learning and teaching

For Interpersonal and Communication Skills: patients, peers and colleagues

- Listening and language skills
- Attentiveness, interest
- Comprehension and self-awareness of patient/physician interaction

For Professionalism: among all parties in the health care environment

- Respect, understanding, sympathy, empathy
- Sensitivity to varied cultures and national origins
- Awareness of issues related to age, gender, religion and disability
- Ethical and legal precepts
- Collaborative attitudes with peers and associates

For Systems Practice:

- Operation and goals of health care systems and managed care
- Awareness of cost effective practices, resource alternatives, and risk/benefit considerations

- Patient management and therapeutic alternatives
- Patient advocacy issues

General Competencies Defined

A. Patient Care
   1. Procedures: routine history and physical, technical skills performance
   2. Interview techniques
   3. Informed decision making
   4. Management plans
   5. Health promotion, maintenance, disease prevention
   6. Team work

B. Medical Knowledge
   1. Core factual cognitive knowledge relative to the scope of medical practice, illness and disease
   2. Analytic and deductive reasoning
   3. Basic science applications

C. Practice Based Learning
   1. Use of scientific evidence and practice based experience: evidence based medicine
   2. Resident self- evaluation and analysis of experience, patient care
   3. Understanding and applying statistical methods
   4. Use of informational technology
   5. Facilitation of the learning and teaching of others

D. Interpersonal and Communication Skills
   1. Listening and speaking skills
   2. Understanding and attentiveness; self-awareness; comprehension of interactions with patients
   3. Establishing a physician/patient relationship

E. Professionalism: patients and colleagues
   1. Respect, understanding, sympathy, honesty
   2. Cultural sensitivity
   3. Age, gender, disability awareness
   4. Ethical and legal practices
   5. Collaboration and sharing with peers and associates

F. Systems Based Practice
   1. Understanding health care operations and goals
   2. Awareness of resources and cost effectiveness and risk/benefit concerns
   3. Management and therapeutic alternatives in managed care environments

Program Mission and Goals

The UNLVSOM Psychiatry Residency Program focuses upon the education of clinically competent and ethical psychiatrists. The resident is expected to understand and appreciate the complex interactions between the biology, the psychology, the social context and the spiritual perspectives of each patient interaction. A wealth of clinical material is provided in varied clinical settings throughout the residency.

Goals for each rotation and for the residency in general are defined according to the ACGME standards of competence.

I. Patient Care:

- A. Residents will demonstrate excellence in completing the psychiatric evaluation, mental status examination and case formulation.
- B. Residents will integrate information accurately to then recommend appropriate intervention from the bio psychosocial model, utilizing each of the areas within this model.
- C. Residents will demonstrate thorough and empathetic interview skills.
- D. Residents will diagnose patients using the rules as written in the DSM-5, and generate an appropriate differential diagnosis.

II. Medical Knowledge:

- A. Residents will demonstrate acquisition of factual and theoretical knowledge within psychiatry by means of scoring in the top 2/3s of peer groups on the PRITE examination.
- B. Residents will demonstrate understanding of illness states and current appropriate interventions for the illness state being treated.
- C. Residents will present current research utilizing critical reasoning skills.

III. Practice Based Learning:

- A. Residents will utilize both medication and psychotherapy appropriately.
- B. Residents will articulate the current best practices standard for specific illness states.
- C. Residents will appropriately describe risks and benefits to patients.
- D. Residents will understand their limitations and demonstrate appropriate referral and/or consultation.

IV. Interpersonal Communication Skills:

- A. Residents will communicate effectively with both patients and families using appropriate techniques and empathy.
- B. Residents will present cases completely and concisely to attending and colleagues.
- C. Residents will chart effectively, appropriately, and completely.
- D. Residents will actively participate in medical student education.

V. Professionalism:

A. Residents will understand, respect, and advocate the fiduciary responsibilities of a psychiatrist.

B. Residents will demonstrate respect for each patient and that patient's family system, ethnic system and cultural system.

C. Residents will be prompt, reliable, timely, honest, altruistic and trustworthy in all encounters with both patients and fellow professionals at all institutions.

D. Residents will adhere to principles of confidentiality.

VI. Systems Based Practice:

A. Residents will experience and understand the provision of healthcare from a variety of systems: public sector, private, managed care.

B. Residents will understand the regulatory aspects of patient care, and conform to the appropriate standard.

C. Residents will demonstrate appropriate decision making capacity regarding the admission and discharge of patients to and from specific levels of care.

Program Description

PGY-1: Half of this year of training provides the resident exposure to general medical rotations: one month of internal medicine inpatient, one month of emergency medicine, two months of family medicine, and two months of neurology. These rotations are focused upon learning the interaction of medical conditions with psychiatric presentations. In addition, the resident will hone general medical skills. The other half of the year provides basic inpatient psychiatry experiences at Southern Nevada Adult Mental Health Services where there is diagnosis and treatment of a wide range of psychiatric illness.

Successful Completion: Complete each rotation, meeting expectations on each area of evaluations, completion of step 3 of the USMLE/COMLEX.

PGY-2: Inpatient psychiatry is provided at the VA hospital, where geriatric evaluation and treatment is provided in addition to substance abuse/dependence and general adult psychopathology.
Seven Hills provides substance abuse/dependence experience.
UMC and Montevista provide a wide range of experience with the assessment and treatment of children and adolescent patients, with substantial contact with family systems. Consult and Liaison psychiatric experience is provided at University Medical Center. UMC also has a small emergency holding area, and substantial experience evaluating and initiating treatment in this setting helps clarify diagnostic questions related to substance induced or medically induced psychiatric conditions. Experience is gained in identifying symptoms of acute intoxication from substances of abuse, providing detoxification, and identifying aftercare options.
SNAMHS : Assessment and triage skills are emphasized during the two month rotation at the SNAMHS crisis observation unit.

Successful Completion: Complete each rotation, meeting expectations on each area of evaluations, successful completion of 3 CSV Exams, completion of clinical checklist form for PGY- 1 and PGY- 2, approved academic project form completed and completion of one comprehensive oral examination. Complete all 12 modules from online NEI psychopharmacology program.

PGY-3: The third year of training focuses upon the outpatient treatment experience. The resident is assigned to the VA outpatient clinic, SNAMHS outpatient clinic, Healthy Minds outpatient clinics and UNLV Student Wellness Clinic. Residents gain experience in making decisions regarding psychopharmacology, and focus psychotherapy skills in cognitive therapy, supportive therapy, psychodynamic therapy, interpersonal therapy, group therapy and family/couples therapy.

Successful Completion: Complete each rotation, meeting expectations on each area of evaluations, completion of clinical checklist form for PGY- 3, completion of second comprehensive oral examination, completion of formal QI project.

PGY-4: Additional time is spent at SNAMHS/ VA/ Dr. Rosenman seeing longitudinal psychotherapy patients and doing electives. The resident may act as a "junior attending" in the administrative psychiatry rotation on the UMC consult team, or other clinical services.

Successful Completion: Complete each rotation, meeting expectations on each area of evaluations, and completion of 3rd comprehensive oral examination, completion of research project.

Didactic time is protected and free of clinical duties. This is scheduled for Wednesdays from 8:00 AM 4:00 p.m.

Selection and Admission Procedures

The process of selecting candidates for the Residency Training Program is personally supervised by the Residency Training Director on an ongoing basis. Preliminary selection decisions are made by the Program Coordinator, based upon the enclosed policies. Final selection decisions are made by the Residency Training Committee. The purpose of the admission procedures is to select candidates with exceptionally strong academic records and interpersonal skills, who have the potential of becoming superior psychiatrists and of making significant contributions to the field.

A. Response to Requests for Information
   1. All medical students and physicians or international graduates who have passed Parts I and II of the USMLE, COMLEX, National Boards, or FLEX examinations desiring information about the program may access our web site by clicking on the Graduate Medical Education link at https://www.unlv.edu/medicine/gme/handbook
   2. Interested medical students and physicians are encouraged to phone the Program Coordinator if further information is desired. (702) 671-5127.
   3. Applications to our program are conducted electronically or in written form through the Electronic Residency Application Service (ERAS) of the Association of American Medical Colleges, 2450 N. Street, N.D., Washington, D.C. 20037. .Information may be obtained through their web page: www.aamc.org/eras.

B. Selecting Candidates for Interviews
   1. Applications are screened by the Program Coordinator for (a) completeness, (b) qualifications for licensing, (c) special experience and training which the candidate may have had (e.g., special internships, clinical or research experience), and (d) strong grades and/or letters of recommendation.
   2. The Residency Director, who subsequently selects candidates to be invited for a formal interview, reviews applications of qualified candidates.

C. Interviews
   1. At least two faculty members and one resident interview applicants, although the resident interview may be informal.
   2. Each interviewer rates the applicant in terms of general acceptability and academic, clinical, and psychological potential. Written impressions and observations of applicants are sent to the Program Coordinator.

D. Ranking
   1. All interviewed candidates are presented to the selection subcommittee of the Residency Training Committee. Committee members review applications and interview reports, and discuss each candidate before ranking candidates. The Committee may request additional information or invite a candidate for a second interview.

E. Alternative Procedures
   1. Occasionally positions will become available in any training year. Interested candidates are asked to provide the information described above, as well as a letter from their training director elsewhere. After two brief telephone interviews by full time faculty (optional), a discussion will be made regarding an invitation to interview. Interviews will be conducted following the protocol outlined above.
   2. A transferring resident should be appointed at the PGY level (and corresponding salary level) which represents his or her residency level in the University of Nevada program. Previous residency training will not be a factor unless credit is granted toward completion of the Las Vegas, Nevada program. The Residency Director determines credit for previous training based upon specialty board requirements. The following is an example: A transferring resident in psychiatry has had a previous year of residency training in family practice. The Residency Director determines that 6 months of the previous training may be credited toward completion of our 4-year psychiatry program.

Resident Responsibilities

A. Lifelong learning begins in medical school, progresses throughout residency, and continues throughout life. A self directed program of self-study is necessary at each of these levels of education.

B. Residents much each own (at bare minimum) the following texts:
1. "APA Textbook of Clinical Psychiatry," latest edition
2. "Essential Psychopharmacology: Neuroscientific Basis. . ." by Steven Stahl, latest edition
3. "Psychodynamic Psychiatry in Clinical Practice" by Glen Gabbard, latest edition
4. "Systems of Psychotherapy" by Prochaska, et al., latest edition
5. "DSM-5," American Psychiatric Association Press

******some of these will be available via Psychiatry Online, you are responsible for the others

C. Residents should also plan to own a truly encyclopedic text such as "Kaplan and Sadock's Comprehensive Textbook of Psychiatry." Although a difficult read, this is a standard reference text for basic knowledge.

D. Residents must attend and participate in at least 90% of lectures. Exceptions to attendance are limited to vacation, serious illness, or patient emergency (which can't be handled by the attending on the service.) Class time is fully protected and general clinical duties should never interfere with scheduled courses or supervision.

E. Residents must participate in medical student education: this includes rounding with medical students, informal feedback to students, completion of medical student evaluations in One45, and formal lectures to groups of medical students.

F. Residents are to provide quality, compassionate, cost effective, and respectful care to patients.

G. Residents must strictly adhere to the policies of medical practice at each participating hospital. Records must be completed in a timely manner.

H. Residents must provide complete, prompt, and clear documentation of all aspects of patient care. Residents must countersign all medical student notes.

I. Residents must participate in at least one hour of onsite clinical supervision each week, and must participate in one hour of off-site clinical supervision each week.

J. Residents must provide 60 - day advance notice to any institution regarding vacation time or education time away from the work site. After institutional approval, leave slips must then be signed by the chief resident then program director. The chief resident will ensure that multiple vacation requests do not impact clinical services prior to approving the request.

K. Residents must notify both the clinical site and the residency coordinator of illness requiring sick leave or any absence due to medical condition.

L. Residents must maintain a written log of all patients seen, demographics regarding the patient, all diagnoses of patient, and treatment modalities used in the care of the patient (psychiatric services only.)

M. Residents must document complete H&Ps, daily progress notes, complete off-service notes, and provide appropriate sign-outs to fellow residents and/or attending's.

N. Residents will dress and act appropriately and professionally in all clinical venues and during didactics days. Residents will maintain professional behavior and conduct consistent with professional obligations on and off clinical services.

O. Residents will respond rapidly to pages. Residents are to be available by pager routinely from 8 AM through 5 PM on all weekdays, and additionally for any time period the resident is designated as being on call for an institution.

P. Residents will notify the chief resident of emergencies that prevent them from taking an assigned call. Residents will make every attempt to find coverage for themselves should illness or emergency situations arise; only if the resident is unable to find reasonable coverage, the Chief Resident will assign another resident to provide call coverage, but the resident may be required to "make up" more than one call to discourage this practice.

Q. Residents must fulfill call obligations as scheduled.

R. Residents must critically evaluate themselves, their students, their attending's, their supervisors, their rotations, other residents, and the residency in general.

S. Residents must understand the importance of proper sleep and how tiredness can affect clinical skills. Residents must take responsibility for obtaining adequate rest each night.

UNLVSOM
Code of Professional Conduct

Standard of conduct

The UNLV/ School of Medicine is committed to an environment of mutual respect. All members of the medical school community are expected to maintain a positive learning environment in which students, faculty, staff and residents treat each other with respect. Members of the community, including institutional leaders, will not tolerate harassment, intimidation, exploitation and/or abuse.

Purpose of policy

This policy is intended to define inappropriate conduct in relationships with students. It also describes the mechanism through which medical students can report violations without fear of retaliation. This policy ensures access to educational programs that prohibit student mistreatment. For the purposes of this policy, community is defined as all sites where UNLV/ School of Medicine students receive training.

Promoting a Positive Learning Environment

UNLV School of Medicine provides ongoing educational and developmental opportunities to promote a positive learning environment respectful of all individuals. The policy will be included in both student and resident handbooks, and will be posted on the medical school website. The topic will be addressed annually throughout medical school.

Residents: The policy will be included in the resident handbook, and will be addressed at resident physician orientation sessions.

Faculty: The policy will be distributed electronically by the Dean to all faculty members, including adjunct and volunteer faculty. The message will include resources for identification and prevention of mistreatment and abuse, as well as instructions to report suspected actions and resources for resolution of alleged occurrences.

Nursing and Other Clinical/Support Staff: A letter will be sent from the Dean to the Chief Executive Officer at affiliated institutions requesting distribution of the policy to all staff interacting with medical school students. Resources will be available for presentations on the topic to various groups at the training sites.

A website is available for reference by students, residents, staff and faculty The policy will also be attached to affiliation agreements with all community partners. treatment of students may occur in many forms and can seriously impair the educational experience. Types of mistreatment include verbal, hierarchical/power, ethnic or cultural, physical, discrimination, and sexual harassment.

Specific examples of mistreatment include but are not limited to:

- Yelling at and/or verbally berating a student in public or private
- Actions that can reasonably be interpreted as demeaning or humiliating (harsh criticism can be very appropriate in a life and death situation)
- Assigning duties as a means of punishing students instead of for educational benefits
- Unwarranted exclusion from learning opportunities
- Threats to fail, assign a lower grade or give a poor evaluation for inappropriate reasons
- Requesting that students complete personal chores or errands
- Unwelcome sexual comments, jokes, innuendo or taunting remarks about a student’s physical appearance, age, gender, ethnicity or culture, sexual orientation/identity or marital status

- Intentional physical contact such as pushing, shoving, slapping, hitting, tripping, throwing objects or aggressive violation of personal space

Procedure for Resolution

Please note that all complaints of sexual harassment and'/or discrimination will be referred to Office of Affirmative Action on the University of Nevada, Reno campus.

Informal Resolution

- Students are encouraged to first utilize any of the informal mechanisms listed below when possible.
    - Direct discussion between student and alleged offender
    - Discussion with course or clerkship coordinator
    - Discussion with UNLVSOM Personnel
    - Fully utilize the resident and faculty evaluation process.

Formal Resolution

When the informal mechanisms mentioned above do not lead to resolution of the incident or behavior, the following protocol will be followed:

- If the incident involves an allegation of mistreatment by a student, the incident will be referred to UNLVSOM Personnel
- http://www.
- If the incident involves an allegation of mistreatment by a resident, due process provisions in the Resident Handbook will be referred to UNLVSOM Personnel
- If the incident involves an allegation of mistreatment by a faculty or staff member, the incident will be referred to the Administrative Code pursuant to Ch. 6.7.1 of the NSHE Code Retaliation

Retaliation against students reporting mistreatment is regarded as a form of mistreatment and will not be tolerated. Accusations that retaliation has occurred will be handled in the same manner as accusations concerning other forms of mistreatment.

Malicious Accusations

A complainant or witness found to have been dishonest or malicious in making the allegations or at any point during the investigation may be subject to disciplinary action.

Campus Resources

The following campus resources may be helpful sources of information or support in dealing with mistreatment or abuse issues:

- UNLVSOM Personnel

Leave Policy

I. Sick Leave

A. All residents receive 15 days of paid sick leave (which will be based on a five day work week) during the initial 12 months of service. Beginning 12 months after the starting date of the contract, the resident will begin to accrue additional sick leave at a rate of 1-1/4 days per full month of service to add to any remaining balance of unused sick leave from the first 12 months of service. Sick leave may be accrued from year to year not to exceed 15 work days at the last day of each month.

B. If a sick day is necessary, the resident is required to notify the clinical supervisor and the Residency Coordinator prior to his/her scheduled start time. If the resident requires more than one day off due to illness, he/she is required to notify the clinical supervisor and the Residency Coordinator each day. Failure to do so may result in disciplinary action.

C. If a resident is out for longer than 3 days, please have them contact :

- Maria Langely: Maria.langley@unlv.edu
- Or Kelly Scherado: Kelly.Scherado@unlv.edu

D. Sick days are for use only in the case of a scheduled physician or dentist appointment, or on those days in which the resident is so physically ill that getting out of bed would be nearly impossible. This degree of illness suggests a severity that would require an appointment with a licensed physician in the community for evaluation and treatment.

E. As physicians, our primary duty is to our patients, both legally and ethically, and by extension, the service where duties to patients are provided. Minor illness such as a cold or aches and pains are not severe enough for a physician to fail to perform the primary role of patient care.

F. Sick day usage will be carefully monitored. Should a pattern of sick days be identified, or if excess days are taken in a particular month, rotation or year, the department will require a note from a community based physician (neither resident, nor University, nor friend) on a daily basis for each sick-day requested from that point forward.

G. Sick days are not for use as general leave days, nor may they be used to extend a scheduled vacation or educational leave.

H. Abuse of the sick day policies will result in the days being ruled as unexcused absences and will require make up days prior to graduation from residency, as required by the ACGME. In addition, abuse of sick day policies may result in disciplinary action as a failure of professional conduct through the University of Nevada.

II. Annual Leave

A. All residents will receive 15 days of annual leave at the start of each PGY, which will be based on a five day work week during the academic year. Unused annual leave may NOT be carried forward to the next year. No sick day can be used before or after annual leave. If you do call in sick, the department will require a note from a community based physician (neither resident, nor University, nor friend)

B. If a scheduled vacation includes a national holiday, no additional time will be given for that holiday. Holidays will be balanced by the Program Director in a fair and equitable manner.

C. Residents must provide 60 days advance notice to any institution regarding vacation time away from the work site. After obtaining written approval from the clinical supervisor, the resident must turn in the leave slip to the chief resident, who will verify that no other resident or attending has leave approval

during the same time period. The chief resident will then submit the leave slip to the Program Director for signature, and a copy of the approved leave slip will be given to the resident.

D. It is the resident's responsibility to insure that all call responsibilities are covered during his or her absence.

E. Unused annual leave will NOT be carried forward to the next training year.

III. Educational Leave

A. All residents will receive 5 days of educational leave at the start of each PGY, which will be based on a five day work week during the academic year.

B. This time may be used to attend an educational conference or to study for and/or take examinations.

C. If the resident uses the time to attend a conference or workshop, he/she will be required to bring in proof of attendance, such as an airline itinerary, conference registration payment receipt, and/or materials/handouts from the conference.

D. Residents must provide 60 days advance notice to any institution regarding education time away from the work site. After obtaining written approval from the clinical supervisor, the resident must turn in the leave slip to the chief resident, who will verify that no other resident or attending has leave approval during the same time period. The chief resident will then submit the leave slip to the Program Director for signature, and a copy of the approved leave slip will be given to the resident.

E. It is the resident's responsibility to insure that all call responsibilities are covered during his or her absence.

F. Unused educational leave may NOT be carried forward to the next training year.

Resident Duty Hours and Call Responsibilities

A. The program fully complies with the institutional policy regarding Duty Hours. Please review the institutional policy via the GME website.

B. PGY-1 work hours will not exceed 18 hours. While on the Primary Care/Neurology track, work shifts will be assigned by those services [IM/ER/Neuro]. While on Psychiatry at SNAMHS, the PGY-1 will alternate weekdays with an 8AM to 5PM work shift with an 8AM to 10PM work shift. The ward attending will be the supervisor form 8AM to 5PM; the RSU attending will be the supervisor from 5PM to 6PM; the PGY-2 resident on the RSU rotation will be the supervisor from 6 PM until 10PM. Weekend day coverage for "high risk" rounds at SNAMHS will have a specific identified on-site attending identified as the supervisor. The resident must identify with the patient both their own status as a resident and the name of the supervisor. Please see Supervision Policy within this manual. PGY-1 residents will have a minimum of 10 hours between work shifts free from clinical duty. PGY-1 residents may not moonlight, and may not take home call of any kind.

For the resident duty hours policy while on the Internal Medicine service and Neurology Service please contact Dr. Sandra Wahi.

For the resident duty hours policy while on the Emergency Medicine Rotation, please contact Dr. Ross Berkley.

There is no night call responsibility at UMC – C & A or UMC consultation service . The RSU rotation will begin with one week [total on the first unit of rotation] of 8AM to 5PM coverage. The balance of the RSU rotation will be a work shift starting between 4 PM and 6PM to midnight, in-house at SNAMHS, with the balance of the evening phone coverage from home. From 6PM to 10PM the resident will act as the supervisor for the PGY-1 resident. PGY-2 and above residents will have a minimum of 10 hours between work shifts free from any clinical duty.

PGY-2
VA: residents on the VA 2E inpatient service are expected to work holidays as if they are regular work days. SNAMHS has no weekend coverage, but work later hours for RSU. Seven Hills allows one weekend per month.
UMC: Weekend coverage as scheduled. Montevista: No weekend coverage

PGY-3 call is limited to VA short call and "home call" to SNAMHS during the first two weeks of each PGY-2 RSU rotation. The PGY-3 resident will provide day coverage to the UMC consult service on weekends.

PGY-4 has no expected call duties, but may be required to provide service one weekend day per week to the UMC consult service while on the Administrative Rotation.

C. There is a cap of seven complete work-ups per RSU evening shift.

D. While in the hospital, the resident must evaluate a patient within one hour of a restraint order being given, unless the hospital provides alternative policies for managing this situation.

F. In the event that the resident complement is reduced, call may not be increased beyond the maximums described above.

G. ACGME work hour's rules are fully respected. Under this system, no resident can exceed 80 hours per week of work averaged over a four- week period while on psychiatry services. The residency director should be immediately notified if ACGME maximum work hours are violated.

H. Residents must have one full day free of clinical responsibilities per week averaged over a four- week period.

Transition of Care/Handoff Policy

Formal training for effective, structured handoff process will be provided to PGY1 residents by a senior resident during orientation. Additionally, resident competency in the handoff process will be monitored and formally evaluated with at least one observed handoff by a senior/chief resident prior to the end of PGY-1. Formal evaluation will include direct feedback to the resident as well as the completion of Resident Handoff Competency Assessment form for the program director's review.

The only occasion in which direct patient care is transitioned from one resident to another is when the PGY1 resident leaves SNAMHS hospital at 10PM, transitioning the coverage of SNAMHS to the PGY2 resident on the RSU service. The PGY1 resident leaving the hospital must meet with the PGY2 resident prior to departing and sign out any problematic patient encounters from the evening to ensure continuity of care and patient safety.

The following template will be completed and utilized for each encountered, problematic patient case to incorporate both verbal and written communication in a face-to-face, uninterrupted handoff process.

Handoff Template

- Date/Time/Location/Unit Psychiatrist:
- Patient identifiers/demographics (must include name, DOB, MR#):
- Concise background psychiatric & medical history:
- Current problems & issues (including diagnoses, symptom/behavioral concerns):
- Current patient status:
- Current medications, PRNs given, other safety interventions:
- Pending labs/radiographic studies if applicable:
- Plan/suggestions:
- Time for questions:

Resident Handoff Competency Assessment

Date:

Resident evaluated:

	Unsatisfactory	Satisfactory	Outstanding
Identified patient			
Pertinent history provided			
Current concerns presented			
Discussed current medications & interventions			
Discussed plans & suggestions			
Both verbal & written communication incorporated			
Ability to answer questions			
Overall Performance			

Senior/Chief Resident Evaluator:

Resident Evaluator Signature:

Resident Evaluator Signature:

Moonlighting Policy

There are opportunities at SNAMHS to moonlight on a limited basis. Moonlighting will consist of home call, crisis unit coverage, face-to-face evaluations and high risk rounds. Residents must have approval of the Program Evaluation Committee, must have passed USMLE Step 3 or equivalent, must receive PRITE score of 350 and higher or completion of remediation if fail, and must be PGY-2 or higher level year of training.
Compensation for moonlighting is paid on a monthly basis. All moonlighting must be considered part of the 80 hour weekly limit on duty hours. Moonlighting must be secondary to required residency activities or calls.

"**External moonlighting outside of the UNLVSOM system is not allowed per policy."**

Anyone who takes Educational Leave or Sick Leave and then provides moonlighting hours on the same day or calls in sick after moonlighting will summarily lose moonlighting privileges for an indefinite time period to be determined by the PEC on a case by case basis.

**** J1 Residents are prohibited from all moonlighting.

Resident Log

A log must be kept on all psychiatric patients and neurologic patients seen during the residency. (See Appendix C for the Patient Log form.) Residents must submit their Patient Log and Summary Sheet by January 10th and July 10th to the training office. The data form may be redesigned from time to time to keep pace with training advancements in the program.

The resident should compile the data into a summary of demographic and diagnostic data. The data is used to monitor resident progress, i.e. at six month evaluations and the yearly review for advancement; to monitor the diversity of one's training experience; to document supervision and didactic hours; and to justify or change program rotations to provide more comprehensive, well-rounded training. Accreditation authorities may periodically review data.

Certification of training is partly based upon the Log Summary Sheet information. The resident is advised to save a copy of all log summary sheets until Board certification.

Experiential Checklists

Experiential checklists are an attempt to make certain residents master basic skills and are competent as general adult psychiatrists before completion of training. Formal checklists are expected to be dynamic and will be reviewed on a yearly basis by the Residency Training Committee. Residents are expected to consult with supervisors regularly regarding completion of these checklists and seek out training activities when necessary. Checklists are found in Appendix C.

Supervision Policy

Onsite and Off-site Formal Supervision

The act of clinical supervision is a mainstay of psychiatric training, and essential in aiding the resident to gain both knowledge and skills as a psychiatrist. Although there is considerable supervision and feedback provided during daily rounds at clinical sites, this is not adequate to serve as the formal supervision required by the ACGME. The resident must meet with his/her on-site clinical supervisor at least one hour per week, and in addition, must meet with his/her off-site clinical supervisor for at least one hour per week. This provides the resident with a minimum of two hours of formal supervision weekly face to face.

The purpose of the supervision is to provide direct feedback in honing each of the skills required under the ACGME competence based educational requirements. Specifically, the supervision time provides assistance, advice, and feedback on the basic skills of becoming a psychiatrist: assessment, interview, diagnostic considerations, and treatment considerations, in addition to evaluation of transference and counter-transference. These sessions will aid in all aspects of the resident's transition from student to professional and should include: Patient Care, Medical Knowledge, Practice Based Learning examples, Interpersonal Communication Skills, Professionalism, and Systems Based Practice Knowledge.

The onsite supervisor is often the attending for the service, but will be assigned by the Chief of service at the facility, often after consultation with the program director. The program director assigns the off-site supervisor.

Additional supervision may be requested for other special projects, such as research, group therapy or family therapy, or issues related to acculturation.

Evaluations will be completed by supervisors either at the end of rotations, or every six months, whichever is more frequent. Evaluations must be completed on a monthly basis for residents who are on probation status.

A resident or a supervisor may request a change of supervisor. It is expected that the resident and the supervisor will have made a significant effort to discuss the problems and concerns prior to a request for change reaching the program director.

Supervisory Levels

There is an additional supervision process defined by the ACGME in terms of levels of supervision. A PGY1 resident begins clinical experience with DIRECT supervision, which means that a supervisor, which may be an attending or an upper year resident, must be directly available on the unit for all of the clinical experiences or INDIRECT SUPERVISION WITH DIRECT SUPERVISION IMMEDIATELY AVAILABLE, in which the supervisor is rapidly available for direct supervision; however the supervisor may be in other areas of the hospital. The Psychiatry RRC has defined the transition to INDIRECT SUPERVISION WITH DIRECT SUPERVISION AVAILABLE [where the supervisor is not immediately available to be within the hospital, but may return to the hospital in a reasonable timeframe] as requiring the resident to demonstrate four competencies:

1. the ability and willingness to ask for help when indicated
2. the ability to gather an appropriate history
3. the ability to perform an emergent psychiatric assessment
4. the ability to present patient findings and data accurately to a supervisor who has not seen the patient.

The facility attending may sign an attestation to these four competencies to present to the PEC, which will officially confirm the status of the resident, with the signature of the program director. The PGY2 and above resident and above should demonstrate skills which allow for the OVERSIGHT level of supervision, in which supervision may be provided by phone.

The patient and staff must be informed of the respective roles of the resident and the supervisor.

Please note that the Psychiatry RRC allows non-physician supervisors to supervise appropriate situations, such as a psychologist providing supervision for group therapy, as an example. The standard for non-physician supervisors is "any licensed practitioner." Note: APNs and PAs may not act as supervisors for residents.

By Policy the resident must contact the supervisor if:

1. There is evidence of serious medication toxicity [NMS, LiCO3]
2. An outpatient becomes acutely suicidal
3. An outpatient becomes assaultive, destructive to property, or homicidal
4. A patient requires transfer to a different level of care
5. A patient demonstrates an acute change in medical status
6. A death of a patient.
7. Any concern regarding patient care which is not specifically listed above.

For the supervision policy while on the Internal Medicine service, please contact Dr. Sandra Wahi.

For the supervision policy while on the Family Medicine service, please contact Dr. Kate Martin.

For the supervision policy while on the Emergency Medicine Rotation, please contact Dr. Ross Berkley.

For the supervision policy while on the Neurology Service, please contact Dr. Sandra Wahi.

Psychotherapy Training Requirements

A. All residents on psychiatry services attend Balint Group to discuss the doctor-patient relationship. This group focuses on non-threatening discussion of transference and counter-transference to improve self-introspection and patient care.

B. PGY-1 & PGY-2 residents are expected to participate in family meetings and group therapy sessions at clinical sites, in addition to interviewing patients daily to gain an appreciation of psychological process. Basic coursework is provided during the PGY-2 year to familiarize residents with the basic concepts of the various schools of psychotherapy.

C. PGY-3 residents markedly enlarge the knowledge base and experience base with psychotherapy in the outpatient settings. Coursework during the PGY-3 year focuses upon the psychotherapeutic modalities. Basic requirements include at least:
   1. Five individual patients in long term psychodynamic therapy weekly for at least 45 weeks.
   2. Three individual patients in brief dynamic therapy from 6 to 40 sessions.
   3. Six individual patients in cognitive behavioral therapy.
   4. Three couples or family therapy.
   5. Twenty sessions as a co-therapist in an outpatient group therapy.
   6. Ten individual patients in supportive therapy.

D. PGY-4 residents participate in advanced seminars in psychotherapy and may continue additional training in any of the above modes of psychotherapy with supervision and ongoing patient care.

Site Standards for Inpatient Resident Training

A. The PGY-1 resident on psychiatry services must carry a case load of not more than 7 cases per workday.

B. The PGY-2 resident on inpatient psychiatry services must carry a case load of not more than 8 cases per workday. On RSU service during a day shift, the resident may evaluate up to 10 patients total. On night shift RSU service, the evaluation cap is 7.

C. The PGY-4 resident case load is site specific, but should be focused upon the educational component of care rather than service requirements.

D. The resident must have adequate time for case evaluation, must participate in team meetings, and must provide input in the patient's care.

E. The PGY -1 and PGY-2 must see each inpatient case individually each weekday, and document the visit in the chart. The resident may not limit visits to treatment team meetings.

The resident must have a minimum of one full hour to complete a patient assessment, with additional time for paperwork requirements.

A maximum of three new patient intakes may be scheduled in one clinic day.

Follow up treatment scheduling must be at the resident's discretion to allow for educational experiences in weekly therapy modalities. The resident must be allowed the option to follow any new patient which he/she evaluates.

PGY -3 Medication management follow up visits must be scheduled for no less than thirty minutes. These visits must be scheduled no later than four weeks from an initial assessment and no later than one month for routine visits after stabilization.

A typical workday should consist of approximately 8 medication follow-up patients and 4 follow-up psychotherapy patients at each site. One of those hours of the day must be dedicated to co-leading a group in an outpatient setting, and/or to off-site supervision.

Chief Resident Position

A. The Chief Resident will be voted upon and/or assigned by the Residency Training Committee in April. The selected resident will assume the duties of Chief Resident on May 1.

B. This is a one year position, typically but not necessarily, held in the PGY-4 year of training.

C. The Chief Resident works closely with the program director and the Residency Training Committee. Specific responsibilities include, but are not limited to: creating the call schedule, helping organize medical student education, addressing training site problems, addressing resident concerns, resolving complaints relating to the call schedule, interviewing applicants to the program, and helping facilitate the transition of new residents into the program.

Duties of Chief Resident(s)

1) Advocate for the residents:
   The Chief Residents are the spokesperson for the residents as a group. The CR(s) is to present the residents' concerns and suggestions as represented by the group. The CR then has the duty to report back the results of the meeting.

2) Conflict Manager for the residents:
   The CR is authorized to resolve any conflicts in schedules, illness, or rotations that can be handled appropriately. Conflicts of a personal nature should be kept in strictest confidence while being addressed in appropriate channels. If the conflict exceeds the CR ability to manage, then consultation with the PD is appropriate.

3) Role Model for the residents:
   The CR is above all else, a model for the junior residents in how to conduct oneself as a physician. The CR should be present at official functions, lectures, meetings, groups and rounds.

4) Resident recruitment and orientation:
   It is a primary responsibility of the CR to orient and assist the new residents beginning their career with UNSOM. It is a primary responsibility of the CR to assign second year "buddy" residents to the new residents, to participate in interviews, selection, and logistics as assigned by PD.

5) Administrative Duties of the Chief Resident;

   a) The CR is responsible for organizing and producing the annual resident retreat report. This duty includes agenda, physical needs, voting requirements, compliance with standing rules and rules of order, composing and assembling the report, and delivering it to PD on time.

   b) The CR is responsible for the introduction and orientation of new residents to the program.

   c) The CR is responsible to see that the yearly call schedule is completed and delivered in a timely manner.

   d) The CR is responsible for delegating any duty for which they hold the authority, when it is in the best interest of the residency to do so.

Research Policy

Each resident must complete at least one scholarly activity over the course of the residency. This requirement is not fulfilled by any of the usual presentations required in the weekly schedule. Scholarly activity may be defined as: conducting research, presenting at a national conference, writing textbook chapters in the area of psychiatry, submitting research for publication, participating in the UNLV/SOM Resident Research day, writing an exhaustive review article on an area of interest, presenting a formal Grand Rounds.

Residents should conceptualize the scholarly activity in the PGY-1 and PGY-2 years, during which time discussion should occur with the supervisor. The program director must approve the scholarly activity: this approval should occur before the end of the PGY-2 year (see Appendix C for the Resident Research/Academic Project form.) The resident has the balance of the PGY-3 and PGY- 4 years to complete and present the project.

This is a graduation requirement for all residents.

QI Project Requirement Policy

Each resident must complete a full QI project, but may collaborate with other residents for this purpose. This project must be completed prior to successfully completing the PGY3 year.

Textbook Reimbursement Policy and Board Reimbursement Policy

Provided a positive budget in the residency moonlighting fund, each PGY-1 resident may request reimbursement for up to $100 in textbooks per academic year. The request must fall within the academic year the books were purchased, and must be processed prior to June 1.

Program Evaluation Committee

A. The PEC is the single committee within this residency which addresses all administrative issues and requirements of the residency.

B. Specific responsibilities of the committee:
1. Establish administrative policies and procedures
2. Review curriculum at least annually
3. Monitor PRITE scores
4. Monitor clinical skills verification examinations
5. Monitor comprehensive oral examinations
6. Certify various competencies as required by the RRC
7. Program evaluation at least annually
8. Review of training site evaluations
9. Monitor program goals and objectives
10. Resident recruitment, interviewing and selection
11. Review resident performance and selection

C. Decisions are made by a majority vote of members present and are binding. Decisions may be appealed to the department chairman within 10 work days. The chairmen will then review the matter, hear arguments and make a final determination within 30 days of the appeal date.

D. Membership, meeting times and agenda
1. Residency training director is the chairman of the committee.
2. Residency coordinator is the secretary of the committee.
3. Membership includes up to three residents, but must include the chief resident.
4. Membership includes one faculty member from each clinical site.
5. Membership includes one faculty member appointed by the chair of psychiatry.
6. At least four members of the committee must be present for formal business or for voting to occur.
7. Meeting time is the first Wednesday of each month at 12 noon.
8. The agenda is set by the residency training director. Members should contact the residency coordinator in advance to have items added to the agenda.
9. Each meeting will include reports of training site status, resident progress/advancement, issues related to resident selection, resident issues regarding the program.
10. Minutes are maintained by the residency coordinator: the first portion of the meeting minutes are open for review, the second portion of the meeting regarding resident progress is confidential and not available for general review.

Clinical Competency Committee (CCC)

A. The goal is to have the CCC review input from different sources. The role of the CCC is to consider all of the evaluations and make an overall decision on how the resident is progressing, and which milestones have been met and which Milestone level to continue to work toward.
B. The chair of the CCC will be appointed by the Program Director
C. Responsibilities of the CCC include:
    a. Reviewing all residents on a semi- annual basis
    b. Prepare milestone evaluations on each resident semi annually
    c. Advise program director regarding resident progress including promotion, remediation and dismissal.

UNIVERSITY OF NEVADA SCHOOL OF MEDICINE
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES
PROGRAM EVALUATION COMMITTEE

2018-2019

Standing Agenda

Training Site Status Report

Resident Issues

Program Marketing and Resident Selection

Review of Resident Progress, Evaluations and Patient Logs

Resident Advancement

Progress Review Meetings

A formally scheduled bi-annual meeting with the Residency Director to review progress through the training program is a condition of the program's accreditation. (See Appendix C for evaluation form.) Residents will be notified regarding this meeting schedule.

The Residency Director and the resident will review the resident's patient log to assess whether or not the resident is seeing an adequate variety of patients by age, sex, and diagnosis and treatment modality. Concerns about the resident's caseload will be communicated to the Residency Training Committee for corrective action. The Residency Director will especially monitor the number of cases in long-term treatment (more than 12 months). The Residency Director will also examine progress on training experiential checklists.
Rotation evaluations as well as PRITE scores, Clinical Skills Examinations, and Comprehensive Oral Examination results will be reviewed with the resident. If negative trends are noted, an effort will be made to provide corrective experiences for the resident.

The personal well- being of the resident will be discussed, particularly if a problem impacts on the resident's training. When needed, referrals will be suggested to deal with personal problems.

The Residency Director will also pay special attention to ethnic and cultural issues to guarantee adequate exposure during training. A written record of progress review meetings will be kept in the resident's file.

Evaluation, Advancement, Discipline/Remediation and Dismissal

A. Examinations

During the fall of each year of training, residents are given the Psychiatry Resident in Training Examination (PRITE) published by the American College of Psychiatrists. The PRITE provides an objective external criterion to help scrutinize curriculum content, goals, and effectiveness. It is not meant to be a certification instrument. It will be used as only one factor among many for assessing the competency of a resident.

The primary objective is to provide educationally useful feedback to residents and the Residency Director. Each resident receives a detailed computer analysis of his/her test performance in comparison with other residents at a similar level of training. The training director receives statistical summary data comparing his/her training program with other groups of participants. In addition, the training director receives copies of test results of individual residents. Otherwise, test results are kept strictly confidential.

The PRITE is a two stage, timed, proctored, and closed-book examination taken under group testing conditions by all residents in the program. The examination takes approximately 150 minutes on two different occasions, usually scheduled early in October of each year.

Thirteen categories of information are examined including neurology and neurosciences, growth and development, adult psychopathology, emergency psychiatry, behavioral science and social psychiatry, psychosocial therapies, somatic treatment methods, patient evaluation and treatment selection, consultation-liaison psychiatry, child psychiatry, alcoholism and substance abuse, and miscellaneous, a category with questions on forensic psychiatry, history of psychiatry, administrative psychiatry, ethics, and topics not elsewhere classified.

As per GMEC policy, a resident who scores less than at the 30%tile in the psychiatry portion of the PRITE as compared with peers at the same level of training will be assigned remediation tasks.

As per the ABPN rules, each resident must successfully complete three clinical skills examinations within the PGY-1 and/or PGY-2 year of psychiatry training. A resident should turn in official signed forms for the evaluation of this interview for each attempt, <u>whether the ultimate score was passing or non-passing.</u> Failure to successfully complete three clinical skills examinations by the end of the PGY-2 year will result in remediation and/or a notice of non-renewal of contract. Three examinations must be passed in order to qualify to take the Board Examination for the American Board of Psychiatry and Neurology in the area of Psychiatry. This examination includes focus upon the ability to establish rapport, conduct a professional psychiatric interview and mental status examination; it does not include any discussion of treatment or of differential diagnosis. The examination is considered to be a basic level examination which tests a skill set which should be accomplished early in psychiatric training. The exam form is available in Appendix C.

During PGY-2, PGY-3, and PGY-4, residents sit for a comprehensive oral examination patterned after former Part II of the American Board of Psychiatry and Neurology. During this examination, the resident examines a patient for 30 minutes, followed by a 30 - minute examination in which the resident presents the case, provides a bio psychosocial formulation, makes multiaxial diagnoses, and discusses a bio psychosocial treatment plan. The exam form is available in Appendix C.

The results of the PRITE, the Clinical Skills Assessment, and the Comprehensive Oral examination are given to the resident and his supervisor for review and feedback. Results are reviewed by the Program Evaluation Committee during reappointment deliberations during the spring of each year.

B. Ongoing Performance Evaluations

Residents are both evaluators of the system and are evaluated by it. Residents provide evaluations of their rotations, clinical supervisors, psychotherapy supervisors, and didactic seminars. (See Appendix C.) These

evaluations provide information to help improve the program. Teaching evaluations are a major basis for promotion of faculty members.

All supervisors for either clinical rotations or individual psychotherapy fill out timely end of rotation forms on all aspects of clinical competence of residents (see Appendix C for rotation-specific evaluation forms.) These are reviewed by the resident and Residency Director. Performance problems and issues are discussed with the Residency Director who may refer the problem to the Program Evaluation Committee , which may make recommendations for remedial action.

C. Evaluation Process

During PGY-1 – 4, evaluation forms will be distributed from the manual at the end of each rotation. The residents will also be given evaluation forms to evaluate faculty members and the rotation. The residency coordinator will file the resident's report on the rotation. Each resident will formally meet with the Residency Director on a semiannual basis to review progress and evaluation materials. These meetings will be documented and information placed in the resident's file in the residency office. If evaluations reflect problems, more frequent evaluations and meetings with the Residency Director will be scheduled.

Residents are expected to attend all seminars and case conferences. The residency coordinator must be contacted if a resident is unable to attend. If lack of attendance becomes an issue, it will be reviewed by the Program Evaluation Committee, which may impose the following sanctions: The resident's reappointment may be delayed and/or a letter of reprimand may be sent, a copy of which will be entered into the resident's personal file. The resident may also be required to obtain reading materials on the didactic subjects taught in his/her absence, and to sit for a written or oral examination on the material. If a resident does not present at his/her scheduled journal club or case conference, the resident will be assigned a topic by the Residency Director or Associate Residency Director and develop an evidence based presentation of 1-2 hours that will include power point.

Following semiannual meetings with the Residency Director, a verbal or written report will be made to the Program Evaluation Committee. A written final evaluation will be prepared for each resident completing the program.

D. Residents who fail to complete A, B and C above will be referred for probation, remediation or discipline per policy established by GME.

Residents will be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional growth. This same process will be followed in making a decision to dismiss a resident whose performance is unsatisfactory.

May 23, 2011

MEMORANDUM

TO: Comprehensive Oral Examination Proctors

FROM: Gregory P. Brown, M.D.

SUBJECT: Instructions for Conducting Comprehensive Oral Examination

The goal of the comprehensive oral examination is to comply with RRC requirements for resident assessment. Please adhere to the following instructions:

1. All comprehensive oral examiners must be board certified by the American Board of Psychiatry and Neurology.

2. As a volunteer comprehensive oral examiner, you will be given a date, time, and place to appear 15 minutes before the actual examination.

3. During this 15 minute pre-examination, you will be furnished with an examination feedback form (see Appendix C) with the examiner's name, resident's name, and examination room.

4. Five minutes before the examination, proceed to the examination room where the patient will be seated.

5. At the scheduled examination time, the resident will appear.

6. Indicate to the resident examinee that he or she has 30 minutes to conduct the examination and that you will inform the examinee when 5 minutes remains.

7. Due to the potential for distraction, do not take notes during the examination, but the resident examinee is permitted to do so if he or she wishes.

8. After 30 minutes, the patient should be excused.

9. Provide time for the resident examinee to briefly collect his or her thoughts, and then present the patient to you.

10. Roughly 10 minutes each should be spent on the presentation, diagnosis, and treatment plan.

11. Do not provide verbal or non-verbal negative or positive feedback during the examination.

12. Stop immediately after 30 minutes and excuse the resident examinee for 5 minutes while you complete the examination feedback form.

13. Commit yourself in writing to comments related to each section of the examination feedback form and to a score before discussing the results with the examinee.

14. Provide feedback regarding both strengths and weaknesses.

15. Remember that this is an examination of clinical skills, and not details which are covered in the preliminary written examination (Part I).

June 30, 2010

UNLV /School of Medicine Department of Psychiatry, Las Vegas - Policy regarding Clinical Skills Certification Examinations:

1. The UNLV/SOM department of psychiatry adopted an AADPRT version of the ABPN approved format for this examination, which is in Appendix C.
2. This policy applies to any PGY-1 resident starting in the UNLV/SOM program July 1, 2007, or after; and to any PGY-2 resident starting in the UNLV/SOM program July 1, 2008, or after, as per ABPN requirements for Board Certification in Psychiatry.
3. Each resident should attempt this observed examination with the unit attending, who MUST be an ABPN certified psychiatrist, at least once every three months (recommended monthly) in the psychiatry portion of the PGY-1 and anytime during the PGY-2 years, until the required number of passes have been obtained.
4. Both passing and failing examination forms must be turned in to the psychiatry office for inclusion in resident files. There is no expectation that all examinations should be passed, as this is a measure of competency which is expected to improve over the course of training.
5. The program requires the resident to complete 3 passing examinations prior to January 1 of the PGY-2 year. This will allow the program to notify the ABPN that the Clinical Skills portion of the Board process is certified by the program. *Note: this is a more stringent policy than the ABPN requires, but the more stringent requirement is allowed by both the ABPN and the RRC.
6. The resident may attempt this clinical examination any number of times, with no penalty during the PGY-1 and PGY-2 years of training; the only requirement is that three passing examinations be completed prior to the completion of the PGY-2 year.
7. A resident who fails to complete three passing scores by the end of the PGY-2 year may receive remediation, or may be given an NNR, as the skill set for this examination is rudimentary regarding establishing the doctor patient relationship.
8. This examination does not substitute for the ‘comprehensive oral’ examinations which occur annually for PGY-2 – PGY-4 residents. As per ACGME/RRC policy, the comprehensive oral examinations have a considerably larger scope of assessment.
9. A resident who fails to complete 3 passing examinations by March 1 of the PGY-2 year should expect to receive an NNR, as the skills assessed by the Clinical Skills Certification Examination is considered essential to the practice of psychiatry.
10. An exception will be made with regards to the time frame for residents transferring in from other programs in their PGY-2 year.

Essentials and Special Requirements

UNLV School of Medicine Psychiatry Residency Program is accredited by the Accreditation Council for Graduate Medical Education. An approved residency program in psychiatry must demonstrate that it provides an educational experience of such excellence as to assure that its graduates will possess sound clinical judgment and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders and the common medical and neurological disorders which relate to the practice of psychiatry. Those individuals who satisfactorily complete this program will be competent to render effective professional care to patients. Furthermore, they will have a keen awareness of their own strengths and limitations and of the necessity for continuing their own professional development.

Both the institution at large and the training program have met specific standards listed in the Essentials of Accredited Residencies.

Quality Assurance

Each clinic or hospital where residents train has quality assurance protocols. Patient care at all training sites, including University Medical Center, VA Medical Center, Montevista, Seven Hills, Healthy Minds and Southern Nevada Adult Mental Health Services, are reviewed by the appropriate services in adherence to Joint Commission on Accreditation of Health Care Organization standards.

Infection Control Policy

Blood had borne pathogens as an e-learning module is available online through the Web Campus system. It is an UNSOM requirement that all residents, new and continuing, must have this training completed in a timely manner as defined by the GME office annually. During orientations to each training site, residents should become familiar with infection control policies particular to the site.

Should a resident be exposed to a blood borne pathogen, he/she should follow the policy outlined in the UNLV GME Resident Handbook Section IX: Human Resources: Bloodborne Pathogen Exposure

https://www.unlv.edu/medicine/gme/handbook

Appendix A

Goals and Objectives of Rotations

Goals and Objectives of Rotations

Introduction:

The ACGME has mandated that programs move to a competence based method of training and evaluation. The UNLV/SOM department of psychiatry in Las Vegas has decided to pilot a competence based evaluation system based upon the Dreyfus Model. This is a substantial change from normative grading scales that faculty and residents may have become accustomed to in other locations. This competence based model focuses upon skill sets that mature as the resident progresses.

The PGY-1 & 2 residents will have requirements defined within a Novice range of expectation. The PGY-3 & 4 residents will have requirements ranging from the Advanced Beginner to the level of Competence. Ranges of Proficient to Expert are reserved for clinicians who have practiced from five to ten years, and are not generally applicable to the resident setting.

There may obviously be some skill sets, such as professionalism, for which even the PGY-1 resident may be held to a standard of Competence rather than Novice, as the Novice skills should have been mastered while a medical student.

Scoring for the evaluations will match the goals line by line, and will consist of "falls short of this expectation," "meets this expectation," or "substantially exceeds this expectation." Remarks from the evaluator must accompany either the deficiency or the exceptional categories, but are welcomed from all evaluators.

Areas of concern in which the evaluator considers the resident as not meeting the expectation will require remediation. This activity will be individually designed and approved by the Residency Training Director and the Residency Training Committee.

PGY-1 Six Month Inpatient Psychiatry Rotation
Southern Nevada Adult Mental Health Services

This rotation is designed to expose residents to the evaluation and treatment of patients on an acute inpatient psychiatric service. In addition to the evaluation of severe mental illness, such as the mood disorders, the schizophrenic spectrum of disorders, the anxiety disorders and the personality disorders, residents will assess co-morbid conditions such as medical factors affecting psychiatric condition and effects of substance abuse and dependence on psychiatric illness. Residents will gain experience with substance detox and management, including weighing diagnostic factors in the evaluation of substance abuse within the context of mental illness.

Objectives:

Patient Care:
1. Resident documents thorough, detailed histories of each patient.
2. Resident recognizes emotional responses from patient interviews.
3. Resident establishes rapport with patient during interviews.

Medical Knowledge:
1. Resident states diagnostic criteria from the DSM-5 for common psychiatric illnesses seen on inpatient services.
2. Resident accurately applies diagnostic criteria to inpatient psychiatric cases.
3. Resident initiates appropriate initial treatment interventions with the support and advice of the attending physician.

Practice Based Learning:
1. Resident documents appropriately in the electronic computerized record.
2. Resident presents difficult cases to supervisor and explores the contributing factors to the challenging case.
3. Resident describes basic class effects of psychotropic medications and the purpose of each in the management of psychiatric cases.

Interpersonal Communication Skills:
1. Resident communicates respect for fellow treatment team members.
2. Resident actively participates in treatment team meetings on inpatient services to encourage bio-psycho-social understanding of the case.
3. Resident discusses how resident is perceived by patients and staff with supervisor.

Professionalism:
1. Resident is timely in appearance and with work product.
2. Resident seeks appropriate consultation regarding cases and feedback regarding diagnosis and treatment.
3. Resident demonstrates honest communications with colleagues, peers, and patients.

Systems Based Practice:
1. Resident appropriately refers patients to lower levels of care in the community as the patients stabilize in inpatient settings.
2. Resident participates in the civil commitment court process on behalf of the resident's patient

PGY-1 Six Month Primary Care Sequence
UMC

This set of rotations includes two months of internal medicine, one month of emergency medicine, one month of family medicine, and two months of neurology. The purpose of completing these requirements is for the resident to understand the inter-relation of psychiatry and medical care. Specifically, the resident should understand the psychiatric presentations of medical illness to encourage appropriate referral, and to understand the physical illness which may affect psychiatric patients.

Objectives:

Patient Care:
1. Resident performs history and physical examination at the level of an early PGY-1 resident on primary care services.
2. Resident identifies medical conditions and participates in the team of treatment.

Medical Knowledge:
1. Resident identifies patients with medical problems which might present with behavioral symptoms.
2. Resident orders proper work-ups for common medical illnesses.

Practice Based Learning:
1. Resident demonstrates ability to use information technology to obtain data related to diagnostic work-up.
2. Resident presents formal didactic material as assigned by the service.

Interpersonal Communication Skills:
1. Resident demonstrates listening skills in the context of medical evaluations and assessment.
2. Resident communicates with senior residents and attending's regarding patient care and expectations.

Professionalism:
1. Resident attends at least 80% of service related activities in a timely manner.
2. Resident respects all patients irrespective of age, gender or disability status.

Systems Based Practice:
1. Resident discusses alternatives of care in terms of risk/benefit analysis.
2. Resident discusses alternatives of care in terms of cost effectiveness.

PGY-2 Inpatient Psychiatry Rotation
Seven Hills Hospital and V.A. Southern Nevada Health Systems (includes geriatrics)

This VA/Seven Hills Hospital inpatient rotation in psychiatry allows the specialized evaluation and treatment of anxiety disorders, mood disorders, psychotic disorders and substance abuse/dependence disorders. This unit is designed for voluntary patients, and includes considerable experience with PTSD in addition to geriatric populations and substance induced psychiatric conditions. The resident will learn the principles of geriatric assessment and treatment.

Objectives:

Patient Care:
1. Resident generates a full differential diagnosis, based upon DSM-5.
2. Resident appreciates and responds to the emotional communications of patients accurately.
3. Resident identifies patients with cognitive decline and evaluates.

Medical Knowledge:
1. Resident assesses diagnosis in consideration of substance and/or cognitive impairment, and appropriately applies DSM-5 diagnostic rules.
2. Resident orders medications from the appropriate medication class for patients evaluated.
3. Resident properly initiates detoxification protocols for substances of abuse.

Practice Based Learning:
1. Resident explores counter-transference emotions regarding patients with co-morbid personality and trauma related issues with supervisor.

Interpersonal Communication Skills:
1. Resident demonstrates an ability to develop rapport with patients during clinical interviews.
2. Resident actively participates in treatment team meetings.

Professionalism:
1. Resident demonstrates empathy and understanding with the patient population.
2. Resident maintains professional interactions with patients, staff and fellow residents.
3. Resident accurately signs-out to the on-call residents.

Systems Based Practice:
1. Resident understands the VA system of care for psychiatric patients.
2. Resident describes the community resources post-discharge for elderly patients, substance abusing patients, and veterans in general.

PGY-2 Consult & Liaison Psychiatry Rotation
University Medical Center

This rotation on the busy consult service at UMC includes experience with adult, adolescent and child presentations ranging from severe psychiatric illness, to substance intoxication to medico-legal assessments including competence to make medical decisions and decisions regarding the implementation of involuntary psychiatric holds (Legal 2000). There is a small emergency holding area covered by this service as well where triage skills are trained.

Objectives:

Patient Care:
1. Resident communicates with referring physicians to focus consultation needs to that requested.
2. Resident obtains an accurate and efficient history from patients.
3. Resident integrates the facts of the case to reliably attain differential diagnosis.

Medical Knowledge:
1. Resident critically analyzes data regarding medical conditions which might present with psychiatric symptoms.
2. Resident recommends the appropriate work-up to determine symptom etiology.
3. Resident recommends the most appropriate medication and/or psychotherapeutic intervention for patients.
4. Resident demonstrates knowledge of medication interactions and appropriately reasons regarding medication choices.

Practice Based Learning:
1. Resident communicates limitations in knowledge regarding case material and appropriately recommends consultation from other specialties.
2. Resident obtains feedback from the referring service regarding the usefulness of the consultation.

Interpersonal Communication Skills:
1. Resident communicates clearly with the referring service.
2. Resident focuses upon communicating an answer to the specific question of the consultation.
3. Resident presents cases to the attending physician in a clear, organized, concise and accurate manner.

Professionalism:
1. Resident completes the consultation within one work day of notification.
2. Resident maintains patient confidentiality by limiting discussions with the consulting service to appropriate times and places.
3. Resident respects other healthcare providers.

Systems Based Practice:
1. Resident understands the Nevada Law regarding involuntary commitment of patients.
2. Resident makes appropriate referrals to other levels of care.
3. Resident initiates the involuntary commitment process when clinically indicated.

PGY-2 Child/Adolescent Psychiatry Rotation
UMC/Montevista

The purpose of this rotation is to allow the resident to evaluate and treat psychiatric illnesses of childhood and adolescence. The resident is also expected to participate in family sessions to learn the dynamics of this type of therapeutic intervention, group therapy with this patient population, and interact meaningfully in treatment teams. This rotation also includes exposure to forensic adolescent population offenders. UMC/Montevista provide a wide range of mentally ill children and adolescents for the resident.

Objectives:

Patient Care:
1. Resident documents thorough history and evaluation from both patients and the patients' families.
2. Resident builds rapport with both child and adolescent patients.
3. Resident diagnoses conditions specific to children and adolescent patients using DSM-5 nomenclature.

Medical Knowledge:
1. Resident describes and understands the family system of patients and how this system affects clinical outcomes.
2. Resident demonstrates appropriate ordering of medications for child and adolescent populations.
3. Resident reviews recent research on treatment modalities and discusses with supervisor.

Practice Based Learning:
1. Resident describes and discusses limitations of knowledge with a focus on developing appropriate referral decisions.
2. Resident discusses transference and counter-transference experiences with clinical supervisor.

Interpersonal Communication Skills:
1. Resident leads or co-leads family meetings for both data gathering and therapeutic encounters.
2. Resident demonstrates tactful confrontation in family systems.
3. Resident presents cases accurately, completely and concisely to the treatment team.

Professionalism:
1. Resident demonstrates proper boundaries with staff, patients and families.
2. Resident demonstrates understanding of confidentiality in the context of families, minors, and legal guardians.
3. Resident demonstrates respect for the social, cultural and religious standards of the family of origin.
4. Resident accurately empathizes with patients without crossing the boundary to sympathy.

Systems Based Practice:
1. Resident appropriately refers patients to lower levels of care when stabilized.
2. Resident employs community resources in discharge planning.

PGY-2 Rotation in Emergency Psychiatry
Southern Nevada Adult Mental Health Services

The resident will evaluate patients in the crisis unit at SNAMHS and perform critical triage responsibilities under the supervision of faculty.

Objectives:

Patient Care:
1. Resident provides timely, accurate, complete evaluation of patients.
2. Resident makes accurate and complete differential diagnosis with an appreciation of medical and substance induced conditions.
3. Resident integrates knowledge to make appropriate disposition decisions.

Medical Knowledge:
1. Resident demonstrates critical analysis of cases and clear thinking skills.
2. Resident initiates treatment and refers to further appropriate treatment.

Practice Based Learning:
1. Resident uses diagnostic studies appropriately throughout the assessment.
2. Resident applies reasonable standard of care in triage decision making.

Interpersonal Communication Skills:
1. Resident presents a complete case to the attending physician.
2. Resident interviews and appropriately weights information from third party sources such as family.
3. Resident communicates effectively and respectfully with other members of the assessment team.

Professionalism:
1. Resident interacts with patients demonstrating an appreciation of their values and ideals.
2. Resident appreciates differences in culture, gender, age, and race and interacts in a non-judgmental manner.
3. Resident respectfully yet clearly communicates limits to patients.

Systems Based Practice:
1. Resident admits patients to inpatient levels of care when clinically appropriate.
2. Resident discharges patients to lower levels of care with appropriate referrals when clinically appropriate.

PGY-3 One Year Outpatient Psychiatry
VA, SNAMHS, HM and UNLV Student Wellness Clinic

The purpose of this rotation is to provide year- long continuity in three different outpatient settings where a wide range of patient demographic, psychiatric illness and treatment modalities may be experienced. The resident is expected to treat patients with different psychotherapeutic modalities (see section of handbook for minimums), in addition to providing psychopharmacologic interventions

Objectives:

Patient Care:
1. Resident documents thorough and complete assessment of outpatient psychiatric patients.
2. Resident accurately diagnoses psychiatric outpatients using the rules established by the DSM-5.
3. Resident prescribes medication of an appropriate class for the condition diagnosed.
4. Resident directly provides psychotherapy to appropriate patients.
5. Resident demonstrates capacity in group therapy, cognitive therapy, psychodynamic therapy, supportive therapy, interpersonal therapy, and family/couples therapy in outpatient settings.

Medical Knowledge:
1. Resident describes the model of cognitive therapy and applies to clinical cases.
2. Resident describes the model of psychodynamic therapy and applies to clinical cases.
3. Resident describes the model of interpersonal therapy and applies to clinical cases.
4. Resident describes the model of short term therapy and applies to clinical cases.
5. Resident describes the model of supportive therapy and applies to clinical cases.
6. Resident describes the model of systems theory and applies to families, couples and groups.
7. Resident appropriately chooses medication class, prescribes, and monitors response with patients.

Practice Based Learning:
1. Resident applies research base within psychiatry to choose therapeutic modality according to best practices.
2. Resident brings difficult cases to clinical supervision for discussion regarding limitations in knowledge base or skills.
3. Resident compares self-assessment with other assessments to illuminate possible limitations.

Interpersonal Communication Skills:
1. Resident establishes rapport with a wide range of patients, in the context of both initial evaluations and in follow up.
2. Resident actively listens to patients and appropriately responds to the patients' verbal and non-verbal communication.
3. Resident monitors the follow up rate of patients.

Professionalism:
1. Resident accepts responsibility for his or her actions.
2. Resident describes an understanding of the fiduciary relationship to patients and applies this standard to patient interactions.
3. Resident presents cases accurately, honestly and respectfully to clinical supervisors.
4. Resident is reliable and timely for duties in the outpatient setting.
5. Resident demonstrates maintenance of boundaries with patients.

Systems Based Practice:
1. Resident utilizes locally available resources for specific patient needs.
2. Resident understands the demographics of the patient population and how this impacts care.
3. Resident provides documentation at standards appropriate for regulatory review.

PGY-4 Rotation is Outpatient/Administrative Psychiatry and/or Telemedicine
UMC/SNAMHS/VA/HM and Roseman Private Office

The advanced resident will attend meetings and classes related to the administration of psychiatry in addition to acting as a junior attending and supervising the work of the junior residents on the service, while reporting to the attending.

Objectives:

Patient Care:
1. Resident models and emulates appropriate interview and diagnosis for the junior resident on this service.
2. Resident respectfully discusses pathology with patients in the hospital setting.

Medical Knowledge:
1. Resident supervises and teaches junior residents on the service.
2. Resident supervises and teaches medical students on the service.

Practice Based Learning:
1. Resident discusses appropriate use of diagnostic testing with junior residents.
2. Resident obtains research material to use scientifically based evidence for treatment decision making.

Interpersonal Communication Skills:
1. Resident lectures and teaches medical students and junior residents in an engaging and respectful manner.
2. Resident demonstrates excellent oral presentation skills to attending to model the skill for junior residents and students.

Professionalism:
1. Resident leads the resident team demonstrating ethical and responsible care.
2. Resident accepts the responsibility for the resident's behavior honestly and with insight.
3. Resident demonstrates proper communication to ensure confidentiality is maintained.

Systems Based Practice:
1. Resident attends QM meetings of the hospital.
2. Resident attends credentialing meeting of the hospital.
3. Resident attends administrative meetings of the hospital.

Appendix B

Goals and Objectives
Didactics Courses

PGY-1&2--Two Year Didactic Cycle

1.01 Grand Rounds

1.02 Case Conference

1.03 Journal Club

1.04 Resident Meeting

1.05 Balint Group

1. Residents will learn to identify the transference of the patient from the presented clinical case.
2. Residents will learn to identify the counter-transference of the physician from the presented clinical case.
3. Residents will learn that transference and counter-transference are normal processes that psychiatrist have a unique capacity to understand.

1.06 Textbook Review – Psychopathology

1. The resident will be exposed to the basic science foundation of psychiatry and illness.
2. The resident will be exposed to the basic psychological and social influences and data that form a foundation for psychiatry.
3. The resident will be exposed to considerable discussion regarding differential diagnosis of psychiatric symptoms.

1.07 Evidence Based Medicine

Define Evidence-Based Medicine (EBM).
Identify the parts of a well-built clinical question.
Identify EBM tools that will improve patient care.
Become familiar with lifelong learning strategies.
Identify key issues that help determine the validity of the results of a study.

1.08 Family & Couples Systems: Assessment, Treatment, and Intervention

1. The resident will become familiar with the history of family therapy as a treatment modality.
2. The resident will learn the five major theories/theorists of family therapy.
3. The resident will learn one model well but respect what the others have to offer.

1.11 Neurology Review

1. To understand the basics of history taking, physical exam and localization in neurology.
2. To understand the common neurologic disorders, their diagnosis, natural history, pathophysiology and approaches to therapy.
3. To recognize and understand the neurologic disorders likely to be encountered in the course of adult psychiatric practice and how to approach these.
4. To recognize psychiatric mimics of neurologic disease and neurologic mimics of psychiatric disease.
5. To understand the role of tests in modern neurologic investigation, particularly Neuro-imaging.

1.12 Adult Assessment, Mental Status Examination and Case Formulation

1. Resident will be able to correctly organize data into a mental status examination format.
2. Resident will be able to correctly identify the data for each portion of the bio psychosocial formulation.
3. Resident will understand the importance of both the mental status examination and the bio psychosocial formulation in the context of diagnosis and treatment planning.
4. Resident will be familiar with the data required to complete a diagnostic psychiatric evaluation.

1.13 Family Assessment

1. The resident will be able to describe the basic principles of Family Assessment.
2. The resident will be able to apply these principles to their own work.
3. The resident will be able to recognize when to use these principles.
4. The resident will be able to recite the five most important ideas of this framework.

1.14 Geriatric Assessment

Be able to describe the age-related changes in human metabolism as they relate to psychiatric treatment.

Be able to identify at least three significant psychosocial stressors frequently associated with advanced age.

Be able to critically assess psychodynamic phenomena in the end-of-life phase of old age.

Outline a logical process for assessment and interpretation of cognitive function.

1.15 Substance Related Disorders and Treatment

1. How to diagnose individuals with addiction
2. How to differentiate abuse vs. dependence
3. How to identify Dual diagnosis vs. primary substance abuse disorder
4. Learn how to treat and detox
5. What is medicinal Marijuana

1.16 Child and Adolescent Psychiatry: Development, Assessment & Treatment

The resident will learn how to perform a comprehensive psychiatric evaluation on patients under 18 with specific sensitivity to developmental lines and family dynamic.

The resident will learn the diagnostic criteria, epidemiology, etiology and comprehensive treatment planning for the major psychiatric diagnoses in the child and adolescent population.

The resident will be provided with an understanding of psychopharmacology as it applies to the youth population, including an overuse of 'off-label' use of medication as well as FDA approved treatments.

The resident will be prepared for boarding exams through the use of interactive patient vignettes, which will solidify their understanding of the material.

1.17 Psychiatric Diagnosis, Treatment, and Psychopharmacology

1. Become competent in DSM- 5 criteria of major psychiatric illnesses.
2. Understand neurotransmitter pathways and deficiencies in psychiatric illness.
3. Describe psychopharmacology and psychotherapy treatment modalities.

1.18 Introduction to Medico legal Concepts

1. The resident will be able to state the legal standards required for involuntary commitment of the mentally ill in the state of Nevada.
2. The resident will understand the specific nature of competence evaluations and how this differs from guardianship.
3. The resident will understand the procedure regarding competence issues within inpatient settings and how this affects capacity to enter into consent.
4. The resident will understand the standards within the state of Nevada for medication of a patient against that person's wishes.
5. The resident will be able to state the four "D"s of malpractice and cite two examples from the inpatient setting.

1.19 Cultural Issues: research from social psychology

1. Resident will be exposed to concepts originating from social psychology.
2. Resident will discuss ethical issues related to the work of social psychologists and experimental design.
3. Resident will consider the findings from social psychology experiments in evaluating patients and systems of care.

1.20 Psychiatric Advanced Directives

1. To provide information on Nevada State Laws governing patient's ability to direct their psychiatric care.
2. To familiarize with various forms of Psychiatric Advance Directives as available to patients in various states.
3. To educate on current research findings on utilization of psychiatric advance directives.
4. To describe essential components of informed consent for treatment.

1.21 Psychosomatics

1. Become familiar with psychiatric symptomatology in medical illness.
2. Be able to evaluate, diagnose, and treat delirium.
3. Describe symptoms and medical risks of somatoform disorders.
4. Be able to identify medical tests that may be needed for evaluation of patients in consultation-liaison psychiatry.

1.22 Alternative Levels of Care: Special Populations

1. Understand the concept of the continuum of care for mental health and residential services.
2. Become familiar with the continuum of care as it exists in Las Vegas.
3. Be familiar with the consumer movement's concerns regarding the scope and nature of traditional mental health systems.
4. Develop empathy for the consumer's experience of the continuum of mental health and residential services.
5. Understand barriers to effective continuity of care within mental health systems.
6. Visit examples of various mental health and residential services.

1.23 History of Psychiatry

1. The resident will be exposed to the history of ancient attempts to understand the psyche.
2. The resident will understand the continuing cycle between more biological versus more psychological understandings of human experience.
3. The resident will understand both the driving forces of de-institutionalization and the sequelae, both positive and negative.

1.24 Introduction to Cognitive Therapy

1. The resident will be able to identify an underlying belief.
2. The resident will gain a basic understanding of Rational Emotive Therapy, as a model for cognitive therapy.
3. The resident will understand the cognitive theoretical explanations of mood disorders.

1.25 Introduction to Psychodynamic Therapy

1. The resident will understand what led Freud to the conclusion that an unconscious level of the mind could exist.
2. The resident will understand how defense mechanisms affect the patient's coping skills and presentation.
3. The resident will become familiar with Freud's basic model of psychological functioning.

1.26 Psychiatric Ethics

1. The resident should be able to articulate the difference in purpose of the ethical standards versus the legal standards.
2. The resident should be able to understand the role of ethical reasoning in care decisions.
3. The resident should gain an appreciation of the complexity of what are otherwise simple clinical decisions.

1.27 Medical Conditions Affecting Psychiatric Status: mild traumatic brain injury

1. Resident will understand the role of mild traumatic brain injury in psychiatric symptom development.
2. Resident will appreciate the diagnostic evaluation of mild traumatic brain injury.
3. Resident will learn the role of fungal infections and psychiatric presentation.

1.28 Human Sexuality

1. The resident will be able to identify the four stages of the sexual response cycle.
2. The resident will be able to distinguish between paraphilia's and non-paraphilia.
3. The resident will understand DSM-5 diagnosis of sexual disorders.

1.29 Suicide and Risk Assessment

1. Identify individuals with potential danger to themselves.
2. Identify individuals with acute suicidal thoughts.
3. Identify individuals with major mental illness or substance abuse and suicidal ideation.
4. Residents will learn how to manage and treat individuals in crisis.

1.30 Ethnicity and Culture, Diagnosis and Treatment

1. Resident will appreciate cultural syndromes and their relationship to psychiatric diagnosis.
2. Resident will demonstrate respect for alternative cultural explanations of psychiatric illness.
3. Resident will understand ethnic variations in the metabolism of psychiatric medications.

PGY-3&4--Two Year Didactic Cycle

1.01 Grand Rounds

1.02 Case Conference

1.03 Journal Club

1.04 Resident Meeting

1.05 Balint Group

1. Residents will learn to identify the transference of the patient from the presented clinical case.
2. Residents will learn to identify the counter-transference of the physician from the presented clinical case.
3. Residents will learn that transference and counter-transference are normal processes that psychiatrist have a unique capacity to understand.

1.06 Textbook Review – Psychopathology

1. The resident will be exposed to the basic science foundation of psychiatry and illness.
2. The resident will be exposed to the basic psychological and social influences and data that form a foundation for psychiatry.
3. The resident will be exposed to considerable discussion regarding differential diagnosis of psychiatric symptoms.

1.07 Evidence Based Medicine

Define Evidence-Based Medicine (EBM).
Identify the parts of a well-built clinical question.
Identify EBM tools that will improve patient care.
Become familiar with lifelong learning strategies.
Identify key issues that help determine the validity of the results of a study.

1.08 Family & Couples Systems: Assessment, Treatment, and Intervention

4. The resident will become familiar with the history of family therapy as a treatment modality.
5. The resident will learn the five major theories/theorists of family therapy.
6. The resident will learn one model well but respect what the others have to offer.

1.11 Neurology Review

1. To understand the basics of history taking, physical exam and localization in neurology.
2. To understand the common neurologic disorders, their diagnosis, natural history, pathophysiology and approaches to therapy.
3. To recognize and understand the neurologic disorders likely to be encountered in the course of adult psychiatric practice and how to approach these.
4. To recognize psychiatric mimics of neurologic disease and neurologic mimics of psychiatric disease.
5. To understand the role of tests in modern neurologic investigation, particularly Neuro-imaging.

2.01 Somatic Treatments: Advanced Psychopharmacology, Electroconvulsive Therapy and the Combining of Psychopharmacological and Psychotherapeutic Modalities

1. Identify indications for ECT and predict treatment outcomes.
2. Become knowledgeable about improved outcomes for combined medication and psychotherapy treatment.

3. Develop understanding of use of polypharmacy in treatment resistant illness.
4. Identify pertinent drug-drug interactions in psychopharmacology.

2.02 Psychodynamic-Therapy

1. Learn the history of the development of psychodynamic theory in relation to the prevalent psychological philosophies of the era with emphasis on the basics of Ego Psychology, Object Relations Theory and Self Psychology.
2. Understand basic psychodynamic concepts, including the Topographical and Structural Models of the mind; Feelings, Anxiety and Defense Mechanisms.
3. Learn to conceptualize the patient's experience and problems from a psychodynamic point of view.
4. Learn the practical application of psychodynamic principles in the course of the clinical interview and ongoing treatment; Identify and address maladaptive Defenses; Dealing with Transference and Counter-transference; understand the concept of Catharsis and Cathexis in relation to healing in therapy.
5. The resident will have a clear understanding of roots and development of Psychodynamic Theory and will be capable of identifying key theorists and their theoretical contributions and concepts.
6. The resident will have a clear understanding of the different basic concepts of the structure of the mind. He/she will be able to recognize the relationship between feelings/drives, anxiety and defenses.
7. The resident will be capable of conducting a psychodynamic interview with a live patient and be able to present the history framing the narrative in a Psychodynamic framework.
8. The resident will be able to discuss the patient interview, identifying issues of resistance, defense mechanisms, and transference and counter-transference experiences.

2.03 Interpersonal Therapy

Provide introduction to the interpersonal therapy model
Apply principles of interpersonal therapy to individual case examples
Demonstrate knowledge of interpersonal theory and IPT research literature.

2.04 Cognitive Therapy

Understand the classic "event-thought-feeling" model of CBT as developed by Beck.
Describe structure of general CBT sessions.
Demonstrate CBT techniques in role play.
Describe barriers to progress in CBT

2.05 Supportive Therapy

1. The resident will be able to describe the basic principles of Supportive Psychotherapy.
2. The resident will be able to apply these principles to their own work.
3. The resident will be able to recognize when to use these principles.
4. The resident will be able to recite the five most important ideas of this framework.

2.06 Group Therapy

1. Define group psychotherapy and list several treatment goals that can be attained by this intervention modality
2. Describe the methods and approaches available to conduct therapy groups and recognize their theoretical and historical origins
3. Evaluate how the group psychotherapy treatment modality can be used to improve the patient's level of psychosocial functioning.

2.07 Clinical Forensic Topics

1. To familiarize with the doctor-expert role.
2. To educate on focused psychiatric assessments (Dangerousness, Malingering, Disability, and Competency).
3. To describe the format of documenting clinical findings in psychiatric reports.
4. To acquaint with potential legal and social impactions of forensic psychiatric findings.

2.08 Correctional Psychiatry

Understand the legal basis for inmates' right to (mental) health care in both jails and prisons.
Understand the concept of double agency.
Appreciate the risk of self-harm behavior in detention centers.
Describe factors to alert the physician to the possibility of malingering.

2.09 Administrative Psychiatry

Be able to discuss the variety of funding sources for mental health services in the U.S.
Understand concepts of civil commitment and related issues of due process.
Understand the role of utilization management in the administration of mental health service organizations.
Appreciate the concept of peer review as a quality management tool.

2.10 Principles of Hypnosis

1. The resident will understand the characteristics of light, medium, and deep trance [somnambulism].
2. The resident will be able to demonstrate the Elman Induction for hypnotic trance.
3. The resident will be able to understand the risks and benefits of considering a hypnotic model for treatment of patients.

2.11 Advanced Medico legal Issues

1. The resident will be able to relate the phases of a lawsuit.
2. The resident will be able to articulate the difference between a treating psychiatrist and an expert psychiatrist.
3. The resident will learn boundaries regarding the role difference of an expert versus a treating clinician.
4. The resident will be able to distinguish between the medical concept of psychosis, and the legal concept of insanity.
5. The resident will be able to apply the Dusky Standard to competence to stand trial evaluations.
6. The resident will be able to assess the legal concept of causation as defined in personal injury lawsuits.

2.12 Sexual Dysfunctions and Sexual Disorders

1. The resident will be able to clearly identify those couples needing formal sex therapy versus those needing general couples therapy with accuracy.
2. The resident will understand the sequence of behavioral exercises provided to the couple over the course of sex therapy.
3. The resident will appreciate the phases of the sexual response cycle and how to apply specific interventions based upon the disrupted phase.

2.13 Practice Models and Career Planning

1. The resident will be able to assess fringe benefits costs to accurately compare employment and private practice effectively.

2. The resident will be able to describe benefits of employment and compare these to the benefits of private practice.
3. The resident will understand the difference between a sole proprietorship and professional corporation.

2.14 Psychological Testing

1. The resident will understand the role of psychological testing, its limitations and strengths.
2. The resident will be able to formulate a proper referral question for psychological testing to the psychologist.
3. The resident will understand the concepts of the development of psychological tests.

2.15 Neuropsychological Testing

1. The resident will understand the role of neuropsychological testing, its limitations and strengths.
2. The resident will be able to formulate a proper referral question for neuropsychological testing to the psychologist.
3. The resident will understand the concepts of the development of neuropsychological tests.

2.16 Spirituality in Psychiatry: Jungian and Transpersonal Therapy

1. The resident will appreciate the diversity of spiritual expression and experience.
2. The resident will learn the challenges in assigning pathology versus non-pathology to particular spiritual experiences.
3. The resident will understand the role of a spiritual assessment in the context of understanding the patient.
4. The resident will understand the concept of individuation as a psychological move towards wholeness.
5. The resident will be able to compare and contrast basic assumptions of the unconscious made by psychodynamic thinkers versus analytic psychological thinkers.
6. The resident will understand the basic concepts of Jungian theory.
7. The resident will be able to state Grof's four stages of transpersonal experience.
8. The resident will be able to understand the growth model described by Wilber.
9. The resident will have basic understanding of physiological measures and psychological results of meditative practice.

<u>OPTIONAL CLASSES</u>

1.31 Identifying and Integrating American Cultural Norms

1.32 Popular Concepts from the Media – Movie "What the Bleep Do We Know"

1. Resident will become aware of basic concepts of the Copenhagen interpretation quantum mechanics.
2. Resident will become aware of the role of peptides in mood and affect regulation.
3. Resident will become aware of alternate mind/brain models based.

1.33 Movie discussion group

1.34 Impact of suicide on survivors

Appendix C

Forms

APPLICANT FOR UNLV/SOM RESIDENCY EVALUATION

Date_____

Applicant_____

Interviewer_____

Medical school graduation and date: _____

Previous residency experience _____Y _____N. If yes, describe reason for transfer: _____

_____

USMLE/COMLEX Pass: Step I____Y ____N Step 2____Y ____N Step 3____Y ____N # of attempts____

Applicant demonstrates substantial interest in psychiatry as a specialty and career: ____Y ____N

Applicant reports significant interest and motivation to remain and practice in the Las Vegas community: ____Y ____N

Applicant displays the capacity to express self clearly and to listen attentively: ____Y ____N

Applicant demonstrates interpersonal skills suggestive of genuine warmth and interest in others: ____Y ____N

Applicant shows capacity for sense of humor: ____Y ____N

Discusses matters related to patient care and psychiatry in a manner suggesting professional attitude: ____Y ____N

Applicant relates interest in research: ____Y ____N

Applicant addresses interest in psychopharmacology and psychotherapy: ____Y ____N

[If reviewed] Are the Personal Statement and Letters of Recommendation positive? : ____Y ____N

COMMENTS: _____

_____

_____

_____

_____

Overall Evaluation: Excellent Above Average Acceptable Unacceptable

10 9 8 7 6 5 4 3 2 1

PGY- 1 SUPERVISION LEVEL
ASSESSMENT FORM

PGY-1 Name: _____ Date: _____

Evaluator Name: _____

Evaluator Status: Faculty _____ Fellow _____ Resident _____

Clinical Setting: _____

Day _____ Night _____ Weekend _____

Number of different patients seen with the resident: _____

The ACGME has defined three levels of supervision for PGY – 1 resident(s):

1. Direct Supervision: the supervising physician is physically present with the resident and patient.

2. 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.

3. Indirect 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.

At the beginning of residency, each PGY-1 must have direct supervision unless there has been a prior assessment of their ability to progress to indirect supervision, based on the criteria set forth in the Duty Hours Requirements. A PGY -1 may progress to being supervised indirectly with direct supervision available only after demonstrating competence in:

a) the ability and willingness to ask for help when indicated

b) gathering an appropriate history

c) the ability to perform an emergent psychiatric assessment; and

d) presenting patient findings and data accurately to a supervisor who has not seen the patient.

Based on your direct observation of this PGY –a resident, please indicate below whether or not he/she has demonstrated the following competencies (Yes, Not Yet, but progressing as expected, No, Unable to assess):

Ability and willingness to ask for help when indicated:
Yes ____ Not Yet_____ No_____ Unable to Assess _____

Gathering an appropriate history:
Yes ____ Not Yet_____ No_____ Unable to Assess _____

Ability to perform an emergent psychiatric assessment:
Yes ____ Not Yet_____ No_____ Unable to Assess _____

Presenting patient findings and data accurately to a supervisor who has not seen the patient:
Yes ____ Not Yet_____ No_____ Unable to Assess _____

The most appropriate level of supervision for this PGY -1 resident is:
___ Direct (in person)

___ Indirect, with direct immediately available (i.e. in-house supervision; requires that the resident has demonstrated some of the above competencies)

___ Indirect, with Direct available (i.e. off-site supervision by phone; requires that the resident has demonstrated all of the above competencies)

Comments and Suggestions for Improvement:

_____ _____
Evaluator Signature and Date Resident Signature and Date

Off- Site Supervisor Evaluation of Resident

Resident name: _____

Supervisor name: _____

Please initial that supervision sessions have happened weekly other than vacation time: _____

The purpose of the supervision is to provide direct feedback in honing each of the skills required under the ACGME competence based educational requirements. Specifically, the supervision time provides assistance, advice, and feedback on the basic skills of becoming a psychiatrist: assessment, interview, diagnostic considerations, and treatment considerations, in addition to evaluation of transference and counter-transference. These sessions will aid in all aspects of the resident's transition from student to professional and should include: Patient Care, Medical Knowledge, Practice Based Learning examples, Interpersonal Communication Skills, Professionalism, and Systems Based Practice Knowledge.

Patient Care:

1. Resident obtains an accurate and efficient history from patients.
2. Resident integrates the facts of the case to reliably attain differential diagnosis.
3. Resident identifies symptom patterns of substance use, intoxication and withdrawal.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____

Medical Knowledge:

1. Resident critically analyzes data regarding medical conditions which might present with psychiatric symptoms.
2. Resident recommends the appropriate work-up to determine symptom etiology.
3. Resident recommends the most appropriate medication and/or psychotherapeutic intervention for patients.
4. Resident demonstrates knowledge of medication interactions and appropriately reasons regarding medication choices.
5. Resident demonstrates appropriate psychotherapeutic understanding and intervention.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____

Practice Based Learning:

1. Resident communicates limitations in knowledge regarding case material and appropriately recommends consultation from other specialties.
2. Resident identifies areas of knowledge deficit and pro-actively seeks self-study materials to improve knowledge and skills.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____

Interpersonal Communication Skills:

1. Resident communicates clearly with the staff, peers, and patients.
2. Resident presents cases to the attending physician in a clear, organized, concise and accurate manner.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____
_____

Professionalism:

1. Resident completes patient care tasks in a timely manner, including time management, telephone calls, face to face interview time with patients.
2. Resident completes documentation and dictation at the time of service ideally, but always within one day.
3. Resident respects other healthcare providers of all disciplines.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____

Systems Based Practice:
1. Resident makes appropriate referrals to other levels of care.
2. Resident initiates the involuntary commitment process when clinically indicated.
3. Resident assigns appropriate referrals for social, 12-step, and vocational assistance as appropriate.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____

Additional ACGME questions:

1. Was able to asses resident performance in communicating with patients and their families.
    - Yes____
    - Not Yet ___
    - Not Observed _____
2. Resident demonstrates the ability to work well with other members of the team.
    - Yes____
    - Not Yet ___
    - Not Observed _____
3. Resident communicated transition of care effectively.
    - Yes____
    - Not Yet ___
    - Not Observed _____
4. Did resident complete record keeping and documentation in a timely manner.

Attending Signature: _____ Date: _____

Resident comments: _____
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Resident Signature: _____ Date: _____

Attending Evaluation of Resident

Resident name: _____

Attending name: _____

Rotation dates: _____

PGY-1 Six Month Inpatient Psychiatry Rotation – SNAMHS

This rotation is designed to expose residents to the evaluation and treatment of patients on an acute inpatient psychiatric service. In addition to the evaluation of severe mental illness, such as the mood disorders, the schizophrenic spectrum of disorders, the anxiety disorders and the personality disorders, residents will assess co-morbid conditions such as medical factors affecting psychiatric condition and effects of substance abuse and dependence on psychiatric illness. Residents will gain experience with substance detox and management, including weighing diagnostic factors in the evaluation of substance abuse within the context of mental illness.

Patient Care:
1. Resident documents thorough, detailed histories of each patient.
2. Resident recognizes emotional responses from patient interviews.
3. Resident establishes rapport with patient during interviews.

Resident has (mark one of these three):
- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Medical Knowledge:
1. Resident states diagnostic criteria from the DSM-5 for common psychiatric illnesses seen on inpatient services.
2. Resident accurately applies diagnostic criteria to inpatient psychiatric cases.
3. Resident initiates appropriate initial treatment interventions with the support and advice of the attending physician.

Resident has (mark one of these three):
- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Practice Based Learning:

1. Resident documents appropriately in the electronic computerized record.
2. Resident presents difficult cases to supervisor and explores the contributing factors to the challenging case.
3. Resident describes basic class effects of psychotropic medications and the purpose of each in the management of psychiatric cases.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Interpersonal Communication Skills:

1. Resident communicates respect for fellow treatment team members.
2. Resident actively participates in treatment team meetings on inpatient services to encourage bio-psycho-social understanding of the case.
3. Resident discusses how resident is perceived by patients and staff with supervisor.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Professionalism:

1. Resident is timely in appearance and with work product.
2. Resident seeks appropriate consultation regarding cases and feedback regarding diagnosis and treatment.
3. Resident demonstrates honest communications with colleagues, peers, and patients.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Systems Based Practice:

1. Resident appropriately refers patients to lower levels of care in the community as the patients stabilize in inpatient settings.
2. Resident participates in the civil commitment court process on behalf of the resident's patients.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Additional ACGME questions:

1. Was able to assess resident performance in communicating with patients and their families.
    - Yes____
    - Not Yet ___
    - Not Observed _____
2. Resident demonstrates the ability to work well with other members of the team
    - Yes____
    - Not Yet ___
    - Not Observed _____
3. Resident communicated transition of care effectively.
    - Yes____
    - Not Yet ___
    - Not Observed _____
4. Did resident complete record keeping and documentation in a timely manner.
    - Yes____
    - Not Yet ___
    - Not Observed _____

Attending Signature: _____ Date: _____

Resident Comments: _____
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Resident Signature: _____ Date: _____

Attending Evaluation of Resident

Resident name: _____

Attending name: _____

Rotation dates: _____

PGY-1 Six Month Primary Care Sequence

This set of rotations includes three months of Internal Medicine, one month of Emergency Medicine, two months of Neuro, and two months of neurology. The purpose of completing these requirements is for the resident to understand the inter-relation of psychiatry and medical care. Specifically, the resident should understand the psychiatric presentations of medical illness to encourage appropriate referral, and to understand the physical illness which may affect psychiatric patients.

Patient Care:
1. Resident performs history and physical examination at the level of an early PGY-1 resident on primary care services.
2. Resident identifies medical conditions and participates in the team of treatment.

Resident has (mark one of these three):
- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Medical Knowledge:
1. Resident identifies patients with medical problems which might present with behavioral symptoms.
2. Resident orders proper work-ups for common medical illnesses.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Practice Based Learning:

1. Resident demonstrates ability to use information technology to obtain data related to diagnostic work-up.
2. Resident presents formal didactic material as assigned by the service.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Interpersonal Communication Skills:

1. Resident demonstrates listening skills in the context of medical evaluations and assessment.
2. Resident communicates with senior residents and attending's regarding patient care and expectations.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Professionalism:

1. Resident attends at least 80% of service related activities in a timely manner.
2. Resident respects all patients irrespective of age, gender or disability status.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Systems Based Practice:
1. Resident discusses alternatives of care in terms of risk/benefit analysis.
2. Resident discusses alternatives of care in terms of cost effectiveness.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
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Additional ACGME questions:

1. Was able to assess resident performance in communicating with patients and their families.
    - Yes____
    - Not Yet ___
    - Not Observed _____
2. Resident demonstrates the ability to work well with other members of the team.
    - Yes____
    - Not Yet ___
    - Not Observed _____
3. Resident communicated transition of care effectively.
    - Yes____
    - Not Yet ___
    - Not Observed _____
4. Did resident complete record keeping and documentation in a timely manner.
    - Yes____
    - Not Yet ___
    - Not Observed _____

Attending Signature: _____ Date: _____

Resident comments: _____
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Resident Signature: _____ Date: _____

Attending Evaluation of Resident

Resident name: _____

Attending name: _____

Rotation dates: _____

PGY-2 Inpatient Psychiatry Rotation –Seven Hills and VA (includes geriatrics)

This Seven Hills and VA inpatient rotation in psychiatry allows the specialized evaluation and treatment of anxiety disorders, mood disorders, psychotic disorders and substance abuse/dependence disorders. This unit is designed for voluntary patients, and includes considerable experience with PTSD in addition to geriatric populations and substance induced psychiatric conditions. The resident will learn the principles of geriatric assessment and treatment.

Patient Care:

1. Resident generates a full differential diagnosis, based upon DSM-5.
2. Resident appreciates and responds to the emotional communications of patients accurately.
3. Resident identifies patients with cognitive decline and evaluates.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Medical Knowledge:

1. Resident assesses diagnosis in consideration of substance and/or cognitive impairment, and appropriately applies DSM-5 diagnostic rules.
2. Resident orders medications from the appropriate medication class for patients evaluated.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Practice Based Learning:

1. Resident explores counter-transference emotions regarding patients with co-morbid personality and trauma related issues with supervisor.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Interpersonal Communication Skills:

1. Resident demonstrates an ability to develop rapport with patients during clinical interviews.
2. Resident actively participates in treatment team meetings.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Professionalism:

1. Resident demonstrates empathy and understanding with the patient population.
2. Resident maintains professional interactions with patients, staff and fellow residents.
3. Resident accurately signs-out to the on-call residents.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Systems Based Practice:

1. Resident understands the VA system of care for psychiatric patients.
2. Resident describes the community resources post-discharge for elderly patients, substance abusing patients, and veterans in general.

Resident has (mark one of these three):

- Met this expectation set_____
- Exceeded this expectation set _____
- Fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Additional ACGME questions:

1. Was able to asses resident performance in communicating with patients and their families.
2. Yes____
3. Not Yet ___
4. Not Observed _____
5. Resident demonstrates the ability to work well with other members of the team.
    - Yes____
    - Not Yet ___
    - Not Observed _____
6. Resident communicated transition of care effectively.
    - Yes____
    - Not Yet ___
    - Not Observed _____
7. Did resident complete record keeping and documentation in a timely manner.
    - Yes____
    - Not Yet ___
    - Not Observed _____

Attending Signature: _____ Date: _____

Resident comments: _____
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Resident Signature: _____ Date: _____

Attending Evaluation of Resident

Resident name: _____

Attending name: _____

Rotation dates: _____

PGY-2 Consult & Liaison Psychiatry Rotation – UMC

This rotation on the busy consult service at UMC includes experience with adult, adolescent and child presentations ranging from severe psychiatric illness, to substance intoxication to medico-legal assessments including competence to make medical decisions and decisions regarding the implementation of involuntary psychiatric holds (Legal 2000). There is a small emergency holding area covered by this service as well where triage skills are trained.

Patient Care:

1. Resident communicates with referring physicians to focus consultation needs to that requested.
2. Resident obtains an accurate and efficient history from patients.
3. Resident integrates the facts of the case to reliably attain differential diagnosis.
4. Resident identifies symptom patterns of substance use, intoxication and withdrawal.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Medical Knowledge:

1. Resident critically analyzes data regarding medical conditions which might present with psychiatric symptoms.
2. Resident recommends the appropriate work-up to determine symptom etiology.
3. Resident recommends the most appropriate medication and/or psychotherapeutic intervention for patients.
4. Resident demonstrates knowledge of medication interactions and appropriately reasons regarding medication choices.

5

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Practice Based Learning:

1. Resident communicates limitations in knowledge regarding case material and appropriately recommends consultation from other specialties.
2. Resident obtains feedback from the referring service regarding the usefulness of the consultation.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Interpersonal Communication Skills:

1. Resident communicates clearly with the referring service.
2. Resident focuses upon communicating an answer to the specific question of the consultation.
3. Resident presents cases to the attending physician in a clear, organized, concise and accurate manner.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Professionalism:

1. Resident completes the consultation within one work day of notification.
2. Resident maintains patient confidentiality by limiting discussions with the consulting service to appropriate times and places.
3. Resident respects other healthcare providers.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Systems Based Practice:
1. Resident understands the Nevada Law regarding involuntary commitment of patients.
2. Resident makes appropriate referrals to other levels of care.
3. Resident initiates the involuntary commitment process when clinically indicated.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Additional ACGME questions:

1. Was able to asses resident performance in communicating with patients and their families.
   Yes____ Not Yet ___ Not Observed _____
2. Resident demonstrates the ability to work well with other members of the team.
   Yes____ Not Yet ___ Not Observed _____
3. Resident communicated transition of care effectively.
   Yes____ Not Yet ___ Not Observed _____
4. Did resident complete record keeping and documentation in a timely manner.
   Yes____ Not Yet ___ Not Observed _____

Attending Signature: _____ Date: _____
Resident comments: _____
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Resident Signature: _____ Date: _____

Attending Evaluation of Resident

Resident name: _____

Attending name: _____

Rotation dates: _____

PGY-2 Child/Adolescent Psychiatry Rotation – University Medical Center/Montevista

The purpose of this rotation is to allow the resident to evaluate and treat psychiatric illnesses of childhood and adolescence. The resident is also expected to participate in family sessions to learn the dynamics of this type of therapeutic intervention, group therapy with this patient population, and interact meaningfully in treatment teams. This rotation also includes exposure to forensic adolescent population offenders. UMC and Montevista provides a wide range of mentally ill children and adolescents for the resident.

Patient Care:

1. Resident documents thorough history and evaluation from both patients and the patients' families.
2. Resident builds rapport with both child and adolescent patients.
3. Resident diagnoses conditions specific to children and adolescent patients using DSM-5 nomenclature.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Medical Knowledge:

1. Resident describes and understands the family system of patients and how this system affects clinical outcomes.
2. Resident demonstrates appropriate ordering of medications for child and adolescent populations.
3. Resident reviews recent research on treatment modalities and discusses with supervisor.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Practice Based Learning:

1. Resident describes and discusses limitations of knowledge with a focus on developing appropriate referral decisions.
2. Resident discusses transference and counter-transference experiences with clinical supervisor.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Interpersonal Communication Skills:

1. Resident leads or co-leads family meetings for both data gathering and therapeutic encounters.
2. Resident demonstrates tactful confrontation in family systems.
3. Resident presents cases accurately, completely and concisely to the treatment team.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Professionalism:

1. Resident demonstrates proper boundaries with staff, patients and families.
2. Resident demonstrates understanding of confidentiality in the context of families, minors, and legal guardians.
3. Resident demonstrates respect for the social, cultural and religious standards of the family of origin.
4. Resident accurately empathizes with patients without crossing the boundary to sympathy.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Systems Based Practice:
1. Resident appropriately refers patients to lower levels of care when stabilized.
2. Resident employs community resources in discharge planning.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Additional ACGME questions:

1. Was able to asses resident performance in communicating with patients and their families.
   Yes____ Not Yet ___ Not Observed _____
2. Resident demonstrates the ability to work well with other members of the team.
   Yes____ Not Yet ___ Not Observed _____
3. Resident communicated transition of care effectively.
   Yes____ Not Yet ___ Not Observed _____
4. Did resident complete record keeping and documentation in a timely manner.
   Yes____ Not Yet ___ Not Observed _____

Attending Signature: _____ Date: _____

Resident comments: _____
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Resident Signature: _____ Date: _____

Attending Evaluation of Resident

Resident name: _____

Attending name: _____

Rotation dates: _____

PGY-2 Rotation in Emergency Psychiatry – SNAMHS

The resident will evaluate patients in the crisis unit at SNAMHS and perform critical triage responsibilities under the supervision of faculty.

Patient Care:
1. Resident provides timely, accurate, complete evaluation of patients.
2. Resident makes accurate and complete differential diagnosis with an appreciation of medical and substance induced conditions.
3. Resident integrates knowledge to make appropriate disposition decisions.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Medical Knowledge:
1. Resident demonstrates critical analysis of cases and clear thinking skills.
2. Resident initiates treatment and refers to further appropriate treatment.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Practice Based Learning:
1. Resident uses diagnostic studies appropriately throughout the assessment.
2. Resident applies reasonable standard of care in triage decision making.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Interpersonal Communication Skills:
1. Resident presents a complete case to the attending physician.
2. Resident interviews and appropriately weights information from third party sources such as family.
3. Resident communicates effectively and respectfully with other members of the assessment team.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Professionalism:
1. Resident interacts with patients demonstrating an appreciation of their values and ideals.
2. Resident appreciates differences in culture, gender, age, and race and interacts in a non-judgmental manner.
3. Resident respectfully yet clearly communicates limits to patients.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set [required if 'substantially exceeded' or 'fallen short' marked] _____
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Systems Based Practice:
1. Resident admits patients to inpatient levels of care when clinically appropriate.

2. Resident discharges patients to lower levels of care with appropriate referrals when clinically appropriate.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Additional ACGME questions:

1. Was able to asses resident performance in communicating with patients and their families.
   Yes____ Not Yet ___ Not Observed _____
2. Resident demonstrates the ability to work well with other members of the team.
   Yes____ Not Yet ___ Not Observed _____
3. Resident communicated transition of care effectively.
   Yes____ Not Yet ___ Not Observed _____
4. Did resident complete record keeping and documentation in a timely manner.
   Yes____ Not Yet ___ Not Observed _____

Attending Signature: _____ Date: _____

Resident comments: _____
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Resident Signature: _____ Date: _____

Attending Evaluation of Resident

Resident name: _____

Attending name: _____

Rotation dates: _____

PGY-3 One Year Outpatient Psychiatry – VA/ SNAMHS/HM/UNLV Student Wellness Clinic

The purpose of this rotation is to provide yearlong continuity in four different outpatient settings where a wide range of patient demographic, psychiatric illness and treatment modalities may be experienced. The resident is expected to treat patients with different psychotherapeutic modalities (see section of handbook for minimums), in addition to providing psychopharmacologic interventions

Patient Care:

1. Resident documents thorough and complete assessment of outpatient psychiatric patients.
2. Resident accurately diagnoses psychiatric outpatients using the rules established by the DSM-5.
3. Resident prescribes medication of an appropriate class for the condition diagnosed.
4. Resident directly provides psychotherapy to appropriate patients.
5. Resident demonstrates capacity in group therapy, cognitive therapy, psychodynamic therapy, supportive therapy, interpersonal therapy, and family/couples therapy in outpatient settings.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Medical Knowledge:

1. Resident describes the model of cognitive therapy and applies to clinical cases.
2. Resident describes the model of psychodynamic therapy and applies to clinical cases.
3. Resident describes the model of interpersonal therapy and applies to clinical cases.
4. Resident describes the model of short term therapy and applies to clinical cases.
5. Resident describes the model of supportive therapy and applies to clinical cases.
6. Resident describes the model of systems theory and applies to families, couples and groups.
7. Resident appropriately chooses medication class, prescribes, and monitors response with patients.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Practice Based Learning:

1. Resident applies research base within psychiatry to choose therapeutic modality according to best practices.
2. Resident brings difficult cases to clinical supervision for discussion regarding limitations in knowledge base or skills.
3. Resident compares self-assessment with other assessments to illuminate possible limitations.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Interpersonal Communication Skills:

1. Resident establishes rapport with a wide range of patients, in the context of both initial evaluations and in follow up.
2. Resident actively listens to patients and appropriately responds to the patients' verbal and non-verbal communication.
3. Resident monitors the follow up rate of patients.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Professionalism:

1. Resident accepts responsibility for his or her actions.
2. Resident describes an understanding of the fiduciary relationship to patients and applies this standard to patient interactions.
3. Resident presents cases accurately, honestly and respectfully to clinical supervisors.
4. Resident is reliable and timely for duties in the outpatient setting.

5. Resident demonstrates maintenance of boundaries with patients.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Systems Based Practice:
1. Resident utilizes locally available resources for specific patient needs.
2. Resident understands the demographics of the patient population and how this impacts care.
3. Resident provides documentation at standards appropriate for regulatory review.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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Additional ACGME questions:

1. Was able to asses resident performance in communicating with patients and their families.
   Yes____ Not Yet ___ Not Observed _____
2. Resident demonstrates the ability to work well with other members of the team.
   Yes____ Not Yet ___ Not Observed _____
3. Resident communicated transition of care effectively.
   Yes____ Not Yet ___ Not Observed _____
4. Did resident complete record keeping and documentation in a timely manner.
   Yes____ Not Yet ___ Not Observed _____

Attending Signature: _____ Date: _____

Resident comments: _____
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Resident Signature: _____ Date: _____

Attending Evaluation of Resident

Resident name: _____

Attending name: _____

Rotation dates: _____

PGY- 4 Rotation in Outpatient /Administrative Psychiatry and/or Telemedicine –UMC/ SNAMHS/VA/HM and ROSENMAN

The advanced resident will attend meetings and classes related to the administration of psychiatry in addition to acting as a junior attending and supervising the work of the junior residents on the service, while reporting to the attending.

Objectives:

Patient Care:

1. Resident documents thorough and complete assessment of outpatient psychiatric patients, and cases seen through the telepsychiatry program.
2. Resident accurately diagnoses psychiatric patients using the rules established by the DSM-5.
3. Resident prescribes medication of an appropriate class for the condition diagnosed.
4. Resident directly provides psychotherapy to appropriate patients.
5. Resident demonstrates capacity in cognitive therapy, psychodynamic therapy, supportive therapy, interpersonal therapy, and family/couples therapy in outpatient settings.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
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_____

Medical Knowledge:

1. Resident describes the model of cognitive therapy and apply to clinical cases
2. Resident describes the model of psychodynamic therapy and apply to clinical cases.
3. Resident describes the model of interpersonal therapy and apply to clinical cases.
4. Resident describes the model of short term therapy and apply to clinical cases.
5. Resident describes the model of supportive therapy and apply to clinical cases.
6. Resident describes the model of systems theory and apply to families, couples and groups.

7. Resident appropriately chooses medication class, prescribes, and monitors response with patients.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____
_____

Practice Based Learning:

1. Resident applies research base within psychiatry to choose therapeutic modality according to best practices.
2. Resident brings difficult cases to clinical supervision for discussion regarding limitations in knowledge base or skills, and follows VA protocols for telepsychiatry supervision.
3. Resident compares self-assessment with other assessments to illuminate possible limitations.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____
_____

Interpersonal Communication Skills:

1. Resident establishes rapport with a wide range of patients, in the context of both initial evaluations and in follow-up.

2. Resident actively listens to patients and appropriately responds to the patients' verbal and non-verbal communication.

3. Resident monitors the follow-up rate of patients.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____
_____

Professionalism:

1. Resident accepts responsibility for his or her actions.

2. Resident describes an understanding of the fiduciary relationship to patients and applies this standard to patient interactions.

3. Resident presents cases accurately, honestly and respectfully to clinical supervisors.

4. Resident is reliable and timely for duties in the outpatient setting.

5. Resident demonstrates maintenance of boundaries with patients.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____

Systems Based Practice:

1. Resident utilizes locally available resources for specific patient needs.
2. Resident understands the demographics of the patient population and how this impacts care.
3. Resident provides documentation at standards appropriate for regulatory review.

Resident has (mark one of these three): met this expectation set_____
substantially exceeded this expectation set _____
or
fallen short of this expectation set _____

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____
_____

Additional ACGME questions:

1. Was able to asses resident performance in communicating with patients and their families.
   Yes____ Not Yet ___ Not Observed _____
2. Resident demonstrates the ability to work well with other members of the team.
   Yes____ Not Yet ___ Not Observed _____
3. Resident communicated transition of care effectively.
   Yes____ Not Yet ___ Not Observed _____
4. Did resident complete record keeping and documentation in a timely manner.
   Yes____ Not Yet ___ Not Observed _____

Attending Signature: _____ Date: _____

Resident comments: _____
_____
_____

Resident Signature: _____ Date: _____

Resident Assessment by non-MD Professional (360 Assessment)

Evaluator name: _____

Date of evaluation: _____

Resident name: _____

Duration of contact with resident: _____

Patient Care:
1. Demonstrated appropriate knowledge and capability in care of patients.
2. Interacted in a non-judgmental manner with patients and families.
3. Collaborated well with co-workers at all levels in the system.

Resident has (mark one of these three): met this expectation set ____
substantially exceeded this expectation set ___
or
fallen short of this expectation set ___

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____
_____

Medical Knowledge:
1. Discussed patient care with scientific knowledge base.
2. Made appropriate interventions in care of patients.

Resident has (mark one of these three): met this expectation set ____
substantially exceeded this expectation set ___
or
fallen short of this expectation set ___

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____
_____

Interpersonal and Communication Skills:
1. Verbally competent with patients and families.
2. Clinical notes and documentation clear, complete and legible.
3. Demonstrated appropriate empathy toward patients and families.
3. Showed respect and courtesy to co-workers, patients, and families.

Resident has (mark one of these three): met this expectation set ____

substantially exceeded this expectation set ___
or
fallen short of this expectation set ___

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____
_____

Professionalism:
1. Timely arrival on service.
2. Complete and timely completion of records.
3. Responsible and complete in patient care decisions.
4. Honest in all interactions with staff, patients and families.

Resident has (mark one of these three): met this expectation set ____
substantially exceeded this expectation set ___
or
fallen short of this expectation set ___

Document comments regarding the above expectation set (required if 'substantially exceeded' or 'fallen short' marked) _____
_____
_____
_____

Professional signature and title: _____Date: _____

Resident comments: _____
_____
_____

Resident signature: _____ Date: _____

Resident Assessment by Patient (360 Assessment)

Resident name: _____ Duration of contact with resident: _____

Medical Knowledge:

1. My doctor discussed my case with me in a manner that suggested an understanding of my condition.

   yes ____
   no _____
   or
   unsure ___

Comments: _____
_____
_____

Interpersonal and Communication Skills:

1. My doctor was interested in me and how I understand the world and my illness.
2. My doctor respected my perspectives.
3. I was able to explain all of my concerns to my doctor.
4. My doctor was professional in discussions with me.
5. My doctor explained my treatment, tests, and evaluation with me.
6. My doctor explained possible side effects of my treatment with me.
7. My doctor was non-judgmental to me and my family.

   yes ____
   no _____
   or
   unsure ___

Comments: _____
_____
_____

Professionalism:

1. My doctor met with me in a timely manner. Y____N___
2. My doctor was honest with me at all times in my treatment. Y___ N____
3. My doctor effectively communicated with me and my family. Y__N__
4. My doctor demonstrated the ability to work well with other members of the team. Y__N__
5. My doctor communicated transition of care effectively. Y___N___
6. My doctor completed record keeping and documentation in a timely manner. Y__ N__ no

Comments _____
_____
_____

Resident comments: _____
_____
_____

Resident signature: _____ Date: _____

Resident Assessment by Self (360 Assessment)

Resident name: _____

Date of evaluation: _____

Patient Care:
Describe your strengths and weaknesses in areas related to patient care (clinical skills, ability to manage complex decision making, availability to patient needs, carefulness, addressing psychosocial aspects of care) _____
_____
_____
_____

Medical Knowledge:
Describe your strengths and weaknesses in areas related to medical knowledge (extensive knowledge of literature, ability to integrate text knowledge into patient care, ability to generate differential diagnosis, ability to write a complete H&P (including accurate MSE and full bio psychosocial assessment])
_____
_____
_____
_____

Practice Based Learning:
Describe your strengths and weaknesses in areas related to practice based learning (assimilation of knowledge and patient care, seeking research based answers to clinical questions, awareness of knowledge weaknesses and willingness to remediate)
_____
_____
_____
_____

Interpersonal and Communication Skills:
Describe your strengths and weaknesses in areas related to interpersonal communication skills (ability to ask open ended questions, clarity of communications with patients, ability to communicate with patients' families, clear concise and complete documentation, neatly written prescriptions, respectfulness towards colleagues peers and patients, ability to listen empathetically)
_____
_____
_____
_____

Professionalism:
Describe your strengths and weaknesses in areas related to professionalism (timeliness, honesty, integrity, ethics, accepting responsibility for own actions, availability to patient needs, respectful of patients including gender, sexual preference, religious perspectives and worldviews, respect of others' knowledge)
_____
_____
_____
_____

Systems Based Practice:
Describe your strengths and weaknesses in areas related to systems based practice (understanding of the role of patients and professionals in systems of care, consideration of cost efficiency within care provision, awareness of community health concerns)

_____
_____
_____
_____

Resident comments: _____
_____
_____

Resident signature: _____ Date: _____

RESIDENT TO RESIDENT (360 Assessment)

Resident name: _____

Date of evaluation: _____

Patient Care

1. Demonstrated appropriate knowledge and capability in care of patients.
2. Interacted in a non-judgmental manner with patients and families.
3. Collaborated well with co-workers at all levels in the system.

Resident has [mark one of these three]: met this expectation set ____
substantially exceeded this expectation set ___
or
fallen short of this expectation set ___

document comments regarding the above expectation set [required if 'substantially exceeded' or 'fallen short' marked] _____
_____
_____
_____

Medical Knowledge

1. Discussed patient care with scientific knowledge base.
2. Made appropriate interventions in care of patients.

Resident has [mark one of these three]: met this expectation set ____
substantially exceeded this expectation set ___
or
fallen short of this expectation set ___

document comments regarding the above expectation set [required if 'substantially exceeded' or 'fallen short' marked] _____
_____
_____
_____

Interpersonal and Communication Skills

1. Verbally competent with patients and families.
2. Clinical notes and documentation clear, complete and legible.
3. Demonstrated appropriate empathy toward patients and families.
4. Showed respect and courtesy to co-workers, patients, and families.

Resident has [mark one of these three]: met this expectation set ____
substantially exceeded this expectation set ___
or

fallen short of this expectation set ___

document comments regarding the above expectation set [required if 'substantially exceeded' or 'fallen short' marked] _____
_____
_____
_____

Professionalism

1. Timely arrival on service.
2. Complete and timely completion of records.
3. Responsible and complete in patient care decisions.
4. Honest in all interactions with staff, patients and families.

Resident has [mark one of these three]: met this expectation set ____
substantially exceeded this expectation set ___
or
fallen short of this expectation set ___

document comments regarding the above expectation set [required if 'substantially exceeded' or 'fallen short' marked] _____
_____
_____
_____

Professional signature and title: _____ Date: _____

Resident comments: _____
_____
_____
Resident signature: _____ Date: _____

Resident Semi-Annual Evaluation

Resident name_____ _____ PGY level_____

Time period for review: _____

Rotations completed:
_____

Supervisors_____ _____

Evaluations (self, attending, supervisor, 360 staff, 360 patient, 360 resident)

Annual oral exams (clinical competency for PGY-1 &2) , comprehensive oral examination for PGY – (2, 3 &4) Clinical Competency # _____ Comprehensive Oral #_____

PRITE score

UMSLE/COMLEX:

Log data

Academic project

Career planning

Resident well-being

Program Director Signature _____ Date_____

Resident Signature _____ Date_____

Resident Comments (if any)

Program: _____ ***today's Date:*** _____

Please rate Program in the following areas:

PROGRAM		Strongly Disagree		Agree		Strongly Agree		N/A
1.	The clinical patient volume and variety experience is excellent	1	2	3	4	5	6	
2.	The teaching/learning experience is excellent	1	2	3	4	5	6	
3.	The program leadership is effective and concerned with residents	1	2	3	4	5	6	
4.	The orientation and Resident Handbook are helpful	1	2	3	4	5	6	
5.	The curriculum and expectations are clear and reasonable	1	2	3	4	5	6	
6.	Evaluations are reasonable and fair and understandable	1	2	3	4	5	6	
7.	My strengths and weaknesses are openly and fairly discussed with me	1	2	3	4	5	6	
8.	Corrective actions are fair, and guidance is available to me	1	2	3	4	5	6	
9.	The Program Departmental Staff (program coordinator and secretarial assistance) are helpful to me	1	2	3	4	5	6	
10.	The Institutional GME Administration (Office of Graduate Medical Education) is helpful to me	1	2	3	4	5	6	
11.	There is opportunity to voice concerns in a confidential manner without fear of intimidation or reprisal	1	2	3	4	5	6	
12.	The working environment, including the hours of duty, is satisfactory and allows personal time for family and recreation	1	2	3	4	5	6	
13.	The goals and objectives of the Program have been met.	1	2	3	4	5	6	

	Unsatisfactory		Satisfactory		Superior	
Evaluation of Program Overall:	1	2	3	4	5	6

Comments: (Please use comment line to explain your rankings above): _____

_____

_____

_____

_____

RESIDENT ASSESSMENT OF FACULTY AND ROTATION

ROTATION: _____ FACULTY NAME: _____ ROTATION DATES: _____

Please rate Faculty in the following areas:

A.	PATIENT CARE	Strongly Disagree		Agree		Strongly Agree		N/A
1.	Clinical skills are excellent	1	2	3	4	5	6	
2.	Manages complex and dynamic situations well	1	2	3	4	5	6	
3.	Accepts a duty and responsibility for patients' care	1	2	3	4	5	6	
4.	Is available for patients' needs	1	2	3	4	5	6	
5.	Is careful and thorough	1	2	3	4	5	6	
6.	Addresses psychosocial aspects of patient care	1	2	3	4	5	6	
		Unsatisfactory		Satisfactory		Superior		
Evaluation of Patient Care:		1	2	3	4	5	6	

Comments: (Please use comment line to explain your rankings above): _____

_____

B.	Medical Knowledge	Strongly Disagree		Agree		Strongly Agree		N/A
1.	Knowledge is extensive and well integrated	1	2	3	4	5	6	
2.	Assesses diagnostic information accurately and clearly	1	2	3	4	5	6	
3.	Able to reason deductively	1	2	3	4	5	6	
4.	Patient skills are appropriate and well developed	1	2	3	4	5	6	
		Unsatisfactory		Satisfactory		Superior		
Evaluation of Medical Knowledge:		1	2	3	4	5	6	

Comments: (Please use comment line to explain your rankings above): _____

_____

C.	Practice Based Learning *	Strongly Disagree		Agree		Strongly Agree		N/A
1.	Effectively uses own experiences as examples	1	2	3	4	5	6	
2.	Aware of shortcomings and takes steps to correct them	1	2	3	4	5	6	
		Unsatisfactory		Satisfactory		Superior		
Evaluation of Practice Based Learning:		1	2	3	4	5	6	

Comments: (Please use comment line to explain your rankings above): _____

_____

D.	INTERPERSONAL, COMMUNICATION SKILLS	Strongly Disagree		Agree		Strongly Agree		N/A
1.	Communicates effectively with patients and patients' families	1	2	3	4	5	6	
2.	Writes clear and concise notes and prescriptions	1	2	3	4	5	6	
3.	Communicates effectively with peers, co-workers, residents and students	1	2	3	4	5	6	
4.	Demonstrates respect, compassion and sympathy to patients and families	1	2	3	4	5	6	
5.	Listens carefully to patients' concerns, and allows patients to express them fully	1	2	3	4	5	6	
		Unsatisfactory		Satisfactory		Superior		
Evaluation of Interpersonal, Communication Skills:		1	2	3	4	5	6	

Comments: (Please use comment line to explain your rankings above):_____

_____

E.	PROFESSIONALISM *	Strongly Disagree		Agree		Strongly Agree		N/A
1.	Honest, trustworthy, ethical	1	2	3	4	5	6	
2.	Accepts responsibilities for actions and mistakes	1	2	3	4	5	6	

3.	Respects professional knowledge and skills of others	1	2	3	4	5	6	
4.	Respects cultural, age, gender, sexual and religious differences and preferences	1	2	3	4	5	6	

	Unsatisfactory		Satisfactory		Superior	
Evaluation of Professionalism:	1	2	3	4	5	6

Comments: (Please use comment line to explain your rankings above):_____

_____

F.	Systems Based Practice	Strongly Disagree		Agree		Strongly Agree		N/A
1.	Understands the role of patients and residents in integrated managed care health systems	1	2	3	4	5	6	
2.	Aware of cost efficiency balanced with the provision of quality care	1	2	3	4	5	6	
3.	Knowledgeable about health promotion and disease prevention issues, and about aspects of community health concerns	1	2	3	4	5	6	

	Unsatisfactory		Satisfactory		Superior	
Evaluation of Systems Based Practice:	1	2	3	4	5	6

Comments: (Please use comment line to explain your rankings above):_____

_____

G.	TEACHING QUALITIES	Strongly Disagree		Agree		Strongly Agree		N/A
1.	Attending is knowledgeable	1	2	3	4	5	6	
2.	Attending enjoys teaching encounters; teaches effectively	1	2	3	4	5	6	
3.	Attending is effective as a teacher in communicating and analyzing patient issues or subject matter	1	2	3	4	5	6	
4.	Attending is able to correlate clinical situation with basic science and physiology	1	2	3	4	5	6	
5.	Attending is prompt, available, dutiful	1	2	3	4	5	6	
6.	Attending is fair, impartial and courteous	1	2	3	4	5	6	

7.	Encourages critical thinking skills and use of evidence based medicine	1	2	3	4	5	6	
8.	Maintains good rapport	1	2	3	4	5	6	
9.	Contributes to teaching conferences	1	2	3	4	5	6	
10.	Provides feedback	1	2	3	4	5	6	
11.	Attending is a role model, exemplar	1	2	3	4	5	6	

	Unsatisfactory		Satisfactory		Superior	
Evaluation of Teaching Qualities	1	2	3	4	5	6

* These areas may not be objective enough for residents to evaluate; these areas require understanding of mood, opinion, and personal understanding by teaching faculty not always evident to residents.

Comments: (Please use comment line to explain your rankings above):_____

_____

H.	ROTATION	Strongly Disagree		Agree		Strongly Agree		N/A
1.	The clinical patient volume and variety of experience is excellent	1	2	3	4	5	6	
2.	The teaching/learning experience is excellent	1	2	3	4	5	6	
3.	The curriculum and expectations are clear and reasonable	1	2	3	4	5	6	
4.	Evaluations are reasonable and fair and understandable	1	2	3	4	5	6	
5.	My strengths and weaknesses are openly and fairly discussed with me	1	2	3	4	5	6	
6.	The lectures and rounds were informative and of high quality	1	2	3	4	5	6	
7.	The goals and objectives of the Rotation have been met.	1	2	3	4	5	6	

	Unsatisfactory		Satisfactory		Superior	
Evaluation of Rotation:	1	2	3	4	5	6

Comments: (Please use comment line to explain your rankings above):

_____

_____

Indicate topics, subjects or clinical training you did not experience, or did not experience fully, but would have liked to:

_____

_____

_____

SEMINAR EVALUATION

Date: _____ Presenter: _____

Seminar Title: _____

PGY-_____ Resident Name Optional):_____

DIDACTIC TEACHING ASSESSMENT		Unsatisfactory		Satisfactory		Superior		N/A
1.	Communicates learning expectations	1	2	3	4	5	6	
2.	Clarity of presentation	1	2	3	4	5	6	
3.	Knowledgeable	1	2	3	4	5	6	
4.	Content relevance	1	2	3	4	5	6	
5.	Handout quality	1	2	3	4	5	6	

Comments – Please offer specific comments relative to items 1-5 if needed:

_____

_____

_____

PERSONAL QUALITIES AND VALUES		Unsatisfactory		Satisfactory		Superior		N/A
1.	Interpersonal skills/rapport	1	2	3	4	5	6	
2.	Professional characteristics	1	2	3	4	5	6	
3.	Enthusiasm	1	2	3	4	5	6	

Comments – Please offer specific comments relative to items 1-3 if needed:

_____

_____

_____

SUMMARY EVALUATION	Unsatisfactory		Satisfactory		Superior		N/A
	1	2	3	4	5	6	

Summative comments – Please offer specific comments concerning the faculty member and the presentation:

_____

_____

JOURNAL CLUB EVALUATION

Thank you for taking the time to evaluate Journal Club. Please use the criteria on the bottom of the page to evaluate.

Resident Name: _____

Journal Club Month: _____

Resident Topic/Paper: _____

	Outstanding	Acceptable	Not Acceptable
Journal club article was distributed to participants at least one week in advance to allow for preparation:			
Analysis of the study design, validity and applicability of the results to his/her practice:			
The resident's knowledge of the results and ability to lead the discussion:			
Visual aids:			
Concise and accurate presentation:			
Ability to answer questions from the audience:			
Overall performance:			

Comments regarding suggestions for improvement or other comments:

_____

_____

_____

_____

Outstanding: The resident did background reading on original research to understand the context of the study, developed a succinct summary of relevant points, and designed slides which were effective and interesting. Furthermore, the presentation was polished and the resident could answer questions from the audience with poise. He or she made conclusions that were warranted, based on the literature.

Acceptable: The resident demonstrated a thorough understanding of the study assigned. A few corrections were necessary or there were a few oversights; however, the majority of the summary was accurate. The slide presentation was well organized and followed the general format for journal club.

Not acceptable: The resident lacked a clear understanding of one or more of the following:
Basic study design, the results, the clinical context of the investigation.
The summary was not concise and there was no clear organizational plan. The resident was not able to answer straightforward questions about the study and it was clear that he or she neglected to read the study carefully or look up basic information for understanding the context of the study.

CASE CONFERENCE EVALUATION

Thank you for taking the time to evaluate Case Conference. Please use the criteria on the bottom of the page to evaluate.

Resident Name: _____

Date: _____

Resident Topic_____

	Outstanding	Acceptable	Not Acceptable
Resident communicates reason for choosing case:			
Presentation is organized and thorough:			
Resident exhibits knowledge of appropriate DSM 5 criteria in differential diagnosis:			
Resident discusses comprehensive bio psychosocial treatment plan:			
Resident is able to recognize and communicate areas of transference and counter transference			
Ability to answer questions from the audience:			
Overall performance:			

Comments regarding suggestions for improvement or other comments:

_____

_____

_____

Outstanding: The resident presents a thorough history of present illness and past psychiatric, substance abuse, medical, social, and family history. There is clear description of symptoms and mental status that allow for differential diagnosis to be made. The resident is able to identify areas of transference and counter transference that impact treatment. The presentation was polished and the resident could answer questions from the audience with poise. Bio psychosocial treatment plan is well developed and specific to case presented.

Acceptable: The resident presented in organized manner with all areas of history having some information. Mental Status exam is well described. The resident is able to discuss areas of counter transference. Bio psychosocial treatment model is utilized with specific interventions provided in each category.

Not acceptable: The resident lacked organization in presentation. Patient history and pertinent symptoms were lacking. The bio psychosocial treatment plan was poorly developed and nonspecific. The resident was not able to answer straightforward questions about the case.

TRAINING SKILLS CHECKLIST FOR PGY-1 AND PGY-2 RESIDENTS

Resident Name:_____

Instructions: It is the resident's responsibility to have an attending faculty member date and initial whenever skills have been demonstrated. EACH box must be signed separately upon completion of task!

By the end of PGY-2

I. ASSESSMENT AND PRESENTATION

1. Conduct an observed comprehensive psychiatric assessment, and provide a bio psychosocial formulation, differential diagnosis, and treatment plan.

2. Determine a patient's competency to consent to, or refuse, psychiatric or medical treatment.

3. Assess a patient's potential to harm self and make appropriate disposition.

4. Assess a patient's potential to harm others and make appropriate disposition.

II. DIAGNOSIS

1. Correctly make the clinical diagnosis of bipolar disorder.

2. Correctly make the clinical diagnosis of major depression or of the criteria for major depression in schizoaffective disorder.

3. Correctly make the clinical diagnosis of schizophrenia.

4. Correctly make the diagnosis of substance abuse.

5. Correctly make the clinical diagnosis of substance dependence.

6. Correctly make the diagnosis of anxiety disorders (e.g., GAD, OCD, panic disorder).

7. Correctly make the diagnosis of dysthymic disorder.

8. Correctly make the diagnosis of somatoform and/or factitious disorders.

9. Correctly make the diagnosis of mood, anxiety, or psychotic disorders secondary to general medical condition.

10. Correctly make the diagnosis of major personality disorders (e.g., borderline, narcissistic, histrionic, obsessive compulsive, dependent, schizoid).

11. Correctly make the diagnosis of dissociative disorder.

12. Correctly make the diagnosis of delusional disorder.

III. SOMATIC TREATMENT

1. Demonstrate safe and effective use of antidepressants including two cases using tricyclic antidepressants, cases with SSRI's and others.

2. Demonstrate safe and effective use of mood stabilizers.

3. Demonstrate safe and effective use of pharmacologic strategies for augmentation of antidepressants or treatment of drug-refractory depression.

4. Demonstrate safe and effective management of anxiety disorders.

5. Demonstrate safe and effective use of antipsychotic medications, including typical and atypical.

6. Demonstrate safe and effective use of sedative hypnotics.

7. Demonstrate safe and effective detoxification from benzodiazepines.

8. Demonstrate safe and effective detoxification from alcohol.

9. Demonstrate safe and effective detoxification from opiates.

IV. SIDE EFFECT MANAGEMENT

1. Demonstrate safe and effective management of side effects secondary to antipsychotic, antidepressant, and mood stabilizer medications.

V. CONSULTATION LIAISON AND MEDICAL PSYCHIATRY

1. Diagnose and manage delirium.

2. Diagnose and manage dementia.

3. Diagnose and manage psychological response to illness, injury, or medical treatment.

VI. CHILD AND ADOLESCENT PSYCHIATRY

1. Diagnose and manage mental retardation.

2. Diagnose and manage attention deficit hyperactivity disorder.

3. Diagnose and manage at least two of the following disorders (one child each).

Dysthymic Disorder	Major Depressive Disorder	Bipolar Disorder

4. Diagnose and manage at least two of the following disorders (one child each).

Pervasive Developmental Disorder	Childhood Anxiety Disorder	Oppositional/Defiant and Conduct Disorders

VII. PSYCHOTHERAPY

1. Provide supportive psychotherapy in the inpatient psychiatric setting.

2. Provide supportive psychotherapy in the consultation/liaison setting.

3. Provide brief crisis psychotherapy.

VIII. GERIATRIC PSYCHIATRY

1. Effective management of side effects and drug interactions in a geriatric patient population.

2. Demonstrate effective assessment and management of diminished cognitive capacity.

3. Demonstrate effective behavioral and pharmacological management of agitation in the elderly.

4. Demonstrate effective focused psychotherapy on issues of illness, loss, and grief.

5. Demonstrate safe and effective treatment of cholinesterase inhibitors.

IX. ADDICTION PSYCHIATRY

1. Demonstrate effective individual and group psychotherapeutic treatment of substance abuse.

2. Demonstrate knowledge and use of modern pharmacotherapeutic strategies for chemical dependency.

3. Attend AA, NA, and/or GA meetings.

Resident Signature_____ Date_____

TRAINING SKILLS CHECKLIST FOR PGY-3 RESIDENTS

Resident Name: _____

Instructions: It is the resident's responsibility to have an attending faculty member date and initial whenever skills have been demonstrated. EACH box must be signed separately at the time a skill is demonstrated.

By the end of PGY-3

I. ASSESSMENT AND PRESENTATION

1. Present a complete bio psychosocial case formulation to an attending.

2. Demonstrate appropriate use of the DSM-5 diagnostic approach in 8 patients.

II. PSYCHOTHERAPY

1. Provide supportive psychotherapy in the outpatient setting.

2. Provide psychodynamic psychotherapy for a minimum of one year in an outpatient setting.

3. Provide brief dynamic psychotherapy in an outpatient setting.

4. Provide cognitive behavioral therapy in an outpatient setting.

5. Provide group psychotherapy in outpatient setting for at least 6 months.

6. Provide marital and/or family therapy.

Resident Signature: _____ Date: _____

RESIDENT LOG FORM

Resident Name: _____Rotation Name and Dates: _____

Att.	Date	Name (initials)	Age	Sex	Eth	Primary Diagnosis	Secondary diagnosis	Secondary diagnosis	Secondary diagnosis	Rx	Rx	Tx

KEY:

Att: Attending
Sex: M/F
Eth: Ethnicity (B/W, NA, etc.)

Date: Date of Contact

Name: Initials Only

Age: Patient Age

Rx: Generic Medication

Rx: Generic Medication

Tx: (Psychotherapy) CBT, etc.

AADPRT Psychiatry Clinical Skills Verification Form CSV.4

Resident Name: _____ Date: _____

Resident Signature: _____ PGY: _____

Examiner: _____

Examiner Signature: _____

Patient Characteristics: Age: _____ Gender: _____

Complexity of Patient

Low:	Patient presents one primary problem with clearly described symptoms
Medium:	Patient presents one problem with vaguely or inconsistently described symptoms or 2-3 problems with clear symptoms
High:	Patient presents multiple problems with vaguely or inconsistently described symptoms

Difficulty of Interview

Low:	Patient is cooperative, well organized, and cognitively intact
Medium:	Patient is abrupt, uncertain, or cognitively compromised
High:	Patient is hostile, disorganized, or cognitively impaired

Directions: Rate each category with a score from 1-8 based on the anchors listed. Performance in each of the areas below is determined by scores on the anchored items. To qualify as passing, each category must have a score $\geq$5.

I. Physician-patient Relationship

- Introduces him/herself, explains purpose of the interview, clarifies roles
- Develops rapport with patient: puts patient at ease and facilitates patient telling their story; provides empathic, nonjudgmental climate
- Comfortable with difficult content e.g. psychotic content, feelings
- Effective communication, using clear and understandable language, and cultural sensitivity
- Closes and ends interview smoothly

Misleads patient about nature of interview	Does not clarify nature of interview	Clear explanation of nature of interview	Clear explanation of nature of interview
Mechanistic, distant, and/or unfriendly, does not exhibit empathy	Limited warmth and empathy	Shows warmth and empathy	Is warm and empathic; Patient appears comfortable being open with the doctor
Is disrespectful, rude, patronizing, or brusque	Generally respectful but occasionally appears annoyed or flustered	Generally respectful	Treats patient with much respect
Talks over or badgers the patient with questions	Is overly pushy when encouraging patient to answer questions	Interview generally flows smoothly	Elicits much information without annoying the patient

Avoids talking to the patient about difficult content		Appears uncomfortable asking questions about difficult subjects		Generally comfortable asking questions about difficult subjects		Appears comfortable asking about difficult content	
Angry/rude when patient difficult		Annoyed or flustered when patient difficult		Handles difficult situations fairly well		Is graceful when patient becomes difficult	
Uses language patient does not understand		Language at times interferes with smooth flow of interview		Uses language that patient understands		Language congruent with patient SES and cultural background	
1	2	3	4	5	6	7	8

II. Conduct of Interview

- Obtains sufficiently detailed data to establish timeline and HPI for DSM-5 differential diagnosis; moves from open ended to specific fluidly
- Obtains screening data on past psychiatric, medical, family and social histories
- Screens for suicidal and homicidal ideation
- Flexibly conducts organized interview, using open and closed ended questions in cohesive manner; Follows cues presented by patient

Misses important data or leaves out critical areas of inquiry		Misses some important information but critical information gathered		Takes fairly accurate and reliable history		Obtains accurate and reliable history	
Interview disorganized, scattered, or superficial		Some difficulty following flow of interview		Interview proceeds in a logical manner		Interview proceeds in a logical and coherent manner	
Shows little appreciation for important bio psychosocial variables in patient's presentation		Gathers some bio psychosocial information but misses some important variables		Covers most pertinent positives and negatives and possible co-morbid conditions		Extracts all important data including bio psychosocial variables in patient's presentation and possible co-morbid conditions	
Does not follow up important leads, superficial, or loses focus and goes off on tangents		Some inconsistency in following up important patient leads, some are pursued, others missed		Usually follows patient's leads without the purpose of the interview getting lost		Strikes a good balance between following the patient's leads and keeping focused	
1	2	3	4	5	6	7	8

III. Case Presentation

- Concise and organized presentation in standard format
- Presents unified story line and conveys good sense of the person
- Prioritizes information obtained in interview
- Mental status observations are accurate, complete

Omits critical data or areas (e.g., suicidality)	Important but not critical areas omitted	Includes most important data	Includes all pertinent positives and negatives
Presentation is disorganized, confusing, scattered, rambling, or superficial	Organization of presentation is fair	Presents organized, accurate, and reliable history	Presents organized, accurate, and concise history
MSE inaccurate or missing critical observations	MSE misses important findings	Accurate and reliable MSE	Accurate, reliable, complete MSE without prompting

Unable to present coherent story line of patient. No sense of the patient as a person		Story line is missing important details and/or has limited sense of the patient as a person		Able to present unified story line and has sense of the person		Presents unified story line and has good sense of the person	
Omits data that would be critical to primary diagnosis		Omits data that would rule in or out common diagnoses that might be co-morbid with the main diagnosis		Covers most pertinent positives and negatives and possible co-morbid conditions		Covers all pertinent positives, negatives, and co-morbid conditions	
1	2	3	4	5	6	7	8

Comments: _____

_____

_____

_____

_____

PSYCHIATRY PATIENT
Comprehensive Oral Examination

Resident Name: _____

Examiner Name: _____

PERFORMANCE RATINGS		
	Unacceptable	Acceptable
Overall Grade	1 2 3 4	5 6 7 8
Physician-Patient Relationship	1 2 3 4	5 6 7 8
Conduct of Interview	1 2 3 4	5 6 7 8
Organization and Presentation of Data	1 2 3 4	5 6 7 8
Phenomenology, Diagnosis and Prognosis	1 2 3 4	5 6 7 8
Etiologic, Pathogenic and Therapeutic Issues (Biologic, Psychologic, Social)	1 2 3 4	5 6 7 8

Comments:

Overall Grade:

Physician-Patient Relationship:

_____

_____

_____

Conduct of Interview:

_____

_____

_____

Organization and Presentation:

_____

_____

_____

Phenomenology, Diagnosis and Prognosis:

_____

_____

_____

Etiologic, Pathogenic and Therapeutic Issues:

_____

_____

_____

_____ _____

Signature Date

Resident Research/Academic Project

Resident name: _____ PGY level: _____ Date: _____

1. Research/academic question:

_____

_____

_____

_____

2. Means of answering the question:

_____

_____

_____

_____

3. Type of analysis to be applied:

_____

_____

_____

_____

4. Proposed venue for presentation/publication:

_____

_____

_____

_____

5. Faculty sponsor for this project:

_____

_____

_____

_____

Program director approval: _____ Date: _____

UNLV SCHOOL OF MEDICINE
RESIDENT INITIAL LEAVE REQUEST FORM - PHYSICIANS AND DENTISTS

1. NAME: _____ 2. TITLE: RESIDENT PHYSICIAN PGY Level_____

3. DIVISION: MDDN – UNLV/SOM 4. DEPT.: PSYCHIATRY, LAS VEGAS

5. I Request From _____ Through _____

I Request From _____ Through _____

I Request From _____ Through _____

6. CHARGED AS FOLLOWS (explain in remarks): ☐ Annual Leave ☐ Sick-Self ☐ Sick-Family
☐ Sick-Death in the Family ☐ Family/Medical Leave ☐ Leave Without Pay (requires prior approval)
☐ Educational (explain in remarks) ☐ Other (explain in remarks, i.e., administrative, military, civil, etc.)

REMARKS: _____

NOTE: Medical absences of extended duration might fall under the Family and Medical Leave Act (FMLA).

7. To the best of my knowledge, the facts stated above are accurate and comply with leave requirements.

Employee's Signature: _____ Date Submitted: _____

8. APPROVAL BY Chief Resident: ☐ Approved ☐ Denied
Signature: _____ Date: _____

Reason for denial _____

9. FINAL APPROVAL Program Director: ☐ Approved ☐ Denied
Signature: _____ _____ Date: _____

Reason for denial _____

10. POSTED BY: _____ Date: _____

SPECIAL SECTION FOR PROGRAM REQUIREMENTS:

__Out–of-town Rotation Administrative leave/boards/other_____ Rotation away from FCM clinic obligation ___

Posted to schedule: _____ added after issue: _____ Nurse Supervisor: ___/___/___ Front Off Supervisor: ___/___/___

Additional remarks: _____
_____
_____

INSTRUCTIONS: This form must be completed in advance of leave except for illness, in which case the leave request must be completed and transmitted no later than two days after return to work. The original must be kept in the departmental records and posted to the leave record, and a copy returned to the employee after final action. NOTE to Coordinators: Annual and sick leave must be earned before it can be taken, refer to Board of Regents leave policy for Resident Physicians and Dentists. For Resident Physicians and Dentists, the Program Director and DIO of Graduate Medical Education signatures are necessary in cases of extended sick leave and require a health certification and appointing authorities approval. I understand I am responsible to inform my Preceptor & Hospital Medical Records Department, update all hospital/clinic medical records before leaving and check my clinic schedule prior to leave as confirmation of this request being received and approved.

I, _____, certify that I am in receipt of an IPAD provided by the UNLV School of Medicine, Department of Psychiatry. I am fully responsible for this device and all contents therein. I am aware of University policy and procedures regarding internet use and downloading material on University based networks. I will return this IPAD to the UNLV School of Medicine, Department of Psychiatry at any time when I leave the program, graduate, or are required to do so by program administration. I understand and agree to return this item in full working condition and with no sub exterior damage (excluding minor scratches). I further understand that I am fully responsible for replacement value in the event of loss or theft. If I am unable or unwilling to do so, I agree to pay the department an amount to fully replace this product with the version currently available from Apple, Inc.

_____

Date Resident

APPENDIX D

ACGME Program Requirements for Graduate Medical Education in Psychiatry

ACGME-approved: February 9, 2015; effective: July 1, 2015
Revised Common Program Requirements effective: July 1, 2016
ACGME approved focused revision: February 6, 2017; effective: July 1, 2017
Revised Common Program Requirements effective: July 1, 2017

ACGME Program Requirements for Graduate Medical Education in Psychiatry
Common Program Requirements are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

Int.A. **Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.**

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Psychiatry is a medical specialty focused on the prevention, diagnosis, and treatment of psychiatric mental, addictive, and emotional disorders. Graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders, together with other common medical and neurological disorders that relate to the practice of psychiatry.

Int.C. The educational program in psychiatry must be 48 months in length. (Core)*

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. (Core)Psychiatry

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. (Core)

I.A.1. The sponsoring institution must:

I.A.1.a) provide at least 50 percent salary support and protected time of 50 percent FTE (at least 20 hours per week) for the program director dedicated to direct program administration and education; and, (Core)

I.A.1.b) provide additional dedicated time and salary support either for the program director or for associate program directors, based on program size. (Core)

I.A.1.b).(1) At a minimum, the following total hours per week must be provided for the program director or combined program director and associate program director: (Core)

Residents	Hours/Week
24-40	30
41-79	40
>80	40 + additional time* allocated for directing program (*10 additional hours for every 20 residents)

I.A.1.b).(2) If the associate program director is used for this support, the associate program director must report directly to the program director. (Core)

I.A.2. There must be a residency coordinator who has adequate time and institutional support, based on program size and complexity, to support the program. (Core)

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. (**Core**)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents; (Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; (Detail)

I.B.1.c) specify the duration and content of the educational

experience; and, (Detail)

I.B.1.d) **state the policies and procedures that will govern resident education during the assignment.** (Detail)

I.B.2. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).** (Core)

I.B.3. The number of and distance between participating sites must allow for full participation by residents in all organized educational aspects of the program. (Core)

II. Program Personnel and Resources

II.A. Program Director

II.A.1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director.** (Core)

II.A.1.a) **The program director must submit this change to the ACGME via the ADS.** (Core)

II.A.2. **The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.** (Detail)

II.A.3. **Qualifications of the program director must include:**

II.A.3.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;** (Core)

II.A.3.b) **current certification in the specialty by the American Board of** Psychiatry and Neurology (ABPN)**, or specialty qualifications that are acceptable to the Review Committee; and,** (Core)

II.A.3.c) **current medical licensure and appropriate medical staff appointment.** (Core)

II.A.4. **The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas.** (Core)
The program director must:

II.A.4.a) **oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;** (Core)

II.A.4.b) **approve a local director at each participating site who is accountable for resident education;** (Core)

II.A.4.c) **approve the selection of program faculty as appropriate;** (Core)

II.A.4.d) **evaluate program faculty;** (Core)

II.A.4.e) **approve the continued participation of program faculty based on evaluation;** (Core)

II.A.4.f) **monitor resident supervision at all participating sites;** (Core)

II.A.4.g) **prepare and submit all information required and requested by the ACGME.** (Core)

II.A.4.g).(1) **This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete.** (Core)

II.A.4.h) **ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;** (Detail)

II.A.4.i) **provide verification of residency education for all residents, including those who leave the program prior to completion;** (Core)

II.A.4.j) **implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting,** (Core)

and, to that end, must:

II.A.4.j).(1) **distribute these policies and procedures to the residents and faculty;** (Detail)

II.A.4.j).(2) **monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;** (Core)

II.A.4.j).(3) **adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,** (Detail)

II.A.4.j).(4) **if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.** (Detail)

II.A.4.k) **monitor the need for and ensure the provision of back**

support systems when patient care responsibilities are unusually difficult or prolonged; (Detail)

II.A.4.l) **comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;** (Detail)

II.A.4.m) **be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;** (Detail)

II.A.4.n) **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:** (Core)

II.A.4.n).(1) **all applications for ACGME accreditation of new programs;** (Detail)

II.A.4.n).(2) **changes in resident complement;** (Detail)

II.A.4.n).(3) **major changes in program structure or length of training;** (Detail)

II.A.4.n).(4) **progress reports requested by the Review Committee;** (Detail)

II.A.4.n).(5) **requests for increases or any change to resident duty hours;** (Detail)

II.A.4.n).(6) **voluntary withdrawals of ACGME-accredited programs;** (Detail)

II.A.4.n).(7) **requests for appeal of an adverse action; and,** (Detail)

II.A.4.n).(8) **appeal presentations to a Board of Appeal or the ACGME.** (Detail)

II.A.4.o) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** (Detail)

II.A.4.o).(1) **program citations, and/or,** (Detail)

II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** (Detail)

II.A.4.p) monitor performance and maintain contact with residents during the first post-graduate year while they are on services other than

psychiatry; and, (Detail)

II.A.4.q) monitor resident stress, including physical or emotional conditions which inhibit performance or learning, as well as drug- or alcohol-related dysfunction. (Detail)

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location. (Core)

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents; and, (Core)

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas. (Core)

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Psychiatry and Neurology**, or possess qualifications judged acceptable to the Review Committee.** (Core)

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; (Detail)

II.B.5.b).(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks; (Detail)

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.5.b).(4) **participation in national committees or educational organizations.** (Detail)

II.B.5.c) **Faculty should encourage and support residents in scholarly activities.** (Core)

II.C. **Other Program Personnel**

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. (Core)

II.D. **Resources**

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. (Core)

II.D.1. Organized clinical services in inpatient, outpatient, emergency, consultation/liaison, and child and adolescent psychiatry must be available. (Core)

II.D.2. There must be offices designated for residents to use to interview patients and accomplish their clinical duties in a professional manner. (Core)

II.D.3. There must be specifically-designated areas for residents to use to perform basic physical examinations and other necessary diagnostic procedures and treatment interventions. (Core)

II.D.4. There must be educational space and equipment, with the capability to record and playback specifically designated for seminars, lectures, and other educational activities. (Core)

II.D.5. There must be equipment with the capacity for recording and viewing clinical encounters available to residents. (Core)

II.D.6. There should be patients of different ages and genders from across the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds. (Detail)

II.D.7. There should be an inpatient population that is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and genders. (Detail)

II.D.8. Patient services that are comprehensive and continuous should be available. (Detail)

II.D.9. Allied medical and ancillary staff members should be available for back-up support. (Detail)

II.E. **Medical Information Access**

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. (Core)

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) **All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant's level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program.** (Core)

III.A.1.b) **A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.** (Core)

III.A.1.c) **A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission.** (Core)

III.A.1.d) **Review Committees will grant no other exceptions to these eligibility requirements for residency education.** (Core)

III.A.1.e) Prior to appointment in the program, applicants must demonstrate sufficient command of English to permit accurate and unimpeded communication. (Core)

III.A.1.f) Prior to entry in the program, each resident must be notified, in writing, of the required length of education for which the program is accredited. (Core)

III.A.2. **Eligibility Requirements – Fellowship Programs**

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC- accredited residency program located in Canada. (Core)

III.A.2.a) **Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.** (Core)

III.A.2.b) **Fellow Eligibility Exception**

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions:** (Core)

III.A.2.b).(1) **Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and** (Core)

III.A.2.b).(2) **Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and** (Core)

III.A.2.b).(3) **Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and;** (Core)

III.A.2.b).(4) **For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and,** (Core)

III.A.2.b).(5) **Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones**

evaluation conducted at the conclusion of the residency program. (Core)

III.A.2.b).(5).(a) **If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training.** (Core)

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

III.B. Number of Residents

The program's educational resources must be adequate to support the number of residents appointed to the program. (Core)

III.B.1. **The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements.** (Core)

III.B.2. Programs should have at least three residents at each level of education. (Detail)

III.C. Resident Transfers

III.C.1. **Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.** (Detail)

III.C.2. **A program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion.** (Detail)

III.C.3. If previous ACGME-accredited education was not in a psychiatry

program, residents may receive up to but no more than 12 months' credit for prior education as part of the expected 48 months of the educational program. (Core)

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must make available to residents and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; (Core)

IV.A.3. Regularly scheduled didactic sessions; (Core)

IV.A.3.a) Each resident should attend a minimum of 70 percent of regularly scheduled didactic sessions. (Detail)

IV.A.3.b) Residents and faculty members should participate in journal clubs, research conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process. (Detail)

IV.A.3.c) Didactic instruction should include regularly scheduled lectures, seminars, and assigned readings that are coordinated with concurrent clinical experiences and are specific to each resident's level of education. (Detail)

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program. (Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) **Patient Care and Procedural Skills**

IV.A.5.a).(1) **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:** (Outcome)

IV.A.5.a).(1).(a) must demonstrate competence in the evaluation and treatment of patients of different ages and genders from diverse backgrounds, and from a variety of ethnic, racial, sociocultural, and economic backgrounds; and; (Outcome)

IV.A.5.a).(1).(b) must demonstrate competence in:

IV.A.5.a).(1).(b).(i) forging a therapeutic alliance with patients and their families of all ages and genders, from diverse backgrounds, and from a variety of ethnic, racial, sociocultural, and economic backgrounds; (Outcome)

IV.A.5.a).(1).(b).(ii) formulating a clinical diagnosis for patients by conducting patient interviews, (Outcome)

IV.A.5.a).(1).(b).(iii) eliciting a clear and accurate history; (Outcome)

IV.A.5.a).(1).(b).(iv) performing a physical, neurological, and mental status examination, including use of appropriate diagnostic studies; (Outcome)

IV.A.5.a).(1).(b).(v) completing a systematic recording of findings in the medical record; (Outcome)

IV.A.5.a).(1).(b).(vi) formulating an understanding of a patient's biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment; (Outcome)

IV.A.5.a).(1).(b).(vii) developing a differential diagnosis and treatment plan for patients with psychiatric disorders; (Outcome)

IV.A.5.a).(1).(b).(viii) managing and treating patients using pharmacological regimens, including concurrent use of medications and psychotherapy; (Outcome)

IV.A.5.a).(1).(b).(ix) managing and treating patients using both brief and long-term supportive, psychodynamic, and cognitive-behavioral psychotherapies; (Outcome)

IV.A.5.a).(1).(b).(x) providing psychiatric consultation in a variety of medical and surgical settings; (Outcome)

IV.A.5.a).(1).(b).(xi) managing and treating chronically-mentally ill patients with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions; (Outcome)

IV.A.5.a).(1).(b).(xii) providing psychiatric care to patients receiving treatment from non-medical therapists and coordinating such treatment; and, (Outcome)

IV.A.5.a).(1).(b).(xiii) recognizing and appropriately responding to family violence (e.g., child, partner, and elder physical, emotional, and sexual abuse and neglect) and its effect on both victims and perpetrators. (Outcome)

IV.A.5.a).(2) **Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.** (Outcome)

IV.A.5.b) **Medical Knowledge**

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents: (Outcome)

must demonstrate competence in their knowledge of:

IV.A.5.b).(1) major theoretical approaches to understanding the patient-doctor relationship; (Outcome)

IV.A.5.b).(2) biological, genetic, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle; (Outcome)

IV.A.5.b).(3) fundamental principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, family, sociocultural, and iatrogenic factors that affect the prevention, incidence, prevalence, and long-term course and treatment of psychiatric disorders and conditions;

(Outcome)

IV.A.5.b).(4) diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, including neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, neurocognitive disorders, seizure disorders, stroke, intractable pain, and other related disorders; (Outcome)

IV.A.5.b).(5) reliability and validity of the generally-accepted diagnostic techniques, including physical examination of the patient, laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing; (Outcome)

IV.A.5.b).(6) indications for and uses of electroconvulsive and neuromodulation therapies; (Outcome)

IV.A.5.b).(7) history of psychiatry and its relationship to the evolution of medicine; (Outcome)

IV.A.5.b).(8) legal aspects of psychiatric practice; (Outcome)

IV.A.5.b).(9) aspects of American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power; and, (Outcome)

IV.A.5.b).(10) medical conditions that can affect evaluation and care of patients. (Outcome)

IV.A.5.c) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome)

Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)

IV.A.5.c).(2) set learning and improvement goals; (Outcome)

IV.A.5.c).(3) identify and perform appropriate learning activities;

(Outcome)

IV.A.5.c).(4) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;** (Outcome)

IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;** (Outcome)

IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;** (Outcome)

IV.A.5.c).(7) **use information technology to optimize learning; and,** (Outcome)

IV.A.5.c).(8) **participate in the education of patients, families, students, residents and other health professionals.** (Outcome)

IV.A.5.d) **Interpersonal and Communication Skills**

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Residents are expected to:

IV.A.5.d).(1) **communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;** (Outcome)

IV.A.5.d).(2) **communicate effectively with physicians, other health professionals, and health related agencies;** (Outcome)

IV.A.5.d).(3) **work effectively as a member or leader of a health care team or other professional group;** (Outcome)

IV.A.5.d).(4) **act in a consultative role to other physicians and health professionals; and,** (Outcome)

IV.A.5.d).(5) **maintain comprehensive, timely, and legible medical records, if applicable.** (Outcome)

IV.A.5.e) **Professionalism**
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

IV.A.5.e).(1) **compassion, integrity, and respect for others;** (Outcome)

IV.A.5.e).(2) **responsiveness to patient needs that supersedes self-interest;** (Outcome)

IV.A.5.e).(3) **respect for patient privacy and autonomy;** (Outcome)

IV.A.5.e).(4) **accountability to patients, society and the profession;** (Outcome)

IV.A.5.e).(5) **sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; and,** (Outcome)

IV.A.5.e).(6) high standards of ethical behavior which include respect for patient privacy and autonomy, ability to maintain appropriate professional boundaries, and understanding the nuances specific to psychiatric practice. (Outcome)

IV.A.5.e).(6).(a) Programs are expected to distribute to residents and must operate in accordance with the AMA Principles of Ethics with "Special Annotations for Psychiatry," as developed by the American Psychiatric Association, to ensure that the application and teaching of these principles are integral parts of the educational process. (Outcome)

IV.A.5.f) **Systems-based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome)

Residents are expected to:

IV.A.5.f).(1) **work effectively in various health care delivery settings and systems relevant to their clinical specialty;** (Outcome)

IV.A.5.f).(2) **coordinate patient care within the health care system relevant to their clinical specialty;** (Outcome)

IV.A.5.f).(3) **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;** (Outcome)

IV.A.5.f).(4) **advocate for quality patient care and optimal patient**

care systems; (Outcome)

IV.A.5.f).(5) **work in interprofessional teams to enhance patient safety and improve patient care quality;** (Outcome)

IV.A.5.f).(6) **participate in identifying system errors and implementing potential systems solutions;** (Outcome)

IV.A.5.f).(7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, ensuring quality, and allocating resources; (Outcome)

IV.A.5.f).(8) practice cost-effective health care and resource allocation that is aligned with high quality of care, including an understanding of the financing and regulation of psychiatric practice, as well as information about the structure of public and private organizations that influence mental health care; (Outcome)

IV.A.5.f).(9) assist patients in dealing with system complexities and disparities in mental health care resources; and, (Outcome)

IV.A.5.f).(10) advocate for the promotion of mental health and the prevention of mental disorders. (Outcome)

IV.A.6. Curriculum Organization and Resident Experiences

IV.A.6.a) Required Clinical Experiences

IV.A.6.a).(1) Residents must have major responsibility for the care of a sufficient number of patients to demonstrate competence with acute and chronic psychiatric illnesses. (Core)

IV.A.6.a).(2) There must be patient care assignments that permit residents to practice appropriate treatment, and to have sufficient time for other aspects of their educational program. (Core)

IV.A.6.a).(2).(a) These clinical responsibilities must be coordinated with and not impinge on the non-patient care aspects of the educational program. (Core)

IV.A.6.a).(3) There must be structured clinical experiences that are organized to provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment phase and/or evolution of their psychiatric disorders/conditions. (Core)

IV.A.6.a).(4) The first year in psychiatry must include:

IV.A.6.a).(4).(a) a minimum of four months in a clinical setting that provides comprehensive clinical care; and, (Core)

IV.A.6.a).(4).(a).(i) This requirement should be met in a primary care specialty setting. (Detail)

IV.A.6.a).(4).(b) no more than eight months FTE in psychiatry. (Core)

IV.A.6.a).(5) Resident experience in neurology must include two months FTE of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. (Core)

IV.A.6.a).(5).(a) At least one month of this experience should occur in the first or second year of the program. (Detail)

IV.A.6.a).(6) Resident experience in inpatient psychiatry must include at least six months, but no more than 16 months FTE, of inpatient psychiatry. (Core)

IV.A.6.a).(6).(a) This must include a minimum of six months of significant responsibility for the assessment, diagnosis, and treatment of general psychiatric patients who are admitted to traditional psychiatry units. (Core)

IV.A.6.a).(7) Resident experience in outpatient psychiatry must include 12 months FTE of organized, continuous, and supervised clinical experience. (Core)

IV.A.6.a).(7).(a) Each resident must have significant experience treating outpatients longitudinally for at least one year, to include: (Core)

IV.A.6.a).(7).(a).(i) initial evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly; (Core)

IV.A.6.a).(7).(a).(ii) participation in multiple treatment modalities that emphasize developmental, biological, psychological, and social approaches to outpatient treatment; (Core)

IV.A.6.a).(7).(a).(iii) application of psychosocial rehabilitation techniques for the evaluation and treatment of differing disorders in a chronically-ill patient population; and, (Core)

IV.A.6.a).(7).(a).(iv) no more than 20 percent children and adolescent patients. (Core)

IV.A.6.a).(8) Resident experience in child and adolescent psychiatry: must include two months FTE of organized clinical experience. (Core)

IV.A.6.a).(8).(a) Supervising faculty members must have current ABPN certification in child and adolescent psychiatry. (Core)

IV.A.6.a).(8).(b) Residents must participate in assessing, evaluating, and treating a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities. (Core)

IV.A.6.a).(9) Resident experience in geriatric psychiatry must include one month FTE of organized experience focused on areas unique to the care of the elderly. (Core)

IV.A.6.a).(9).(a) **Each resident's geriatric psychiatry experience** must include:

IV.A.6.a).(9).(a).(i) diagnosis and management of mental disorders in geriatric patients with coexistent medical disorders; (Core)

IV.A.6.a).(9).(a).(ii) diagnosis and management, including management of the cognitive component, of degenerative disorders; (Core)

IV.A.6.a).(9).(a).(iii) basic neuropsychological testing of cognitive functioning in the elderly; and, (Core)

IV.A.6.a).(9).(a).(iv) management of drug interactions. (Core)

IV.A.6.a).(10) Resident experience in addiction psychiatry must include one month FTE of organized experience focused on the evaluation and clinical management of patients with substance abuse/dependence problems, including dual diagnosis. (Core)

IV.A.6.a).(10).(a) Residents must have experience with treatment modalities that include:

IV.A.6.a).(10).(a).(i) detoxification, overdose management, and maintenance pharmacotherapy; (Core)

IV.A.6.a).(10).(a).(ii) the use of therapeutic techniques that address the psychological and social consequences of addiction, to include confronting and intervening in chronic

addiction rehabilitation used in recovery stages from pre-contemplation to maintenance; and, (Core)

IV.A.6.a).(10).(a).(iii) self-help groups. (Core)

IV.A.6.a).(11) Resident experience in consultation-liaison must include two months FTE in which residents consult, under supervision, on other medical and surgical services. (Core)

IV.A.6.a).(12) Resident experience in forensic psychiatry must include experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency. (Core)

IV.A.6.a).(13) Resident experience in emergency psychiatry must be conducted in an organized, supervised psychiatric emergency service. (Core)

IV.A.6.a).(13).(a) This experience must not be counted as part of the 12-month outpatient requirement. (Core)

IV.A.6.a).(13).(b) Resident experiences must include crisis evaluation and management, and triage of psychiatric patients. (Core)

IV.A.6.a).(13).(c) On-call experiences alone must not fulfill the requirement for resident experience in emergency psychiatry. (Detail)

IV.A.6.a).(14) Resident experience in community psychiatry must provide residents with a cohort of persistently and chronically-ill patients in the public sector, such as in community mental health centers, public hospitals and agencies, and other community-based settings. (Core)

IV.A.6.a).(14).(a) This experience must include learning about, and using community resources and services in planning patient care, as well as consulting and working collaboratively with case managers, crisis teams, and other mental health professionals. (Core)

IV.A.6.a).(15) Electives must have written curriculum with goals and objectives, and learning experiences that lead to specified learning outcomes. (Core)

IV.A.6.a).(15).(a) The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor. (Core)

IV.A.6.b) Residents at all levels must be provided at least two hours of

faculty preceptorship weekly, one hour of which must be individual. (Core)

IV.A.6.c) Residents must have experience participating in psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance, and performance improvement. (Core)

IV.A.6.d) For residents who enter subspecialty education in child and adolescent psychiatry prior to completing general psychiatry requirements, certain clinical experiences with children, adolescents, and families taken during the period when the resident is designated as a child and adolescent psychiatry resident may be counted toward general psychiatry requirements as well as child and adolescent requirements, thereby fulfilling program requirements in both general and child and adolescent psychiatry. The following guidelines must be met for these experiences: (Core)

IV.A.6.d).(1) experience is limited to child and adolescent psychiatry patients; (Core)

IV.A.6.d).(2) no more than 12 months may be double-counted; (Core)

IV.A.6.d).(3) there must be documentation from the child and adolescent psychiatry program director for all areas for which credit is given in both programs; (Core)

IV.A.6.d).(4) there must be no reduction in total length of time devoted to education in child and adolescent psychiatry; and, (Core)

IV.A.6.d).(5) only the following experiences should be used to meet requirements in both general and child and adolescent psychiatry:

IV.A.6.d).(5).(a) one month FTE of child neurology; (Core)

IV.A.6.d).(5).(b) one month FTE of pediatric consultation; (Core)

IV.A.6.d).(5).(c) one month FTE of addiction psychiatry; (Core)

IV.A.6.d).(5).(d) forensic psychiatry experience; (Core)

IV.A.6.d).(5).(e) community psychiatry experience; and, (Core)

IV.A.6.d).(5).(f) no more than 20 percent of the resident's psychiatry outpatient experience. (Core)

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic

principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

IV.B.2. **Residents should participate in scholarly activity.** (Core)

IV.B.2.a) The program must provide residents with opportunities for research and development of research skills for residents interested in conducting research in psychiatry or related fields. (Core)

IV.B.2.b) The program must provide interested residents access to and the opportunity to participate actively in ongoing research under a mentor. (Core)

IV.B.2.c) All residents must be educated in research literacy and in the concepts and process of evidence-based clinical practice to develop skills in question formulation, information searching, critical appraisal, and medical decision-making. (Core)

IV.B.3. **The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.** (Detail)

V. Evaluation

V.A. Resident Evaluation

V.A.1. **The program director must appoint the Clinical Competency Committee.** (Core)

V.A.1.a) **At a minimum the Clinical Competency Committee must be composed of three members of the program faculty.** (Core)

V.A.1.a).(1) **The program director may appoint additional members of the Clinical Competency Committee.**

V.A.1.a).(1).(a) **These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings.** **(Core)**

V.A.1.a).(1).(b) **Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee.** **(Core)**

V.A.1.b) **There must be a written description of the responsibilities of the Clinical Competency Committee.** (Core)

V.A.1.b).(1) **The Clinical Competency Committee should:**

V.A.1.b).(1).(a) **review all resident evaluations semi-annually;** (Core)

V.A.1.b).(1).(b) **prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and,** (Core)

V.A.1.b).(1).(c) **advise the program director regarding resident progress, including promotion, remediation, and dismissal.** (Detail)

V.A.2. **Formative Evaluation**

V.A.2.a) **The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.** **(Core)**

V.A.2.b) **The program must:**

V.A.2.b).(1) **provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones;** **(Core)**

V.A.2.b).(2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);** **(Detail)**

V.A.2.b).(3) **document progressive resident performance improvement appropriate to educational level; and,** **(Core)**

V.A.2.b).(4) **provide each resident with documented semiannual evaluation of performance with feedback.** **(Core)**

V.A.2.c) **The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.** **(Detail)**

V.A.2.d) The program must conduct an annual formal evaluation of the core medical knowledge of each resident in the second, third, and fourth years, and conduct an examination across biological, psychological, and social spheres that are defined in the **program's written goals and objectives.** (Core)

V.A.2.e) The program must formally conduct a clinical skills examination for

each resident. (Core)

V.A.2.e).(1) This examination should include an annual evaluation of the resident's:

V.A.2.e).(1).(a) ability to interview patients and families; (Detail)

V.A.2.e).(1).(b) ability to establish an appropriate doctor/patient relationship; (Detail)

V.A.2.e).(1).(c) ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history; (Detail)

V.A.2.e).(1).(d) ability to assess mental status; (Detail)

V.A.2.e).(1).(e) ability to provide a relevant formulation, differential diagnosis, and provisional treatment plan; and, (Detail)

V.A.2.e).(1).(f) ability to make an organized presentation of the pertinent history, including the mental status examination. (Detail)

V.A.2.f) The program must monitor clinical records on major rotations to assess resident competence to: (Core)

V.A.2.f).(1) document an adequate history and perform mental status, physical, and neurological examinations; (Core)

V.A.2.f).(2) organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues; (Core)

V.A.2.f).(3) proceed with appropriate laboratory and other diagnostic procedures; (Core)

V.A.2.f).(4) develop and implement an appropriate treatment plan followed by regular and relevant progress notes regarding both therapy and medication management; and, (Core)

V.A.2.f).(5) prepare an adequate discharge summary and plan. (Core)

V.A.2.g) Residents' teaching abilities must be documented by evaluations from faculty members and/or learners. (Core)

V.A.2.h) The record of evaluation must demonstrate that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. (Core)

V.A.2.h).(1) In the case of transferring residents, the records must include the experiences in the prior and current program.

(Core)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. (Core)

V.A.3.b) The program director must provide a summative evaluation for each resident upon completion of the program. (Core)

This evaluation must:

V.A.3.b).(1) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Detail)

V.A.3.b).(2) document the resident's performance during the final period of education; (Detail)

V.A.3.b).(3) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision; and, (Detail)

V.A.3.b).(4) include a summary of any documented evidence of unethical behavior, unprofessional behavior, or clinical incompetence, or a statement that none has occurred. (Core)

V.A.3.b).(4).(a) Where there is such evidence, it must be comprehensively recorded, along with the resident's response(s) to that evidence. (Core)

V.A.3.c) 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. (Outcome)

V.A.3.c).(1) 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. (Core)

V.A.3.c).(2) Satisfactory demonstration of the competencies during the three required evaluations must be documented prior to completion of the program. (Core)

V.B. Faculty Evaluation

V.B.1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.** (Core)

V.B.2. **These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.** (Detail)

V.B.3. **This evaluation must include at least annual written confidential evaluations by the residents.** (Detail)

V.C. Program Evaluation and Improvement

V.C.1. **The program director must appoint the Program Evaluation Committee (PEC).** **(Core)**

V.C.1.a) **The Program Evaluation Committee:**

V.C.1.a).(1) **must be composed of at least two program faculty members and should include at least one resident;** **(Core)**

V.C.1.a).(2) **must have a written description of its responsibilities; and,** **(Core)**

V.C.1.a).(3) **should participate actively in:**

V.C.1.a).(3).(a) **planning, developing, implementing, and evaluating educational activities of the program;** **(Detail)**

V.C.1.a).(3).(b) **reviewing and making recommendations for revision of competency-based curriculum goals and objectives;** **(Detail)**

V.C.1.a).(3).(c) **addressing areas of non-compliance with ACGME standards; and,** **(Detail)**

V.C.1.a).(3).(d) **reviewing the program annually using evaluations of faculty, residents, and others, as specified below.** **(Detail)**

V.C.2. **The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation.** **(Core)**

The program must monitor and track each of the following areas:

V.C.2.a) **resident performance;** **(Core)**
V.C.2.b) **faculty development;** **(Core)**

V.C.2.c) **graduate performance, including performance of program graduates on the certification examination; (Core)**

V.C.2.c).(1) At least 70 percent of a program's graduates who completed the program in the preceding three years should take the certifying examination in general psychiatry. (Outcome)

V.C.2.c).(2) At least 70 percent of a program's graduates from the preceding three years who take the ABPN certifying examination in general psychiatry for the first time must pass. (Outcome)

V.C.2.c).(3) At least 70 percent of the program's eligible graduates from the preceding three years taking the American Osteopathic Board of Neurology and Psychiatry (AOBNP) psychiatry written qualifying examination for the first time must pass. (Outcome)

V.C.2.c).(4) At least 70 percent of the program's eligible graduates from the preceding three years taking the AOBNP psychiatry oral/clinical certifying examination for the first time must pass. (Outcome)

V.C.2.d) **program quality; and, (Core)**

V.C.2.d).(1) **Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)**

V.C.2.d).(2) **The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program. (Detail)**

V.C.2.e) **progress on the previous year's action plan(s). (Core)**

V.C.3. **The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)**

V.C.3.a) **The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)**

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- ***Excellence in the safety and quality of care rendered to patients by residents today***

- ***Excellence in the safety and quality of care rendered to patients by today's residents in their future practice***

- ***Excellence in professionalism through faculty modeling of:***

  - ***the effacement of self-interest in a humanistic environment that supports the professional development of physicians***

  - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***

- ***Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal 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. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) **The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** **(Core)**

VI.A.1.a).(1).(b) **The program must have a structure that promotes safe, interprofessional, team-based care.** **(Core)**

VI.A.1.a).(2) **Education on Patient Safety**

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. **(Core)**

VI.A.1.a).(3) **Patient Safety Events**

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) **Residents, fellows, faculty members, and other clinical staff members must:**

VI.A.1.a).(3).(a).(i) **know their responsibilities in reporting patient safety events at the clinical site;** **(Core)**

VI.A.1.a).(3).(a).(ii) **know how to report patient safety events, including near misses, at the clinical site; and,** **(Core)**

VI.A.1.a).(3).(a).(iii) **be provided with summary information of their institution's patient safety reports.** **(Core)**

VI.A.1.a).(3).(b) **Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.** **(Core)**

VI.A.1.a).(4) **Resident Education and Experience in Disclosure of**

Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) **All residents must receive training in how to disclose adverse events to patients and families.** (Core)

VI.A.1.a).(4).(b) **Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.** (Detail)

VI.A.1.b) **Quality Improvement**

VI.A.1.b).(1) **Education in Quality Improvement**

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) **Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.** (Core)

VI.A.1.b).(2) **Quality Metrics**

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a) **Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** (Core)

VI.A.1.b).(3) **Engagement in Quality Improvement Activities**

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) **Residents must have the opportunity to participate in interprofessional quality improvement activities.** (Core)

VI.A.1.b).(3).(a).(i) **This should include activities aimed at reducing health care disparities.** (Detail)

VI.A.2. Supervision and Accountability

VI.A.2.a) ***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.***

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) **Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)**

VI.A.2.a).(1).(a) **This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)**

VI.A.2.a).(1).(b) **Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)**

VI.A.2.b) ***Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.***

VI.A.2.b).(1) **The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate**

to the situation. (Core)

VI.A.2.c) **Levels of Supervision**

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c).(1) **Direct Supervision – the supervising physician is physically present with the resident and patient.** (Core)

VI.A.2.c).(2) **Indirect Supervision:**

VI.A.2.c).(2).(a) **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.** (Core)

VI.A.2.c).(2).(b) **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.** (Core)

VI.A.2.c).(3) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** (Core)

VI.A.2.d) **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** (Core)

VI.A.2.d).(1) **The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.** (Core)

VI.A.2.d).(2) **Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.** (Core)

VI.A.2.d).(3) **Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** (Detail)

VI.A.2.e) **Programs must set guidelines for circumstances and events**

in which residents must communicate with the supervising faculty member(s). (Core)

VI.A.2.e).(1) **Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.** (Outcome)

VI.A.2.e).(1).(a) **Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available.** (Core)

VI.A.2.e).(1).(b) PGY-1 residents should progress to being supervised indirectly with direct supervision available only after demonstrating competence in:

VI.A.2.e).(1).(b).(i) the ability and willingness to ask for help when indicated; (Detail)

VI.A.2.e).(1).(b).(ii) gathering an appropriate history; (Detail)

VI.A.2.e).(1).(b).(iii) the ability to perform an emergent psychiatric assessment; and, (Detail)

VI.A.2.e).(1).(b).(iv) presenting patient findings and data accurately to a supervisor who has not seen the patient. (Detail)

VI.A.2.f) **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.** (Core)

VI.B. Professionalism

VI.B.1. **Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.** (Core)

VI.B.2. **The learning objectives of the program must:**

VI.B.2.a) **be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events;** (Core)

VI.B.2.b) **be accomplished without excessive reliance on residents to fulfill non-physician obligations; and,** (Core)

VI.B.2.c) **ensure manageable patient care responsibilities.** (Core)

VI.B.3. **The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.** **(Core)**

VI.B.4. **Residents and faculty members must demonstrate an understanding of their personal role in the:**

VI.B.4.a) **provision of patient- and family-centered care;** **(Outcome)**

VI.B.4.b) **safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;** **(Outcome)**

VI.B.4.c) **assurance of their fitness for work, including:** **(Outcome)**

VI.B.4.c).(1) **management of their time before, during, and after clinical assignments; and,** **(Outcome)**

VI.B.4.c).(2) **recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team.** **(Outcome)**

VI.B.4.d) **commitment to lifelong learning;** **(Outcome)**

VI.B.4.e) **monitoring of their patient care performance improvement indicators; and,** **(Outcome)**

VI.B.4.f) **accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.** **(Outcome)**

VI.B.5. **All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.** **(Outcome)**

VI.B.6. **Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.** **(Core)**

VI.C. **Well-Being**

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of

professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

VI.C.1. This responsibility must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, (Core)

VI.C.1.d).(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment,

including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. **There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work.** (Core)

VI.D. Fatigue Mitigation

VI.D.1. **Programs must:**

VI.D.1.a) **educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;** (Core)

VI.D.1.b) **educate all faculty members and residents in alertness management and fatigue mitigation processes; and,** (Core)

VI.D.1.c) **encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.** (Detail)

VI.D.2. **Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue.** (Core)

VI.D.3. **The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.** (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. **Clinical Responsibilities**

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)

VI.E.2. **Teamwork**

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)

VI.E.2.a) Contributors to effective interprofessional teams should include

consulting physicians, psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients. (Detail)

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) **Residents should have eight hours off between scheduled clinical work and education periods.** (Detail)

VI.F.2.b).(1) **There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.** (Detail)

VI.F.2.c) **Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.** (Core)

VI.F.2.d) **Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.** (Core)

VI.F.3. **Maximum Clinical Work and Education Period Length**

VI.F.3.a) **Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.** (Core)

VI.F.3.a).(1) **Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.** (Core)

VI.F.3.a).(1).(a) **Additional patient care responsibilities must not be assigned to a resident during this time.** (Core)

VI.F.4. **Clinical and Educational Work Hour Exceptions**

VI.F.4.a) **In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:**

VI.F.4.a).(1) **to continue to provide care to a single severely ill or unstable patient;** (Detail)

VI.F.4.a).(2) **humanistic attention to the needs of a patient or family; or,** (Detail)

VI.F.4.a).(3) **to attend unique educational events.** (Detail)

VI.F.4.b) **These additional hours of care or education will be counted toward the 80-hour weekly limit.** (Detail)

VI.F.4.c) **A Review Committee may grant rotation-specific exceptions**

for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

The Review Committee for Psychiatry will not consider requests for exceptions to the 80-hour limit to the residents' work week.

VI.F.4.c).(1) **In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*.** **(Core)**

VI.F.4.c).(2) **Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO.** **(Core)**

VI.F.5. **Moonlighting**

VI.F.5.a) **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety.** **(Core)**

VI.F.5.b) **Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.** **(Core)**

VI.F.5.c) **PGY-1 residents are not permitted to moonlight.** **(Core)**

VI.F.6. **In-House Night Float**

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. **(Core)**

VI.F.6.a) Residents should not be scheduled for more than four consecutive weeks of night float during the required one-year, full-time outpatient psychiatry experience. (Detail)

VI.F.6.b) Residents should not be scheduled for more than a total of eight weeks of night float during the one-year of consecutive outpatient experience. (Detail)

VI.F.7. **Maximum In-House On-Call Frequency**

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). **(Core)**

VI.F.7.a) On psychiatry rotations, in-house call must occur no more frequently than every fourth night, averaged over a four-week period. (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

***

*__Core Requirements:__ Statements that define structure, resource, or process elements essential to every graduate medical educational program.
__Detail Requirements:__ Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.
__Outcome Requirements:__ Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition
For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.
(http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic Recogniton Requirements.pdf)

Appendix E
Street Terms – White House Drug policy

Office of National Drug Control Policy – Street Terms

http://www.*whitehousedrugpolicy*.gov/streetterms/

Appendix F

UNLV School of Medicine

GME Resident Handbook

UNLV/SOM

Resident Physician, Resident Dentist and Fellow
Handbook of Policies and Procedures

The Graduate Medical Education Resident Handbook is available at the following link:

https://www.unlv.edu/medicine/gme/handbook

The following are included in the Graduate Medical Education Resident Handbook:

Section 1: Introduction

Section II: Conditions of Employment

Section III: Training Environment

Section IV: Clinical Experience and Education

Section V: Supervision

Section VI: Academic Actions

SectionVII: GME Office Responsibilities

Section VIII: GMEC Responsibilities

Section IX: Human Resources

Section X: Appendices

This policy book will be reviewed annually and amended and updated as needed. Residents are expected to become familiar with and comply with all policies including, but not limited to, those in Sections 1–Section X set forth in this policy book.