

**UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE – PHOENIX
PSYCHIATRY PROGRAM MANUAL**

Table of Contents

RESIDENCY PROGRAM

PROGRAM AIM	4
EDUCATIONAL OBJECTIVES, COMPETENCIES AND MILESTONES	4
COMPETENCY BASED SKILLS, MILESTONES AND SUBCOMPETENCIES FOR	5
CLINICAL ASSIGNMENTS	5
PGY-1	5
PGY-2	8
PGY-3	9
PGY-4	10
PSYCHOTHERAPY COMPETENCIES	11
GENERAL COMPETENCIES	11
A.C.G.M.E. GENERAL COMPETENCIES OUTCOMES PROJECT	17
PSYCHIATRY RESIDENT ROLES AND RESPONSIBILITIES	18
PSYCHIATRY MILESTONE PROJECT	21
A.C.G.M.E. NEXT ACCREDITATION SYSTEM (NAS) MILESTONES 2.0	22
DOCUMENTATION OF CLINICAL EXPERIENCES	23
PLANNED EDUCATIONAL /DIDACTIC EXPERIENCES	23
SCHOLARLY ACTIVITIES: TEACHING, PRESENTATION SKILLS, RESEARCH, ETC.	25
PATIENT SAFETY AND QUALITY IMPROVEMENT CURRICULUM AND PROJECTS	26
CLINICAL ROTATIONS	26
ELECTIVES	27
DIDACTICS: LECTURES, SEMINARS, CONFERENCES, ETC.	27
EDUCATIONAL OBJECTIVES: LINES OF RESPONSIBILITY AND	29
FACULTY SUPERVISION OF RESIDENTS	29
SPONSORING INSTITUTION	30
PARTICIPATING CLINICAL SITES	30

POLICIES

DIVERSITY AND INCLUSION POLICY	33
APPLICATION, ELIGIBILITY & SELECTION PROCESS POLICY	34
EDUCATION POLICY COMMITTEE	35
CLINICAL COMPETENCY COMMITTEE	35
PROGRAM EVALUATION COMMITTEE	35
RESIDENT'S PERFORMANCE ASSESSMENT AND EVALUATIONS	35
Formative Evaluations	35
Cognitive Examinations	36
Clinical Skills Evaluations	36
Summative Evaluation	36
CRITERIA FOR ADVANCEMENT AND GRADUATION	36
General Criteria for Advancement	37
FACULTY EVALUATIONS, QUALIFICATIONS AND RESPONSIBILITIES	38
EXPERIMENTATION AND INNOVATION	39

RESIDENT SAFETY	39
GRIEVANCE PROCEDURES FOR RESIDENTS AND FACULTY	39
ATTENDANCE POLICY	39
MOONLIGHTING POLICY	39
VACATION AND SICK POLICY	39
JURY DUTY.....	41
BEREAVEMENT LEAVE.....	41
MATERNITY & PATERNITY LEAVE/FAMILY AND MEDICAL LEAVE	41
EDUCATIONAL LEAVE POLICY	41
PATIENT LOGS.....	41
COMPLIANCE POLICY	42
DISASTER POLICY	42
MEDICAL RECORD POLICY.....	42
OTHER RULES, REGULATIONS, POLICIES, ETC.	43
CLINICAL LEARNING ENVIRONMENT REVIEW (CLER)	44
THE LEARNING AND WORKING ENVIRONMENT.....	44
PATIENT SAFETY	45
QUALITY IMPROVEMENT	45
SUPERVISION AND ACCOUNTABILITY	45
RESIDENT SUPERVISION.....	45
PROFESSIONALISM.....	46
WELL-BEING.....	47
FATIGUE MITIGATION AND MANAGEMENT.....	48
CLINICAL RESPONSIBILITIES.....	48
TEAMWORK.....	48
TRANSITIONS OF CARE	48
CLINICAL EXPERIENCE AND EDUCATION	49
ON-CALL SCHEDULE DEVELOPMENT AND GUIDELINES FOR UACOMP PSYCHIATRY	50

EVALUATION FORMS

CLINICAL ROTATION EVALUATIONS:	53
INSTRUCTIONS FOR ACCESSING NEW INNOVATIONS	60
SUPERVISION STATUS SUMMARY.....	61
EVALUATION OF PGY-1 FOR INDIRECT SUPERVISION:	62
IMMEDIATELY AVAILABLE - Form A	62
EVALUATION FOR INDIRECT SUPERVISION FORM B	63
EVALUATION FOR SUPERVISORY CAPABILITY TO OTHER RESIDENTS Form C	64
EVALUATION OF PATIENT CARE TRANSITION	65
TRANSITION OF CARE SELF ASSESSMENT.....	67
SEMI-ANNUAL GENERAL COMPETENCIES RESIDENT SELF-ASSESSMENT	68
Interpersonal & Communication Skills: Resident Self-Assessment	70
ACGME General Competency: Interpersonal & Communication Skills.....	71
360° Evaluation of Resident Performance.....	71
Practice Based Learning and Improvement.....	72
Practice Based Learning and Improvement: Attending Feedback	73
Practice Based Learning and Improvement.....	74
Part II: Use of Research Evidence & Application of Research & Statistical Methods	74
Practice Based Learning and Improvement/ Interpersonal and Communication Skills	75

Part III: Facilitate Learning of Others	75
ACGME GENERAL COMPETENCIES PROFESSIONALISM: SELF-ASSESSMENT	76
ACGME GENERAL COMPETENCIES PROFESSIONALISM: Faculty Feedback	77
MEDICAL KNOWLEDGE COMPETENCY IMPROVEMENT PLANS	78
Systems-Based Practice.....	79
PSYCHIATRY CLINICAL SKILLS EVALUATION FORM (CSV V.2)	81
Evaluation for Competency in Supportive Psychotherapy	84
Evaluation for Competency in Combined Psychopharmacology and Psychotherapy	85
Evaluation for Competency in Psychodynamic Psychotherapy	86
Evaluation for Competency in Cognitive-Behavioral Therapy	88
Evaluation for Competency in Brief Therapy	89
ECT and other Neuromodulation Techniques Education Module Checklist.....	90
WORK DUTY HOURS.....	91
LOGGING CLINICAL AND EDUCATION WORK HOURS IN NEW INNOVATIONS	93
RESIDENT'S MONTHLY EVALUATION OF CLINICAL & DIDACTICS EXPERIENCE	96
SAMPLE: Evaluation of Rotation by a Resident	96
SAMPLE EVALUATION: EVALUATION OF SUPERVISOR BY RESIDENTS	98
RESIDENT'S MONTHLY EVALUATION OF DIDACTICS EXPERIENCE	99
SAMPLE: EVALUATION OF SEMINARS BY A RESIDENT	99
TREATMENT LOGS	100
ELECTIVE REQUEST FORM	101
VACATION/TIME OFF	102
MOONLIGHTING REQUEST	103
ADULT INPATIENT PSYCHIATRY	104
PSYCHIATRIC DISCHARGE SUMMARY.....	105
CONSULTATION-LIAISON PSYCHIATRY	106
OUTPATIENT PSYCHIATRY.....	107

UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE - PHOENIX PSYCHIATRY RESIDENCY PROGRAM MANUAL

The **A.C.G.M.E.** describes Residency as 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.

I. THE RESIDENCY PROGRAM

Our Psychiatry Residency Program embraces the A.C.G.M.E. conviction that patient care is improved through better education of the next generation of physicians through **competency based assessable outcomes**.

PROGRAM AIM

Our Psychiatry Residency Program aims to train virtuous Psychiatrists who function as exemplary clinicians, capable teachers and knowledgeable managers of health care resources. The program is designed to provide a solid foundation of knowledge for lifelong professional development. Beyond the fundamental goals of training highly skilled, caring and ethical psychiatrists, our educational philosophy genuinely considers an integrated bio-psycho-social model the cornerstone of understanding and treating patients.

EDUCATIONAL OBJECTIVES, COMPETENCIES AND MILESTONES

The following competency based educational objectives are assessable outcomes of clinical skills, professional practices and areas of knowledge each resident should acquire over the expected forty-eight months of this fully-accredited training program. The A.C.G.M.E. has identified numerous significant points in the development of a Psychiatrist referred to as Milestones. Resident performance on these Milestones is one of the required data elements for our program's accreditation in the **Next Accreditation System (NAS)**. Such is elaborated in more detail on [page 22](#) of the Program Manual.

Our fundamental educational objectives are that our graduates become competent, caring and ethical Psychiatrists possessing sound clinical judgment with the requisite skills and a high order of knowledge about the diagnosis, treatment and prevention of all psychiatric disorders as well as the medical and neurological illnesses which relate to the practice of Psychiatry. Our Psychiatry Residents are expected to provide patient care that is compassionate, appropriate and effective for both the treatment of health problems and the promotion of health. The Educational Objectives, Competencies and Milestones are given to each resident and member of our faculty at the beginning of the academic year. They should be reviewed regularly and the residents and supervising faculty are expected to discuss the pertinent sections at the beginning of each assignment. These guidelines are not meant to be exhaustive. It is expected that each resident's level of expertise will progressively develop with subsequent training. It is also appreciated that trainees enter the program with different skill sets, fund of knowledge and backgrounds. Upon completion of training our residents are expected to have consistently demonstrated sufficient competence in rendering effective professional care to psychiatric patients without direct supervision. Our graduates are also expected to have a keen awareness of their own strengths and limitations and recognize the necessity for a commitment to lifelong self-evaluation, practice-based learning, professional development and to meeting the needs of society.

Residents have supervised experiences in the evaluation and treatment of patients of different ages and gender across the life cycle and from a variety of ethnic, racial, sociocultural and economic backgrounds. They are expected to develop the capacity to conceptualize all illnesses in terms of phenomenological, biological, psychological and sociocultural factors. Residents should actively strive to provide humanistic and ethical care through cost-effective management and utilization of available clinical and community resources and monitor the outcomes of their efforts. The basic clinical skills to be developed include the abilities to gather and organize relevant data, integrate the data into a formulation of the problems

which supports a well-reasoned differential diagnosis, then develop and implement a comprehensive evidence-based treatment plan with follow-up care.

In the clinical learning environments, each patient must have an identifiable, appropriately-credentialed and privileged attending physician or suitably licensed independent practitioner approved by the Psychiatry Residency Review Committee (RRC) who is ultimately responsible for the patient's care.

The clinical responsibilities for each resident are based on PGY-level, patient safety, resident education, severity and complexity of patient illness or condition and available support services.

Residents must care for patients in an environment that maximizes effective communication. This includes the opportunity to work as a member of interprofessional teams that are appropriate to the delivery of care in the specialty. Transition of care events, e.g., "hand-offs" are key events demonstrating professional communication.

The specific Educational Objectives, Competencies and Milestones are organized in the usual progression of graduate training but the sequence may be variable.

The Psychiatry Residency Program operates in accordance with the "AMA Principles of Ethics with Special Annotations for Psychiatry" as developed by the American Psychiatric Association. Residents are given a copy at the beginning of training and an updated version when necessary. The application and teaching of these principles are integral parts of the educational process and expected professional practice.

COMPETENCY BASED SKILLS, MILESTONES AND SUBCOMPETENCIES FOR CLINICAL ASSIGNMENTS

The A.C.G.M.E. and its Psychiatry Residency Review Committee (RRC) have developed Specialty Specific Milestones as a significant part of its "**Next Accreditation System**" or **NAS and were updated in July 2021**. Milestones 2.0 for Psychiatry are included in this Program Manual on [page 22](#). This significant transition in Graduate Medical Education is a welcomed opportunity to improve both the quality and value of training in Psychiatry.

The A.C.G.M.E. concept of Milestones includes expected levels of performance (Dreyfus Model) for the sequential stages of graduate training from completion of medical school (Novice), through the expected levels of performance during (Competent) the residency program up to graduation (Proficient) and ultimately the advanced specialist resident or practicing physician (Master).

The following are our current Competency Based Skills and Milestones expected to be acquired during the core clinical assignments over the course of our four-year training program. Each is paired with the more pertinent General Competencies although others are likely relevant. Broad elaborations for each General Competency are listed on [pages 11-16](#) of our Program Manual.

Patient Care=PC, Medical Knowledge=MK, Practice Based Learning and Improvement=PBLI, Interpersonal and Communication Skills=ICS, Professionalism=PROF, and Systems Based Practice=SBP are indicated after each expected educational objective.

PGY-1

While on services other than Psychiatry, PGY-1 residents are supervised by the appropriate faculty and more senior resident preceptors in those settings but are expected to maintain periodic contact with the Program Director as well as the resident's designated Primary Supervisor in our Department of Psychiatry. A general educational objective of the Medicine, Pediatric, Emergency Medicine and Neurology experiences is to become familiar with physical conditions that can affect psychiatric evaluation and care. It is also expected that the PGY-1 resident will use these experiences to prepare for successful and timely completion of USMLE Step III or COMLEX Level 3 of the licensing exam.

Medicine Rotations: In general, the objectives of training for this part of the first post-graduate year are to acquire general medical skills and knowledge relevant to the practice of Psychiatry and crystallize one's identity as a physician. Three months of PGY-1 are devoted to **internal medicine** and one month in the **emergency center**.

The emergency center experience is predominantly medical evaluation and treatment as opposed to surgical procedures. When scheduling permits, one month of internal medicine may be substituted by **outpatient pediatrics**. Specific clinical objectives and Milestones are provided by the respective disciplines but broadly include:

1. Learn to initiate clinical examinations and diagnostic studies for patients presenting with common medical and surgical disorders. [PC, MK, PBLI]
2. Assume direct responsibility under supervision for the diagnosis, treatment planning and general medical care of physically ill patients. [PC, PBLI, ICS]

3. Provide comprehensive and continuous care for patients with medical illnesses and make appropriate referrals. [PC, PROF, SBP]
4. Learn to recognize somatic disorders likely to be regarded as psychiatric and vice versa. [MK, PBLI]
5. Appreciate the interaction between psychiatric, medical and surgical treatments. Psychiatry trainees maintain contact with our department while on internal medicine, pediatrics and emergency medicine rotations through collaboration with the Psychiatry Consultation-Liaison Services and various interdisciplinary conferences. [MK, PROF, SBP]
6. Work compassionately, respectfully and with professional integrity with patients, their families and other members of the health care team. [PC, PROF, SBP]
7. Develop a sense of responsibility for the care of one's patients. [PROF]
8. Crystallize one's identity as a physician. [PROF]

Neurology: In general, the educational objectives during the Neurology assignments are to comprehend the diagnosis and treatment of neurological disorders commonly encountered in the practice of Psychiatry, such as neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, neurocognitive disorders, seizure disorders, stroke, intractable pain, and other related disorders. There is a minimum of two months supervised clinical experience in neurology during the residency typically taken during PGY-1 or if necessary for transferring residents during PGY-2. This required rotation is a combination of inpatient, consultation and outpatient experiences involving general Neurology and specialty clinics including headache, epilepsy, memory disorders, multiple sclerosis and others. There are also opportunities for additional neurology outpatient and consultation experiences during PGY-4. Several elements of the **Neuroscience Milestone (MK3)** are included in the Neurology assignments. Residents gain exposure to **neuropsychological testing and neuroimaging** in a variety of clinical settings throughout the training program and a **Neurology Seminar** is offered during PGY4. It can be taken during PGY3 if leaving the program early.

Specific objectives include:

1. To be able to obtain a thorough history regarding neurological disease. [PC, ICS, PBLI]
2. To perform and accurately document a comprehensive neurological examination. [PC]
3. To make suitable differential diagnoses utilizing clinical examination skills, laboratory testing, neuroimaging, neurophysiologic and neuropsychological testing. [MK, PBLI, SBP]
4. To plan and carry out treatment, under supervision, of clinically important neurological illnesses. [PC, ICS]
5. To be familiar with the growing interface of neurology, psychiatry and the biobehavioral sciences. Again, Psychiatry residents maintain contact with our department while on neurology through our Consultation-Liaison Service and various interdisciplinary conferences and meeting periodically with the Program Director and the resident's Primary Supervisor. [MK, SBP]

While assigned to the Internal Medicine, Pediatrics, Emergency Medicine and Neurology teaching services, our residents will follow the A.C.G.M.E. Clinical and Educational work hours and supervision requirements for those respective medical specialties.

Adult Inpatient Psychiatry: Many of the specialty specific educational objectives for the PGY-1 rotations on the Adult Inpatient Psychiatry Service are the same as the PGY-2 rotations in that setting and are listed below. There is an appreciation that a resident's level of expertise, sophistication, need for supervision, etc. progresses from PGY-1 through PGY-2. Specific A.C.G.M.E. Milestone requirements regarding supervision are listed on [pages 29](#). In general, an ability to assume increased responsibility for patient care and one's own Professional development are expected to advance from year to year throughout the residency program. For those reasons several relevant Milestone subcompetencies are assigned to beginner (PGY-1) v.s. mid-level (PGY-2), respectively in our assessment tools.

While assigned to the Adult Inpatient Service, each resident has significant responsibility for the assessment and treatment of a variety of acutely ill patients. The experience provides residents ample opportunities to develop competence in the comprehensive biopsychosocial assessment and continuous, evidence-based management of patients with acute conditions. Specific clinical skills and milestones and subcompetencies to be acquired and successfully achieved include the ability to:

1. Conduct a comprehensive psychiatric interview and examination demonstrating an understanding of relevant phenomenological, biological, psychological and social issues. [MK, ICS, PROF]
2. Clearly, accurately and systematically obtain and document within the expected timeframes via Electronic Medical Records a detailed history, comprehensive physical, neurological and mental status examinations; daily progress notes; and discharge summaries. [ICS, PROF]
3. Utilize and understand appropriate laboratory studies, imaging and neurophysiologic studies in evaluating a psychiatric patient. [MK, PBLI, SBP]

4. Appreciate the use, reliability and validity of common psychological and neuropsychological testing and work collaboratively with a psychologist using such to evaluate your own patients. [MK, SBP]
5. Formulate and differentiate psychiatric illness using appropriate diagnostic criteria, current standard nomenclature, i.e. DSM, and all other relevant data. [MK, PBLI]
6. Formulate and document appropriate evaluation and treatment plans from a biopsychosocial perspective and implement such through personal efforts. [PC, MK, ICS]
7. Use any psychopharmacologic agent well with an understanding of indications, contraindications, doses, side effects, medication interactions, etc. [MK, PBLI]
8. Conduct supportive therapy with an increasing awareness of interpersonal and psychodynamic issues and the value of psychological insight. [PC, ICS]
9. Develop an awareness of transference and countertransference issues and deal with them appropriately and professionally. [MK, PC, PBLI, PROF]
10. Work cooperatively with other medical and allied behavioral health professionals in information gathering, treatment planning, teaching, utilization review, triage and referral.
11. Become familiar and involved with quality improvement, patient safety, case management and develop leadership skills for interdisciplinary team management. [ICS, PROF, SBP]
12. Appreciate the value and appropriateness of inpatient groups and milieu activities through observation and participation. [MK, PC, SBP]
13. Understand the indications and uses of electroconvulsive therapy. Each resident is expected to successfully complete the ECT Education Module prior to the completion of PGY-3. [PC, MK]
14. Distinguish "organic" from more psychologically determined illnesses. [MK, PBLI]
15. Evaluate and manage psychiatric emergencies including the evaluation and treatment of suicidal and dangerous patients. [PC, MK, PBLI]
16. Undergo formal training in Crisis Prevention Institute (CPI) procedures to understand the indications, safe use and various regulations for seclusion and restraints including the ability to recognize and respond to signs of physical distress in a patient who has been restrained or secluded and other nonviolent interventions. [MK, PC, SBP]
17. Develop emergency safety skills such as de-escalation, mediation, conflict resolution, active listening and relevant verbal and observational methods. [PC, MK, ICS]
18. Familiarize oneself with patient's rights, basic forensic issues including the petitioning and commitment process, and the ethics and economics of psychiatric practice. [MK, SBP]
19. Understand the indications and integration of different treatment modalities, including individual, family and group therapies, psychosocial rehabilitation, behavior therapy, pharmacological, ECT and other somatic therapies. [PC, MK, PBLI]
20. Conduct a family interview. [PC, ICS]
21. Develop teaching and supervisory skills to medical students, less experienced residents and other health care professionals. [ICS, PROF]
22. Learn to effectively manage multiple tasks in a time-efficient manner. [ICS, PROF, PC]
23. Utilize the information discussed and assigned as reading in the lectures, conferences and seminars, in particular the Introduction to Clinical Psychiatry Lectures, the Clinical Science Lecture Series, Interviewing, Presentation Skills, Formulation and Clinical Skills Evaluation Conference, as an educational foundation for further professional development (see "Core Curriculum I" topics list). [MK, PBLI]
24. Effectively and safely both transfer and receive patient care responsibilities from colleagues and other healthcare professionals.

Chemical Dependency: In addition to the frequent evaluation and treatment of patients with "dual diagnoses" in many clinical settings throughout the residency, there is a one-month focused assignment **during both PGY-1 and PGY-2** in the Substance Abuse Treatment Program (SATP) at the nearby V.A. Medical Center as described in more detail on [page 30](#). This is an intense, specialized rehabilitation program utilizing a multidisciplinary approach to evaluate and treat patients with significant chemical dependency problems. The PGY-1 experience has an outpatient focus and includes time with the multi-disciplinary chronic pain program. The resident functions as a member of the multidisciplinary treatment team, serves as a co-therapist with experienced faculty for group treatment as well as having individual responsibility for patient care. Before completing the residency, each resident is expectedly skilled in the recognition of signs of substance use and dependence, medical detoxification, management of overdose, maintenance pharmacotherapies, psychological consequences, family violence and its effect on both victims and perpetrators of addiction, and an appropriate awareness of group,

rehabilitation and self-help treatment approaches. Supervision is provided by the full-time faculty including Psychiatrists, Psychologists and certified addiction therapists. Electives in Addiction Psychiatry are also available during PGY-4. [PC, MK, SBP] Relevant Milestones are elaborated in subcompetencies SBP2, SBP3, PBLI1, and PROF1. Residents are expected to obtain Buprenorphine education training during the rotation and also complete a Tobacco Cessation Education Program. Residents will become familiar with medication assisted treatment for substance use disorders.

Per the A.C.G.M.E. Specialty Specific Supervision requirements, PGY-1 Psychiatry Residents 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.

An Evaluation for Indirect Supervision with Direct Supervision Available is included on [page 63](#) (Form B).

PGY-2, PGY-3 and PGY-4 residents may provide direct or indirect supervision for more junior residents as long as the following requirements are met:

- a) Both the junior resident and supervising resident should inform patients of their respective roles in that patient's care; and,
- b) Assignment is based on the needs of each patient and the skills (demonstrated competency in medical expertise and supervisory capability) of the individual more senior supervising resident.

An attending faculty is always available to provide back-up supervision, which may be by phone. The checklist forms to monitor a resident's progression through these specific Supervision Milestones are included on [pages 61-63](#) (Form A, B, C).

Residents transferring to our program at PGY-2 must provide documentation of successful completion of an A.C.G.M.E. accredited PGY-1 including the Internal Medicine, Family Medicine or Pediatric requirements or others acceptable to the A.B.P.N. allowing qualification for its certification examination. For transferring residents with a general medical PGY-1 background, PGY-2 typically includes 10-12 months Adult Inpatient Psychiatry, the required 2 months Neurology experiences if necessary, and several hours each week with outpatients. Subsequent required rotations are scheduled over PGY-3 and PGY-4.

PGY-2

Adult Inpatient Psychiatry: Many of the specialty specific educational objectives for the PGY-2 and PGY-3 rotations on the Adult Inpatient Psychiatry Service are similar as those listed above. Again, there is an appreciation that a resident's level of expertise, sophistication, need for supervision, etc. **must progress** from PGY-1 to PGY-2, approaching a level 3 Milestones assessment of the requisite clinical skills, knowledge, subcompetencies, threads, etc. by the end of PGY-2.

PGY-1 residents must qualify for indirect supervision with direct supervision available to advance to PGY-2. The pertinent evaluation form is included on [page 63](#). (Form B)

PGY-2 residents must qualify to provide direct or indirect supervision for more junior residents under the A.C.G.M.E. guidelines listed above upon demonstrating the pertinent competencies noted within the Roles and Responsibilities section ([pages 18-20](#)) and General Criteria for Advancement: PGY-2 to PGY-3 ([pages 36-37](#)) to be able to advance to PGY-3. An **Evaluation for Supervisor Capability Form** is included on page 68 (Form C). [MK, PC, ICS, PROF, SBP]

Child and Adolescent Psychiatry: These clinical experiences provide residents with several opportunities to assess and treat children, adolescents and their families with a variety of Psychiatric disorders under the supervision of full-time, board certified child and adolescent psychiatrists. The required PGY-2 or PGY-3 assignment occurs through the Behavior and Development Department of the nearby Phoenix Children's Hospital and includes inpatient, outpatient, and consultation experiences as described in more detail on [page 31](#). Residents will also rotate at Banner Behavioral Health Hospital for an Adolescent Psychiatry experience. There are also numerous opportunities to provide Psychiatric consultation of adolescent patients at B-UMCP especially while assigned to the C-L Service. In general, **the educational objectives for these child and adolescent experiences are to acquire an understanding of biological, psychological, social, economic, cultural, gender, ethnic and family factors that influence normal and abnormal development, appreciate the types of psychopathology associated with younger age groups, and become knowledgeable of appropriate treatments including a**

multidisciplinary approach to younger patients and their families. [PC, MK, SBP] Relevant Milestones 2.0 are elaborated in subcompetencies MK1, MK2 ICS1, ICS2, ICS3, .

Consultation-Liaison/Emergency Psychiatry: Residents are assigned to our Psychiatric C-L Service at B-UMCP on a part-time basis **during both PGY-2 and PGY-3.** While on this service, our residents directly interact with other medical and surgical disciplines in inpatient, outpatient, rehabilitation and emergency settings and learn to diagnose and treat psychophysiological disorders. Specific responsibilities include assessment of all available clinical information, liaison with treating physicians including housestaff, nursing and other disciplines, contact with the family and careful examination of the patient. The residents assigned to this service should also develop treatment skills including pharmacologic, psychotherapeutic, crisis intervention, educational and liaison techniques. While on the C-L Service, residents work closely with psychiatry and psychology faculty, and actively teach medical students and residents from other medical specialties. During PGY-3 and PGY-4, our residents can provide outpatient consultation to the other training programs' clinic patients including Internal Medicine, Family Medicine, OB-Gyn, Addiction Medicine and others. [PC, MK, SBP, ICS] Senior residents also have the opportunity to be involved in outpatient Transplant Evaluations and Collaborative Care with Family Medicine and Internal Medicine. Relevant Milestones 2.0 are elaborated in subcompetencies PC3, PC6, PROF1, PROF2, PROF3, ICS1, ICS2 (PGY-2) and PC5, PC6, MK3, SBP2, PBLI1, PROF1, ICS1, ICS2, and ICS3 (PGY-3).

Emergency Psychiatry: Emergency Psychiatry experiences occur in a variety of settings throughout the residency. Key assignments include a part-time rotation usually during PGY-2 at the 24-hour Urgent Psychiatric Center in Phoenix which provides an organized, supervised psychiatric emergency service as well as during Consultation – Liaison/Emergency Psychiatry Rotations as a PGY-2 and PGY-3 at B-UMCP. Both assignments involve crisis evaluation and management, and triage. Similar Emergency Psychiatry experiences occur at B-UMCP during PGY-1 in concert with a more senior resident on-call and during PGY-2, 3 and 4 on-call. Essentially all of the ambulatory outpatient assignments (including the PGY3 VA ambulatory care rotation) will also include some urgent Psychiatric experiences necessitating crisis evaluation and management and triage. (PC, MK, PBL and SBP) Relevant Milestones are elaborated in subcompetency MK2.

Chemical Dependency 2: See PGY-1 description. This is a second month of Chemical Dependency with an emphasis on inpatient rehabilitation. Relevant Milestones are SBP2, PBLI1 and PROF1.

PGY-3

Forensic Psychiatry experiences occur throughout the training program in a variety of settings allowing residents to assess and treat patients with potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability and competency. These are areas of acute focus during the Consultation-Liaison/Emergency Psychiatry service during PGY2 and PGY3 as well as during the VA Outpatient walk-in/Emergency Clinic and the Emergency Psychiatry experience at the Urgent Psychiatric Center (PGY2). During the **Community Psychiatry** rotation there is exposure to forensics reports and assessment and treatment of patients on parole and probation. Residents will also rotate at a local county jail during PGY4 and will be exposed to both Correctional and Forensic Psychiatry. (MK, SBP)

Outpatient Psychiatry: PGY-2, 3 and 4: Our Psychiatry Residents begin outpatient evaluation and treatment with selected cases at the **B-UMCP Behavioral Health Center Outpatient Clinic** during PGY-2 under the supervision of the full-time faculty. This longitudinal outpatient experience continues through PGY-3 and PGY-4. The amount of time in this outpatient setting is determined by the resident's other clinical assignments but expectedly increases from year to year. By the end of PGY-2, residents are expected to be able to conduct supportive therapy, often in conjunction with medication management. Also, each PGY-2 resident should begin the process of developing an awareness and understanding of psychodynamic issues, psychological insight, transference and countertransference phenomena as well as the value of brief, cognitive and behavioral therapies. Residents learn to use our webcam resources to facilitate outpatient supervision and utilize a virtual platform for some outpatient visits.

During PGY-3 and PGY-4, the outpatient Psychiatry experiences at B-UMCP expand in regards to the time devoted, types of patients and therapies provided. By the end of PGY-4, the B-UMCP outpatient experience has provided exposure to both acute and chronic illnesses, patients of both sexes, age ranges from late teens through older age and diverse ethnic, racial, social and economic backgrounds. Residents must have some patients that are seen continuously for at least one year and should include some patients seen on a weekly basis. Long-term psychotherapy experiences emphasizing a developmental and biopsychosocial approach are expected as well as assessment and treatment of patients requiring Supportive, Psychodynamic, CBT, Brief and Combined Psychotherapy and Medication Management models.

In addition to the longitudinal outpatient experiences at B-UMCP, our residents are also involved in the assessment and treatment of Psychiatric outpatients during the **Child and Adolescent Psychiatry rotation at P.C.H.** and the **Chemical Dependency rotation at the V.A.M.C.;** during the **Geropsychiatry, Community Psychiatry, V.A. Ambulatory Care** and with the **Employee Assistance Program at A.S.U during PGY-3.** Our PGY-3 and PGY-4 residents also provide evaluation and consultation to patients referred from the IM, Family Medicine, OB-GYN, Surgery, Addiction Medicine and other

specialty outpatient clinics on-campus at B-UMCP. By the end of PGY-4, our residents have easily met the A.C.G.M.E. requirement of no less than one year full-time equivalent caring for Adult Outpatients. [PC, MK, PBLI, SBP, ICS] Relevant Milestones are elaborated in subcompetencies, (PGY2) PC1, PC2, PC3, PC4, PC5, MK2, MK4, SBP1, SBP2, SBP3, PBLI1, PBLI2, PROF3, ICS1, ICS3 (PGY3) and MK1, MK3, SBP3, PROF2 (PGY4) and PC6, PROF1, and ICS2 (ASU-EAO).

Geriatric Psychiatry experiences also occur over the course of training, in a variety of clinical settings and each resident has no less than one month full-time equivalent and typically more evaluating and treating older patients. Such includes direct care of older patients on the Adult Inpatient Service, our outpatient Behavioral Health Center at B-UMCP, our Consultation-Liaison/Emergency Psychiatry Service at B-UMCP, during PGY-3. During PGY-3 there is also a part-time two-month assignment which includes time at the **Banner Alzheimer's Institute (BAI) Memory Disorders Clinic** and **Geriatric Psychiatry Outpatient Clinic** on the B-UMCP Campus and both Geriatric inpatient and outpatient clinics at the **VAMC**. There are also opportunities to understand the usefulness of neuropsychological testing and neuroimaging as it relates to cognitive functioning in the elderly at BAI. [PC, MK, SBP] Relevant Milestones are elaborated within subcompetencies PC1, MK1, MK3, ICS1 ICS2, and ICS3 (GOP1 and GOP2).

During PGY-3, our residents participate part-time over three months in an **outpatient public sector-community based mental health program** and provide supervised clinical care to individuals with serious and often persistent chronic mental illness. This **Community Psychiatry** outpatient rotation focuses on developing psychopharmacologic, psychotherapeutic, social, crisis and rehabilitative interventions in the context of a case management model which is described in more detail on page 32. Several community psychiatry electives are also available during PGY-4 at various programs focusing on chemical dependent pregnant women, substance abuse, individuals with HIV/AIDS, minority groups and others. [MK, SBP] Relevant Milestones are elaborated within subcompetency SBP1 SPB2, SBP3, PROF1.

PGY-4

The overall objectives for the PGY-4 residents are that the responsibilities, skills and information obtained during PGY-1, PGY-2 and PGY-3 are expanded and refined while new skills and knowledge are developed. There continues to be an emphasis on a biopsychosocial evaluation and treatment approach. Senior residents also assist in providing lectures to medical students and assist faculty organizing Grand Rounds and Career Options Conferences. The Senior residents participate in a variety of Medical Education and Departmental administrative meetings with faculty at B-UMCP, BBHH and the VAMC involving experiences in utilization review, patient safety and quality improvement programs, patient safety and performance improvement, peer review, quality assurance programs, and root cause analysis sessions. [PC, PBL, IPC, SBP]

Senior residents will take part in a variety of part-time **Administrative Psychiatry** experiences at the VAMC and BBHH [PC, SBP] (as available) and may also consider potential electives as a **Senior Inpatient Resident** or **Senior C-L Resident**. Senior residents will also rotate at the **Lower Buckeye Jail** and are involved in evaluating and treating correctional patients. Relevant Milestones are elaborated within subcompetencies PC1, PC2, PC3, PC5, PROF2, SBP2, SBP3, PBL2, PROF1, PROF2, ICS1, AND ICS2.

PGY-4s rotate as the Senior Outpatient Administrative Resident (SOAR) assisting with outpatient triage, organizing our group supervision outpatient case conferences, crisis supervision, etc. [ICS, PROF, SBP] and are expected to assume additional administrative and teaching responsibilities assisting the Program Director [ICS, PROF, SBP]. Relevant Milestones are elaborated within subcompetencies SBP1, SBP3 (Administrative Psychiatry), PGY4 OP Competencies PC1, PC2, PC3, PC4, PC5, PC6, MK1, MK2, MK3, MK4, SBP1, SBP2, SBP3, PBLI1 PBLI2, PROF1, PROF2, PROF3, ICS1, ICS2, ICS3 (PGY4) and PC6, PROF2, SBP2, and ICS2 (ASU-EAO).

Electives typically occur **during PGY-4** and are designed to enrich the educational experience of residents in furthering their personal needs, interests and future professional plans. Electives are part-time allowing for continuous care of ongoing outpatients, attendance at lectures, seminars, conferences and supervision and usually occur over 4-5 months during PGY-4. They must be based on specific written educational goals with assessable Milestone subcompetencies related objectives developed by the approved faculty preceptor and the resident that are well constructed, purposeful and lead to effective learning experiences. The choice and approval of electives is made with the advice of the Program Director and approved by the Program's Residency Education Policy Committee.

As the resident proceeds through these more advanced levels of training, he or she must satisfactorily **demonstrate the capability to manage the number and scope of patients seen by a practicing general psychiatrist**. Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Supervision:

Each clinical rotation has built-in **individual and group supervision** typically occurring several hours every week by the full-time faculty assigned to that specific clinical setting. Each resident also has at least weekly individual supervision for the care of his or her outpatients seen in our Behavioral Health Center Outpatient Clinic at B-UMCP. A “**Primary Supervisor**” is assigned annually to each resident for this longitudinal supervision and assistance in monitoring and facilitating the resident’s educational progress. PGY2, 3 and 4 residents will also participate in a weekly group supervision case conference with various outpatient supervisor participation.

PGY-2, 3 and 4 Psychiatry Residents are actively **involved in the direct and indirect supervision of PGY-1 and other new residents**. PGY-3 and PGY-4 residents take on these responsibilities at the onset of each academic year mentoring and evaluating new residents so the new residents can successfully advance from direct to indirect supervision requirements **as determined by the A.C.G.M.E.** and listed on [page 8](#) of this Residency Program Manual [ICS, PROF].

To summarize, from the previous several pages, the broad training and educational objectives include the following:

1. Learn to evaluate and provide competent and continuous care for patients from diverse backgrounds with acute and chronic Psychiatric illnesses in a variety of clinical settings appreciating and appropriately responding to the biological, psychological, sociocultural, economic, ethnic, gender, age, religious, sexual orientation, family and iatrogenic influences. [PC, MK, PBLI]
2. Utilize biopsychosocial evaluation and treatment approaches while in a variety of settings by developing clinical skills and theoretical and practical knowledge for pharmacologic, brief and long term individual psychotherapy, couple and family therapy, group therapy, crisis intervention, as well as psychodynamic, interpersonal, cognitive, supportive and behavior therapies, social rehabilitation and other treatment modalities. Also learn to provide psychiatric care to patients receiving treatment from non-medical therapists and assisting in the coordination of such treatment. [MK, ICS, SBP]
3. Effectively and safely both transfer and receive patient care responsibilities from other healthcare professionals.
4. Develop knowledge and skills in the ethical, administrative, teaching, supervisory, utilization review, performance improvement, patient safety, economic, regulatory and quality management aspects of Psychiatry in multidisciplinary clinical and educational settings. [PROF, SBP]
5. Learn to effectively manage multiple tasks in a time-efficient and timely manner. [ICS, PROF, PC]
6. Become mindful and prepared to meet the needs of society as a knowledgeable, skilled, compassionate and principled professional able to practice with an interprofessional team. [PROF, SBP]
7. Develop an awareness of one’s own personal strengths and limitations and of the necessity for continuing professional development. [PBLI, PROF]

These broad training and educational objectives are aligned with the A.C.G.M.E. Psychiatry N.A.S. Milestones.

PSYCHOTHERAPY COMPETENCIES

Beyond the various clinical skills, Milestone competencies, subcompetencies and areas of knowledge listed throughout this manual of which each resident should gain competence and familiarity, the A.C.G.M.E.’s Residency Review Committee (R.R.C.) for Psychiatry has also identified several specific forms of **psychotherapy** treatment in which residents must demonstrate competence prior to graduation. These include: **brief and long-term supportive, psychodynamic, and cognitive-behavioral therapies**. We also assess competency in managing and treating patients with the concurrent use of medications and psychotherapy (**combination therapy**). Detailed evaluation forms regarding these treatment competencies are included in this manual on [pages 84-89](#). [PC, MK, PBLI] Relevant Milestones are elaborated within subcompetencies PC4 and MK4.

GENERAL COMPETENCIES

Several years ago, the A.C.G.M.E. established **GENERAL COMPETENCIES** in the **6** domains described below which residents in all disciplines are required to develop to the level expected of a new practitioner prior to graduation. These General Competencies are now clearly imbedded and assessed in our Psychiatry specialty specific educational goals, objectives, skills, etc. Also, our Psychiatry Residency Program and the Medical Center’s Department of Graduate Medical Education have worked in concert to develop several more generic educational experiences, resources and assessment methods which promote and measure the attainment of these **GENERAL COMPETENCIES** by each resident. We have also assigned several General Competencies to our Competency Based Skills and Milestones on [pages 5-7](#) and our year-to-year Psychiatry Roles and Responsibilities on [pages 18-20](#). The provision and acquisition of these educational objectives and competencies are shared responsibilities between the program, its affiliated institutions, the faculty and most importantly the

resident. It is the resident's responsibility to utilize all of these resources and satisfactorily demonstrate his or her competence in each category. Example evaluation forms are included in this manual. A link to each General Competency Psychiatry Specific Milestones is accessible at:

<https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones2.0.pdf?ver=2020-03-10-152105-537>

Broadly, the **GENERAL COMPETENCIES** and **SUBCOMPETENCIES** include:

PATIENT CARE AND PROCEDURAL SKILLS (PC): 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 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 must demonstrate competence in:

- 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
- Formulating a clinical diagnosis for patients by conducting patient interviews
- Eliciting a clear and accurate history
- Performing a physical, neurological, and mental status examination, including use of appropriate diagnostic studies
- Completing a systematic recording of findings in the medical record
- Formulating an understanding of a patient's biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment
- Developing a differential diagnosis and treatment plan for patients with psychiatric disorders
- Managing and treatment patients using pharmacological regimens, including concurrent use of medications and psychotherapy
- Managing and treatment patients using both brief and long-term supportive, psychodynamic and cognitive-behavioral psychotherapies
- Providing psychiatric consultation in a variety of medical and surgical settings
- Managing and treating chronically-mentally ill patients with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions
- Providing psychiatric care to patients receiving treatment from non-medical therapists and coordinating such treatments

- 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

Psychiatry specific milestone 2.0 Patient Care subcompetencies include:

1. **Psychiatric Evaluation**
2. **Psychiatric Formulation and Differential Diagnosis**
3. **Treatment Planning and Management**
4. **Psychotherapy**
5. **Somatic Therapies (including Psychopharmacology and Neurostimulation Therapies)**
6. **Clinical Consultation**

Patient Care: (Curriculum Organization and Resident Experience):

- a) Residents must have major responsibility for the care of a sufficient number of patients to demonstrate competence with acute and chronic psychiatric illness. There must be patient care assignments must permit residents to practice appropriate treatment, and to have sufficient time for other aspects of their educational program. These clinical responsibilities must be coordinated with and not impinge on the non-patient care aspects of the education program.
- b) Residents must be provided 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.
- c) The first year in psychiatry must include a minimum of four months in a clinical setting that provides comprehensive clinical care and should be met in a primary care specialty setting. There should not be more than eight months FTE in psychiatry.
- d) Additional clinical rotation requirements over the course of training:

- (1) Neurology: two FTE months of supervised clinical experiences in the diagnosis and treatment of patients with neurological disorders/conditions. At least one month should occur in the first or second year of the program.
- (2) Inpatient Psychiatry: six but no more than 16 months FTE of inpatient psychiatry of which there must be 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
- (3) Outpatient Psychiatry: 12-month FTE organized, continuous, and supervised clinical experience and each resident must have significant experience treating outpatients longitudinally for at least one year. This should include:
 - a. initial evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly;
 - b. participation in multiple treatment modalities that emphasize developmental, biological, psychological and social approaches to outpatient treatment;
 - c. application of psychosocial rehabilitation techniques for the evaluation and treatment of differing disorders in a chronically ill patient population; and
 - d. Up to 20% FTE time of the patients seen may be children and adolescents. This portion of education may be used to fulfill the 2-month Child and Adolescent Psychiatry requirements, so long as this component meets the requirement for child and adolescent psychiatry as set forth in 4.a and 4.b below.
- (4) Child and Adolescent Psychiatry: two-month FTE organized clinical experience in which the residents:
 - a. Have supervising faculty members who have ABPN certification in child and adolescent psychiatry and
 - b. 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.
- (5) Geriatric Psychiatry: one-month FTE organized experience focused on the specific competencies in areas that are unique to the care of the elderly. These include:
 - a. diagnosis and management of mental disorders in geriatric patients with multiple comorbid medical disorders
 - b. diagnosis and management (including management of the cognitive component) of the degenerative disorders
 - c. basic neuropsychological testing of cognitive functioning in the elderly
 - d. management of drug interactions.
- (6) Addiction Psychiatry: one-month FTE organized experience focused on the evaluation and clinical management of patients with substance abuse/dependence problems, including dual diagnosis. Treatment modalities should include
 - a. detoxification, management of overdose, maintenance pharmacotherapy,
 - b. 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
 - c. the use of self-help groups.
- (7) Consultation-Liaison: minimum two-month FTE experience where residents consult under supervision on other medical and surgical services.
- (8) Forensic Psychiatry: This experience must include experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency.
- (9) Emergency Psychiatry: This experience must be conducted in an organized, supervised psychiatric emergency service, but not as part of the 12-month outpatient requirement. Experiences must include crisis evaluation and management, and triage of psychiatric patients. On-call experiences may be a part of this experience but alone must not fulfill the requirement for resident experiences in Emergency Psychiatry.
- (10) Community Psychiatry: This experience must provide residents with a cohort of persistently and chronically-ill patients in the public sector, (e.g. community mental health centers, public hospitals and agencies, and other community-based settings). Opportunities should exist to learn about and using community resources and services in planning patient care, as well as to consult and work collaboratively with case managers, crisis teams and other mental health Professionals.
- (11) Electives must have written curriculum with goals and objectives and learning experiences that lead to specified learning outcomes. The choice of elective must be made with the advice and approval of the program director and the appropriate preceptor.

- (12) Residents at all levels of training must have faculty preceptorship weekly, one hour of which must be individual.
- (13) Residents must have experience participating in psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance, and performance improvement.
- (14) Experiences may be completed on a full or part-time basis so long as the stated full-time equivalent (FTE) experience is met. For residents who plan to 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:
 - i. limited to child and adolescent psychiatry patients;
 - ii. up to a maximum of 12 months that can be double counted;
 - iii. documentation by child and adolescent psychiatry program director for all areas for which credit is given in both programs;
 - iv. no reduction in total length of time devoted to education in child and adolescent psychiatry, which must remain at 2 years; and
 - v. only the following experiences can be used to meet requirements in both general and child and adolescent psychiatry;
 - vi. 1-month FTE of child neurology;
 - vii. 1-month FTE of pediatric consultation;
 - viii. 1-month FTE of addiction psychiatry;
 - ix. Forensic psychiatry experience;
 - x. Community psychiatry experience; and
 - xi. Up to 20% of outpatient experience of the Program Requirements for Psychiatry.

2. **MEDICAL KNOWLEDGE (MK): 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. (CURRICULUM)**

- a) Didactic instruction must be systematically organized, thoughtfully integrated, based on sound educational principles, and include regularly scheduled lectures, seminars, and assigned readings.
- b) The didactic sessions must be scheduled to ensure a minimum of 70% of resident attendance while adhering to program duty hour policy. Didactic and clinical education must have priority in the allotment of residents' time and energy.
- c) The didactic curriculum must include the following specific components:
 - Major theoretical approaches to understanding the patient-doctor relationship.
 - 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.
 - 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.
 - 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.
 - 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.
 - Indications for and uses of electroconvulsive and neuromodulation therapies.
 - History of psychiatry and its relationship to the evolution of medicine.
 - Legal aspects of psychiatric practice.

- 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.
- Medical conditions that can affect evaluation and care of patients.

Psychiatry specific milestone 2.0 Medical Knowledge subcompetencies include:

- 1. Development through the Life Cycle**
 - 2. Psychopathology**
 - 3. Clinical Neuroscience**
 - 4. Psychotherapy**
- Use of case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in the diagnosis and management of cases; and,
 - Instruction in research methods in the clinical, biological, and behavioral sciences related to psychiatry, including techniques to appraise the professional and scientific literature and to apply evidence based findings to patient care.

Each program must provide the following:

- (a) All residents must be educated in research literacy. Research literacy is the ability to critically appraise and understand the relevant research literature and to apply research findings appropriately to clinical practice. The concepts and process of Evidence Based Clinical Practice include skill development in question formulation, information searching, critical appraisal, and medical decision-making, thus providing the structure for teaching research literacy to psychiatry residents. The program must promote an atmosphere of scholarly inquiry, including the access to ongoing research activity in psychiatry. Residents must be taught the design and interpretation of data.
- (b) The program must provide residents with research opportunities and the opportunity for development of research skills for residents interested in conducting research in psychiatry or related fields. The program must provide interested residents access to and the opportunity to participate actively in ongoing research under a mentor. If unavailable in the local program, efforts to establish such mentoring programs are encouraged.
- (c) The program must ensure the participation of residents and faculty in journal clubs, research conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process.

3. SYSTEMS-BASED PRACTICE (SBP): 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. Residents are expected to:

- Work effectively in various health care delivery settings and systems relevant to their clinical specialty.
- Coordinate patient care within the health care system relevant to their clinical specialty.
- Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate.
- Advocate for quality patient care and optimal patient care systems.
- Work in interprofessional teams to enhance patient safety and improve patient care quality.
- Participate in identifying system errors and implementing potential systems solutions.
- 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.
- 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.
- Assist patients in dealing with system complexities and disparities in mental health care resources.
- acknowledging the importance of medical errors and examining systems to prevent them
- maintain a mechanism to ensure that charts are appropriately maintained and readily accessible for patient care and regular review for supervisory and educational purposes;
- Collaborate with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients; and
- Monitor clinical records on major rotations to assess resident competencies to:
 - document an adequate history and perform mental status, physical, and neurological examinations;

- organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues;
- proceed with appropriate laboratory and other diagnostic procedures;
- develop and implement an appropriate treatment plan followed by regular and relevant progress notes regarding both therapy and medication management; and
- timely prepare an adequate discharge summary and plan.
- Advocate for the promotion of mental health and the prevention of mental disorders.

Psychiatry specific milestone 2.0 SBP subcompetencies include:

- 1. Patient Safety and Quality Improvement**
- 2. System-Navigation for Patient-Centered Care**
- 3. Physician Role in Healthcare Systems**

4. PRACTICE-BASED LEARNING AND IMPROVEMENT (PBLI) (how you get better): 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. Residents are expected to develop skills and habits to be able to meet the following goals:

- taking primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and rotation-specific goals and objectives, as well as, attendance at conferences;
- Identify strengths, deficiencies, and limits in one’s knowledge and expertise.
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.
- Incorporate formative evaluation feedback into daily practice.
- Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems
- Use information technology to optimize learning.
- Participate in the education of patients, families, students, residents and other health professionals.

Psychiatry specific milestone 2.0 PBLI subcompetencies include:

- 1. Evidence-based and**
- 2. Reflective Practice and Commitment to Personal Growth**

There must be a record that demonstrates that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. In the case of transferring residents, the records should include the experiences in the prior and current program.

The record must be reviewed periodically with the program director or a designee and must be made available to the surveyor of the program. The record may be maintained in a number of ways and is not limited to a paper-driven patient log.

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

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest
- Respect for patient privacy and autonomy
- Accountability to patients, society and the profession
- Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
- 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.

Our residents receive 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.

Psychiatry specific milestone 2.0 Professionalism subcompetencies include:

- 1. Professional Behavior and Ethical Principles**
- 2. Accountability/Conscientiousness**
- 3. Self-awareness and Help-seeking**

6. INTERPERSONAL AND COMMUNICATION SKILLS (ICS): Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.
- Communicate effectively with physicians, other health professionals, and health related agencies.
- Work effectively as a member or leader of a health care team or other professional group.
- Act in a consultative role to other physicians and health professionals.
- Maintain comprehensive, timely, and legible medical records, if applicable.

Psychiatry specific milestones 2.0 ICS subcompetencies include:

- 1. Patient and family-centered communication, colleagues, and members of the healthcare team**
- 2. Interprofessional and team communication**
- 3. Communication within Health-Care Systems**

A.C.G.M.E. GENERAL COMPETENCIES OUTCOMES PROJECT

Our efforts to implement the required A.C.G.M.E. General Competencies Outcomes Project have evolved in several phases and are now imbedded in all aspects of our Psychiatry Residency. Initially there was a concerted effort to instill a mindfulness in our faculty and residents about all of the General Competencies. This initial comprehensive phase continues and has been formalized by the inclusion of assigned readings, lectures and discussion of the General Competencies throughout our curriculum. All of our rotation specific evaluation forms are organized in reference to the General Competencies. Competency specific, Milestone oriented self-assessments and assessments by faculty, interdisciplinary professionals, support staff, students, patients and others of each resident occur regularly, too.

A team of faculty and residents has identified a comprehensive list of expected “Roles and Responsibilities” for each level of training and assigned one or more General Competencies to each as listed on [pages 18-20](#). This merging of practical skills with sometimes more abstract attributes is updated periodically and provides tangible examples for both the residents and faculty to consider in their General Competency and Psychiatry specific Milestone assessments.

As a four-year residency, there will be one or two specific General Competencies highlighted within an academic year and the cycle repeated at least every four years. For each highlighted General Competency, there is a purposeful inclusion of the topic in a variety of lectures, seminars, conferences, Grand Rounds, on-line learning modules, Clinical Skills Evaluations and other examinations, as well as utilizing AMA GME educational modules and Interdisciplinary Conferences at B-UMCP. Expectedly, results of our ongoing Process Improvement component of the Outcomes Project will result in “highlighting” a particular or elemental aspect of a General Competency for the entire residency group or select levels of training. These tend to result in subsequent routine inclusion of this highlighted feature in our curriculum. Recent examples have included an “Opportunities for Improvement” worksheet for each resident and his/her supervisor to review after the annual written PRITE examination [MK], an on-line video to improve communication of patient care handoffs [IPC], Performance Improvement and Patient Safety Conference [PBL], the formalizing of an on-line Patient Safety and Quality Improvement curriculum (PROF), and others.

Throughout our General Competencies Outcomes Project, we have identified and utilized a variety of valid assessment tools. Examples of these tools include 360° evaluations from nurses, students and peers, videos via webcams of a resident’s clinical interviews and psychotherapy sessions to review with supervisors, the self-assessment and faculty General Competencies and new Milestone specific evaluations, numerous routine evaluations from every clinical service and supervisor and a focused discussion and evaluation on a specific “highlighted” competency by designated faculty for each resident. We have asked all of our “Clinical Skills Evaluation” examiners to pose questions relevant to our highlighted General Competency to each of their examinees. Standardized, nationally scored examinations such as the PRITE and ABPN exam results of our graduates, etc. are also used as validated assessment tools. Appreciably, this multifaceted educational and assessment approach is a project in progress in that new tools are introduced each year.

The NAS with general and specialty specific Milestones, our Clinical Competency Committee and aggregate reporting of residents' and faculty achievements semi-annually to the A.C.G.M.E. are the next phase of this Outcomes Project. Our ongoing quality improvement process of the Residency Program is included in the Annual Program Evaluation and used to identify opportunities for improvement at the program level. This will be used in preparation for the program's Self-Study and 10-year Accreditation Site Visit.

COMPETENCY ASSESSMENT METHODS

Proficiency and competence in the General Competencies and specialty specific subcompetencies and Milestone related "threads" are assessed using a variety of techniques. As noted above, our "toolbox" of assessment techniques includes but is not limited to supervisor evaluations, as well as evaluations from peers, medical students, patients, support staff, ancillary professionals, etc. to approach a 360° feedback model; audio and videotapes of patient encounters including psychotherapy sessions; oral and standardized written and on-line examinations; case reports; chart and progress note reviews; patient care observations; simulated clinical encounters; Clinical Skills Evaluations as required by the A.C.G.M.E. and A.B.P.N.; patient care narratives; and other methods. Self-assessment and self-directed learning are cornerstones of the process as well. [MK, PBLI, PROF]

Residents falling short in the development of expected proficiencies and competencies are expected to work closely with the faculty to develop remedial programs for timely correction of the deficiencies in order to advance through the program.

PSYCHIATRY RESIDENT ROLES AND RESPONSIBILITIES, THE GENERAL COMPETENCIES AND SPECIALTY SPECIFIC SUB-COMPETENCIES

The Joint Commission which accredits healthcare organizations requires Academic Medical Centers to develop job descriptions for residents in specialty training programs. Our faculty and residents regularly update the following detailed list of roles and responsibilities to fulfill this obligation. They are not meant to exclude or replace the educational objectives, Competencies, Sub-competencies, and Milestones previously listed but to heighten their relevance. Each has been matched with several **General Competencies** noted within brackets. Patient Care = PC, Medical Knowledge = MK, Practice Based Learning and Improvement = PBLI, Interpersonal and Communication Skills = ICS, Professionalism = PROF, and Systems Based Practice = SBP.

First Year (PGY-1) while assigned to Inpatient Psychiatry, Internal Medicine, Pediatrics, Emergency Medicine, Neurology, Chemical Dependency Treatment Program and extended work periods:

- These residents usually start after graduating from medical school. As such they are expected to perform a thorough history and physical examination, establish a differential diagnosis and initial diagnostic and treatment plan using concepts and principles learned in medical school and expectedly broadened throughout PGY-1. [PC, MK, PBLI]
- In contrast to a medical student who participates in activities primarily to learn, the first-year resident is expected to assume responsibility for the care of the patient. This means that s/he is in the designated places at the proper time, dressed in appropriate attire, answers pages promptly, responds promptly to emergencies, sees patients in a timely manner, maintains good written notes in the Electronic Medical Record (EMR) and contributes as a team member. This ability to contribute may take 2 to 3 months to become manifest. [PC, MK, ICS, PROF, PBLI]
- The resident will demonstrate knowledge and use of policies and procedures of the department and B-UMCP relevant to the care of his or her patients. Specific attention will be given to the appropriate use of seclusion and restraints, nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening and verbal and observational methods. [PC, MK, PBLI, SBP]
- Throughout the first year, working in the inpatient setting, emergency center and medical floors, the resident will continue to refine his or her interviewing skills to gather information relevant to the psychiatric problem and to develop an organizing framework to use this information more effectively and efficiently. This will be manifest in the ability of the first-year resident to be the major presenter of new cases in which treatment plans are recommended and then refined by the team. [PC, MK, ICS, PROF, PBLI]
- **By the end of the PGY-1 year, the resident will have clearly demonstrated competence in the ability and willingness to ask for help when indicated; gather an appropriate history; the ability to perform an emergent psychiatric assessment; and present patient findings and data accurately to a supervisor who has not seen the patient allowing the resident to advance to indirect supervision with direct supervision available status.** [PC, MK, ICS, PROF]
- Effectively utilize inpatient electronic Medical Records (EMR) in a timely manner. [PC, ICS, PROF]

- By the end of the first year the resident will have developed the capability to take charge of morning rounds and patient care handoffs. [ICS, PROF]
- By the end of the first year, the resident will be capable of initiating and monitoring the pharmacological management of the vast majority of patients seen in the inpatient unit.
- In family meetings, the responsibility for running the sessions will gradually shift from the social worker or attending psychiatrist to the first-year resident. [PC, MK, ICS, PROF, PBLI]
- By the end of the first year, the nursing staff will be comfortable in coming to the first-year resident for advice in addressing many of the patient care problems on the inpatient unit in lieu of the attending physician. [PC, MK, ICS, PROF, PBLI]
- Establish Practice Based Learning behaviors such as setting self-directed learning and improvement goals and incorporating formative evaluation feedback into daily practice. [PBLI, PROF]
- By the end of the first year, the resident will be able to appropriately and safely transfer care responsibilities of patients with colleagues. [PC, ICS, PROF]
- The resident will collaborate in interprofessional teams to enhance quality improvement of patient safety, patient care, identify system errors and implementing potential system solutions. [SBP, ICS]

Second Year (PGY-2) while assigned to Inpatient Psychiatry, Consultation-Liaison and Emergency Psychiatry, Chemical Dependency, Child Psychiatry, B-UMCP Behavioral Health Outpatient Clinic and on-call:

- At the beginning of the second year, the resident will have achieved all of the performance capabilities described under the first year. [PC, MK, ICS, PROF, PBLI, SBP]
- Effectively utilize outpatient Electronic Medical Records (EMR). [PC, ICS, PROF]
- During the second year, the resident progressively will incorporate a psychotherapy relationship into the overall therapeutic regimen in addition to pharmacological management. [PC, MK, PBLI]
- During the second year, the resident will expand his or her capability to reliably develop a differential diagnosis and treatment plan for common and less common inpatient and consultation psychiatric problems and will be able to justify this based on scientific evidence. [PC, MK, ICS, PBLI]
- By the end of the year, the resident will be able to establish, maintain and repair a relationship with patients in which difficulties are common, such as the hostile patient or psychologically immature patient. [PC, MK, ICS, PBLI, PROF]
- The resident will demonstrate the ability to have a different style needed to manage an outpatient where mutual agreement is required in contrast to the inpatient setting where the patient care team is much more dominant. [PC, MK, ICS, PROF, PBLI]
- The resident will show the ability to manage his or her own outpatient schedule. [PROF, SBP]
- The resident will become familiar with the indications, clinical evaluation and techniques of electroconvulsive therapy by participating in simulated and actual procedures. [PC, MK, PBLI]
- The resident will demonstrate the capability to manage the patient using a much broader context such as other medical issues, cultural and socioeconomic factors. [PC, PBLI, SBP]
- The resident will demonstrate the ability to supervise first year residents and medical students. [PC, MK, ICS, PROF, PBLI, SBP]
- The resident will routinely identify and perform appropriate self-learning activities. [PBLI, PROF]
- The resident will be able to use learning technology to optimize the educational experience including webcams for demonstration of outpatient sessions to supervisors. [PBLI, ICS]
- The resident will be able to participate in the education of patients, families, students, residents and other health Professionals. [ICS, PROF]
- The resident will demonstrate a level of medical and psychiatric knowledge and Professionalism sufficient to safely and effectively supervise fellow residents with less experience. [MK]
- The resident will demonstrate the capability to provide accurate and helpful feedback to peers and subordinates. [MK, PROF, ICS]
- The resident will supervise subordinates in a respectful and supportive manner. [ICS, PROF]
- The resident will collaborate in interprofessional teams to enhance quality improvement of patient safety, patient care, identify system errors and implementing potential system solutions. [SBP, ICS]

Third Year PGY-3 while assigned to Consultation-Liaison Psychiatry, Geropsychiatry, Community Psychiatry, V.A. Outpatient Psychiatry, B-UMCP Behavioral Health Outpatient Clinic (including ASU-EAO patient evaluations) and on-call:

- At the beginning of the third year, the resident will have achieved all of the performance capabilities described under the second year. [PC, MK, ICS, PROF, PBLI, SBP]
- During the third year, the resident will expand his or her capability to develop a differential diagnosis and treatment plan for common and less common outpatient psychiatric problems and is able to justify this based on scientific evidence. [PC, MK, ICS, PROF, PBLI]
- The resident will demonstrate the capability of relating to his or her patients as the primary therapist. [PC, ICS]
- The resident will demonstrate the capability of effectively managing outpatient sessions and telephone time with patients. [PC, MK, PBLI]
- The resident will develop the capability to independently initiate and monitor the pharmacological management of various psychiatric disorders. [PC, MK, PBLI, SBP]
- The resident will demonstrate the capability of scheduling supervisory sessions and use these for his or her own learning effectively. [ICS, PROF]
- The resident will be capable of working with medical students and helping them acquire knowledge and skills appropriate to their specialty interest, e.g., the diagnosis and management of delirium for students interested in orthopedic surgery. [ICS, PROF]
- The resident will demonstrate the capability of mentoring and supervising more junior residents and medical students. [ICS, PROF]
- The resident will become facile in relating with patients in sensitive areas such as sexual problems. [PC, MK, ICS, PROF]
- The resident will know and use community resources available for ambulatory psychiatric problems. [SBP]
- The resident will demonstrate the capability to manage the patient using a much broader context such as other medical issues, cultural and socioeconomic factors. [PC, PBLI, SBP]
- The resident will demonstrate the capability of interacting with other medical specialties when there are combined medical and psychiatric problems. [PC, MK, ICS, PROF, PBLI, SBP]
- By the end of the third year, the resident will be capable of functioning as an independent basic clinical psychiatrist. [PC, MK, ICS, PROF]
- The resident will demonstrate sensitivity and responsiveness to a diverse patient population including but not limited to gender, age, culture, race, religion, disabilities, and sexual orientation. [PC, MK, ICS, PROF]
- The resident will be able to identify strengths, deficiencies and limits in his/her knowledge and expertise. [MK, PBLI, PROF]
- The resident will be able to locate, appraise and assimilate evidence from scientific studies related to his/her patient's health problems. [PBLI, ICS]
- The resident will collaborate in interprofessional teams to enhance quality improvement of patient safety, patient care, identify system errors and implementing potential system solutions. [SBP, ICS]

Fourth Year (PGY-4) while assigned to various electives, the Senior Administrative Outpatient Resident position, Forensic/Correctional Psychiatry, Administrative Psychiatry, our Outpatient Clinic, on-call, etc.:

- At the beginning of the fourth year, the resident will have achieved all of the performance capabilities described under the third year. [PC, MK, ICS, PROF, PBLI, SBP]
- The resident will demonstrate the capability to diagnose and manage complex psychiatric problems that have a high probability of surprises using creative and improvisational approaches. [PC, MK, ICS, PROF, PBLI, SBP]
- The resident will demonstrate the capability of using a wide variety of available community resources. [SBP]
- The resident will demonstrate administrative capability such as scheduling, dealing with rotation difficulties, advising residents, mediating problems between residents and establishing, monitoring and enforcing policies and expectations of the program. [ICS, PROF, SBP]
- The resident will effectively interact with all members of the team dealing with managing psychiatry patients at B-UMCP and assisting in the management of the Psychiatry Residency program. [PC, MK, ICS, PROF, PBLI, SBP]
- The resident will effectively deal with appropriate people within B-UMCP who impact patient care or the operation of the Psychiatry Residency program including participating and contributing to departmental and institutional committees. [ICS, PROF, SBP]
- The resident will provide leadership in interprofessional teams to enhance quality improvement of patient safety, patient care, identify system errors and implementing potential system solutions. [SBP, ICS]
- The resident will demonstrate the ability to investigate and evaluate his/her care of patients, to appraise and assimilate scientific evidence and to continuously improve patient care based on constant self-evaluation and life-long learning. [PBLI, PROF]

Psychiatry Milestone Project: The Psychiatry Milestone Project is A Joint Initiative of The A.C.G.M.E. and the American Board of Psychiatry and Neurology

The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME-accredited residency or fellowship programs. The Psychiatry Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of competency in Psychiatry. They neither represent the entirety of the dimensions of the six General Competency domains nor are they designed to be relevant in any other context.

Milestone Reporting: The Milestones are designed for programs to use in semi-annual reviews of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident progresses from entry into residency through graduation. In the initial years of implementation, the ACGME Review Committee will examine aggregate **Milestone performance data** for each program's residents as one element in the Next Accreditation System to determine whether residents overall are progressing. Thus, aggregate resident performance will be an additional measure of a program's ability to educate its residents.

The Program Director has the responsibility of ensuring that residents' progress on all **21 psychiatry subcompetencies** is documented every six months through the Clinical Competency Committee (CCC) review process. The CCC's decisions should be guided by information gathered through formal and informal assessments of residents during the prior six-month period. The ACGME does not expect formal, written evaluations of all milestones (each numbered item within a subcompetency table) every six months. For example, formal evaluations, documented observed encounters in inpatient and outpatient settings, and multisource evaluation should focus on those subcompetencies and milestones that are central to the resident's development during that time period.

Progress through the Milestones will vary from resident to resident, depending on a variety of factors, including prior experience, education, and capacity to learn. Residents learn and demonstrate some skills in episodic or concentrated time periods (e.g., formal presentations, participation in quality improvement project, child/adolescent rotation scheduling, etc.). Milestones relevant to these activities can be evaluated at those times. The ACGME does not expect that resident progress will be linear in all areas or that programs organize their curricula to correspond year by year to the Psychiatry Milestones.

For each six-month reporting period, review and reporting will involve selecting the level of milestones that best describes a resident's current performance **Level**. Milestones are arranged into **numbered Levels**. These levels do not correspond with post-graduate year of education.

Selection of a **Level** for a subcompetency implies that the resident substantially demonstrates the Milestones in that level, as well as those in lower levels. A general interpretation of **Levels** for psychiatry is below:

Has not Achieved Level 1: The resident does not demonstrate the milestones expected of an incoming resident.

Level 1: The resident demonstrates milestones expected of an incoming resident.

Level 2: The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.

Level 3: The resident continues to advance and demonstrate additional milestones; the resident demonstrates the majority of milestones targeted for residency in this subcompetency.

***Level 4:** The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.

Level 5: The resident has advanced beyond performance targets set for residency and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

***Level 4 is designed as the graduation target and does not represent a graduation requirement.** Making decisions about readiness for graduation is the purview of the residency Program Director. Study of milestone performance data will be required before the ACGME and its partners will be able to determine whether Level 4 milestones and milestones in lower levels are in the appropriate level within the developmental framework, and whether milestone data are of sufficient quality to be used for high stakes decisions.

A.C.G.M.E. Next Accreditation System (NAS) Milestones 2.0: General Competencies and Subcompetencies

PATIENT CARE

- PC1 Psychiatric Evaluation
- PC2 Psychiatric Formulation and Differential Diagnosis
- PC3 Treatment Planning and Management
- PC4 Psychotherapy
- PC5 Somatic Therapies (see example reporting format)
- PC6 Clinical Consultation

MEDICAL KNOWLEDGE

- MK1 Development through the life cycle
- MK2 Psychopathology
- MK3 Clinical Neuroscience
- MK4 Psychotherapy
- MK5 Somatic Therapies
- MK6 Practice of Psychiatry

SYSTEM BASED PRACTICE

- SBP1 Patient Safety and Quality Improvement
- SBP2 System Navigation for Patient-centered Care
- SBP3 Physician Role in Healthcare Systems

PRACTICE BASED LEARNING and IMPROVEMENT

- PBLI1 Evidence-based and Informed Practice
- PBLI2 Reflective practice and commitment to personal growth

PROFESSIONALISM

- PROF1 Professional Behavior and Ethical Principles
- PROF2 Accountability/Conscientiousness
- PROF3 Self-awareness and Help-seeking

INTERPERSONAL and COMMUNICATION SKILLS

- ICS1 Patient and Family-centered Communication
- ICS2 Interprofessional and Team Communication
- ICS3 Communication within Healthcare Systems

The diagram below presents an example set of milestones for one sub-competency in the same format as the milestone report worksheet. For each reporting period, a resident's performance on the milestones for each sub-competency will be indicated by:

- selecting the level of milestones that best describes the resident's performance in relation to those milestones OR
- selecting the "Has not Achieved Level 1" response option

General Competency		Sub-competency			Developmental Progression or Set of Milestones	
Patient Care 2: Care of Patients with Chronic Illness						
Level 1	Level 2	Level 3	Level 4	Level 5		
Recognizes that common conditions may be chronic (e.g., anxiety, high blood pressure)	Identifies variability in	Determines the potential impact of comorbidities on disease progression	Balances the competing needs of patients' comorbidities			
Formulates a basic management plan that addresses a chronic illness	Identifies appropriate clinical guidelines to develop and implement plans for management of chronic conditions	Synthesizes a patient-centered management plan that acknowledges the relationship between comorbidities and disease progression	Applies experience with management of patients with chronic conditions	Leads multidisciplinary initiatives to manage patient populations with chronic conditions and comorbidities		
Recognizes that chronic conditions have an impact beyond the disease process	Identifies the impact of chronic conditions on individual patients and the others involved in their care	Develops collaborative goals of care and engages the patient in self-management of chronic conditions	Facilitates efforts at self-management of chronic conditions, including engagement of family and community resources	Initiates supplemental strategies (e.g., leads patient and family advisory councils, community health, practice innovation) to improve the care of patients with chronic conditions		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:						
						Not Yet Completed Level 1 <input type="checkbox"/>
						Not Yet Assessable <input type="checkbox"/>

DOCUMENTATION OF CLINICAL EXPERIENCES: Treatment Logs and Clinical Records

Each resident is expected to submit **monthly “logs”** of his or her treatment cases from each clinical assignment including Neurology **promptly at the end of each rotation**. The only exceptions are the months during Internal Medicine, Internal Medicine-VAM, Emergency Medicine and Pediatrics. These records must demonstrate that the resident has met the educational requirements of the program in regard to variety and number of patients, length of time and frequency of treatment, diagnoses and treatment modalities. These treatment case logs are to be reviewed monthly and signed-off by designated faculty supervisors and as part of the formal semi-annual reviews with the Program Director. A sample form is located on [page 100](#).

Residents’ electronic health records of their patients are reviewed routinely by the assigned supervising faculty in every clinical setting in reference to accuracy, timeliness of completion, organization and readable documentation, history taking, clinical evaluation, treatment and medication management. Hospital and departmental policies must be followed regarding content, timeliness, etc. for all health care records.

PLANNED EDUCATIONAL /DIDACTIC EXPERIENCES

Regularly scheduled, formal didactic instruction in the form of lectures, seminars, conferences and required reading are fundamental to the educational experience. The lecture series and seminars are systematically organized in a progressive fashion over the course of training and broadened by clinical conferences, teaching rounds, Journal Club, Grand Rounds, visiting lecturers, faculty supervision, interdisciplinary conferences, electives, additional readings, etc. A.C.G.M.E. requirements mandate no less than 70% attendance (excluding vacations) at required educational experiences. This is monitored and documented in each resident’s portfolio. Lectures are recorded and available for remote viewing or available for review afterwards.

The following is a **general overview of the didactic curriculum** provided at each level of training and organized to demonstrate relevance to the specific clinical assignments. Residents are expected to routinely prepare for, attend promptly and participate in the requisite didactic educational activities. Except for patient care emergencies, service needs and clinical responsibilities should not prevent the resident from attending these planned educational experiences. It is the resident’s responsibility to notify faculty, nurses, secretaries, etc. when he or she will be attending a lecture, etc. and inform the Program Director when such is not being supported as “protected” time.

PGY-1

Internal Medicine, Pediatrics and Emergency Medicine: While assigned to these rotations it is expected that our residents actively attend and participate in the numerous scheduled conferences, lectures, teaching rounds, Grand Rounds, etc. provided by these departments. Interaction with the Psychiatry Department is available and encouraged through various interdisciplinary conferences and our Consultation-Liaison Service.

Neurology Rotation: The curriculum for the neurology rotation essentially follows the same parameters described for the internal medicine, pediatrics and emergency medicine rotations. **Clinical Neurology lectures** and **Advanced Clinical Neuroscience Seminar** are part of the Psychiatry Residency curriculum and broaden the clinical neurology, neuropsychiatric and neurobehavioral experiences.

PGY-1 or PGY-2

Adult Inpatient Psychiatry: The didactic curriculum for residents on the Adult Inpatient Psychiatry rotations during PGY 1 and 2 includes the following: our **Core Curriculum I's** twice weekly **Introduction to Clinical Psychiatry Lecture Series** each summer which is followed by the weekly **Clinical Science Lecture Series** both of which are outlined on a separate page. PGY-1 and transfer PGY-2's are expected to attend the **Interviewing, Presentation Skills, Formulation, and Clinical Skills Evaluation Conference** as well. There are also daily inpatient teaching rounds, frequent **Inpatient Case Conferences**, and group and individual supervision with the full-time faculty. All inpatient residents also attend both the weekly departmental **Grand Rounds** and the monthly **Journal Club and Research Literacy Program**. Specific educational and training objectives as well as the pertinent subcompetency Milestones associated with the Adult Psychiatry Inpatient clinical experiences are described in other sections. The fund of knowledge gained by assigned readings, lectures, conferences, etc. is actively integrated with the supervised clinical experiences.

Chemical Dependency 1: The schedule for this rotation allows for regular attendance at all the other lectures, seminars, etc. expected at these levels of training and these are complemented by specific lectures, readings, on-line modules and individual supervision while on this sub-specialty service at the V.A.M.C. There is a month-long **Substance Abuse didactic module in the Clinical Science Lecture Series** as well. Residents will participate in the monthly Addiction Medicine Journal Club on the rotation.

PGY-2

Consultation-Liaison Service: A comprehensive **Consultation-Liaison/Emergency Psychiatry Seminar** is provided during PGY-2 and PGY-3 coinciding with the years on that service and assigned residents participate in regular Case Conferences and receive group and individual supervision from the full-time faculty.

Outpatient Psychiatry: In addition to the relevant **Core I Clinical Psychiatry Lectures** a required **Introduction to Psychotherapy Seminar** is offered during PGY-2. Weekly individual supervision for each resident's outpatient caseload is also provided by the full-time faculty. Residents will also attend a **Reproductive Psychiatry Conference** and the **Advanced EBM Psychopharmacology Conference**. PGY-2 residents are encouraged to attend the weekly **Group Supervision Case Conference** when their rotations allow such.

Child and Adolescent Psychiatry: The educational curriculum for the Child and Adolescent Psychiatry rotation is provided the same academic year residents are assigned to that service and includes didactic instruction, supervision by full-time faculty and reading regarding the assessment and treatment of younger patients and families, developmental theory, psychopathology and multidisciplinary collaboration. A required, comprehensive **Child and Adolescent Psychiatry Lecture Series** and a **Family Assessment and Therapy Seminar** are offered as well during the same academic year.

EPOQ - Emergency Psychiatry, Outpatient, Quality Improvement/Patient Safety Rotation: The educational curriculum includes participation in an on-line curriculum for QI/PS (IHI modules), ECT Module, and on-line Research Modules (CITI modules and MedED Portal Research Education Program)

Chemical Dependency 2: See Chemical Dependency 1 above.

PGY-3 and PGY-4

A variety of seminars, lecture series and conferences are offered during the latter two years of training. The Introduction to Psychotherapy Seminar given during PGY-2 is expanded during **PGY-3 and PGY-4** by several more advanced psychotherapy seminars including a **Cognitive-Behavioral Therapy Seminar**, a **Psychodynamic Psychotherapy Seminar** and a comprehensive **Advanced Psychotherapies Seminar** addressing brief, interpersonal, supportive, and combination medication management and psychotherapy models, crisis management, EMDR, grief therapy, etc., as well as a weekly **Group Supervision Case Conference**. There is also a specific seminar for **Group Therapy**. There are several other required seminars for the advanced residents each of which address in depth the following areas: **Consultation-**

Liaison/Emergency Psychiatry (PGY-2 and 3); Clinical Neurology; Advanced Clinical Neurosciences; Forensics; Administrative Psychiatry; Career Options and Practice Management; Psychiatric Ethics; Board Preparation.

New seminars are often developed reflecting the dynamic expansion of knowledge in Psychiatry and requests by our trainees and faculty. This includes a new wellness curriculum that is distributed monthly to residents and faculty. Again, attendance and active participation are expected at weekly Departmental **Grand Rounds**, the monthly **Journal Club and Research Literacy Program**, and various **Interdisciplinary Conferences** sponsored by the Department of Graduate Medical Education including the **Interdisciplinary Quality Improvement/Patient Safety Conference**.

SCHOLARLY ACTIVITIES: TEACHING, PRESENTATION SKILLS, RESEARCH, ETC.

Our residents are expected to take advantage of and participate in the broad array of scholarly activities available throughout the Medical Center and participating training sites and to interact as teachers and consultants for more junior residents and medical students and professional training programs in related fields such as internal medicine, family practice, neurology, pediatrics, ob-gyn, psychology, social service and nursing. As the **Academic Medical Center for the University of Arizona College of Medicine's Phoenix Campus** and a key teaching site for the **third-year Psychiatry clerkship of the College of Medicine's Phoenix Campus** and a variety of fourth-year medical student electives, there are ample opportunities to routinely supervise and teach medical students. Throughout the training program, residents are also expected to develop **scholarly presentation and discussion skills** with faculty and fellow trainees to promote a spirit of inquiry and scholarship. These experiences at rounds, case conferences, lectures, Journal Club and seminars involve developing skills in integrative case formulation including neurobiological, phenomenological, psychological and sociocultural issues involved in the assessment and management of presented cases. There are also opportunities for **Interdisciplinary Conferences** addressing important, broad medical issues such as quality improvement and patient safety, professionalism, medical humanities, Wellness, etc. Residents are also able to enroll in GME sponsored **Programs of Individualized Education (PIE)** programs. These programs focus on Leadership Development for Residents, Residents as Educators, Personal Best: Emotional Intelligence and Coaching, Addressing Health Disparities, and Wellness and Resiliency. All resident's research, develop, and present topics of his or her choice at the **Department's Grand Rounds**. Our advanced residents also provide didactic **lectures to our third-year clerkship medical students**. Several components of our curriculum including a monthly **Journal Club and Research Literacy Program** foster scholarly techniques to appraise the professional and scientific literature to advance our residents' knowledge of the basic principles of research and to apply evidence-based findings to patient care. Our **on-line Research Curriculum** during EPOQ also further expands the resident's knowledge base regarding research principles. An **Advanced Clinical Neuroscience Seminar** provides additional exposure to basic neuroscience literature pertinent to clinical Psychiatry.

Our residents are strongly encouraged to personally participate in **clinical and neuroscientific research** sponsored by our Department and affiliated training sites as well as the internationally recognized **Banner Alzheimer's Institute and Memory Disorders Program**. Each resident is encouraged to meet with the Institute's Scientific Director to discuss individual scholarly interests and potential research endeavors. An elective within the **Banner Research Institute** is also available allowing our residents to learn under supervision how to critically review scientific studies submitted to the **Banner Institutional Review Board**. In addition, the University of Arizona College of Medicine-Phoenix offers a **Master's degree in Clinical Translational Science** with an emphasis in Neuroscience to our residents. This program is available as a research track for residents typically during PGY4. Our Grand Rounds program also includes local Psychiatry researchers who discuss basic research principles and also present his or her research projects. Residents are encouraged to consider joining their projects. Our residents are also encouraged to participate in our local **Academic Excellence Day** which is open to residents and fellows throughout the medical community and is a convenient forum for our residents to present their research efforts by paper presentations and posters. Residents have opportunities to present scholarly activity at the annual Arizona Psychiatric Society meeting as well as develop and submit Quality Improvement and Patient Safety Projects for the B-UMCP "**High Value Idea Competition**" as well as at the annual **B-UMCP Graduate Medical Education Quality and Safety Day**. Whenever possible, time and funding will be provided to assist residents presenting their research papers at local, regional and national scientific meetings.

Under the supervision of and guidance of our faculty Psychologists and Neuropsychologists, our residents have experience with the interpretation of **psychological and neuropsychological tests** most commonly used. Some of these experiences should occur with the residents' own patients.

PATIENT SAFETY and QUALITY IMPROVEMENT CURRICULUM AND PROJECTS

Quality Improvement and Patient Safety are critical to the mission of Banner, the Medical Center, and our University of Arizona College of Medicine-Phoenix Department of Psychiatry and Psychiatry Residency Program. Banner Health and in particular B-UMCP have been national leaders promoting Patient Safety and Q.I. and our Psychiatry Program is imbedded in that culture. The Next Accreditation System highlights the importance of residency programs to actively embrace Patient Safety and Q.I. and along those lines our Residency has expanded its efforts in these areas. Fundamental elements of the Patient Safety and Q.I. curriculum initiative for our Psychiatry Residents include the following:

- (1) Teaching principles of Q.I., performance improvement, team-work, patient safety, learning from defects, and the culture of safety.
- (2) Developing an infrastructure for residents to participate, design and lead Q.I. and Patient Safety projects.
- (3) Identifying and creating new forums for continuous review of individual, departmental and system quality metrics.
- (4) All in an effort to improve quality and safety by our faculty and residents.

All residents are expected to be involved in a Quality Improvement project during residency and have time during our “EPOQ” (Emergency Psychiatry/Outpatient Psychiatry/Quality Improvement) rotation in PGY2 to develop and work on a project. PGY2s also meet monthly to discuss and work on QI/PS projects and continue with these meetings through PGY3 & 4 so that projects can be completed. Requirements to better learn and experience the principles of Patient Safety and Q.I. include participation in our Residency’s Patient Safety and Q.I. didactic curriculum and completing on-line Q.I. training and development and implementation of Patient Safety and Q.I. projects prior to graduation. PGY2 residents will participate in a monthly QI/PS meeting to work on projects and continue to focus on learning QI/PS principles. PGY3 and PGY4’s will be encouraged to attend and continue to work on these projects. The residents can also participate in our yearly Quality Improvement and Patient Safety Conference (former Morbidity and Mortality Conference) as well as the B-UMCP Graduate Medical Education Quality and Safety Day Conference. Our residents also have an opportunity to participate in the Graduate Medical Education Interdisciplinary Patient Safety and Quality Council.

Our program has also partnered with the Phoenix VA to sponsor a post-graduate position for a Psychiatry Chief Resident in Quality and Safety (CRQS). We anticipate that the person in this position will assist with further development of QI/PS projects in our department as well as expanding interdisciplinary QI/PS projects.

CLINICAL ROTATIONS: 2022–2023: Typical required clinical assignments for each level of training include:

PGY-1: Internal Medicine (*B-UMCP and V.A.M.C.; one-month Ambulatory Pediatrics at P.C.H. may be substituted*)

Emergency Medicine (B-UMCP)

Neurology (B-UMCP)

Adult Inpatient Psychiatry (B-UMCP)

Chemical Dependency 1 (V.A.M.C.)

PGY-2: Adult Inpatient Psychiatry (B-UMCP)

Consultation-Liaison/Emergency Psychiatry (B-UMCP)

Child and Adolescent Psychiatry (Phoenix Children's Hospital & Banner Behavioral Health Hospital)

EPOQ: Emergency Psychiatry (Urgent Psychiatric Center)/Quality Improvement & Patient Safety (B-UMCP)

Outpatient Psychiatry (B-UMCP Behavioral Health Center, continuous part-time extending through PGY-3 and PGY-4)

Chemical Dependency 2 (VAMC)

PGY-3: Consultation-Liaison/Emergency Psychiatry (B-UMCP) & Collaborative Care (B-UMCP)

Community Psychiatry (Southwest Network)

Geriatric Psychiatry (B.A.I. and VAMC)

V.A. Outpatient Psychiatry (V.A.M.C.)

Outpatient Psychiatry (B-UMCP, continuous part-time extending through PGY-4 including collaboration with ASU-EAO program)

PGY-4: Outpatient Psychiatry (B-UMCP, continuous part-time)

Senior Outpatient Administrative Resident (B-UMCP)

Administrative Psychiatry (BBHH, VAMC)

Forensic/Correctional Psychiatry Rotation

ELECTIVES

Residents who have satisfactorily completed the required educational objectives of PGY-1, 2 and 3 are encouraged to develop and pursue a variety of clinical, administrative, educational or research tracts usually during PGY-4 to complement and enrich the preceding required rotations and further individual needs, interests and career plans. PGY4 Electives are part-time over 4-5 months allowing continuous care of ongoing outpatients and attendance at required lectures, conferences, seminars, etc. and supervision. When scheduling permits, PGY3s may participate in electives when on a full-time outpatient psychiatry month. All electives **must have written goals and assessable objectives** which are well constructed, purposeful, compliant with the accreditation requirements in general psychiatry, and lead to effective learning experiences. The choice of electives must be made with the advice and approval of the Program Director and the appropriate faculty preceptor and submitted to our Residency Education Policy Committee prior to implementation for review and approval. An **Electives Request form** is included in this manual (evaluation forms). Expectedly the formal evaluation process of a resident's performance on an elective will include pertinent subcompetency Milestones. Several well-supervised elective experiences are available at B-UMCP or in the community at affiliated sites and currently include:

- Administrative Resident Positions in Outpatient, Consultation-Liaison and Inpatient Settings at B-UMCP
- Post-Traumatic Stress Disorders Program at V.A.M.C.
- Forensic Psychiatry
- Disability Evaluations
- Adolescent Psychiatry at Banner's Scottsdale Behavioral Health Center
- Consultation-Liaison Psychiatry at B-UMCP and the V.A.M.C.
- Emergency Psychiatry @ UPC
- Electroconvulsive Therapy
- Substance Abuse Programs: Southwest Network, VAMC, BBHH
- Addiction Resource Center at B-UMCP
- Interdisciplinary Chronic Pain Program at V.A.M.C.
- Primary Care/Mental Health Integration (Collaborative Care) at V.A.M.C
- Arizona Legal Center
- Geropsychiatry
- Research Design and Methodology
- Toxicology
- Transcultural Community Psychiatry at various community sites
- Translational Genomics Research
- Transmagnetic Stimulation
- Medical Informatics
- Banner Alzheimer's Institute (BAI) at B-UMCP Campus
- Banner's Memory Disorders Program
- Palliative Care
- Women's Health
- Behavioral Neurology (Banner Sun Health Research Institute)
- Sleep Medicine (Neurology at B-UMCP)
- Quality Improvement and Patient Safety Initiatives
- VA-Prescott Substance Abuse, PTSD, Outpatient Psychiatry

DIDACTICS: LECTURES, SEMINARS, CONFERENCES, ETC.

A systematically organized, thoughtfully integrated didactic curriculum is provided to facilitate our residents obtaining knowledge of the established and evolving biomedical, clinical, epidemiological and psychosocial-behavioral sciences as well as the application of this knowledge to patient care.

Didactic and clinical education have priority in the allotment of residents' time and energy. Lectures, conferences and supervision are considered "protected time" and scheduled to ensure a minimum of 70% attendance while adhering to our program's clinical work and education period policies.

The following is a list of our current lecture series, conferences and seminars which make up the didactic portion of our Residency Program's curriculum. Core I refers to lectures, conferences and seminars laying a foundation of knowledge in Psychiatry during PGY-1 and PGY-2. Core II includes the more advanced didactics building on that foundation. Formal

Psychotherapy seminars and conferences begin in PGY-2 and continue through PGY-3 and PGY-4 coinciding with relevant clinical experiences in outpatient settings. There are also several regularly scheduled Case Conferences in a variety of clinical settings.

After each course title we have identified which of the six General Competencies are expectedly highlighted in the framework of that didactic experience. These include Patient Care (PC), Medical Knowledge (MK), Practiced Based Learning and Improvement (PBLI), Interpersonal and Communication Skills (ICS), Professionalism (PROF), and Systems Based Practice (SBP). Both residents and faculty are expected to align these educational experiences with the pertinent Milestone Subcompetencies as well.

CORE CURRICULUM I

- Introduction to Clinical Psychiatry Lecture Series (PC, MK) (specifics outlined below*)
- Clinical Science Lecture Series (PC, MK) (specifics outlined below*)
- Interviewing, Presentation Skills, Formulation, and Clinical Skills Evaluation (ICS, PROF, MK)
- Inpatient Case Conferences (PC, PBLI)
- Child and Adolescent Psychiatry Lecture Series (PC, MK, SBP)
- Advanced EBM Psychopharmacology (PC, MK, PBLI)
- Reproductive Psychiatry (PC, MK)
- Research Seminar (MK, PBLI)

CORE CURRICULUM II

- Consultation - Liaison/Emergency Psychiatry Seminar (PC, MK, SBP)
- Clinical Neurology Seminar (PC, MK)
- Advanced Clinical Neuroscience Seminar (MK, PBLI)
- Forensic Psychiatry Seminar (MK, PROF, SBP)
- Career Options and Practice Management Conferences (PROF, SBP)
- Psychiatric Ethics and Professionalism Seminar (PROF, PC)
- Senior Residents' Board Review Course (MK)
- Administrative Psychiatry (SBP, MK)
- Geriatric Psychiatry (PC, MK)

PSYCHOTHERAPY SEMINARS

- Introduction to Psychotherapy Seminar (PC, MK, ICS)
- Psychodynamic Psychotherapy Seminar (PC, MK, ICS, PROF)
- Advanced Psychotherapies Seminar – (PC, MK, ICS, PROF)
- Cognitive Behavioral Therapy Seminar (PC, MK, ICS, PROF)
- Group Therapy Seminar (PC, ICS, PROF, SBP)
- Family Therapy Seminar (PC, ICS, PROF)

ALL RESIDENTS

- GME Interdisciplinary Quality Improvement and Patient Safety Seminar (PBLI, SBP)
- Institute for Healthcare Improvement Open School Quality Improvement online program (PGY2) (PBLI, SBP)
- Research On-line Curriculum (MedEd Portal) (PBLI)
- Buprenorphine Training (PC, MK)
- Caring with Compassion online program for Health Care Disparities (MK, PC, PBLI, SBP)
- TMS On-line Curriculum (APA) (PGY-3) (MK, PC)
- CBT-Insomnia On-line curriculum (MK, PC)
- APA Physician Leadership Program
- Grand Rounds (weekly)
- Journal Club and Research Literacy (monthly)
- Training Director's luncheons (monthly)

CASE CONFERENCES

- Inpatient Case Conferences (PC, MK, PBLI)
- Consultation –Liaison Clinical Conferences (PC, MK)
- Group Supervision Case Conferences (PC, MK, PBLI)

***CORE CURRICULUM I - PGY-1 and PGY-2**

Introduction to Clinical Psychiatry Lecture Topics (twice-weekly lectures each Summer)

1. Psychiatric History and Examination
2. DSM-5, Psychiatric Phenomenology and Nomenclature
3. Risk Assessment and Management of the Agitated Patient
4. Antidepressants
5. Schizophrenia Spectrum Disorders
6. Antipsychotics
7. Bipolar, Depressive and Related Disorders
8. Mood Stabilizers
9. Anxiety Disorders and Anxiolytics

10. Personality Disorders
11. Mental Disorders due to Medical Conditions
12. Diagnostic Use of Laboratory
13. Next Accreditation System (NAS) and Milestones
14. Managing Stress and Fatigue for Patient Safety & Personal Well-Being
15. Transitions of Care
16. Basic Neuroscience 3-D Brain
17. Teaching Medical Students
18. Adverse Effects of Medications

Clinical Science Lecture Topics (weekly lectures Fall through Spring)

1. Introduction to Ethics
2. Introduction to Patient Safety and Quality Improvement
3. Geriatric Psychiatry and Neurocognitive Disorders
4. Psychological and Neuropsychological Testing
5. Defense Mechanisms
6. Somatic Symptom and Related Disorders
7. Substance Related and Addictive Disorders
8. Eating Disorders
9. History of Psychiatry
10. Introduction to Psychiatry and the Law
11. Introduction to Supportive Psychotherapy
12. Introduction to Milieu and Group Therapies
13. Sleep-Wake Disorders
14. Community Psychiatry
15. Integrative & Collaborative Care
16. Adult ADHD
17. Electroconvulsive Therapy and Neuromodulation Interventions
18. Culturally Diverse Populations
19. Trauma and Stressor Related Disorders
20. Epidemiology of Psychiatric Illness
21. Paraphilic Disorders
22. OCD and Related Disorders
23. Introduction to Patient Safety and Quality Improvement
24. Dissociative Disorders
25. Integrated and Collaborative Care
26. Adult ADHD
27. Lesbian, Gay, Bisexual and Transgender Patients
28. Social Determinants of Mental Health

EDUCATIONAL OBJECTIVES: LINES OF RESPONSIBILITY AND FACULTY SUPERVISION OF RESIDENTS

Supervision remains a cornerstone of the clinical training experience for our residents. Each of our residents receives a **minimum of two hours of direct supervision per week**, at least one of which is individual. There is a one hour Group Supervision Outpatient Case Conference for PGY2-4 residents. The extent and nature of supervision are partly determined by the resident's level of experience and ability as well as the patients' acuity. How this occurs is described more specifically in other parts of this Psychiatry Residency Program Manual, the Medical Center's Housestaff Manual as well as various clinical service manuals provided our residents at the start of a new assignment. The A.C.G.M.E. requires that all patient care must be supervised by qualified faculty or residents. Supervision in our program is provided by designated full-time faculty in every clinical setting. **Each resident has a Primary Supervisor** with whom the resident meets weekly through the academic year. All new admissions to an inpatient service, consultations, crisis and emergency assessments, more complicated outpatient intakes, etc. are staffed with a designated attending faculty psychiatrist as part of the initial assessment process. The resident is expected to clearly document in the Electronic Medical Record which attending provided this supervision. All supervising faculty at B-UMCP as well as participating institutions in conjunction with the local Site Director must be approved by the Program Director. The community faculty is encouraged to obtain a U of A COM Phoenix Faculty Appointment in the Department of Psychiatry. All faculty are expected to be familiar with the contents of our Psychiatry Residency Program Manual and the A.C.G.M.E. Psychiatry accreditation requirements with special reference to the Psychiatry training requirements for direct and indirect supervision. Supervising faculty are expected to discuss the pertinent educational objectives with each resident they supervise and complete and discuss with the resident the necessary evaluations of the resident's performance. In addition to **maximizing the resident's educational experience**, supervisors also assist the resident to **focus on patient safety and quality patient care**. Our faculty supervisors are also expected to assist residents in learning to **recognize and develop strategies to minimize the effects of fatigue and stress**. Formal review of each **resident's medical record documentation** of history taking, clinical evaluation and treatment including

medication management and timeliness is also part of the supervision process. This occurs in most clinical settings as an ongoing day-to-day occurrence by the assigned faculty and/or senior supervising residents when appropriate.

The A.C.G.M.E. competencies required of a more advanced resident to be designated as a supervising resident and for a new resident to advance from direct to indirect supervision status are described within the respective Competency Based Skills and Milestones ([page 5](#)), Roles and Responsibilities ([pages 18-20](#)) and Criteria for Advancement ([pages 37](#)) and Supervision Policies ([pages 45](#)) sections of this Manual. All residents are expected to inform their patients of their supervisory status.

Selecting the Appropriate Milestone Level for our Residents: The Role of Supervision:

Faculty supervisors, especially those overseeing clinical care, will directly assess many Milestones. The Clinical Competency Committee (CCC) assessment is based on evaluations completed by these clinical supervisors along with other assessments, including performance on tests and evaluations from other sources. The process of Milestone assessment assumes that all residents are supervised in their clinical work, as outlined in the ACGME's supervision levels and requirements. For the purposes of evaluating a resident's progress in achieving Patient Care and Medical Knowledge Milestones, though, it is important that the evaluator(s) determine what the resident knows and can do, separate from the skills and knowledge of his or her supervisor.

Implicit in Milestone Level evaluation of Patient Care (PC) and Medical Knowledge (MK) is the assumption that during the normal course of patient care activities and supervision, the evaluating faculty member and resident participate in a clinical discussion of the patient's care. During these reviews the resident should be prompted to present his or her clinical thinking and decisions regarding the patient. This may include evidence for a prioritized differential diagnosis, a diagnostic workup, or initiation, maintenance, or modification of the treatment plan, etc. **In offering his or her independent ideas, the resident demonstrates his or her capacity for clinical reasoning and its application to patient care in real-time.**

As residents progress, their knowledge and skills should grow, allowing them to assume more responsibility and handle cases of greater complexity. They are afforded greater autonomy - within the bounds of the ACGME supervisory guidelines - in caring for patients. At Levels 1 and 2 of the Milestones, a resident's knowledge and independent clinical reasoning will meet the needs of patients with lower acuity, complexity, and level of risk, whereas, at Level 4, residents are expected to independently demonstrate knowledge and reasoning skills in caring for patients of higher acuity, complexity, and risk. Thus, one would expect residents achieving Level 4 milestones to be senior residents at an oversight level of supervision. **In general, one would not expect beginning or junior residents to achieve Level 4 milestones.** At all levels, it is important that residents ask for, listen to, and process the advice they receive from supervisors, consult the literature, and incorporate this supervisory input and evidence into their thinking.

SPONSORING INSTITUTION

The University of Arizona College of Medicine-Phoenix (UACOM-P) is the **primary sponsoring institution for the Psychiatry Residency Program at Banner-University Medical Center Phoenix (B-UMCP)**. B-UMCP serves as the main clinical and educational facility for the teaching program. UACOM-P abides by the Institutional Requirements expected from the A.C.G.M.E.

PARTICIPATING CLINICAL SITES

The **B-UMCP campus** provides the great majority of clinical assignments and most of the didactics. Adult Inpatient Psychiatry, a longitudinal Outpatient Clinic experience, and Consultation-Liaison Psychiatry all occur at B-UMCP. More detailed descriptions of the educational goals for these foundational clinical experiences are elaborated earlier in the Program Manual. Each involves different PGY assignments. Milestone subcompetencies are also aligned with the resident's level of training as such:

Adult Inpatient Psychiatry: Beginner (PGY-1): PC1, PC2, PC3, PC4, PC5, PC6, MK1, MK2, MK3, MK4, SBP1, SBP2, SBP3, PBLI1, PBLI2, PROF1, PROF2, PROF3, ICS1, ICS2, and ICS3

Mid-Level (PGY-2): PC2, PC2, PC4, PC5, PC6, MK1, MK2, MK3, MK4, SBP1, SBP2, SBP3, PBLI1, PBLI2, PROF1, PROF2, PROF3, ICS1, ICS2, and ICS3.

Outpatient Clinic: Beginner (PGY-2): PC1, PC2, PC3, PC4, PC5, MK2, MK4, PBLI1, PBLI2, SBP1, SBP2, SBP3, PROF3, ICS1, ICS3.

Mid-Level (PGY-3): PC1, PC4, PC5, MK1, MK3, MK4, SBP1, SBP3, PBLI1, PBLI2, PROF2, PROF3, ICS1, ICS3

Advanced (PGY-4): PC1, PC2, PC3 PC4, PC5, PC6, MK1, MK2, MK3, MK4, SBP1, SBP2, SPB3, PBLI1, PBLI2, PROF1, PROF2, PROF3, ICS1, and ICS3

Consultation-Liaison:

Beginner (PGY-2): PC3, PC6, PROF1, PROF2, PROF3, ICS1 and ICS

Mid-Level (PGY-3): PC5, PC6, MK3, SBP2, PBLI1, PROF1, PROF3, ICS1, ICS2 and ICS3

Other nearby affiliated or participating institutions offer complementary and integral educational opportunities to the Psychiatry Residency while allowing continuity of the expected didactic, clinical and peer interactions at the sponsoring institution. Such participating sites include the Phoenix V.A. Medical Center (Internal Medicine, chemical dependency, ambulatory mental health, collaborative care, TMS, Geriatric Psychiatry, and elective programs); Phoenix Children's Hospital (pediatrics; child and adolescent psychiatry); Arizona State University's Employee Assistance Program; Urgent Psychiatric Center (emergency psychiatry) Banner Behavioral Health (ECT, Adolescent Psychiatry, Administrative Psychiatry), Banner Alzheimer's Institute (Geriatrics) and nearby community mental health programs. Formal affiliation Program Letters of Agreement (PLA) between the Psychiatry Residency Program and each of these participating institutions specify off-site faculty and their educational and supervisory responsibilities; the duration and content of the educational experience; and the policies and procedures that will govern resident education and evaluation during the assignment. A member of the teaching faculty in each participating institution is designated by the Program Director to assume responsibility for the day-to-day activities at the affiliated institution. Overall coordination by the Program Director with the affiliation site faculty liaison insures that the educational effort conforms to all specialty specific and the other A.C.G.M.E. requirements.

Chemical Dependency (CD) – this is a two-month assignment between PGY-1 and PGY-2 with inpatient, outpatient and residential treatment substance abuse programs at the nearby **Phoenix V.A. Medical Center**. Show Lin, MD and Carlos Carrera, M.D are the lead faculty supervisors but assigned residents will also work closely with other qualified counselors, psychologists and nurses in the assessment and treatment of individual patients as well as group therapy experiences. This assignment is essentially full-time at the V.A.M.C. for PGY-1 residents except for didactic sessions and approximately 1 full day and 4 half-days for PGY-2's. Milestone subcompetencies aligned with this experience include SBP2, PBLI1 and PROF1. Residents assigned to this rotation are *required to take 1-week vacation at either the beginning or end of the month*.

Child and Adolescent Psychiatry (CAP) (PGY-2 or PGY-3) – this is a 70% time allotment assignment over 3 months (to meet the 2 month FTE A.C.G.M.E. requirement) at the nearby Phoenix Children's Hospital (PCH) and Banner Behavioral Health Hospital (BBHH). The experience includes inpatient, outpatient and consultation experiences. Gaby Ritfeld, M.D. is the Site

Director. Milestone subcompetencies aligned with this experience include MK1, MK2, ICS1, ICS2, and ICS3.

- Ongoing Adult Outpatients and Supervision: The schedule on CAP allows regular attendance for the PGY-2 or PGY-3 residents at their respective didactic seminars at B-UMCP and leaves sufficient time for the resident's ongoing outpatient caseload and weekly meetings with the Primary Supervisor at the B-UMCP BHC Outpatient Clinic.
- Vacation: *One-week vacation during the CAP rotation is required* (please make sure adequate coverage of your outpatients has been arranged beforehand). Those residents with an overlapping month should arrange vacations during that month.
- Supervision: Child Psychiatry: Full-time faculty at PCH and BBHH. Ongoing Adult Outpatients and Intakes: Assigned Primary Supervisor at B-UMCP.

Community Psychiatry (CP) – this is a one-day per week assignment usually during PGY-3 over three months at a **Community Mental Health Center**. The CP experience includes attendance at multidisciplinary staff meetings and supervised assessment and treatment of serious mentally ill outpatients as a member of the treatment team using an Active Treatment and Supportive Case Management model. Involvement with patients under court ordered treatment and outreach to supervisory care settings, shelters and group homes are also expected. Henry Brown, D.O. is the Clinical Site Director. Milestone subcompetencies aligned with this experience include PC1, PC2, PC3, MK2, SBP1, SBP2 SBP3, and PROF1.

- Ongoing Adult Outpatients and Supervision: this schedule allows regular attendance for the PGY-3 residents at their didactic seminars and conferences and leaves time available for the required outpatient caseload and weekly meetings with the Primary Supervisor at the B-UMCP BHC Clinic or other concurrent clinical assignments.
- Vacation: requests during this assignment should be discussed with the Site Director well in advance so their staff can adjust your schedule. Residents should limit their vacation to one five (5) day block to minimize days missed during this experience.
- Supervision: Community Mental Health Clinic: Henry Brown, D.O, et al. Ongoing Adult Outpatients and Intakes: Assigned Primary Supervisor.

V.A. Ambulatory Psychiatry (VAOP) – a part-time assignment at the Phoenix V.A. Medical Center during PGY-3 includes a variety of integrated, individual and group outpatient experiences. Amanda Cattelino, M.D. is the Site Director for this assignment and she will organize supervised training opportunities including brief psychotherapy, outpatient continuity clinic, crisis assessments, TMS and involvement with their Primary Care/Mental Health Integration (Collaborative Care) Clinic. Other clinical as well as clinical research and teaching opportunities are available. The schedule at the V.A.M.C.

while on this outpatient assignment allows time for didactics and ongoing outpatient cases and weekly meetings with the resident's Primary Supervisor at B-UMCP. Residents assigned to this rotation are expected to take one (1) week vacation in a block and should discuss such with Dr. Cattelino well in advance. Milestone 2.0 subcompetencies aligned with this experience include PC1, PC2, PC3, PC5, PC6, MK2, MK3, SBP2, SBP3, PBLI2, PROF1, PROF2, ICS2, ICS3. Residents will return as PGY-4's for additional Administrative Psychiatry experiences (SBP1, SBP3).

A.S.U. Employee Assistance Office (EAO) – a two to three month part-time assignment with the **E.A.O. Outpatient Clinic on the A.S.U. campus** during PGY-3 or PGY-4. The experience includes assessment and ongoing treatment (pharmacologic and brief psychotherapy) of employees and qualified dependents at one of the largest universities in the United States. Resident will be able to provide consultations for these patients as well as ongoing outpatient care in our B-UMCP BHC clinic. There will also be opportunities to provide consultation to the program's clinical staff, educational in-services to psychology and counseling graduate students and participate with the E.A.O. team in organizational consultations, risk assessments, etc. Jillian McManus, DBH, LCSW is Director of the E.A.O. and will provide oversight for the experience and coordinate weekly staffings with the Psychologists in the E.A.O. Clinical supervision is provided by the B-UMCP full-time Primary Supervisor. This assignment is one-half day a week (Thursdays AM and/or PM). Residents planning to take vacation time while on this assignment must notify the E.A.O. staff well in advance. Milestone subcompetencies aligned with this experience include PC6, PROF2, SBP2, and ICS2.

Senior Outpatient Administrative Resident (SOAR) - the designated Senior Outpatient Administrative Resident (SOAR) has the following administrative, supervisory and clinical responsibilities:

- Works with the B-UMCP-B.H.C. Outpatient Clinic Director and Senior Practice Manager or designee to develop and monitor PGY-2, 3 and 4 residents' schedules for outpatient case loads and new patient intakes.
- Serves as a liaison and resource to the support staff in the screening, triage and scheduling referrals from the Adult Inpatient Psychiatry Unit and other B-UMCP based outpatient clinics and institutes.
- Actively assists the PGY-2 residents regarding initial outpatient evaluations, clinical emergencies, etc.
- Participates as an active clinician in the Outpatient Clinic maintaining an expected outpatient caseload for his or her level of training expectedly, involving 20 hours per week dependent upon other responsibilities.
- Provides emergent coverage of post-call residents' outpatients.
- Helps organize and schedule the weekly Group Supervision Case Conference.
- Attends the Department of Psychiatry Medical Staff Committee (noon, 1st Tuesday during September, December, March and June) either virtually or in one of the administrative conference rooms.
- Participates in Administrative experiences at BBHH with their CMO including Utilization Management, Quality Council, Patient Event/Safety Reviews, Clinical Consensus Group meetings. Additional Administrative experiences at VAMC with Dr. Amanda Cattelino includes Quality Assurance, Credentialing/Peer Review, Root Cause Analysis Reviews.

Milestone 2.0 subcompetencies aligned with this experience include PC1, PC2, PC3, PC4, PC5, PC6, MK1, MK2, MK3, MK4, SBP1, SBP2, SBP3, PBLI1, PBLI2, PROF1, PROF2, PROF3, ICS1, ICS2, ICS3.

Senior Residents' Administrative Responsibilities – qualified senior residents share the following administrative, supervisory, teaching and clinical responsibilities:

- Assists in administrative, scheduling, educational and teaching responsibilities as needed.
- Organizes and hosts the Department's weekly Grand Rounds under the direction of faculty.
- Organizes the monthly Career Options and Practice Management conferences.
- Provides designated lectures to the U of A COM third-year medical students.
- Participates as an active clinician in the outpatient clinic maintaining an expected caseload.

**UNIVERSITY of ARIZONA COLLEGE OF MEDICINE - PHOENIX
PSYCHIATRY RESIDENCY PROGRAM**

II. POLICIES

The University of Arizona office of Graduate Medical Education provides each resident an on-line Housestaff Manual at the start of training which is revised and updated annually. The manual can be found at <https://phoenixmed.arizona.edu/gme>

Specific areas covered in that manual include: basic duties and responsibilities; certification of residency or fellowship training; compliance education and training programs; contract related items; delinquent records policy; disaster policy; disciplinary action policy for residents; resident impairment; drug testing policy; automatic suspension; duty work hours; education of stress; sleep deprivation; fatigue and substance abuse; evaluations of residents and fellows; eligibility and selection of residents; family medical leave; fingerprint clearance cards; housestaff counselor; international medical graduates; leave of absence; malpractice policy; meal policy; moonlighting non-competition; miscellaneous requests from program directors; on-call rooms; on-call and holidays; on-call for residents rotating between departments; pagers; parking; patient relationships; other learners, paychecks; problem solving and grievance procedures; professional activities outside of program (moonlighting); professional liability coverage; quality issues involving residents; residency closure or reduction in graduate medical education resources; residency program offices; residency promotion and graduation; rotation of residents from external programs; security ID badges; scrubs: supervision of residents and medical students; transition of care; disability benefits, subpoenas, vendor interactions; documentation for employment; vacation leave; visiting residents and fellows; employee assistance program; harassment policy; health insurance benefits for residents and families; jury duty; occupational health services policy; photography/videotaping in the clinical setting; reporting and prevention of infection; retirement plans; substance abuse policy; due process guidelines; non-disciplinary and disciplinary actions; resident and fellow impairment; drug testing policy, administrative leave procedures; automatic suspension grievance; TB skin test and other topics. In addition, there is a University of Arizona Graduate Medical Education Diversity and Inclusion Policy. Both the Office of Graduate Medical Education's Housestaff Manual and the B-UMCP Employee Manual are available on-line. Several aspects of these policies are summarized below or elaborated as they pertain to the Psychiatry Residency Program. Each resident is also given a copy of the current A.C.G.M.E. Requirements of Accredited Residencies for Psychiatry which are also available on-line at <http://www.acgme.org/acgmeweb/>.

DIVERSITY AND INCLUSION POLICY

At the University of Arizona COM Phoenix Department of Psychiatry and within the Psychiatry Residency Program, we believe in fostering a culture of Inclusive Excellence. All identities and differences including, but not limited to, race, ethnicity, gender identity/expression, sex, sexual orientation, age, religion, language, abilities/disabilities, socioeconomic status, educational backgrounds and geographic region are embraced and valued. A culture of Inclusive Excellence creates role models, broadens perspectives, combats negative stereotyping and optimizes our ability to provide world-class health care for all.

Inclusive Excellence Statement

Through Inclusive Excellence, the University of Arizona College of Medicine – Phoenix is committed to and champions diversity and inclusion as core values central to its mission. Inclusive Excellence is the intentional driver of diversity and inclusion, which harnesses the differences, talents and unique qualities of all individuals. Inclusive Excellence engages the individual and system in practices that advance diversity in all that we do. Inclusive Excellence is inextricably linked to our pursuit of excellence in our educational, clinical and research missions to meet the needs of the residents, fellows, students, faculty, staff and the communities we serve. Through Inclusive Excellence we are committed to mitigating health disparities, especially for marginalized groups and vulnerable populations, in order to improve community health outcomes.

Recruitment and Retention

To serve this mission, we have active and ongoing processes to optimize our recruitment and retention of a diverse and inclusive team of residents, fellows, faculty, and staff members. This diversity includes an emphasis on those who are underrepresented in medicine and medical leadership.

APPLICATION, ELIGIBILITY & SELECTION PROCESS POLICY

Upon receiving a request for information about the Psychiatry Residency a potential applicant is directed to information about our program on our website at <http://phoenixmed.arizona.edu/psychiatry-residency>.

The interested PGY-1 applicant should forward through ERAS the following:

- Completed Common Application Form (CAF)
- Personal Statement
- Medical Student Performance Evaluation from Medical School
- Three letters of recommendation from attending physicians familiar with applicant's past and current work and professional integrity
- Photograph
- Transcript from Medical School
- USMLE, COMLEX or comparable licensing authority Transcripts
- ECFMG Status Report if pertinent
- Copies of current licenses and certificates of previous residencies (via mail)
- Competency Based letter of reference from the Program Director of any previous residency programs if applicable which details specific clinical experiences, performance and professional integrity
- Signed authorization to contact references form

Our program fully complies with the A.C.G.M.E. Institutional Requirements for resident eligibility. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME –accredited residency programs must be completed in ACGME residency programs, Residency programs must receive verification of each applicant’s level of competency in the required clinical field using ACGME or CanMEDS Milestones assessment from the prior training program. (ACGME Program Requirements for Graduate Medical Education in Psychiatry –Resident Appointments)

Applicants for the Psychiatry Residency Program must be students in good standing of an LCME or AOA accredited medical school. Students enrolled in medical school outside of the United States must have received an ECFMG certificate, too. To be entered into the Match, the student applicant must have passed both Step I and Step II licensing exam requirements. Residents are selected based upon their preparedness, ability, aptitude, academic credentials, communication skills including sufficient command of English, professionalism, integrity and personal qualities. Our program will not discriminate in regard to sex, race, age, religion, color, national origin, disability or veteran status.

If screening of the PGY-1 application materials finds the candidate suitable for consideration, an interview is arranged at a mutually convenient date usually for some time between mid-October and late January. The applicant is typically interviewed by several faculty and residents; each is responsible to submit a completed "Resident Applicant Evaluation." This information will be reviewed by the Applicant Review Committee. Those candidates applying for PGY-1 positions through the Match are ranked through the National and Resident Matching Program.

PGY-2 APPLICANTS AND TRANSFERRING RESIDENTS

PGY-2 applicants and other residents applying to transfer to this program must follow the same procedures as PGY-1 applicants except enrolling in the Match. A brief transferring application form will be provided and should be returned with the other documentation listed above. Documented evidence of graduation from an accredited school, either actual or anticipated successful completion of an acceptable A.C.G.M.E. PGY-1 including comprehensive and continuous patient care such as internal medicine, family medicine, pediatrics or a transitional year program and the ability to be licensed are also required. A **summative competency-based performance evaluation** and documentation specifying all clinical and didactic experiences for which the applicant has been given credit from the current or most recent Director of training as well as statements of past performance and personal integrity are also necessary. At least two other letters of recommendation from supervising faculty familiar with the applicant's past and recent clinical work and professional integrity are expected as well as an authorization from the applicant to contact all references, previous employers, etc. A transferring resident's educational program must be sufficiently individualized so that the educational and clinical requirements are met before graduation. Our Program Director is also required to provide similar verification of residency education for our residents who may transfer from the program prior to completion of their training.

EDUCATION POLICY COMMITTEE

The Psychiatry Education Policy Committee (EPC) is composed of members of the psychiatry program teaching staff. This committee should include representation from the residents as well as a member of the teaching staff from each ACGME-approved subspecialty fellowship programs that is affiliated with the psychiatry residency. There should be a written description of the committee, including its responsibility to the sponsoring department or institution and to the program director. The EPC has three central tasks: assist the Program Director in planning, developing, implementing and evaluating all significant features of the residency including the curriculum, goals and objectives of the program; assist in evaluating both residents and teaching staff; and assist in the selection of applicants to the training program through a Residency Applicant Review Subcommittee. The EPC meets regularly and consists of the Program Director, the residency program coordinator, various faculty and resident representatives. The Program Director or designee serves as the liaison between the Education Committee, Department of Psychiatry and the Department of Graduate Medical Education at B-UMCP, and affiliated institutions.

CLINICAL COMPETENCY COMMITTEE

As required by the A.C.G.M.E. NAS, the Program Director appoints the Clinical Competency Committee (CCC) and should not chair the committee. The required functions of the CCC include reviewing all resident evaluations semi-annually; preparing and assuring the reporting of Milestones evaluations of each resident semi-annually to the ACGME and advising the Program Director regarding resident progress, including promotion, remediation, and dismissal. At a minimum the CCC must be composed of three members of the program faculty. Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team.

PROGRAM EVALUATION COMMITTEE

Beyond ongoing evaluation efforts by the Program Director, faculty, residents and collectively by our Psychiatry Education Policy Committee, there are several other formal mechanisms in place to assist in evaluating all aspects of the training program. Such include a Program Evaluation Committee (PEC) composed of at least two faculty and one resident. The PEC reviews the program annually using evaluations of faculty, residents and others.

The PEC actively participates in planning, developing, implementing and evaluating educational activities of the program; reviewing and making recommendations for revision of curriculum goals and objectives; and addressing areas of non-compliance with ACGME standards. Through the PEC, a formal, systematic evaluation of the curriculum occurs annual and rendered as a written **Annual Program Evaluation** (APE). The program is expected to monitor and track resident performance, faculty development, graduate performance – including performance on the ABPN certification examination and program quality. Our residents and faculty have the opportunity to evaluate the program confidentially and in writing at least annually. Evaluation tools include the annual ACGME resident and faculty surveys, an annual internal anonymous on-line survey and monthly didactic and clinical rotations feedback tool. The results of these assessments are used with several other program evaluation results to improve the program. Our Graduate Medical Education office also surveys the residents annually regarding the institution and the training program and provides feedback to the program.

The PEC prepares a written plan of action to document initiatives to improve performance in identified areas as well as show how such will be measured and monitored. These plans are reviewed and documented by the faculty and documented in minutes.

RESIDENT'S PERFORMANCE ASSESSMENT AND EVALUATIONS

Formative Evaluations: Each resident's performance is formally assessed and documented in a timely manner during each rotation or similar educational assignment by a variety of mechanisms described throughout this manual. The results of these evaluations are used to assist the resident to improve his or her performance. These assessments are continually being developed and include a variety of methods that produce an accurate assessment of a resident's competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice on the Psychiatry Milestones. The assessments result in at least semi-annual written evaluations (but typically more frequently) which are routinely provided to the resident in a timely manner. For block rotations of greater than three months in duration, evaluations will be completed at least every three months and at completion. These assessments include evaluation by faculty, patients, peers, self, students and other professional staff in an effort to achieve progressive improvements in the resident's competence, milestone achievement and overall performance. These assessments contain information on the resident's progress toward meeting the expected educational objectives, his or her major strengths and opportunities for improvement or remediation.

Cognitive Examinations: The Cognitive Knowledge of every resident is formally examined at least annually with the Psychiatry Residency In-Training Examination (**PRITE**). This examination crosses the relevant biological, psychological and social spheres that are defined throughout this manual.

Clinical Skills Evaluations: Formal **Clinical Skills Evaluations (CSE)** by faculty occur at least once annually for PGY-1's, PGY-2s, PGY-3s and PGY-4s assessing clinical skills across biological, psychological and social spheres. Required components of this formal CSE include interviewing skills, the ability to establish an appropriate doctor-patient relationship and to elicit an appropriate present and past psychiatric, medical, social and developmental history as well as assessing patient's mental status and providing a relevant formulation, differential diagnosis and provisional patient assessment and treatment plan as expected for the resident's level of training. Demonstration of competence in psychiatric interviewing must be attained prior to completion of the program. These CSEs are documented and quantified and provided to the resident, and when necessary, remediation opportunities are provided. Residents are not allowed to advance to the next year of education, or graduate, unless the competence for their level of education in each area is documented. The **American Board of Psychiatry and Neurology (ABPN)** requires documentation of competence in interviewing and presentation skills no less than three times as a prerequisite to applying for board certification. These evaluations must be done by at least two different ABPN certified Psychiatrists. Satisfactory demonstration of the competencies during these evaluations is required prior to graduation. Residents' teaching and supervising abilities are also documented by evaluations from faculty and learners. Evaluation records must also demonstrate that the resident has met the educational requirements of the program with regard to variety of patients, diagnoses and treatment modalities as documented on patient care logs. In the case of transferring residents, the records should include the experiences in the prior and current program.

If a resident's performance at the CCC reviews does not meet the standards and objectives of the Residency Program such will be reviewed by the Program Director who has the authority to issue a letter of concern to the resident. When there are significant concerns, such will be reviewed by the Program Director or faculty designee and if necessary the EPC and ultimately, if appropriate, the GME Committee. The EPC may decide no action is needed, issue a warning, increase the level of supervision provided the resident, place the resident on probation for a period of time and schedule a subsequent review, or dismiss the resident from the training program. The EPC will attempt to clarify problems and discuss such with the resident. Each situation will be addressed individually; nonetheless, patient care and safety are to remain priorities. If necessary and suitable, the program will develop specific remedial plans for residents who do not perform satisfactorily. Residents cannot advance to the next year of training or graduate from the program unless the outcome from the remedial plan results in sufficient attainment of educational objectives, clinical skills and competencies established by the program pertinent to his or her level of training. These and the other types of assessments and records are provided to the resident and reviewed at least semi-annually with the Program Director or other faculty designee.

The Office of Graduate Medical Education has written policies and protocols regarding resident's performance and evaluation and when appropriate they will be implemented concurrently with this program policy. Specifics of the review and due process procedures are described in the Medical Education Housestaff Manual which is available on-line and revised annually.

Summative Evaluation

At least annually, there will be a **Summative Evaluation** of each resident that includes their readiness to progress into the next year of the program. This evaluation includes documentation of the resident's performance during the final period of education. It will also verify that the resident has demonstrated sufficient competence to practice Psychiatry without direct supervision. The Psychiatry Milestones are used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of training. This final evaluation will include any documented evidence of unethical behavior, unprofessional behavior, or clinical incompetence or a statement that such has not occurred. When there is such evidence, it must be comprehensively recorded, along with the resident's response(s) to such evidence. This summative evaluation is reviewed and attested by the graduating resident and will become part of the resident's permanent record maintained by the institution.

CRITERIA FOR ADVANCEMENT AND GRADUATION

The Psychiatry Clinical Competency Committee, the Education Policy Committee and ultimately the Medical Center's Graduate Medical Education Committee, the Medical Center's Executive Committee, and the Banner Board are responsible for determining the advancement and graduation of each resident. Upon departure from the program a Summative Evaluation in the form of a transcript and a summary document as described above are developed for each resident. These documents summarize the type and length of clinical rotations, didactic experiences, etc. for which the resident has received credit as well as acknowledgement of the resident's general competence and knowledge, skills, and behaviors necessary to enter autonomous practice and the ability to practice independently without direct supervision and a statement regarding ethical and professional behavior. Each graduating resident is provided a copy of his or her transcript and summary document.

General Criteria for Advancement

1. The resident will sufficiently demonstrate the acquisition of specific knowledge, clinical skills, competence and professionalism expected by the A.C.G.M.E. NAS, Common and specialty specific Psychiatry requirements as outlined in the Residency Program Manual's educational objectives for each level of training and specified experiences. Such will include roles, responsibilities, Milestones and increasing competence and independence in the evaluation and continuous management of patients with acute and chronic psychiatric illnesses in a variety of clinical settings.
2. The resident will maintain professional conduct, compassion, and ethical integrity in the care and treatment of patients and families and in the interactions with staff and colleagues.

General Criteria for Advancement: PGY-1 to PGY-2

Rotations typically include: Internal Medicine, Pediatrics (optional replacement of one month of Internal Medicine), Emergency Medicine, Neurology, Adult Inpatient Psychiatry, Chemical Dependency when applicable and extended duty assignments.

1. The resident will be competent in the general medical skills, Milestones and knowledge relevant to the practice of psychiatry, such that the resident can perform competent clinical evaluation and assessment of patients presenting with common medical, surgical and neurological disorders and be able to collaborate with colleagues from other medical specialties in treating such patients.
2. Through both inpatient and emergency psychiatry experiences during PGY-1, the resident will be competent in crisis intervention, evaluation and management of acutely ill, chemically dependent, suicidal, and dangerous patients, psychiatric triage, and the stabilization and disposition of patients.
3. PGY-1 Residents are also expected to have successfully progressed from requiring direct supervision to indirect supervision status with direct supervision available by demonstrating the following A.C.G.M.E. milestones:
 - 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 date accurately to a supervisor who has not seen the patient.
4. If applicable, the resident will competently evaluate and treat patients with significant chemical dependency problems, including the recognition of signs and symptoms of abuse and dependence and the management of medical detoxification.

General Criteria for Advancement: PGY-2 to PGY-3

Rotations typically include: Adult Inpatient Psychiatry, Chemical Dependency, Consultation-Liaison Psychiatry, Emergency Psychiatry, Outpatient Psychiatry, Child and Adolescent Psychiatry, Quality Improvement and Patient Safety experience, Chemical Dependency when applicable and On-call assignments (These rotations may be different for transferring residents). In addition to the general criteria expected at the end of PGY-1, the advancing resident must also meet the following criteria.

1. Through Inpatient, Outpatient and Emergency Psychiatry experiences the resident's level of competence will progress in being able to more independently manage the evaluation and treatment of acutely ill, suicidal and dangerous patients, crisis intervention, psychiatric triage, conducting supportive psychotherapy and psychopharmacology, and the stabilization and disposition of patients.
2. Through the Consultation-Liaison/Emergency Psychiatry experience, the resident will successfully perform competent clinical evaluation and assessment of patients presenting with psychiatric symptoms and coexistent medical, surgical, and neurological disorders and be able to collaborate with colleagues from other medical specialties in assessing and treating such patients.
3. Through Child and Adolescent Psychiatry experiences, the resident will develop competence in the understanding of the biological, psychological, social, economic, cultural, gender, ethnic and family factors that influence normal and abnormal development. The resident will acquire an understanding of the types of psychopathology and the appropriate treatments associated with younger age groups and their families.
4. The resident will competently evaluate and treat patients with significant chemical dependency problems, including the recognition of signs and symptoms of abuse and dependence and the management of medical detoxification.
5. The resident demonstrates level of medical and psychiatric knowledge sufficient to safely supervise fellow residents with less experience.
6. The resident demonstrates capability to provide accurate and helpful feedback to peers and to supervise subordinates.
7. The resident supervises subordinates in a respectful and supportive manner.
8. Attainment of relevant NAS Milestone subcompetencies are also considered for advancement.

General Criteria for Advancement: PGY-3 to PGY-4 and PGY-4 to Completion

Rotations typically include but are not limited to: Outpatient Psychiatry, Community Psychiatry, Emergency Psychiatry, Consultation-Liaison/Emergency Psychiatry, Geriatric Psychiatry, Forensic Psychiatry, On-call responsibilities and various psychiatric electives. In addition to the general criteria expected at the end of PGY-2, the advancing resident must also meet the following criteria.

1. Over the course of the more advanced levels of training the resident will demonstrate competence in the biopsychosocial evaluation and management of psychiatric patients and provide a balanced treatment approach to include brief and long-term individual psychotherapy, supportive, psychodynamic, cognitive and behavior therapy, psychopharmacological therapy, crisis intervention and social rehabilitation. Advanced residents will also be familiar with family assessment and therapy, group therapy and other appropriate treatment modalities and be able to competently evaluate and assist in the management of older patients with declining cognitive functioning.
2. The resident will be competent in the administrative, teaching, supervisory, utilization and Quality Improvement and Patient Safety aspects of Psychiatry in multidisciplinary clinical and education settings.
3. The PGY-3 resident must be able to provide direct or indirect supervision for a more junior resident while having an attending physician available for back-up supervision which may be by phone.
4. Attainment of relevant NAS Milestone subcompetencies are also considered for advancement and ultimately graduation.

General Criteria for Graduation

1. Graduates will be proficient physicians who can independently practice General Psychiatry without direct supervision with a high degree of professionalism, compassion, and adherence to ethical behavior as published by the American Psychiatric Association, as well as, pertinent licensing, accreditation, departmental and Medical Center policies and guidelines.
2. Graduates must demonstrate competence in psychiatric interviewing prior to completion of the program.
3. Graduates will be proficient to independently provide a biopsychosocial evaluation and management of psychiatric patients and provide an appropriate, balanced treatment approach.
4. Graduates will independently and proficiently supervise and monitor other mental health professionals and students.
5. Graduates will sufficiently prepare for, participate in and demonstrate competence in the educational and clinical training provided during the residency as outlined in the Program's Residency Manual, the A.C.G.M.E. accreditation requirements and expected by the American Board of Psychiatry and Neurology. Such will include regular attendance and participation of scheduled didactic seminars throughout all years of training, accurate completion and submitting of case logs demonstrating an adequate depth and breadth of clinical experiences, sufficient performance on standardized written and clinical exams and passing evaluations by supervising faculty for all required experiences and professional skills.
6. Graduates will demonstrate a commitment to life-long learning through ongoing regular study.

Competence means that the physician is well-qualified, capable and adequate for the identified task and purpose. It implies that with sufficient practice, the physician will become proficient, which means that the physician consistently performs the given skills with expert correctness and facility.

FACULTY EVALUATIONS, QUALIFICATIONS AND RESPONSIBILITIES

All members of the teaching staff must be licensed practitioners who demonstrate a strong interest in the education of residents and students, sound clinical and teaching abilities, support of the goals and objectives of the program, commitment to their own continuing medical education and Professional development, and personal participation in scholarly activities, such as peer-reviewed funded research and publications, presentation of case reports at society meetings, participation in educational organizations, etc. Faculty are also expected to encourage and support residents in scholarly activities. Our faculty psychiatrists should be certified by the A.B.P.N. or have equivalent qualifications. They should be readily available for clinical consultation and actively participate in the planning, organization and presentation of educational conferences as well as clinical teaching and supervision.

Each clinical setting has designated faculty responsible for the day-to-day supervision of the residents in that setting. These supervising faculty work closely with the Program Director. The Program Director has the authority to approve or remove program faculty at all sites in the residency program. The performance of the faculty are evaluated by the program no less than annually. The evaluations include a review of their clinical teaching abilities, commitment to the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. This evaluation includes annual written confidential evaluations by residents as well. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.

EXPERIMENTATION AND INNOVATION

Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged in our program. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC and must include the educational rationale and method of evaluation. The sponsoring institution, UACOM-P, and our program are jointly responsible for the quality of education offered to residents for the duration of such a project.

RESIDENT SAFETY

Appreciating that mental health professionals need to be aware of the potential for physical aggression and assaultive behavior in the course of our duties, our interns and transferring PGY-2 residents partake in a 6-hour training class sponsored by AVADE at the onset of our Residency Program. This workshop is not meant to be exhaustive. It complements Banner's Policies and Guidelines on this topic, helps promote safety during residency training, serves as a stimulus for discussion among trainees and supervising faculty and provides expected "next steps" should a situation occur requiring such. A refresher AVADE class is offered annually for all residents and faculty.

GRIEVANCE PROCEDURES FOR RESIDENTS AND FACULTY

A resident or faculty member who has a grievance should contact the Program Director or if more appropriate the Designated Institutional Official (D.I.O.) for Graduate Medical Education, depending on the nature of the problem. It is expected that this contact will initiate some resolution or, if indicated, further assessment.

ATTENDANCE POLICY

Excluding on-call, the clinical work and education period **weekdays are routinely from 7:30 or 8:00 a.m. until 4:30 or 5:00 p.m.** Specific patient care responsibilities frequently extend beyond these hours. Routine attendance at all required lectures, conferences, seminars, supervision, Journal Club, Grand Rounds, etc. is required of our residents. Except for patient care emergencies, clinical responsibilities should not prevent the resident from attending scheduled didactic conferences and supervision sessions. The workday schedule for each clinical assignment is determined by the responsible faculty in accordance with the A.C.G.M.E. Clinical and Educational work hour policies. The A.C.G.M.E. Psychiatry Residency Review Committee expects no less than 70% attendance (excluding vacations) at scheduled didactics and this is monitored and documented by attendance rosters and included in each resident's portfolio.

MOONLIGHTING POLICY

The decision regarding whether or not residents are permitted to "moonlight" is left up to the discretion of the Program Director. The general institutional and ACGME policies note that:

1. 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.
2. 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.
3. PGY-1 residents are not permitted to moonlight.

Expectedly, a resident's "moonlighting" activities will not be beyond his or her level of competence and occur in a setting with adequate supervision. Private practice settings are not acceptable "moonlighting" activities. Moonlighting residents must have passed the Step III licensing exam. If, at any time, in the judgment of the Program Director, the resident's "moonlighting" activities are considered inappropriate or the resident's performance, concerns about physical or mental fatigue, undue stress, required work hours, expected caseloads (including outpatient) or educational achievements are compromised by "moonlighting", or unsatisfactory independent of "moonlighting" activities, he or she will be asked to either curtail or discontinue these outside activities. Poor performance on the PRITE or other standardized examinations will warrant remedial studying and preclude permission to moonlight. A resident's expected housestaff responsibilities plus "moonlighting" activities must be consistent with the A.C.G.M.E. Resident Clinical and Educational guidelines which must not exceed eighty hours per week when averaged over a particular month. To ensure compliance with these guidelines any employment outside the Residency Program must be explicitly approved in writing by the Program Director. The moonlighting resident will be expected to include their moonlighting hours in their daily work duty hour log in New Innovations documenting adherence to the 80-hour rule. The approved written statement of permission will be included in the resident's file. The request to "moonlight" form is included in this manual. Any approved "moonlighting" activities must be periodically reviewed by the Program Director no less than semi-annually. Failure to follow these guidelines may constitute grounds for the resident's dismissal from the program.

VACATION and SICK POLICY

Psychiatry residents are allowed a maximum of 4-week vacation each academic year (5 weekdays and weekends as scheduling permits) plus 6 Banner designated "holidays" unless on an assignment requiring their clinical coverage and 5 sick days. Residents are encouraged to consider these days as a collection of vacation (PTO), and/or "wellness" days and utilize them as such. It may be beneficial to not plan all of the allotted vacation days early in the year and

“bank” some for potential wellness days. However, keep in mind that you will want to plan to use any remaining vacation days before the end of the year and we cannot accommodate large numbers of residents using PTO all at the same time. Vacation days do not carry over into the next year.

During PGY1: interns are required to take 5-day vacation, preferably consecutively, during each of the following assignments: neurology, EM (the 5 days are built into the schedule with at least one weekend off) and CD at either the beginning or end of the month. Additional vacation days can be scheduled during Pediatrics or the remaining month of Neurology. Vacation days will not be approved for Internal Medicine either at B-UMCP or VAMC. Sick days can be taken as needed on any rotation when the resident feels unable to work due to illness and/or concerns for infecting colleagues or patients. Sick days used will be monitored and consideration given to whether the resident attended a sufficient number of days to be given credit for a rotation. Wellness days can also be taken as needed but we ask for careful consideration when assigned to inpatient psychiatry to ensure there is an adequate number of remaining residents to provide patient care. Wellness days used will be deducted from the total number of allotted vacation days. Interns may be assigned as a “Helper” on the inpatient unit for Banner recognized holidays (typically on a Monday holiday but could be other days) if assigned to Inpatient Psychiatry. On those occasions, interns typically work less than half a day providing follow up care. Interns will not be provided with a “make up” holiday. PGY-1 residents are also off one week without pay but with benefits the week before starting PGY-2.

During PGY2, 3, or 4: residents are expected to schedule their vacation, preferably in 5 consecutive day increments during any of the following assignments: EPOQ, Community Psychiatry, Geriatric Psychiatry at either the beginning or end of either month, VA Outpatient, Outpatient Psychiatry, Child and Adolescent Psychiatry, Consultation-Liaison Psychiatry those months when more than 2 residents are assigned and Inpatient Psychiatry those months when 5 or more residents are assigned but no more than 5 days in succession and clinical coverage permits. Sick days can be taken as needed on any rotation when the resident feels unable to work due to illness and/or concerns for infecting colleagues or patients. Sick days used will be monitored as noted above for PGY-1’s. Wellness days can also be taken as needed but we ask for careful consideration when assigned to inpatient psychiatry or Consultation Liaison Psychiatry to ensure there is an adequate number of remaining residents to provide patient care. Wellness days used will be deducted from the total number of allotted vacation days. Typically, PGY2 residents will be assigned to work on Banner holidays for 24 hours; PGY3s and PGY4s are rarely assigned. A substitute day off (“holiday make up”) can be allocated, if scheduling permits, to another date during the same month. It is possible that a Banner holiday will be preceded or followed by another Banner required vacation day (e.g. the Friday after Thanksgiving); if a resident is only assigned to the outpatient clinic and not assigned to other services, the resident will have that day off as well and will not be charged with a vacation day.

All time off requests need to be signed by another resident providing coverage for on-call, outpatients and back-up call and **authorized by the faculty Clinical Director for each affected rotation. All outstanding medical records, treatment logs and evaluations must be completed and signed prior to the approval and taking vacation or education leave.** Once the vacation request form is completed, the resident will need to obtain the Program Coordinator’s signature and approval. The coordinator will monitor the necessary compliance as the vacation approaches.

Neither vacation time nor educational leave may be carried over into the next year of training. It is the resident’s responsibility to schedule his/her vacation throughout the year during the specific rotations indicated above and so it is not bunched up nearing the end of the year causing hardship for others. When that occurs, it is less likely vacation will be granted, so plan ahead.

Both the A.C.G.M.E. and the A.B.P.N. have restrictions regarding time off and **board eligibility**. Any prolonged absence beyond authorized vacation must be discussed with the Program Director to ensure all accreditation and board eligibility requirements are satisfied. Beginning July 1, 2021, the ABPN instituted a **Leave of Absence Policy**. Programs must allow a minimum of 6 weeks of time away from training for purposes of parental, caregiver, and medical leave at least once during training without exhausting all other allowed time away from training and without extending training. Within ABPN and ACGME policy guidelines, it is up to the program director and the program clinical competency committee (CCC) to determine whether a given resident has met training requirements or must extend their period of training. Please see GME Sick Policy in the GME House Staff Manual C:\Users\COchoa1\Banner Health\UACOMP - GME - 6. House Staff Manual\2022_2023 UACOM House Staff Manual_FINAL.pdf

JURY DUTY

Employees are encouraged to serve on jury duty and fulfill their court-related, civic obligations. Banner Health provides staff members time off to do so without change in status or loss of pay. Employees should notify their supervisor upon receipt of a summons or subpoena. Individuals summoned for jury duty or appearing as subpoenaed witnesses are expected to work during normal working hours whenever court is not in session or when their presence in court is not required. Jury duty served on a regular day off negates any pay from Banner for that day. Individuals appearing in court on their own behalf are required to use PTO.

BEREAVEMENT LEAVE

In the event of the death of an immediate family member, employees may take up to three shifts of paid bereavement leave from scheduled work during a period of seven consecutive days to attend to his/her needs. For purposes of this policy, immediate family is defined as a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, stepchild, stepparent, legal guardian, the same members of a spouse's family, or any member of the employee's immediate household. 1 day per year for the employee to attend services of someone other than immediate family member.

MATERNITY & PATERNITY LEAVE/FAMILY AND MEDICAL LEAVE

Newly eligible employees have 31 days to enroll in this benefit. Team members identified via Workday as a Resident and approved for STD, are paid at 100% of their salary for up to 26 weeks. The eligible date is date of hire.

Short Term Disability is not limited to maternity leaves and is available to any eligible employee who experiences a qualifying medical condition, such as delivery of a child that impacts your ability to work. If you qualify, you begin to receive STD benefits, with no waiting period. Once STD begins, you will receive 100% percent of your base salary through STD.

Family Medical Leave (FML) - Provides qualified employees with up to 12 weeks of unpaid, job - protected leave for events such as the birth or adoption of a child or a serious health condition of the employee. FML is unpaid. If available, you must use Paid Time Off (PTO) and / or AZ Sick for any time away from work while on FML. If eligible, short - term Disability, in combination with available PTO and / or AZ Sick, may also be a source of pay during FML. Benefits will continue while on FML *if you pay your portion of the cost.*

Medical Leave of Absence - May be granted for a serious health condition if you are ineligible for Family Medical Leave. This leave requires the written support of your personal physician and may be approved for a period of up to 12 weeks. Paid Time Off (PTO) and / or AZ Sick must be used if available. If eligible, short - term Disability (STD), in combination with available PTO and / or AZ Sick, may also be a source of pay during FML. If PTO, AZ Sick or STD are not available, this is an unpaid leave. If you are on a Medical Leave of Absence and have used all available PTO and / or AZ Sick, you should contact Human Resources to see if you are eligible for Banner's PTO Donation Program. Benefits will continue while on Medical Leave of Absence *if you pay your portion of the cost*

EDUCATIONAL LEAVE POLICY

Annual educational leave is available, when scheduling permits, for all levels of training for the indicated number of days: PGY-1: Up to 2 days; PGY-2: Up to 3 days; PGY-3: Up to 5 days; PGY-4: Up to 5 days. Educational leave can be used one time during the residency for taking licensing exams. Educational leave must be approved by the Residency Coordinator and the faculty Director of the clinical rotation affected by the leave with the same stipulations as vacation. A request form must be completed and coverage arranged by the resident as needed. If attending an educational conference, a copy of the conference brochure should be attached to the completed request form. Upon returning from the conference, the trainee will present a summary of the information obtained in a suitable forum, e.g. Journal Club, Grand Rounds, Case Conference, etc. which is attended by faculty and fellow residents. Funding for registration, travel, accommodations, etc. is currently at the discretion of the Medical Center's Administration. It is possible that the Medical Center's Department of Education will develop an educational leave policy for all trainees that would supersede these guidelines.

Educational leave can be applied toward taking licensing examinations on one occasion or interviewing for fellowships or employment positions. Otherwise vacation time should be used for these activities.

PATIENT LOGS

Residents maintain logs of all treatment cases throughout training. The resident and his or her supervising faculty should carefully monitor the number, breadth, balance, type, etc. of treatment cases routinely and strive to remediate any deficiencies. Each resident will be given blank log templates at the beginning of the academic year. They should transfer the information from all continuing cases on the previous month's logs to the current forms. At the end of each month each resident should ask the appropriate supervisory faculty to carefully review his or her logs and subsequently co-sign them.

After reviewing his or her logs with the appropriate supervisors, the resident should then submit the completed, co-signed logs to the Residency Coordinator. Vacations, educational leave, graduation certificates, etc. will not be granted unless all the logs are current, accurate, complete and co-signed by supervising faculty. Residents will review their logs with the Program Director at least semiannually.

During PGY-1, residents must remember to use **separate log sheets** for Neurology, Chemical Dependency and Adult Inpatient Psychiatry. Also, for all residents on-call, all Emergency Center Psychiatric on-call evaluations, on-call consultations in the Towers, Rehab Center, etc. and admissions to Inpatient Psychiatry unless subsequently followed by you, should be logged on a **separate on-call log sheet** clearly marked “**Emergency Psychiatry**”. Clinical experiences in Emergency Psychiatry at the Urgent Psychiatric Center should be logged on the appropriate month’s Emergency Psychiatry log. PGY-1 residents should return log sheets for the months assigned to Internal Medicine, Pediatrics and Emergency Medicine rotations with such noted; it is optional for PGY-1’s to log specific cases for these rotations but we need the monthly log sheet returned for your files. In summary, residents should keep separate logs for each month’s clinical assignments, emergency psychiatry on-call and ongoing outpatient cases at B-UMCP. If residents need extra blank log templates, please contact the Residency Coordinator.

Every resident’s logs will be reviewed during each semi-annual review with the Program Director. Residents should expect that this information may well need to be acknowledged when applying to the boards, fellowships, licensing bodies, insurance companies, etc., so it is to everyone’s advantage to be thorough and accurate.

COMPLIANCE POLICY

Banner’s Compliance Department has established a telephone number that you can use to report any activity at Banner that appears to violate the Banner Code of Conduct or any law or Banner policy. The ComplyLine is toll-free from anywhere in the United States. It is answered 24-hours-a-day, seven days a week by an operator who is trained to take your report of suspected illegal or unethical activity. A call to the ComplyLine can be confidential or anonymous at your request – no one will attempt to identify you. Finally, a call to the ComplyLine will satisfy your obligation to report suspected illegal or unethical activity to a compliance officer. As Banner employees, residents must remain current in completing their expected Compliance education and training modules. ***Banner’s ComplyLine – (888) 747-7989.***

DISASTER POLICY

In the highly unlikely event there is a disaster curtailing access to our usual training facilities, the Department of Medical Education’s Disaster Policy (MEDR 1-028) which is included in the Housestaff Manual will take effect. To facilitate communication between our residents, faculty and staff all residents are expected to provide current cell phone numbers and e-mail addresses to our Residency Program Coordinator and Practice Manager and provide updates when indicated.

MEDICAL RECORD POLICY

Residents electronically transcribing, dictating, handwriting or typing patient medical records are responsible for ensuring that such are not only thorough, accurate and completed within the specified time period for that clinical service but also strictly, following all of Banner’s and the Department’s requirements and policies. The Program Director and Residency Coordinator are notified about any resident who is delinquent with inpatient medical records. **Residents with delinquent inpatient or outpatient records are not allowed to take vacation or educational leave. A delay in completing delinquent medical records is considered a breach of Professionalism and may result in disciplinary action.**

Timely Completion of Medical Records/Complete Medical Record - The Medical Record is not considered complete until all its essential elements are documented and authenticated, and all final diagnoses and any complications are recorded, consistent with these Rules. No medical record shall be considered complete without fulfilling the documentation requirements except on order of the Medical Executive Committee.

Timely Completion of Medical Record Documents - All medical record documents shall be completed within time frames defined below:

Documentation Requirement	Timeframe	Exclusions
Emergency Room Report	Documented within 24 hours of discharge/disposition from the ED	
Admitting Progress Note	Documented within 24 hours of admission	
History & Physical	Documented within 24 hours of admission and before invasive procedure	
Consultation Reports	Documented within 24 hours of consultation	
Post op Progress Note	Documented immediately post-op when there is a delay in the availability of the full report	
Provider Coding Clarification	Completed within 7 days of notice.	
Operative Report	Documented immediately post-op and no later than 24 hours after the procedure.	
Special Procedures Report	Documented within 24 hours of notice.	
Discharge Summary Report	Documented at the time of discharge but no later than 24 hours after discharge.	Not required on all admissions less than 48hrs, or for normal vaginal deliveries and normal newborns
Discharge Progress Note	Documented at the time of discharge but no later than 24 hours after discharge for all admissions less than 48hrs or for normal vaginal deliveries and normal newborns.	
Death Summary	Documented at the time of death/disposition or within 24 hours of death.	
Death Pronouncement Note	Completed at the time the patient is pronounced or within 24 hours of death.	
Transfer Summary	Documented at the time of transfer no later than 24 hours.	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 7 days from the date of notice.	
Verbal Orders	Dated, time and authenticated within the timeframe specified by state regulation Alaska = 72 hours Arizona = 72 hours California = 48 hours Colorado = 48 hours Nebraska = 48 hours Nevada = 48 hours Wyoming = 24 hours	
Psychiatric Evaluation	Documented within 24 hours of admission	
Home Health Face to Face Discharge Documentation	Documented within 30 days of discharge	

OTHER RULES, REGULATIONS, POLICIES, etc.

As physicians in training in the specialty of Psychiatry at B-UMCP, our residents are expected to become familiar with and follow the rules, regulations, guidelines, etc. of U of A COM-Phoenix, the Medical Center at B-UMCP, Banner Health and of their relevant professional licensing associations, the American Psychiatric Association, (including the “AMA Principles of Ethics with Special Annotations for Psychiatry”), the A.C.G.M.E., Joint Commission, HIPAA, Medicare (CMS), and Department of Psychiatry, and other pertinent licensing, professional and regulatory organizations. This information is contained in available policy manuals or pertinent websites, in distributed handouts, in-services or through the specified agency.

CLINICAL LEARNING ENVIRONMENT REVIEW (CLER)

As a component of its Next Accreditation System, the ACGME has established the CLER program to assess the graduate medical education learning environment of each sponsoring institution and its participating sites. CLER emphasizes the responsibility of the sponsoring institution for the quality and safety of the environment for learning and patient care, a key dimension of the ACGME Common Program Requirements. The intent of CLER is “to generate national data on program and institutional attributes that have a salutary effect on quality and safety in settings where residents learn and on the quality of care rendered after graduation.”

The CLER program’s ultimate goal is to move from a major targeted focus on duty hours to that of broader focus on the GME learning environment and how it can deliver both high-quality physicians and higher quality, safer, patient care. *CLER assesses sponsoring institutions in the following six focus areas:*

- **Patient Safety** – including opportunities for residents to report errors, unsafe conditions, and near misses, and to participate in inter-professional teams to promote and enhance safe care.
- **Health Care Quality** – including how sponsoring institutions engage residents in the use of data to improve systems of care, reduce health care disparities and improve patient outcomes.
- **Teaming** – recognizes the dynamic and fluid nature of how many individuals come together in the course of providing patient care; recognizes that team members can identify and capitalize on their various professional strengths to coordinate care that is both safe and efficient.
- **Supervision** – including how sponsoring institutions maintain and oversee policies of supervision concordant with the ACGME requirements in an environment at both the institutional and program level that assures the absence of retribution.
- **Well-Being** – including how sponsoring institutions: (i) demonstrate effective and meaningful oversight of duty hours across all residency programs institution-wide; (ii) design systems and provide settings that facilitate fatigue management and mitigation; and (iii) provide effective education of faculty members and residents in sleep, fatigue recognition, and fatigue mitigation.
- **Professionalism** – with regard to how sponsoring institutions educate for professionalism, monitor behavior on the part of residents and faculty and respond to issues concerning: (i) accurate reporting of program information; (ii) integrity in fulfilling educational and professional responsibilities; and (iii) veracity in scholarly pursuits.

THE LEARNING AND WORKING ENVIRONMENT

The ACGME has established the following guiding principles regarding the learning and working environment for Residency education.

- 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 and
 - 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

The following areas are fundamental aspects of the Learning and Working Environment in our training program. Descriptions of each are listed below and some are also explored earlier in the program manual in Part I: THE RESIDENCY PROGRAM.

- Patient Safety, Quality Improvement, Supervision and Accountability
- Professionalism
- Well-Being
- Fatigue Management and Mitigation
- Clinical Responsibilities, Teamwork and Transitions of Care
- Clinical Experience & Education

PATIENT SAFETY

The ACGME guidelines include recognition that programs have a Culture of Safety, where the organization encourages continuous identification of vulnerabilities and a willingness to transparently deal with them and identify areas for improvement. Our residents work in an interprofessional, team-based care on a regular basis and encourages both residents and faculty to participate in patient safety programs as well as to create patient safety projects in inpatient and outpatient settings both at our primary teaching hospital as well as at community sites.

Residents participate in educational activities focusing on patient safety issues, how to recognize and report patient safety events, as well as how to discuss these events with patients and their families when appropriate. If patient safety issues occur during clinical experiences, residents have the opportunity to be involved in discussing the events with faculty, team members as well as patients and their families. These topics are also covered as part of the department's didactic program. All residents have an introductory lecture to Patient Safety and Quality Improvement as a PGY1 or 2 and also complete the IHI Patient Safety and Quality Improvement on line modules and an AMA GME Education Module on Patient Safety. Faculty and residents attend and may also be participants in our hospital's multidisciplinary Patient Safety and Quality Improvement Conferences that are held at least quarterly. During PGY2, residents have a one-month rotation "EPOQ" which is a combination of Emergency Psychiatry, outpatient psychiatry, and focused time to complete the IHI modules as well as to begin developing a patient safety/quality improvement project or to join an existing team and assist with an existing project. PGY2's will participate in a monthly PS/QI meeting to work on projects and continue with PS/QI education. PGY3 and PGY4 residents will participate to continue to work on their projects or assist PGY2s.

QUALITY IMPROVEMENT

The ACGME guidelines recognize the need for education in Quality Improvement, Quality Metrics, and Engagement in Quality Improvement Activities. Our residents receive training and experience in understanding quality improvement processes through lectures in our core psychiatric didactics, completing the IHI on-line modules on Quality Improvement, and as noted above, participating in the B-UMCP Multidisciplinary Quality Improvement and Patient Safety conferences and our monthly PS/QI meetings. Health care disparities are an important component of Quality Improvement and our residents are exposed to many patients in varied clinical settings where health care disparities are recognized and discussed. There is an introductory lecture during PGY-1 on Health Care Disparities. During the Community Psychiatry rotation, residents complete an on-line program "Caring with Compassion" that has seven modules focusing on health care disparities; the topics covered are very pertinent to this patient population. As noted above, patients are given time to initiate a new Quality Improvement project or to join an existing team during PGY2. The program encourages projects within our department as well as interdisciplinary ones.

SUPERVISION AND ACCOUNTABILITY

The ACGME and our program recognize that 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. Our supervision policies are outlined earlier in the manual.

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.

RESIDENT SUPERVISION

Each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or approved licensed independent practitioner) who is responsible and accountable for the patient's care. This information should be available to residents, faculty members, other members of the health care team, and patients. Residents and faculty members must inform patients of their respective roles in each patient's care.

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. 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.

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:

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

Indirect Supervision:

- with direct supervision *immediately* available – the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision.
- with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities and is available to provide Direct Supervision.

Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the Program Director and faculty members. The Program Director must evaluate each resident's abilities based on specific criteria guided by the milestones. Faculty members functioning as supervising physicians must delegate portions of care to residents, based on the needs of the patient and the skills of the residents. Senior residents or fellows should serve in a supervisory role of 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.

Our program has guidelines for circumstances and events in which residents must communicate with the supervising faculty members (such as the transfer of a patient to an acute care medical unit, suicide attempt, AMA request, elopement, new admission or consult, etc.)

Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

Initially, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available. PGY-1 residents should 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

Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

PROFESSIONALISM

The ACGME expects and our program supports that the program, 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. Specifically, our residents participate in the "LIFE" curriculum which provides education about the risks of fatigue, sleep deprivation, and provides guidance about how to best mitigate these issues.

The learning objectives of the program must be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events and be accomplished without excessive reliance on residents to fulfill non-physician obligations and ensure manageable patient care responsibilities. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.

Residents and faculty members must demonstrate an understanding of their personal role in the provision of patient- and family-centered care, safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events. Residents and faculty members should understand their personal role in the assurance of their fitness for work, including management of their time before, during, and after clinical assignments, and recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. Residents and faculty members must also demonstrate an understanding of their personal role in the commitment to lifelong learning, monitoring of their patient care performance improvement indicators, and accurate reporting of clinical and education work hours, patient outcomes, and clinical experience data.

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.

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. In our program these topics are addressed in the University of Arizona College of Medicine-Phoenix Office of Graduate Medical Education Housestaff Manual.

WELL-BEING

The ACGME and our program recognizes that 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 (as noted above). 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.

The responsibility for Well-Being must include efforts to enhance the meaning that each residents 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. It also includes attention to scheduling, work intensity, and work compression that impacts resident well-being as well as evaluating workplace safety data and addressing the safety of residents and faculty members.

The program must have policies and programs that encourage optimal resident and faculty member well-being. Our residents are given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

The program must include 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 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 as well as provide access to appropriate tools for self-counseling, and treatment including access to urgent and emergent care 24 hours a day, seven days a week.

Our program and Sponsoring Institution has developed an interdisciplinary Wellness Committee that is addressing these issues and has hired a dedicated housestaff psychologist to provide easily accessible care for residents and fellows. There is also an Employee Assistance Program and mental health coverage available through the health care benefits provided to residents and their families. A resident/fellow/student wellness space has been created in a renovated space in one of our medical towers.

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. Residents may use their vacation time as “wellness days” as needed and do not need pre-planning as vacation does.

FATIGUE MITIGATION AND MANAGEMENT

The ACGME and our program is committed to promoting patient safety and resident well-being while providing a supportive educational Learning and Working environment. Our residents and faculty are educated to recognize the signs of fatigue and sleep deprivation, alertness management and fatigue mitigation processes, and also encourage residents to use fatigue mitigation processes to manage the potential and negative effects of fatigue on patient care and learning. Our residents participate in the “LIFE” curriculum to learn about these important topics and there are regular inservices for residents and faculty that address fatigue, wellness, and burnout. The ACGME has established various regulations regarding the clinical work and education periods, wellness, fatigue and the learning and working environment which are included in the ACGME Psychiatry Program Requirements, a copy of which is provided each resident at the start of the academic year. Residents are provided a monitoring form (which is included in this manual) at the end of each month to complete and sign as an accurate attestation and submit to the Program Director. This form includes questions inquiring if a resident has struggled with fatigue or stress during the month. Residents are also to personally report any potential infractions of these regulations to the Program Director immediately. In addition, the ACGME Resident Survey and the University of Arizona College of Medicine-Phoenix Graduate Medical Education Office survey residents on these matters and the results are reviewed by our program. A program specific tally of days off per month is reviewed by our Program Director to ensure the schedule is providing adequate time off for rest. Our residents are provided individual sleep rooms when on-call and Taxi/Ride Share vouchers or reimbursement are available for transportation for residents who may be too fatigued to safely drive themselves home. On call schedules are developed with an identified back up (or “sick call”) resident who is expected to be in town with their pager or cell phone on in the event that the resident scheduled for call is unable to take or complete their on-call assignment.

CLINICAL RESPONSIBILITIES

The ACGME and our program expects that 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. Please refer to the section labeled “Supervision and Lines of Responsibility” on (p.29-30) for a more description of this important topic.

TEAMWORK

The ACGME and our program expect that 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. In Psychiatry, 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. These interprofessional teams exist in each clinical setting where our residents rotate for psychiatry experiences.

TRANSITIONS OF CARE

The ACGME and our program recognizes that programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. 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. Program must ensure that residents are competent in communicating with team members in the hand-over process. Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergencies (see FATIGUE above).

Transitions of Care occur daily on our clinical services. Residents are oriented to our Transition of Care program during Orientation Week and faculty and the Senior Inpatient Resident oversee the Transition of Care (aka “check out”) event. Residents are strongly encouraged to participate in Transition of Care face to face and not to rely only on phone calls, computer, or paper documentation. We utilize our electronic health record to create a check-out list which includes patient demographic information, a brief summary of admission history and diagnostic impressions, updated medication list including available prn “as needed” medications, and a “notes” section that can be used to communicate potential issues on call. The Consultation-Liaison service uses a secure form on our department Microsoft Teams C/L communication tool to

document new consults and patients the service is following so that the resident on call has information if he or she is contacted about a consultation-liaison patient.

All inpatient residents are expected to be on time for the Transitions of Care meeting at 7:45 am in the Resident's room in the Inpatient Psychiatry Unit. The Adult Inpatient Psychiatry residents and one of the residents assigned to the Consultation-Liaison service will participate in the meeting. Medical students assigned to the inpatient unit will attend as well. The post-call resident is responsible for leading the meeting and he or she reviews any new admissions as well as significant events that occurred during the on-call period. He or she will return updated sign out sheets with the events that document significant events in the patient's medical record. These notes should be forwarded to the attending psychiatrist on call for signature and to the inpatient attending caring for the patient daily for review. The post call resident will discuss any consultation-liaison issues with the consultation-liaison resident. This can include calls received about active c/l patients, new consults that were completed overnight that may need follow up, as well as new consults that were not completed. If any Inpatient Psychiatry patients were transferred to the medical floor while on call, this information will also be relayed to the senior c/l resident. Faculty may attend the Transition of Care meeting and are able to provide feedback to the residents regarding his or her communication skills. The attending can complete an evaluation of the Transition of Care process (see [pages 65-66](#) in the forms section) and the resident will also complete a self-assessment about his or her Transition of Care capabilities.

At the end of the workday, each resident on the Adult Inpatient Psychiatry unit will check out face to face (or virtually if needed) with the senior resident on call and intern (if applicable) at 4:30PM either on the Inpatient Unit or in the outpatient clinic. The attending on-call will attend or call in as able to the transition of care meeting. Check out plans in the EHR should be updated and medication lists should be accurate. Residents are encouraged to review all "prn" medications so that emergent needs are anticipated and available if indicated. Any pertinent clinical information including pending labs, anticipated phone calls, pending consultations should be related to the resident on call. Special attention in the afternoon Transitions of Care should be given to any new day admission to the inpatient unit. The senior Consultation-Liaison resident will meet with the on -call resident and transfer the Consultation-Liaison pager to the on-call resident and review the Consultation-Liaison check out sheet on the Microsoft Teams C/L Communication Tool and review any issues that may arise on call with these patients (obtaining collateral from family, monitoring medication effects, etc.).

Finally, during the PGY2-4 years, residents seeing outpatients are expected to relay any acute concerns about his or her outpatients to the resident on call if he or she is anticipating an issue overnight or over a weekend with an outpatient. This information can be included on the consultation-liaison communication tool. In addition, residents who are going on vacation or taking an educational leave are expected to have a Transitions of Care meeting with the resident who has agreed to cover the resident's outpatients during this time. The resident should review his or her patient log with the covering resident and provide guidance regarding how to manage possible urgent matters that may arise with his or her outpatients. The covering resident should document any clinical contact including phone calls, prescription renewals, and clinic visits in the outpatient medical record and review these events with the resident when he or she returns.

CLINICAL EXPERIENCE AND EDUCATION

The ACGME guidelines and our program and Sponsoring Institution support that there must be 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. The ACGME guidelines that our program follows are such:

- 1. 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**
2. The program is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. **Residents should have eight hours off between scheduled clinical work and education periods.**
 - a. 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.
- 3. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.**
- 4. 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.

5. **Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. 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.** Additional patient care responsibilities must not be assigned to a resident during this time.
6. 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:
 - a. To continue to provide care to a single severely ill or unstable patient
 - b. Humanistic attention to the needs of a patient or family or
 - c. To attend unique educational events
 The additional hours of care or education will be counted toward the 80-hour weekly limit.
7. **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. Time spent by residents in internal and external moonlighting must be counted toward the 80-hour maximum weekly limit. PGY-1 residents are not permitted to moonlight.** (see Moonlighting Policy in Program Manual [p.39](#))
8. Night float must occur within the context of the 80-hour and one-day-off-in seven requirements. Residents should not be scheduled for more than four consecutive weeks of night float during the required one-year, full-time outpatient psychiatry experience. Residents should not be scheduled for more than a total of eight weeks of night float during the one-year of consecutive outpatient experience. (Our program does not currently have a night float system).
9. Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). **On psychiatry Rotations, in-house call must occur no more frequently than every fourth night, averaged over a four-week period.**
10. 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. At-home must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. 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.

ON-CALL SCHEDULE DEVELOPMENT AND GUIDELINES FOR UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE-PHOENIX PSYCHIATRY RESIDENCY PROGRAM

Presently a more senior resident under the supervision of the Psychiatry Residency Director with input from members of the Program's On-Call Task Force develops the residents' monthly on-call schedule. The on-call schedule should reflect the patient care needs of the Medical Center and the availability of residents as a group to share call and provide necessary back-up while strictly adhering to the A.C.G.M.E. Clinical and Educational Work guidelines for our specialty. The Program Director has the ultimate authority and responsibility for an on-call schedule to be in place.

Some general guidelines for on-call include (but are not limited to) the following:

1. Residents should not be on-call for Psychiatry on average more often than every fourth day any particular month. One day out of seven averaged over the course of 4 weeks must be free of program duties.
2. More advanced residents approved to supervise will assist PGY-1 residents during their extended clinical work and education period through direct supervision or indirect supervision with direct supervision immediately available. PGY-1 residents are expected to be signed-off for indirect supervision telephonically (with direct supervision available) before advancing to PGY-2. The supervising more senior resident must directly supervise our new residents in Emergency Center evaluations, consultations, admissions to the Inpatient Unit, etc. until the more junior resident has attained indirect supervision status. It is expected that when a new resident is asked to do a consultation of a patient already hospitalized, that the more senior supervising resident personally "walk through" with the new resident about how such is done. This means the senior resident will assist the new resident directly inquiring about the consultation request, seeing the patient together, assisting in composing the write-up, add his/her own comments, discussing the recommendations with the referring doctor, etc. A new resident should not see a patient in consultation on his or her own until the walking through process has occurred satisfactorily to the supervising residents, the attendings and the PGY-1 resident. This usually takes at least 4-5 consultations and expectedly should include altered

mental status, safety (SI, HI), post suicide attempt and capacity assessments. An on-call attending is always available by phone to assist the PGY-1 and supervising resident.

It is not appropriate for the supervising resident to leave the Medical Center and ask the new resident to “call me as needed”. When a medical student also happens to be on-call, the more senior resident should take the lead for supervising and teaching the student as well. All PGY-2, PGY-3 and PGY-4 on-call admissions, patients seen in the Emergency Center and consultations are to be staffed with the attending on call usually by phone.

3. Extended Clinical and Educational Work periods for PGY-1’s are typically 4:30 p.m. until approximately 9:00p.m. weekdays and 8:00 a.m. until no later than midnight on weekends. The PGY-1 residents should have no less than 8 hours away from the hospital between shifts. After hours on-call for PGY-2, 3 and 4 residents is typically 4:30 p.m. until 8:00 a.m. weekdays and 8:00 a.m. until 8:00 a.m. the next day, weekends and holidays allowing for the A.C.G.M.E. “4 Hour” post-call responsibilities. Residents must have at least 14 hours free of clinical work and required education after 24 hours of in-house call. Usually over the first six months in the academic year, PGY-1 residents will have their extended clinical and education work periods those evenings, weekends and holidays also assigned to PGY-3 and 4 residents. Later in the year, the PGY-1 may eventually have clinical education work periods of up to 24 hours with up to 4 hours of additional time for post-call responsibilities. Those residents transferring into the program at the PGY-2, 3 or 4 levels will expectedly take additional independent on-call during their subsequent year(s) of training usually to be equal the typical amount of call for those years of training. Residents should not leave another clinical or educational experience to begin call early and the responsibilities after 8:00 a.m. post-call for PGY-2, 3 and 4 residents should allow for continuity and a safe transition of patient care, and attendance at educational conferences within the A.C.G.M.E. clinical and education work period guidelines. This includes attending the daily transfer of care meeting on the inpatient unit each morning when the post-call resident will review all new admissions and any significant events involving established patients.
4. Those developing the on-call schedule must also develop a workable substitute or “back-up” on-call schedule that can be implemented in case of fatigue, illness, unexpected leave, etc.
5. Residents having transferred into the program after PGY-1 will be assigned to the on-call schedule dependent upon their previous experience typically requiring limited direct supervision.
6. The proposed on-call schedule should be submitted to the Residency Program’s Coordinator or designee no later than the fifteenth of the preceding month so it can be distributed in a timely manner.
7. It is the responsibility of the assigned resident to inform other services (e.g. Internal Medicine, Neurology, Pediatrics, etc.) if his/her Psychiatry on-call schedule interferes with the other services subsequent month’s schedule or A.C.G.M.E. work duty hours guidelines.

More specific expectations presently include the following:

1. Residents starting on-call on Saturdays, Sundays and holidays will arrive promptly at 8:00 a.m. on the Adult Inpatient Unit.
2. The resident finishing on-call the previous day or night (e.g. Fridays, Saturdays or holidays) will meet the arriving on-call resident at 8:00 a.m. on the Adult Inpatient Unit.
3. The finishing and arriving residents will actively engage in the transfer of care of patients admitted the previous 24 hours and other patients needing further assessment or follow-up (including consultations), etc. This may include the finishing on-call resident writing follow-up notes on people he/she admitted or was responsible for the previous day or night and identifying tasks for the arriving on-call resident to follow-up, etc.
4. The attending on-call weekends and holidays will also be on the Inpatient Unit at 8:00 a.m. each day to actively assist in this transfer of care.
5. Third year medical students and fourth year medical students on elective will take on-call with our residents weeknights and on Saturdays from 8:00 a.m. through the early evening hours. It is the on-call resident’s responsibility to insure this is a worthwhile learning experience for the medical students. Expectedly, early in the academic year the assigned on-call supervising more senior resident will assume the medical student teaching responsibilities.
6. Regarding “sick call/back-up” responsibilities, the primary resident on-call will always have the option to call in the designated back-up resident if he or she feels the number or type of cases requiring assessment and care are beyond the capabilities of one person or if the primary on-call resident feels he or she is too fatigued and needs to be relieved

(in the latter case, the “back-up” resident would complete the primary resident’s on-call duty). The on-call attending must be informed of such circumstances.

7. Since the time of day when the services of the “sick call/back-up” resident may be needed is unpredictable, the “sick call/back-up” resident on-call **must** be available throughout the expected hours of call (Fridays 4:30 p.m. – 8:00 a.m.; Saturdays, Sundays and holidays 8:00 a.m. – 8:00 a.m.; weekdays 4:30 p.m. – 8:00 a.m.) by pager and able to come to the hospital to assist the primary resident within 30 minutes. **All residents are required to provide a working personal telephone number to the Residency Program and hospital operator so they can be reached in an emergency.**
8. The assigned senior (PGY-3 and 4) supervising residents will provide supervision to new residents and similarly for any new resident joining the residency later in the year or at a more advanced level as they complete day-time admissions to Inpatient Psychiatry. This back-up will initially include in-house direct supervision and assistance as described above.
9. The attending on-call **always** has the right to direct the designated “sick call/back-up” resident to come in and help.
10. The senior supervisor and sick call/back-up call schedule must adhere to the ACGME Clinical Experience and Education Guidelines. The designated resident under the supervision of the Program Director is responsible for developing the complete on-call schedule.

III. EVALUATION FORMS

CLINICAL ROTATION EVALUATIONS:

Clinical rotation evaluations are a keystone to the ongoing (formative) performance assessment process for each trainee. Depending on the nature and length of a rotation, designated supervising faculty will complete a clinical rotation evaluation at some time during the experience which must be reviewed and signed by the resident then forwarded to the Program Director. An example rotation evaluation with Milestones 2.0 for PGY2 Outpatient follows. Rotation specific Milestone subcompetencies will be added to each evaluation.

The diagram below presents an example set of milestones for one sub-competency in the same format as the milestone report worksheet. For each reporting period, a resident's performance on the milestones for each sub-competency will be indicated by:

- selecting the level of milestones that best describes the resident's performance in relation to those milestones OR
- selecting the "Not Yet Completed Level 1" or "Not Yet Assessable" response option

General Competency		Sub-competency			Developmental Progression or Set of Milestones	
Patient Care 2: Care of Patients with Chronic Illness						
Level 1	Level 2	Level 3	Level 4	Level 5		
Recognizes that common conditions may be chronic (e.g., anxiety, high blood pressure)	Identifies variability in	Determines the potential impact of comorbidities on disease progression	Balances the competing needs of patients' comorbidities	Leads multidisciplinary initiatives to manage patient populations with chronic conditions and comorbidities		
Formulates a basic management plan that addresses a chronic illness	Identifies appropriate clinical guidelines to develop and implement plans for management of chronic conditions	Synthesizes a patient-centered management plan that acknowledges the relationship between comorbidities and disease progression	Applies experience with management of patients with chronic conditions	Initiates supplemental strategies (e.g., leads patient and family advisory councils, community health, practice innovation) to improve the care of patients with chronic conditions		
Recognizes that chronic conditions have an impact beyond the disease process	Identifies the impact of chronic conditions on individual patients and the others involved in their care	Develops collaborative goals of care and engages the patient in self-management of chronic conditions	Facilitates efforts at self-management of chronic conditions, including engagement of family and community resources			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:						
						Not Yet Completed Level 1 <input type="checkbox"/>
						Not Yet Assessable <input type="checkbox"/>

Looks a lot like an EPA!

Milestone

**Subject Name**

Status
 Employer
 Program
 Rotation
 Evaluation Dates

Evaluated by: Evaluator Name

Status
 Employer
 Program

UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE - PHOENIX PSYCHIATRY RESIDENCY PROGRAM

EVALUATION OF RESIDENT ON OP (PGY-2)

Instructions:

These evaluations are based on the A.C.G.M.E. Milestones 2.0 (effective July 1, 2021) for Psychiatry which use descriptive anchors for each competency. In general: Level 1 represents expected skills of an incoming resident. Level 2 resident advancing but not performing at mid-residency level. Level 3 resident demonstrates majority of Milestones in this sub-competency. Level 4 resident substantially demonstrates majority of Milestones in this sub-competency; designed as graduation target but not requirement. Level 5 is aspirational and expected to be attained once in practice; only a few exceptional residents will reach this level. Milestone levels do not necessarily correlate with PGY level.

Please click on the circle that represents the level the resident has demonstrated during the rotation or other specified training experience. You should click the circle in between levels if the resident is approaching but not yet attained a set of skills. Patient Care and Medical Knowledge now have two additional options outside of levels 1 - 5: Not Yet Completed Level 1 and Not Yet Assessable. The evaluating faculty and resident should review and discuss this assessment. (PC1), etc. refer to the relevant sub-competency for this observed skill, attribute, etc. Such were provided to you and the resident at the beginning of the academic year and are accessible on-line at www.acgme.org. Comments are encouraged!

PATIENT CARE

Provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

1 Patient Care 1: Psychiatric Evaluation**A: Gathers and organizes findings from the patient interview and mental status examination****B: Gathers and organizes data from collateral sources****C: Screens for risk and integrates risk assessment into the patient evaluation**

Level 1	Level 2	Level 3	Level 4	Level 5
Collects general medical and psychiatric history and completes a mental status examination	Efficiently acquires an accurate and relevant history and performs a targeted examination customized to the patient's presentation	Uses hypothesis-driven information gathering to obtain complete, accurate, and relevant history	Elicits and observes subtle and unusual findings	Serves as a role model for gathering subtle and accurate findings from the patient and collateral sources
Collects relevant information from collateral sources			Interprets collateral information and test results to determine necessary additional steps in the evaluation of complex conditions	
Screens for risk of harm to self, to others, or by others			Incorporates risk and protective factors into the assessment of complex patient presentations, including eliciting information not readily offered by the patient	
	Selects appropriate laboratory and diagnostic tests	Interprets collateral information and test results to determine necessary additional steps		Serves as a role model for risk assessment
	Engages in a basic risk assessment and basic safety planning	Incorporates risk and protective factors into the assessment of imminent, short, and long-term patient safety and the safety of others		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- Not yet assessable
- Not Yet Completed Level 1

Comment

1 Patient Care 2: Psychiatric Formulation and Differential Diagnosis

A: Organizes and summarizes findings and generates differential diagnosis

B: Identifies contributing factors and contextual features and creates a formulation

C: Uses the emotional responses of clinician and patient as diagnostic information

Level 1	Level 2	Level 3	Level 4	Level 5
Organizes and accurately summarizes information obtained from the patient evaluation to develop a clinical impression	Integrates information from the most relevant sources to develop a basic differential diagnosis for common patient presentations	Develops a thorough and prioritized differential diagnosis while avoiding premature closure for a range of patient presentations	Develops differential diagnoses in complex cases and incorporates subtle, unusual, or conflicting findings	Serves as a role model in the development of accurate and complete differential diagnoses and formulations
Recognizes that biological, psychosocial, and developmental/life cycle factors play a role in a patient's presentation	Identifies the biological, psychosocial, and developmental/life cycle factors that contribute to a patient's presentation	Synthesizes all information into a concise but comprehensive formulation, taking into account biological, psychosocial, and developmental/life cycle factors	Develops formulations based on multiple conceptual models	
Recognizes that clinicians have emotional responses to patients	Recognizes that clinicians' emotional responses have diagnostic value		Integrates clinician's and patient's emotional responses into the diagnosis and formulation	
		Begins to use the clinician's emotional responses to the patient to aid formulation		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not yet assessable

Not Yet Completed Level 1

Comment

2 Patient Care 3: Treatment Planning and Management

A: Creates treatment plan

B: Monitors and revises treatment when indicated

C: Incorporates the use of community resources

Level 1	Level 2	Level 3	Level 4	Level 5
Identifies potential biopsychosocial treatment options	Engages the patient in the selection of evidence-based biopsychosocial treatment, recognizing that comorbid conditions and side effects impact treatment	Applies an understanding of psychiatric, neurologic, and medical comorbidities in the management of common presentations	Devises individualized treatment plan for complex presentations; integrates multiple modalities and providers in a comprehensive approach	Supervises treatment planning of other learners and multidisciplinary providers
Recognizes that acuity affects level of care and treatment monitoring		Selects the most appropriate interventions, treatments, and adjustments in treatment in common presentations based on consideration of patient factors and acuity		
Gives examples of community resources	Selects the most appropriate level of care based on acuity and monitors treatment adherence and response	Selects the most appropriate interventions, treatments, and adjustments in treatment in common presentations based on consideration of patient factors and acuity	Selects the most appropriate interventions, treatments, and adjustments in treatment in complex presentations based on consideration of patient factors and acuity	Participates in the creation or administration of community-based programs
	Coordinates care with community resources		Locates and connects patients to community resources in complex and difficult situations	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Not yet assessable

1 Patient Care 4: Psychotherapy

A: Establishes therapeutic alliance and manages boundaries

B: Selects, sets goals, and provides psychotherapies including supportive, psychodynamic, and cognitive-behavioral

C: Manages therapeutic process

Level 1	Level 2	Level 3	Level 4	Level 5
Establishes a working relationship with patients demonstrating interest and empathy	Establishes a bounded therapeutic alliance with patients with uncomplicated problems	Establishes and maintains a therapeutic alliance with patients with uncomplicated problems, and can recognize and avoid boundary violations	Establishes and maintains therapeutic alliance with patients with complicated problems, and can anticipate and appropriately manage boundary violations	Assesses and can help repair troubled alliances and/or boundary difficulties between junior residents and their patients
Lists the three core psychotherapies	Uses the common factors of psychotherapy in providing supportive therapy to patients	Provides selected psychotherapies (including supportive, psychodynamic, and cognitive-behavioral), sets goals and integrates therapy with other treatment modalities	Selects appropriate psychotherapeutic modality based on case formulation, tailors the therapy to the patient, and provides psychotherapy (at least supportive and one of psychodynamic or cognitive-behavioral) to complex patients	Tailors psychotherapeutic treatment based on awareness of own skill sets, strengths, and limitations
Accurately identifies patient emotions, particularly sadness, anger, and fear	Identifies and reflects the core feelings and key issues for the patient during the session	Identifies and reflects the core feelings, key issues and what the issues mean to the patient during the session, while managing the emotional content and feelings elicited	Identifies and reflects the core feelings, key issues, and what the issues mean to the patient within and across sessions	Links feelings, recurrent/central themes/schemas and their meaning to the patient as they shift within and across sessions
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- Not yet assessable
- Not Yet Completed Level 1

MEDICAL KNOWLEDGE

Demonstrate knowledge about established and evolving biomedical, clinical, epidemiological and social-behavioral sciences and the application of this knowledge to patient care.

2 Medical Knowledge 2: Psychopathology (includes Knowledge of Diagnostic Criteria, Epidemiology, Pathophysiology, Course of Illness, Comorbidities, and Differential Diagnosis of Psychiatric Disorders, including Substance Use Disorders and Presentation of Psychiatric Disorders across the Life Cycle and in Diverse Patient Populations)

A: Knowledge to identify and treat psychiatric conditions

B: Knowledge at the interface of psychiatry and the rest of medicine

Level 1	Level 2	Level 3	Level 4	Level 5
Identifies the major psychiatric diagnostic categories	Demonstrates sufficient knowledge to identify and assess common psychiatric conditions	Demonstrates sufficient knowledge to identify and treat common psychiatric conditions throughout the life cycle	Demonstrates sufficient knowledge to identify and treat atypical and complex psychiatric conditions throughout the life cycle	Applies knowledge to identify and manage uncommon conditions at the interface of psychiatry and medicine
Gives examples of interactions between medical and psychiatric symptoms and disorders	Demonstrates sufficient knowledge to identify common medical conditions in psychiatric patients	Applies knowledge to identify and treat common psychiatric symptoms due to other medical illness	Applies knowledge to identify and treat a wide range of psychiatric conditions in patients with comorbid medical disorders and ensures treatment of medical conditions in psychiatric patients	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- Not yet assessable
- Not Yet Completed Level 1

Comment

1 Medical Knowledge 4: Psychotherapy

A: Fundamentals

B: Practice and indications

C: Evidence base

Level 1	Level 2	Level 3	Level 4	Level 5
Identifies psychotherapy as an effective modality of treatment	Describes the common elements across psychotherapeutic modalities	Identifies the central theoretical principles across the three core psychotherapeutic modalities: supportive, psychodynamic, cognitive-behavioral	Explains the theoretical mechanisms of therapeutic change in each of the three core modalities	Incorporates new theoretical developments into knowledge base
Describes the basic framework of a psychotherapeutic experience	Lists the basic indications and benefits of using psychotherapy	Identifies the techniques of the three core individual psychotherapies	Compares the selection criteria and potential risks, and benefits of the three core individual psychotherapies	Demonstrates sufficient evidence-based knowledge of core individual therapies to teach others
Lists the three core psychotherapy modalities	Describes the evidence for one core psychotherapy modality		Analyzes the evidence base for combining psychotherapy and pharmacotherapy	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- Not yet assessable
- Not Yet Completed Level 1

PRACTICE BASED LEARNING AND IMPROVEMENT

Ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve patient care practices based on self-evaluation and life-long learning

1 Practice-Based Learning and Improvement 1: Evidence-Based and Informed Practice

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates how to access and summarize available evidence for routine conditions	Articulates clinical questions and initiates literature searches to provide evidence-based care	Locates and applies the best available evidence to the care of patients applying a hierarchy of evidence	Critically appraises and applies evidence even in the face of uncertainty and conflicting evidence to guide care, tailored to the individual patient	Coaches others to critically appraise and apply evidence for complex patients; and/or participates in the development of guidelines
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- Not yet assessable
- Not Yet Completed Level 1

PROFESSIONALISM

Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

2 Professionalism 3: Well-Being

Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes the importance of addressing personal and professional well-being	Lists available resources for personal and professional well-being	With assistance, proposes a plan to promote personal and professional well-being	Independently develops a plan to promote personal and professional well-being	Creates institutional level interventions that promote colleagues' well-being
	Describes institutional resources designed to promote well-being	Recognizes which institutional factors affect well-being	Describes institutional factors that positively and/or negatively affect well-being	Describes institutional programs designed to examine systemic contributors to burnout
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- Not yet assessable
- Not Yet Completed Level 1

Comment

INTERPERSONAL AND COMMUNICATION SKILLS

Ability to demonstrate interpersonal and communication skills that result in effective information exchange, handoff to other professionals and collaborating with patients, their families, and professional associates.

1 Interpersonal and Communication Skills 1: Patient- and Family-Centered Communication

Level 1	Level 2	Level 3	Level 4	Level 5
Uses language and nonverbal communication to demonstrate empathic curiosity, respect, and to establish rapport	Establishes a therapeutic relationship in straightforward encounters using active listening and clear language	Establishes a therapeutic relationship in challenging patient encounters; uses nonverbal communication skills effectively	Effectively establishes and sustains therapeutic relationships, with attention to patient/family concerns and context, regardless of complexity	Mentors others in situational awareness and critical self-reflection to consistently develop positive therapeutic relationships
Identifies common barriers to effective communication; accurately communicates own role within the health care system	Identifies complex barriers to effective communication	When prompted, reflects on personal biases that may contribute to communication barriers	Independently recognizes personal biases and attempts to proactively minimize their contribution to communication barriers	Role models self-awareness practice while identifying and teaching a contextual approach to minimize communication barriers
	Organizes and initiates communication with patient/family by introducing stakeholders, setting the agenda, clarifying expectations, and verifying understanding of the clinical situation			
Recognizes communication strategies may need to be adjusted based on clinical context		With guidance, sensitively and compassionately delivers medical information, elicits patient/family values, goals and preferences; acknowledges uncertainty and conflict	Independently, uses shared decision making to align patient/family values, goals, and preferences with treatment options to make a personalized care plan	Role models shared decision making in patient/family communication including those with a high degree of uncertainty/conflict
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- Not yet assessable
- Not Yet Completed Level 1

Comment

GENERAL PROFESSIONALISM

10* Have you reviewed and co-signed the resident's patient treatment log for this rotation?

- Yes
- No
- N/A

11* Did the resident attend at least 70% of scheduled supervision sessions?

- Yes
- No
- N/A

12* Has this resident performed sufficiently to be given credit for this required experience?

- Yes
- No
- N/A

13* Please comment on resident professionalism during this experience (as applicable) with patients, families, staff, providers, etc.

14* Please comment on resident interpersonal and communication skills during this experience (as applicable) with patients, families, staff, providers, etc.

15* General Comments:

INSTRUCTIONS FOR ACCESSING NEW INNOVATIONS - our ON-LINE EVALUATION SYSTEM

FACULTY/ATTENDINGS

Evaluations are housed in New Innovations, an on-line software system that contains resident evaluations for faculty to complete. Faculty will receive notice via e-mail shortly before the end of the month (if the resident is on a two or three-month rotation you will receive the evaluation notice shortly before the end of the final month). The word Psychiatry will be on the subject line. You may Click on the link listed in the e-mail (please paste this e-mail address as a favorite so you may refer to it for future evaluations). This is a Web based product; you may access from home or anywhere in addition to the office. Website: www.new-innov.com.

New Innovations Log – In Procedures:

Access New innovations: www.new-innov.com (or click on the link in your e-mail notification)

- a) Enter the Institution Name: UACOMP (all caps)
- b) Enter your User Name: (your User Name is your first initial and last name NO spaces, i.e., jsmith)
- c) Enter your Password: (exactly the same as your login name)

(This password can be changed after you log in for the first time by simply clicking below your name on the upper right-hand side and selecting “Change Password”. *However, if you do change your password and then cannot remember what it is, the Residency Coordinator will need to reset the password to the default password.*

d) A “Welcome Page” will open on your computer with several panels. Check the “**Notifications**” panel and it will state that you have “x” number of evaluations to complete. You may click on that line and it will open up the evaluations page. You will see a picture of the resident you need to evaluate and below the picture, the name of the rotation. Click on the name of the rotation and it will open up the form for that specific resident. Once you have finished at the bottom of the page you will see a certification statement confirming your digital signature for this document. Please click to confirm your identity.

There will be 4 columns as below:

Submit Final

Save Draft

Save Draft and Print

Not Enough Time

If you have completed the evaluation please click on **Submit Final**. If you are unable to complete evaluation due to an interruption, click on **Save Draft**. You can log in later to complete at a later time. You can also print your draft by clicking on **Save Draft and Print**. **Not Enough Time** is reserved for those rotations that are extremely limited in time and should be used if you feel the resident has not met the attendance requirement for the rotation.

To Log out, simply click just below your Name on the Upper Right-Hand side and click on Logout.

If you have any questions, please call the Psychiatry Residency Coordinator at 602-521-3617.

RESIDENTS

It is your responsibility to review faculty evaluations in New Innovations and electronically sign upon reviewing. It is also your responsibility to complete Resident Evaluation of Faculty and Rotation. In addition, New Innovations will send out notifications to complete a survey on Didactic seminars. Residents will also log their work hours in New Innovations using the mobile app or by logging in to New Innovations online. Please do all possible to complete in a timely manner.

Resident Log In procedures are exactly the same as faculty log on.

University of Arizona College of Medicine Phoenix
Psychiatry Residency Training Program

SUPERVISION STATUS SUMMARY

Resident's Name: _____

PGY-1:

Evaluation for Indirect Supervision: Immediately Available **DATES PASSED**
Form A: Indirect, with Direct immediately available in-house _____

Evaluating Attending: _____

Form B: Indirect, with Direct available telephonically _____

Evaluating Attending: _____

Reviewed by Program Director: _____ **Date:** _____

PGY-2:

Evaluation for Supervisory Capability to other residents (form C) **DATE PASSED**
Form C: Supervisory Capability _____

Evaluating Attending: _____

Reviewed by Program Director: _____ **Date:** _____

PGY-3:

Evaluation for Supervisory Capability to other residents (Form C) **DATE PASSED**
(if not passed during PGY-2)

Form C: Supervisory Capability _____

Evaluating Attending: _____

Reviewed by Program Director: _____ **Date:** _____

**University of Arizona College of Medicine Phoenix
Psychiatry Residency Training Program**

**EVALUATION OF PGY-1 FOR INDIRECT SUPERVISION:
IMMEDIATELY AVAILABLE - Form A**

Resident's Name: _____ **PGY Level:** _____ **Date:** _____

Evaluator Name: _____ **Evaluator Status:** Faculty

Patient Encounter: Faculty, resident, patient face to face Faculty & patient face to face; resident remote

The A.C.G.M.E. has defined three levels of supervision for PGY-1 residents:

1. Direct Supervision: the supervising physician is physically present with the resident and patient. Expectedly PGY-1 residents will demonstrate this level of competency at onset of academic year.
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.** PGY-1 Resident expectedly will progress to this level of supervision early in academic year.
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. PGY-1 Resident will expectedly progress to this level of supervision before the end of the academic year.

Based on your direct observation of this PGY-1 resident, please indicate below whether or not he/she has demonstrated the following competencies (Y=yes, NY=not yet, but progressing as expected, N=no):

The ability and willingness to ask for help when needed	<input type="checkbox"/> Y	<input type="checkbox"/> NY	<input type="checkbox"/> N
Gathering an appropriate history	<input type="checkbox"/> Y	<input type="checkbox"/> NY	<input type="checkbox"/> N
Ability to perform an emergent psychiatric assessment	<input type="checkbox"/> Y	<input type="checkbox"/> NY	<input type="checkbox"/> N
Presenting patient findings and data accurately to a supervisor	<input type="checkbox"/> Y	<input type="checkbox"/> NY	<input type="checkbox"/> N
Verify patient name and introduce self to patient	<input type="checkbox"/> Y	<input type="checkbox"/> NY	<input type="checkbox"/> N

The most appropriate level of supervision for this PGY-1 resident is:

Direct (in person): Remediation Plans and Reassessment Date: _____

Indirect, with Direct immediately available (i.e. in-house supervision)

Evaluating Physician: _____ Date: _____

Resident: _____ Date: _____

Reviewed by Program Director: _____ Date: _____

**University of Arizona College of Medicine Phoenix
Psychiatry Residency Training Program**

***EVALUATION FOR INDIRECT SUPERVISION
WITH DIRECT SUPERVISION AVAILABLE - Form B**

Resident's Name: _____ PGY Level: _____ Date: _____

Evaluator Faculty Name: _____ Clinical Setting: _____

Day Night Weekend Number of different patients seen with the resident: _____

The A.C.G.M.E. has defined three levels of supervision for PGY-1 residents:

1. Direct Supervision: the supervising physician is physically present with the resident and patient. Expectedly PGY-1 residents will demonstrate this level of competency at onset of academic year.
2. Indirect Supervision with direct supervision immediately available: a supervising physician (e.g. faculty or supervising resident) is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. PGY-1 Resident expectedly will progress to this level of supervision early in academic year.
3. Indirect supervision with direct supervision available: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. PGY-1 Resident will expectedly progress to this level of supervision before the end of the academic year.

COMPETENCY	PERFORMANCE	COMMENTS & REMEDIATION PLANS
Medical Knowledge: 1. The resident recognizes clinical signs and symptoms which necessitate immediate action to protect patient and coworker safety. 2. The resident demonstrates knowledge of appropriate methods for managing patient agitation, violence and self-harm behaviors.	Met <input type="checkbox"/> Not Met <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/>	_____ _____ _____ _____
Patient Care: 1. The resident acts in a timely manner to effectively address clinical issues which may affect the safety of patients and coworkers, including seeking appropriate supervision. 2. The resident gathers a patient history adequate to guide appropriate diagnosis and treatment. 3. The resident adequately performs an emergent evaluation, including assessment of drug withdrawal, suicide, violence and homicide risk as appropriate.	Met <input type="checkbox"/> Not Met <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/>	_____ _____ _____ _____ _____
Interpersonal and Communication Skills: 1. The resident accurately presents patient findings and data to a supervisor who has not yet seen the patient.	Met <input type="checkbox"/> Not Met <input type="checkbox"/>	_____ _____
Professionalism: 1. The resident demonstrates an awareness of when to ask for assistance in the care of patients and demonstrates a willingness to do so when needed. 2. The resident is aware of supervisory lines and accesses them appropriately to obtain clinical supervision. 3. The resident practices within his or her scope of expertise.	Met <input type="checkbox"/> Not Met <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/>	_____ _____ _____ _____

***Determination for Indirect Supervision with Direct Supervision Available:** Must satisfactorily meet **ALL** competency requirements listed above to be certified to move from direct supervision to indirect supervision with direct supervision available (i.e. not on site immediately available but available for audio or visual supervision).

Evaluating Faculty: _____ Date: _____

Resident: _____ Date: _____

Reviewed by Program Director: _____ Date: _____

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

**EVALUATION FOR SUPERVISORY CAPABILITY TO OTHER RESIDENTS
Form C**

Resident's Name: _____ PGY Level: _____ Date: _____

COMPETENCY	PERFORMANCE	COMMENTS
Medical Knowledge: 1. The resident demonstrates level of medical and psychiatric knowledge sufficient to safely supervise fellow residents with less experience.	Met <input type="checkbox"/> *Not Met <input type="checkbox"/>	_____ _____ _____
Interpersonal and Communication Skills: 2. The resident demonstrates capability to provide accurate and helpful feedback to peers and to subordinates.	Met <input type="checkbox"/> *Not Met <input type="checkbox"/>	_____ _____ _____
Professionalism: 3. The resident supervises subordinates in a respectful and supportive manner. 4. The resident informs patients appropriately of his/her role in their care.	Met <input type="checkbox"/> *Not Met <input type="checkbox"/> Met <input type="checkbox"/> *Not Met <input type="checkbox"/>	_____ _____ _____

Determination for Supervisory Capability: Must meet ALL competency requirements listed above to be certified to supervise other residents.

*Remediation Plans and Reassessment Date: _____

Evaluating Attending or Resident: _____ Date: _____
Print Name Signature

Residents' Signature: _____ Date: _____

Reviewed by Program Director: _____ Date: _____

EVALUATION OF PATIENT CARE TRANSITION

Psychiatry Residency Program
Banner – University Medical Center Phoenix
Evaluation of Patient Care Transition

Transferring Physician: _____ Setting: _____
Date/Time of handoff: _____

1. Outgoing physician clearly identified patient by two identifiers (e.g. name, MRN, age, gender)	Yes	No		NOTES:
2. Working problems were included with severity level for each (mild, mod, severe)	Yes	No		
3. Evolving issues and anticipated problems were identified along with suggested methods to address each where appropriate (e.g., evolving medical problem, request for premature discharge, etc)	Yes	No	N/A	
4. Pending tests/tasks/consults were discussed	Yes	No	N/A	
5. Family contacts were discussed	Yes	No	N/A	
6. Covering attending identified	Yes	No		
7. Feedback to transferring physician:				

Systems-Based Practice 2: System Navigation for Patient-Centered Care

A: Coordinates patient care

B: Safely transitions care

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of care coordination	Coordinates care of patients in routine clinical situations effectively using the roles of the interprofessional teams	Coordinates care of patients in complex clinical situations effectively using the roles of their interprofessional teams	Role models effective coordination of patient-centered care among different disciplines and specialties	Analyzes the process of care coordination and leads in the design and implementation of improvements
Identifies key elements for safe and effective transitions of care and hand-offs	Performs safe and effective transitions of care/hand-offs in routine clinical situations	Performs safe and effective transitions of care/hand-offs in complex clinical	Role models and serves as a patient advocate for safe and effective transitions of care/hand-	Improves quality of transitions of care within and across health care delivery systems to
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Interpersonal and Communication Skills 2: Interprofessional and Team Communication

Level 1	Level 2	Level 3	Level 4	Level 5
Uses language that values all members of the health care team	Communicates information effectively with all health care team members	Uses active listening to adapt communication style to fit team needs	Coordinates recommendations from different members of the health care team to optimize patient care	Role models flexible communication strategies that value input from all health care team members, resolving conflict when needed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments: Not Yet Completed Level 1 <input type="checkbox"/>				

Evaluating Faculty: _____ Signature: _____ Date _____

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

TRANSITION OF CARE SELF ASSESSMENT

Please complete and review with your Primary supervisor or inpatient attending. Remember to sign and then return to Program Director when complete. Choose the bullet that best describes your performance.

	Falls below expectations	Approaches	Meets expectations
Take handoff seriously	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arrives on time for handoff meeting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keep check out sheet up to date	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Includes anticipatory guidance on check out sheet "If ... then..."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When passing on critical information I repeat myself and request read back	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I use the read back technique when receiving important information	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Resident (Print): _____ Level of Training: _____

Resident (Signature): _____ Date: _____

Supervisor (Print): _____ Setting: _____

Supervisor (Signature): _____ Date: _____

Program Director (Signature): _____ Date: _____

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

SEMI-ANNUAL GENERAL COMPETENCIES RESIDENT SELF-ASSESSMENT

Name: _____ Date: _____

Indicate the level of confidence you have in the following areas of patient care.	Not Confident		Reasonably Confident		Extremely Confident
1. Communicate effectively and demonstrate caring respectful behaviors when interacting with patients and their families	1	2	3	4	5
2. Gather essential and accurate information about your patients	1	2	3	4	5
3. Make informed decisions about diagnostic & therapeutic interventions based upon patient information and preferences, up to date scientific evidence and clinical judgment	1	2	3	4	5
4. Develop, carry out and modify management plans	1	2	3	4	5
5. Counsel and educate patients and their families	1	2	3	4	5
6. Use information technology to support patient care decisions and patient education	1	2	3	4	5
7. Perform competently all medical and psychiatric procedures considered essential for your area of practice	1	2	3	4	5
8. Provide health care services aimed at preventing health problems or maintaining health	1	2	3	4	5
9. Work with health care Professionals including those from other disciplines to provide patient focused care	1	2	3	4	5
Indicate the level of confidence you have in the following areas of medical knowledge.	Not Confident		Reasonably Confident		Extremely Confident
10. Demonstrate investigative & analytic approaches to clinical situations	1	2	3	4	5
11. Know and apply basic and clinical services appropriate to your discipline	1	2	3	4	5
Indicate the level of confidence you have in the following areas of practice based learning and improvement.	Not Confident		Reasonably Confident		Extremely Confident
12. Analyze your clinical practice to identify important learning needs and construct goals/plans for improvement	1	2	3	4	5
13. Locate, appraise, and assimilate evidence from scientific studies related to your patients' health problems	1	2	3	4	5
14. Obtain information about your own population of patients and the larger population from which your patients are drawn	1	2	3	4	5
15. Critically appraise the literature on diagnosis, prognosis, therapy, and harm	1	2	3	4	5
16. Use information technology to manage information, access on-line medical information and support your learning needs	1	2	3	4	5
17. Effectively teach students and other health care Professionals	1	2	3	4	5
Indicate the level of confidence you have in the following areas of interpersonal and communication skills.	Not Confident		Reasonably Confident		Extremely Confident
18. Create and sustain therapeutic, ethically sound relationships with your patients, maintaining appropriate boundaries	1	2	3	4	5
19. Use effective listening skills	1	2	3	4	5
20. Elicit and provide information using effective verbal and nonverbal communications skills	1	2	3	4	5
21. Use effective writing skills	1	2	3	4	5
22. Work effectively with others as a member or leader of a health care team or other professional group	1	2	3	4	5

PLEASE COMPLETE SIDE 2

Indicate the level of confidence you have in the following areas of Professionalism.	Not Confident		Reasonably Confident		Extremely Confident
1. Demonstrate respect, compassion, integrity; responsiveness to needs of patients and society that supercedes self-interest; accountability to patients, society and profession; commitment to excellence and on-going professional development	1	2	3	4	5
2. Demonstrate an understanding and commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent and business practices	1	2	3	4	5
3. Demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities	1	2	3	4	5
Indicate the level of confidence you have in the following areas of systems based practice.	Not Confident		Reasonably Confident		Extremely Confident
4. Understand how your patient care and other professional practices affect other health care Professionals, our health system, and the larger society, and how these elements of the system affect your own practice	1	2	3	4	5
5. Know how types of medical practice and delivery systems differ from one another including methods of controlling health care costs and allocating resources	1	2	3	4	5
6. Practice cost-effective health care and resource utilization that does not compromise quality of care	1	2	3	4	5
7. Advocate for quality patient care and assist patients in dealing with system complexities	1	2	3	4	5
8. Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance	1	2	3	4	5

Resident Signature

Date

Program Director

Date

Side 2

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

**ACGME General Competency:
Interpersonal & Communication Skills: Resident Self-Assessment**

Resident Name: _____ **Date:** _____

Level (circle one): **PGY-1** **PGY-2** **PGY-3** **PGY-4**

For each item, circle the number that corresponds with how characteristic the behavior is of you.

INTERPERSONAL AND COMMUNICATION SKILLS		Highly Characteristic		Not at all Characteristic			Don't Know
1.	Communicates clearly	5	4	3	2	1	DK
2.	Is willing to answer questions and provide explanations	5	4	3	2	1	DK
3.	Seeks to understand others' views	5	4	3	2	1	DK
4.	Treats others with respect (e.g. does not demean, insult, or make others feel inferior)	5	4	3	2	1	DK
5.	Provides equitable care, regardless patients'/decedents' SES, ethnicity or gender	5	4	3	2	1	DK
6.	Assists or fills-in for others when needed	5	4	3	2	1	DK
7.	Negotiates and compromises when disagreements occur	5	4	3	2	1	DK
8.	Tends to have disagreeable interactions with co-workers and support staff	5	4	3	2	1	DK
9.	Accepts responsibility (i.e. does not blame others or the system)	5	4	3	2	1	DK
10.	Misrepresents or falsifies actions and/or information	5	4	3	2	1	DK
11.	Maintains comprehensive, legible and timely records	5	4	3	2	1	DK
12.	Completes tasks and fulfills responsibilities	5	4	3	2	1	DK
13.	Responds promptly when on call or when paged	5	4	3	2	1	DK
14.	"Hands-off" between shifts appropriately for continuity of care	5	4	3	2	1	DK
15.	Responds poorly to feedback or suggestions from others	5	4	3	2	1	DK

Resident: _____ **Date:** _____

Program Director: _____ **Date:** _____

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

**ACGME General Competency: Interpersonal & Communication Skills
360° Evaluation of Resident Performance
For Peers, Attending, Co-Workers (Nursing, Social Work)**

Resident Name: _____ **Date:** _____

Level (circle one): PGY-1 PGY-2 PGY-3 PGY-4 **Rotation:** _____

Rater (circle one): **Attending** **Nursing** **Social Work**

For each item, circle the number that corresponds with how characteristic the behavior is of the resident you are evaluating.

INTERPERSONAL AND COMMUNICATION SKILLS		Highly Characteristic		Not at all Characteristic			Don't Know
1.	Communicates clearly	5	4	3	2	1	DK
2.	Is willing to answer questions and provide explanations	5	4	3	2	1	DK
3.	Seeks to understand others' views	5	4	3	2	1	DK
4.	Treats others with respect (e.g. does not demean, insult, or make others feel inferior)	5	4	3	2	1	DK
5.	Provides equitable care, regardless of patients'/decedents' SES, ethnicity or gender	5	4	3	2	1	DK
6.	Assists or fills-in for others when needed	5	4	3	2	1	DK
7.	Negotiates and compromises when disagreements occur	5	4	3	2	1	DK
8.	Tends to have disagreeable interactions with co-workers and support staff	5	4	3	2	1	DK
9.	Accepts responsibility (i.e. does not blame others or the system)	5	4	3	2	1	DK
10.	Misrepresents or falsifies actions and/or information	5	4	3	2	1	DK
11.	Maintains comprehensive, legible and timely records	5	4	3	2	1	DK
12.	Completes tasks and fulfills responsibilities	5	4	3	2	1	DK
13.	Responds promptly when on call or when paged	5	4	3	2	1	DK
14.	"Hands-off" between shifts appropriately for continuity of care	5	4	3	2	1	DK
15.	Responds poorly to feedback or suggestions from others	5	4	3	2	1	DK

Rater: _____ **Date:** _____

Resident: _____ **Date:** _____

Program Director: _____ **Date:** _____

**University of Arizona College of Medicine – Phoenix
Psychiatry Residency Training Program**

**ACGME General Competency:
Practice Based Learning and Improvement: Self-Assessment
Part I: Analyze and Improve Own Practice**

Resident Name: _____ **Date:** _____
Level (circle one): **PGY-1** **PGY-2** **PGY-3** **PGY-4** **Rotation:** _____

• **For PGY-1 and PGY-2 Residents**

PRACTICE BASED LEARNING AND IMPROVEMENT (<i>Residents ability to apply daily clinical practice to own learning and development</i>)					
	Makes same mistakes again and again. Oblivious of context. No appreciation of ethnic or cultural variations.	Needs frequent prompting to adjust. Slow to learn from previous mistakes. Minimal appreciation of ethnic or cultural variations.	Improves and adds to own development by learning from day to day clinical practice. Adapts to cultural backgrounds and work situations without undue assumptions.	⊕ Learns quickly from practice. Anticipates and adapts to different cultural backgrounds and work situations. Assimilates and applies relevant literature.	⊕⊕ Excellent learning from practice. Rapidly acquires, assimilates and applies relevant literature. Recognizes and utilizes strengths and weaknesses of systems.
	○	○	○	○	○

• **For PGY-3 and PGY-4 Residents**

PRACTICE BASED LEARNING AND IMPROVEMENT (<i>Residents ability to apply daily clinical practice to own learning and development</i>)					
	Unable to incorporate his or her own experience. Limited to or no ability to use rounds or patient care as learning experiences.	Struggles to benefit from ward teaching. Erratic response to feedback from faculty and ancillary personnel.	Uses clinical examples to learn treatment planning, differential diagnoses, and follow-up. Steadily adds individual patient data to fund of knowledge.	⊕ Formulate treatment in response to expanded awareness of his or her experience. Uses rating scales and objective measures of efficacy.	⊕⊕ Consistently and accurately utilizes clinical experience to improve patient care. Readily gathers and applies current literature to his or her own patients.
	○	○	○	○	○

Comments and/or examples of Practice Based Learning & Improvement: _____

Resident: _____ **Date:** _____

Program Director: _____ **Date:** _____

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

**ACGME General Competency:
Practice Based Learning and Improvement: Attending Feedback
Part I: Analyze and Improve Own Practice**

Resident Name: _____ **Date:** _____
Level (circle one): **PGY-1** **PGY-2** **PGY-3** **PGY-4** **Rotation:** _____
Rater: **Attending** _____

• **For PGY-1 and PGY-2 Residents**

<u>PRACTICE BASED LEARNING AND IMPROVEMENT</u> (<i>Residents ability to apply daily clinical practice to own learning and development</i>)					
	Makes same mistakes again and again. Oblivious of context. No appreciation of ethnic or cultural variations.	Needs frequent prompting to adjust. Slow to learn from previous mistakes. Minimal appreciation of ethnic or cultural variations.	Improves and adds to own development by learning from day to day clinical practice. Adapts to cultural backgrounds and work situations without undue assumptions.	⊕ Learns quickly from practice. Anticipates and adapts to different cultural backgrounds and work situations. Assimilates and applies relevant literature.	⊕⊕ Excellent learning from practice. Rapidly acquires, assimilates and applies relevant literature. Recognizes and utilizes strengths and weaknesses of systems.
	○	○	○	○	○

• **For PGY-3 and PGY-4 Residents**

<u>PRACTICE BASED LEARNING AND IMPROVEMENT</u> (<i>Residents ability to apply daily clinical practice to own learning and development</i>)					
	Unable to incorporate his or her own experience. Limited to or no ability to use rounds or patient care as learning experiences.	Struggles to benefit from ward teaching. Erratic response to feedback from faculty and ancillary personnel.	Uses clinical examples to learn treatment planning, differential diagnoses, and follow-up. Steadily adds individual patient data to fund of knowledge.	⊕ Formulate treatment in response to expanded awareness of his or her experience. Uses rating scales and objective measures of efficacy.	⊕⊕ Consistently and accurately utilizes clinical experience to improve patient care. Readily gathers and applies current literature to his or her own patients.
	○	○	○	○	○

Comments and/or examples of Practice Based Learning & Improvement: _____

Resident: _____ **Date:** _____

Program Director: _____ **Date:** _____

**ACGME General Competency:
 Practice Based Learning and Improvement
 Part II: Use of Research Evidence & Application of Research & Statistical Methods
 *Self-Assessment***

Resident Name: _____ Date: _____

EVIDENCE BASED MEDICINE

Indicate the level of confidence you have in formulating answerable clinical questions.	Not Confident		Reasonably Confident		Extremely Confident
1. I am regularly curious about clinical problems in many of my clinical settings and identify foreground questions	1	2	3	4	5
Indicate the level of confidence you have in finding the best available evidence.	Not Confident		Reasonably Confident		Extremely Confident
2. I regularly perform electronic searches to answer my questions	1	2	3	4	5
3. I have become efficient in my searching	1	2	3	4	5
4. I know the best sources for current evidence to answer my questions. I am becoming comfortable using a widening array of sources	1	2	3	4	5
5. I am skillful at using MeSH headings, limiters, thesaurus, EBM filters, and shortcuts when searching MEDLINE	1	2	3	4	5
6. My searches compare favorably with those performed by research librarians or respected colleagues	1	2	3	4	5
7. Effectively teach students and other health care Professionals searching skills	1	2	3	4	5
Indicate the level of confidence you have in critically appraising the literature.	Not Confident		Reasonably Confident		Extremely Confident
8. I have a good understanding of basic statistical concepts, clinical epidemiology, and study design/methodology	1	2	3	4	5
9. I am comfortable applying critical appraisal guides to my evaluation of an article	1	2	3	4	5
10. I am becoming more accurate and efficient in understanding and calculating some critical appraisal measures, such as NNT's and likelihood ratios	1	2	3	4	5
Indicate the level of confidence you have in applying the best evidence to your patient.	Not Confident		Reasonably Confident		Extremely Confident
11. I change my patient care practices based on best available evidence, my patients' preferences and my clinical judgment	1	2	3	4	5
12. I am able to justify whether or not to apply critically appraised findings to an individual patient	1	2	3	4	5
Indicate the level of confidence you have in teaching EBM	Not Confident		Reasonably Confident		Extremely Confident
13. I regularly assist others in the EBM process by teaching and modeling how to ask answerable questions, how to search the literature, critically appraise articles, write CATs, and apply the findings	1	2	3	4	5
Indicate the level of confidence you have in pursuing continued development in learning and teaching EBM	Not Confident		Reasonably Confident		Extremely Confident
14. I regularly seek out EBM supervision and learning opportunities to improve my skills	1	2	3	4	5
15. I regularly identify my learning needs in EBM skill development and set personal goals and plans to achieve further competence	1	2	3	4	5

Resident: _____ Date: _____

Program Director: _____ Date: _____

**ACGME General Competency:
 Practice Based Learning and Improvement/ Interpersonal and Communication Skills
 Part III: Facilitate Learning of Others
 *Medical Student Evaluation of Resident Teaching***

Resident: _____ **Setting:** Inpatient C/L Outpatient Lecturer (circle one)

Evaluator level of training (please circle): MS3 MS4

During this rotation, my teacher (resident) generally.....

	Strongly Disagree			Strongly Agree			N/A
	1	2	3	4	5	0	
1. Establishes a good learning environment	1	2	3	4	5	0	
2. Allows me autonomy appropriate to my level/experience/competence	1	2	3	4	5	0	
3. Organizes time to allow for both teaching and caregiving	1	2	3	4	5	0	
4. Offers regular feedback (both positive and negative)	1	2	3	4	5	0	
5. Clearly specifies what I am expected to know and do during this training period	1	2	3	4	5	0	
6. Adjust teaching to my needs (experience, competence, interest)	1	2	3	4	5	0	
7. Asks questions that promote learning (clarifications, probes, Socratic questions, reflective questions, etc.)	1	2	3	4	5	0	
8. Gives clear explanations/reasons for opinions, advice, etc.	1	2	3	4	5	0	
9. Coaches me on my clinical skills (interview, diagnostic, procedural, etc.)	1	2	3	4	5	0	
10. Incorporates research data and/or practice guidelines into teaching	1	2	3	4	5	0	
11. Teaches diagnostic skills (clinical reasoning, selection or interpretation of tests, etc.)	1	2	3	4	5	0	
12. Teaches effective patient and/or family communication skills	1	2	3	4	5	0	
13. Teaches principles of cost-appropriate care	1	2	3	4	5	0	
14. Presented well organized material in lecture	1	2	3	4	5	0	
15. Used Blackboard, PowerPoint or other visual aids effectively	1	2	3	4	5	0	

Resident: _____ **Date:** _____

Program Director: _____ **Date:** _____

**University of Arizona College of Medicine
Psychiatry Residency Training Program**

ACGME GENERAL COMPETENCIES PROFESSIONALISM: SELF-ASSESSMENT

Resident Name: _____

Requisite Skills of professionalism: Residents must demonstrate a commitment to carrying out Professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

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

MANAGEMENT OF CLINICAL RESPONSIBILITY	Inappropriate, antagonistic attitude. Late to clinical responsibilities with no regard to inconveniences of others. Unprepared. Often absent or unreachable.	Usually present, but frequently disinterested. Rarely adequately prepared. Cannot keep up with clinical data. Difficult to track down.	Adequately prepared and organized for clinical and educational activities. Delegates appropriately. Solid attendance and availability.	Ably manages all patient responsibilities and educational experiences. Adept at managing many complicated patients. Impeccable attendance.	Superbly organized clinician with exceptional attitude and unusual ability to coordinate care for many complex patients while participating fully in educational requirements of residency training
○	○	○	○	○	○
DOCUMENTATION	Inaccurate. Major omissions. Disorganized. No appreciation of the legal risks inherent in charting.	Unfocused notes with many omissions or marked over-inclusion. Many late and/or untimed entries.	Complete documentation that includes all basic information and satisfies legal expectations.	Well organized and thorough. Precise charting that reflects appreciation for the medical record as a part of the patient's care.	Concise without losing completeness. Always timely. Able to use the medical record as an important tool in both patient care and medicolegal affairs.
○	○	○	○	○	○
TEACHING	Never teaches. Often ignores the students or only expects them to provide service.	Rarely teaches and ineffective when the attempt is made. No active organization of educational endeavors.	Solid clinical teacher who adds didactic sessions to the student's and lower level resident's workday.	Above average bedside teacher who conveys difficult aspects of psychiatric knowledge to learners of all levels.	Exceptional and enthusiastic teacher. Systematically covers many areas of psychiatry for all the members of the team. Regularly arranges educational experiences
○	○	○	○	○	○
ETHICAL DECISION MAKING & CULTURAL SENSITIVITY	Does not accept moral standards for decision making. Prejudiced. Dishonest. Attempts to cover up errors.	Irregularly applies moral standards. Not always impartial. May try and minimize or camouflage mistakes and shortcomings.	Applies moral standards to personal and clinical decisions that are relevant to the role of resident. Admits errors. Aware of cultural differences	Ethical and reasoned decision-making process. Acknowledges equality of all people.	Exceptional decision-maker who respects human dignity without bias. Utilizes cultural differences to maximize care delivery.
○	○	○	○	○	○
PERSONAL QUALITIES	Unreliable and unfocused. No initiative. Inflexible. Takes credit without shouldering blame. Unprofessional in dress and demeanor.	Inefficient. Requires frequent input to motivate. Poorly responsive to feedback. Occasionally inappropriately dressed. Overestimates his/her ability.	Effective and reliable. Flexible person who implements feedback effectively. Appropriately seeks help. Professional appearance and demeanor.	Eager learner who is efficient, conscientious, and helpful. Seeks feedback. Accepts the inevitability of errors.	Highly motivated and exceptionally productive. Always helpful. Appropriately seeks new responsibility. Accentuates the abilities of the rest of the team. Shares success and credit readily.
○	○	○	○	○	○
ADMINISTRATIVE SKILLS	Unable to supervise or inappropriately supervises. Cannot make decisions. Fails to accomplish paperwork and reports.	Marginally effective at supervision. Inconsistent appreciation for necessary documentation standards and paperwork.	Able to coordinate and supervise team. Good planner. Effective at ensuring that necessary documentation is complete and timely	Easily adapts to the administrative and supervisory role. Independently coordinates team function.	Exemplary organizer, supervisor and leader. Fosters excellence within the team and encourages compliance with documentation and Required paperwork.
○	○	○	○	○	○

Primary Supervisor Review: _____

Date: _____

Was this evaluation reviewed with the resident? Yes No

Remedial plans discussed with resident? No Yes; Discuss plan: _____

Supervisor Signature: _____

Date _____

Resident Signature: _____

Date _____

Director of Residency Training: _____

Date _____

ACGME GENERAL COMPETENCIES PROFESSIONALISM: Faculty Feedback

Resident Name: _____ Evaluator's Name: _____

Method of Evaluation: Clinical Teaching Performance Feedback Clinical Experiences

Requisite Skills of Professionalism: Residents must demonstrate a commitment to carrying out Professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

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

MANAGEMENT OF CLINICAL RESPONSIBILITY	Inappropriate, antagonistic attitude. Late to clinical responsibilities with no regard to inconveniences of others. Unprepared. Often absent or unreachable.	Usually present, but frequently disinterested. Rarely adequately prepared. Cannot keep up with clinical data. Difficult to track down.	Adequately prepared and organized for clinical and educational activities. Delegates appropriately. Solid attendance and availability.	Ably manages all patient responsibilities and educational experiences. Adept at managing many complicated patients. Impeccable attendance.	Superbly organized clinician with exceptional attitude and unusual ability to coordinate care for many complex patients while participating fully in educational requirements of residency training
	○	○	○	○	○
DOCUMENTATION	Inaccurate. Major omissions. Disorganized. No appreciation of the legal risks inherent in charting.	Unfocused notes with many omissions or marked over-inclusion. Many late and/or untimed entries.	Complete documentation that includes all basic information and satisfies legal expectations.	Well organized and thorough. Precise charting that reflects appreciation for the medical record as a part of the patient's care.	Concise without losing completeness. Always timely. Able to use the medical record as an important tool in both patient care and medicolegal affairs.
	○	○	○	○	○
TEACHING	Never teaches. Often ignores the students or only expects them to provide service.	Rarely teaches and ineffective when the attempt is made. No active organization of educational endeavors.	Solid clinical teacher who adds didactic sessions to the student's and lower level resident's workday.	Above average bedside teacher who conveys difficult aspects of psychiatric knowledge to learners of all levels.	Exceptional and enthusiastic teacher. Systematically covers many areas of psychiatry for all the members of the team. Regularly arranges educational experiences
	○	○	○	○	○
ETHICAL DECISION MAKING & CULTURAL SENSITIVITY	Does not accept moral standards for decision making. Prejudiced. Dishonest. Attempts to cover up errors.	Irregularly applies moral standards. Not always impartial. May try and minimize or camouflage mistakes and short-comings.	Applies moral standards to personal and clinical decisions that are relevant to the role of resident. Admits errors. Aware of cultural differences	Ethical and reasoned decision-making process. Acknowledges equality of all people.	Exceptional decision-maker who respects human dignity without bias. Utilizes cultural differences to maximize care delivery.
	○	○	○	○	○
PERSONAL QUALITIES	Unreliable and unfocused. No initiative. Inflexible. Takes credit without shouldering blame. Unprofessional in dress and demeanor.	Inefficient. Requires frequent input to motivate. Poorly responsive to feedback. Occasionally inappropriately dressed. Overestimates his/her ability.	Effective and reliable. Flexible person who implements feedback effectively. Appropriately seeks help. Professional appearance and demeanor.	Eager learner who is efficient, conscientious, and helpful. Seeks feedback. Accepts the inevitability of errors.	Highly motivated and exceptionally productive. Always helpful. Appropriately seeks new responsibility. Accentuates the abilities of the rest of the team. Shares success and credit readily.
	○	○	○	○	○
ADMINISTRATIVE SKILLS	Unable to supervise or inappropriately supervises. Cannot make decisions. Fails to accomplish paperwork and reports.	Marginally effective at supervision. Inconsistent appreciation for necessary documentation standards and paperwork.	Able to coordinate and supervise team. Good planner. Effective at ensuring that necessary documentation is complete and timely	Easily adapts to the administrative and supervisory role. Independently coordinates team function.	Exemplary organizer, supervisor and leader. Fosters excellence within the team and encourages compliance with documentation and Required paperwork.
	○	○	○	○	○

Other comments: _____

Was this evaluation reviewed with the resident? Yes No

Remedial plans discussed with Resident? No Yes; Discuss plan: _____

Evaluator's Signature: _____ Date _____

Resident's Signature: _____ Date _____

Director of Residency Training _____ Date _____



**University of Arizona College of Medicine-Phoenix
Psychiatry Residency Training Program
Medical Knowledge Competency Improvement Plans**

Resident's Name: _____ **Level:** _____

PRITE Psychiatry areas of strength: _____

PRITE Psychiatry areas for improvement: (Choose at least 2)

- _____ **Development & Maturation**
- _____ **Behavioral & Social Sciences**
- _____ **Epidemiology**
- _____ **Diagnostic Procedures**
- _____ **Psychopathology & Associated Conditions**
- _____ **Treatments**
- _____ **Consultation/Collaborative Integrated Care**
- _____ **Issues in Practice**
- _____ **Research & Scholarship Literacy**
- _____ **Administration & Systems**

Study Plans: Please outline your self-study plan and/or consider these options if desired:

- Review missed PRITE questions and look up correct answers in PRITE references**
- Utilize Question banks for review (note source) _____**
- Review board review course materials (note source) _____**
- Read chapters in a standard, comprehensive psychiatry textbook (such as Kaplan and Sadock, Textbook of Psychiatry) (note source) _____**
- Optional: if you want to review Neurology in addition to at least 2 Psychiatry areas review Kaufman's Clinical Neurology for Psychiatrists and do practice questions**
- Other (be specific): _____**

Re-assessment Strategies (be specific) _____

Resident's signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

Program Director signature: _____ Date: _____

Andrea Waxman, M.D.

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

**ACGME General Competency:
Systems-Based Practice
Discussion Topics**

Resident: _____ PGY1 PGY 2 PGY3 PGY4

Faculty Discussant: _____

Case Review

Patient Initials: _____ Date : _____

Inpatient Outpatient Consultation-Liaison

Topics to Review (SBP2):

1. Understanding Resources, Providers, and Systems

- Can the resident identify the patient's resources to pay for health care? (i.e.: private pay, sliding scale, HMO, Medicare, AHCCCS)
Never Sometimes Always
- Can the resident identify other providers involved in the patient's care?
Never Sometimes Always
- Does the resident understand the capacities and limitations of these other providers?
Never Sometimes Always
- Does the resident actively involve other providers in the patient's care?
Never Sometimes Always
- Does the resident appropriately collaborate with and use consultants?
Never Sometimes Always
- Does the resident know how to obtain authorization for services for the patient?
Never Sometimes Always

2. Cost-Appropriate Care

- Is the resident aware of the cost of the treatment plan to the patient?
Never Sometimes Always
- Is the resident aware of how to obtain authorization if a medication is not covered?
Never Sometimes Always
- Does the resident know how to obtain authorization for additional services or a higher level of service?
Never Sometimes Always

PSYCHIATRY CLINICAL SKILLS EVALUATION FORM (CSV v.2)

Psychiatry Clinical Skills Evaluation Form (CSV v.2)

Resident Name Resident Signature

Level of Training PG Date

Examiner Name Examiner Signature

Patient Type

Physician-Patient Relationship (overall)	<input type="checkbox"/> Unacceptable	<input type="checkbox"/> Acceptable
Develops rapport with patient	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Responds appropriately to patient	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Follows cues presented by patient	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Psychiatric Interview (overall) Length of interview = _____	<input type="checkbox"/> Unacceptable	<input type="checkbox"/> Acceptable
Obtains sufficient data for DSM differential diagnosis	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Obtains psychiatric, medical, family, and social histories	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Obtains cultural, racial, and ethnic histories	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Obtains gender identity and sexual histories	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Screens for suicidal and homicidal ideation	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Uses open- and close-ended questions	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Performs an adequate mental status examination	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Case Presentation (overall)	<input type="checkbox"/> Unacceptable	<input type="checkbox"/> Acceptable
Organized and accurate presentation of history	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8
Organized and accurate presentation of mental status findings	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8

- 1-2 Very Unacceptable: Gross deficiencies or Gross mismanagement
- 3-4 Unacceptable: Several important deficiencies or Unsatisfactory manner (disorganized)
- 5-6 Acceptable: Several relatively minor inefficiencies or errors or Adequate
- 7-8 Very Acceptable: No significant criticisms or Reflects the most current techniques and procedures

Comments:

November 2020

American Board of Psychiatry and Neurology, Inc. ~ www.abpn.com ~ Phone: 847.229.6500 ~ Fax: 847.229.6600 ~ Email: questions@abpn.com

Psychiatry Residency Program
Guidelines for Observed Clinical Interview

Resident Name: _____

Rotation: _____

	Adequately Performed		Comments/Documenting Statement
	YES	NO	
DOCTOR-PATIENT RELATIONSHIP			
Rapport/Alliance			
Introduces self to patient			
Puts patient at ease			
Asks if patient understands/explains purpose of interview			
Responds to appropriately to patient's feelings			
Eliciting Data			
Moves from open-ended to specific			
Follows patient's lead/cues to explore important issues and feelings			
Makes interview a positive experience for patient			
DOCTOR-PATIENT RELATIONSHIP OVERALL COMPETENCY			

	Adequately Performed		Adequately Documented		Comments/Documenting Statement
	YES	NO	YES	NO	
CONDUCT OF THE INTERVIEW					
Presenting symptoms					
Past psychiatric history					
Treatment history (hospitalization, medication, psychotherapy, somatic therapies)					
Family psychiatric history					
Substance abuse history					
Legal history					
Risk (suicide/homicide)					
Mental Status Examination					
Appearance					
Behavior/Demeanor					
Attention/Concentration					
Affect/Mood					
Speech					
Thought content					
Thought process					
Cognitive (intellectual, counting/calculating, abstract thinking, judgment/insight)					
Past Medical & Surgical History					
CONDUCT OF THE INTERVIEW OVERALL COMPETENCY					

	Adequately Performed		Comments/Documenting Statement
	YES	NO	
CASE PRESENTATION			
Presents data in organized manner			
Interprets data meaningfully			
CASE PRESENTATION OVERALL COMPETENCY			
DIFFERENTIAL DIAGNOSIS & FORMULATION			
Differential Diagnosis			
Moves from general to specific			
Considers most likely diagnostic categories			
Considers using ancillary procedures for appropriate reasons (lab tests, other procedures)			
Justifies and/or rules out diagnoses with available data			
Reaches reasonable provisional diagnosis			
Formulation			
Comments appropriately on biological, developmental, psychological, sociocultural factors			
DIFFERENTIAL DIAGNOSIS & FORMULATION OVERALL COMPETENCY			
TREATMENT & DISPOSITION			

SUMMARY IMPRESSION: ADEQUATE INTERVIEW AND DISCUSSION _____ INADEQUATE INTERVIEW AND DISCUSSION _____

ATTENDING NAME: _____ SIGNATURE: _____

DATE: _____ RESIDENT SIGNATURE: _____

**University of Arizona College of Medicine - Phoenix
 Psychiatry Residency Training Program
 Evaluation for Competency in Combined Psychopharmacology and Psychotherapy**

Resident: _____

PGY- _____

Evaluator: _____

Setting: _____

Dates of Evaluation: _____

Skills	Not Apparent*	Emerging+	Apparent•
Ability to integrate biological and psychological aspects of a patient's history			
Ability to provide psychoeducation about psychiatric illness and commonly prescribed psychotropic medications			
Ability to understand how the meaning of a medication to a patient can impact its efficacy; learn to explore what medications mean to a patient			
Ability to demonstrate a basic understanding of diagnosis-specific psychotherapy and medication management			
Ability to recognize and manage transference and countertransference in prescribing medications			
Recognize how medication can positively or negatively effect psychotherapy and how psychotherapy can positively or negatively effect medication management			
Identify psychological aspects of noncompliance			

+Emerging implies the skill is coming to fruition but not fully evident.

•Apparent implies the skill is evident.

For a trainee to receive credit for this Psychotherapy Competency the majority of the skills must be Apparent (evident) and the remainder Emerging.

Received credit: Yes No*

*Remedial Plans: _____

General Comments: _____

Methods of Evaluation:

_____ Direct Observation

_____ Videotapes

_____ Audiotapes

_____ Case Presentation

_____ Written Report

_____ Other: _____

Signed:

Resident: _____

Date: _____

Supervisor: _____

Date: _____

Program Director: _____

Date: _____

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

Evaluation for Competency in Psychodynamic Psychotherapy

Resident: _____

PGY- _____

Evaluator: _____

Setting: _____

Dates of Evaluation: _____

Skills	Not Apparent*	Emerging+	Apparent•
Initiating Treatment			
Ability to identify and effectively begin treatment with an appropriate patient for an exploratory psychodynamically oriented psychotherapy			
Ability to recognize resistances to treatment and address them interpretively			
Ability to establish and maintain a treatment frame (e.g., frequency and length of sessions, dealing with patient's family and other agencies, etc.) appropriate to an exploratory psychodynamically oriented psychotherapy			
Treatment			
Ability to establish a therapeutic alliance			
Ability to facilitate the patient's expression of affective material, to enable the patient to talk freely and openly			
Ability to empathize with the patient's affective states and to convey an empathic understanding			
Ability to listen uncritically and with openness			
Ability to tolerate affective expressions, including hostility, sexuality, affection, etc.			
Ability to identify and respond appropriately and flexibly to a variety of defenses in the clinical setting			
Ability to frame interpretations that aid patient in recognizing defense operations			
Ability to effectively confront, clarify and interpret previously preconscious and unconscious material in the therapeutic setting			
Ability to distinguish between a supportive and an interpretive intervention			
Ability to frame an interpretation linking the patient's present experience, history, and transference			
Ability to assess the patient's response to an interpretation including identifying confirmatory responses and manifestations of resistance to insight			
Ability to work with manifest dream material in an interpretive manner			
Ability to integrate medication with psychotherapy			

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

Evaluation for Competency in Psychodynamic Psychotherapy

Resident: _____

Skills	Not Apparent*	Emerging+	Apparent•
<u>Transference</u>			
Ability to recognize transference implications in the patient's material in sessions with the patient			
Ability to help patient become aware of transference when appropriate			
Ability to link transference to past and current relationships in sessions with the patient			
<u>Countertransference</u>			
Ability to recognize countertransference reactions to the patient			
Ability to work with negative and positive countertransference reactions to the patient			
<u>Supervision</u>			
Ability to present a psychodynamic formulation based on the perspectives of drive/ego, object relations, and self-psychologies			
Ability to form an educational alliance with the supervisor			
Ability to present a dynamically oriented summary of a session with a patient in psychodynamic psychotherapy			
Ability to recognize parallel process in supervision			
Ability to utilize insights from supervision with the patient			
<u>Termination</u>			
Ability to assess patient's readiness for termination			
Ability to assess patient's gain in psychotherapy			
Ability to work through termination issues with the patient			

+Emerging implies the skill is coming to fruition but not fully evident.

•Apparent implies the skill is evident.

For a trainee to receive credit for this Psychotherapy Competency the majority of the skills must be Apparent (evident) and the remainder Emerging.

Received credit: Yes No*

*Remedial Plans: _____

General Comments: _____

Methods of Evaluation:

_____ Direct Observation _____ Case Presentation
 _____ Videotapes _____ Written Report
 _____ Audiotapes _____ Other: _____

Signed:

Resident: _____ Date: _____

Supervisor: _____ Date: _____

Program Director: _____ Date: _____

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

Evaluation for Competency in Cognitive-Behavioral Therapy

Resident: _____

PGY- _____

Evaluator: _____

Setting: _____

Dates of Evaluation: _____

Skills	Not Apparent*	Emerging+	Apparent•
Ability to conceptualize a variety of problems from a cognitive-behavioral framework			
Ability to socialize patient into cognitive model			
Ability to pace and effectively structure time within the therapy session			
Ability to demonstrate an understanding of, form and foster a collaborative therapeutic relationship			
Ability to use Socratic questioning and guided discovery in a therapeutic manner			
Ability to identify and focus on key cognitions and behavior			
Ability to construct and assign appropriate homework and address issues of homework non-compliance			
Ability to develop and implement a specific, focused treatment plan within the cognitive-behavioral model			
Ability to design and implement appropriate behavioral experiments			
Ability to develop and implement a plan for maintenance of therapeutic gains			

YES	NO	
		Treated a panic disorder patient with cognitive-behavioral therapy
		Treated an OCD patient with cognitive-behavioral therapy
		Treated a patient with major depressive disorder with cognitive-behavioral therapy

+Emerging implies the skill is coming to fruition but not fully evident.

•Apparent implies the skill is evident.

For a trainee to receive credit for this Psychotherapy Competency the majority of the skills must be Apparent (evident) and the remainder Emerging.

Received credit: Yes No*

*Remedial Plans: _____

General Comments: _____

Methods of Evaluation:

_____ Direct Observation

_____ Videotapes

_____ Audiotapes

_____ Case Presentation

_____ Written Report

_____ Other: _____

Signed:

Resident: _____

Date: _____

Supervisor: _____

Date: _____

Program Director: _____

Date: _____

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

Evaluation for Competency in Brief Therapy

Resident: _____ PGY- _____

Evaluator: _____

Setting: _____ Dates of Evaluation: _____

Skills	Not Apparent*	Emerging+	Apparent•
Resident will be able to select suitable patients for the particular appropriate model chosen for brief therapy			
Resident will demonstrate understanding of indications and contraindications for brief therapy			
Resident will be able to develop a formulation using the brief therapy model selected			
Resident will be able to educate the patient about the goals, objectives and time frame of brief therapy (specify: Psychodynamic, IPT, etc.)			
Resident will be able to establish and maintain a therapeutic alliance			
Resident will be able to establish and adhere to a time limit			
Resident will be able to establish and adhere to a focus			
Resident will be able to utilize at least one well-defined model of brief therapy			
Resident will be able to recognize and identify affects in the patient and himself/herself			
Resident will demonstrate understanding of the use of brief therapy in the overall treatment needs of the patient			
Resident will demonstrate understanding that continued education in brief therapy is necessary for further skill development			

+Emerging implies the skill is coming to fruition but not fully evident.

•Apparent implies the skill is evident.

For a trainee to receive credit for this Psychotherapy Competency the majority of the skills must be Apparent (evident) and the remainder Emerging.

Received credit: Yes No*

*Remedial Plans: _____

General Comments: _____

Methods of Evaluation:

_____ Direct Observation _____ Case Presentation
 _____ Videotapes _____ Written Report
 _____ Audiotapes _____ Other: _____

Signed:

Resident: _____ Date: _____

Supervisor: _____ Date: _____

Program Director: _____ Date: _____



**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program**

**ECT and other Neuromodulation Techniques Education Module Checklist
2021-2022**

Resident Name _____

Experience

✓ = Completed

1. Attended Core I Lecture (PGY1-2)

2. Completed recommended reading (PGY1-2)

3. Evaluated pre-ECT patient

4. Participated in Sim Center experience (if in-person experience not available)

5. Observed ECT procedure

6. Completed ECT Quiz

Score _____

7. TMS at VAMC (PGY3)

8. Completed APA TMS online module (PGY3)

9. VNS (if available)

10. Other (specify)

WORK DUTY HOURS

Dear UA COM-P House Staff,

Thank you for your commitment to patient care, curiosity, and serving the community here at BUMCP and at our other participating sites. Your health and well-being are important to us and are necessary for you to provide the highest quality of patient care and excel within your training program.

Starting February 1, 2020, a standardized duty hour process will be implemented for all programs. The standardization of the program's tracking and monitoring of clinical and education hours allows the Graduate Medical Education Committee greater opportunity to provide oversight on our duty hour compliance and allows earlier interventions when needed.

What this means for you:

1. Beginning on February 1st, you will log duty hours for every rotation for every program (including those that are non-ACGME accredited).
2. Log duty hours as close to the shift as possible providing the most accurate information. Your programs will be following up to make sure that you log in a timely fashion (at least within 2 weeks of the shift).
3. The duty types have been simplified to have a narrower set of options to choose from within New Innovations. The chart below indicates the available duty types and their definitions.

Duty Types	General Description of Trainees' Work
Call	Only used if trainees in your program are scheduled for in-house calls. The ACGME identifies an In House Call as: Duty hours beyond the normal workday when residents are required to be immediately available in the assigned institution
Called in from Home	Applies if your trainees are scheduled for Pager Call (a.k.a. Home Call). Used for hours that a resident/fellow are actually called into the hospital
Day Off	Used for time away
Moonlighting	Applies for your residents/fellows to log their Moonlighting hours
Shift	Used to log scheduled work time/hours
Patient Care from Home	Trainees are allowed to do work-related tasks at home, such as paperwork or taking work-related calls

4. Download the New innovations app (available on iOS) to make it easier to log your hours. (attached is the New Innovations Mobile App PDF file providing additional information).
5. As you learn about the new duty types and logging expectations, your program will reach out if there are items to clarify. This is only to confirm that the data is accurate as we get used to the new logging process.

We understand how hard you work. The duty hour limits are set by ACGME and based on a systematic review of literature focus on patient safety, resident well-being, and education. We are committed to providing the best environment for your education and patient care and appreciate your commitment to providing us feedback so that we can continue improving.

Thank you,

Cheryl W. O'Malley, MD, FACP, FHM
Associate Dean, Graduate Medical Education
Associate Professor, Department of Medicine
University of Arizona College of Medicine-Phoenix

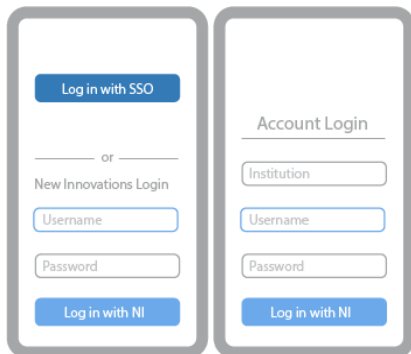
App Updates

Depending on your phone settings, you may need to manually update New Innovations. If it seems like you're missing any features, check for an update.



Logging In

1. Tap the button to log in.
2. You'll see one of two login screens depending on whether your institution uses SSO (single sign-on).



If you see the first screen:

3. Your institution uses SSO. An SSO login button displays above a New Innovations login option. The SSO button says "log in with [your institution name]"
4. Tap the top (SSO) button if you have an SSO account with your institution. Log in on the portal that appears.
5. If you yourself don't use SSO, use the New Innovations login below instead. You will probably use the New Innovations login option if you don't use SSO to log into any other accounts.

If you see the second screen:

3. Your institution doesn't use SSO. You'll see your institution name and fields to enter your New Innovations username and password.
4. Enter your New Innovations username and password.
5. Tap "Log In."

Logging in next time

You'll stay logged in to New Innovations until either of these happens:

- You're inactive for 30 days
- We update the app

Using the App



Work Hours

You can complete some Work Hour tasks in the mobile app and others through a browser only.

Tasks	On the App	On the Web
Add today's work hours	✓	✓
Add work hours from 13 or fewer days ago	✓	✓
Add work hours 14+ days ago	X	✓
Add future work hours	X	✓
Add notes/comments	X	✓
Approve work hours	✓	✓
View violations	✓	✓
Mark as "did not work" if you missed scheduled hours	✓	✓

What are the dots?

- Log violation notices are red
- Logs-awaiting-approval notices are yellow

What if I can't edit a log?

You can't edit logs if they are locked (by a finance application) or already signed off

LOGGING CLINICAL and EDUCATION WORK HOURS IN NEW INNOVATIONS

Duty Hours - Log

Enter Duty Hour Logs Online

When residents log in to New Innovations, they will see a duty hours panel on their Home Page. This panel displays information about hours they have logged for the last four weeks. It also provides them with a link, Log My Hours, to take them right to the logging page.

Week	Hours	V/L	Calls
Jul 10 - Jul 16	72.0	0	1
Jul 17 - Jul 23	72.0	0	1
Jul 24 - Jul 30	72.0	0	1
Jul 31 - Aug 03	No Hours	0.0	0

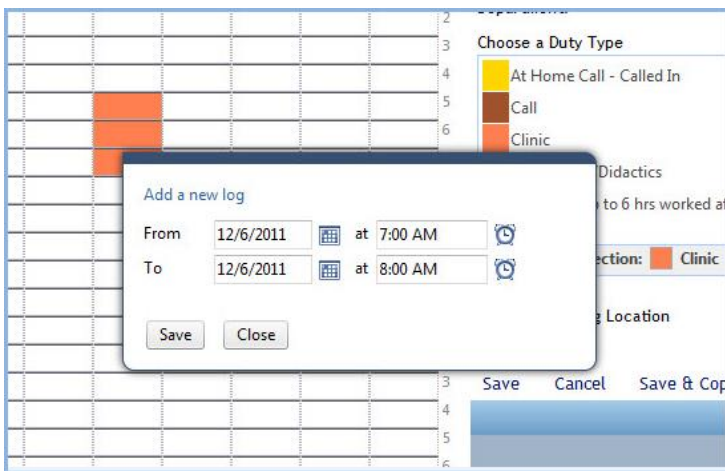
9 day(s) off

Rotation Information [Log My Hours >](#)

AN:ANESTHESIA-EM (Anesthesiology) 7/1/2011 - 7/31/2011
JAS:SURG:TRAUMA-GH (JAS Surgery) 8/1/2011 - 8/31/2011

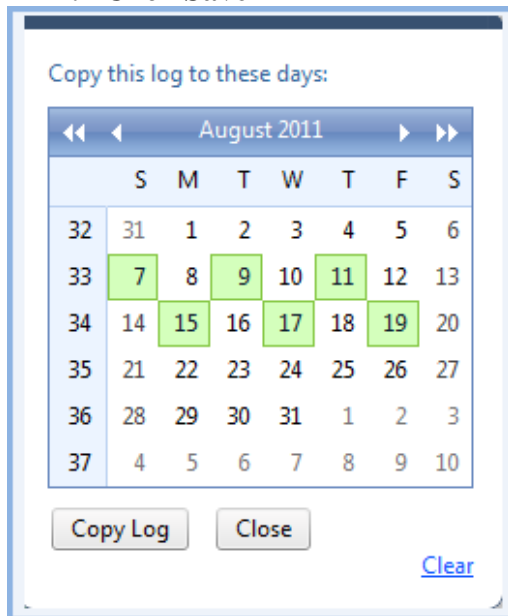
Hours can also be logged by going into the Duty Hours module:

1. Go to *Duty Hours > Log Hours*
2. Click the Duty Type or Assignment Definition from the list on the right side of the page
3. Log Hours:
 - Click and drag the cursor over the cells that represent the time worked
 - Right + Click the cells on a day you want to log hours for and Set the Exact Date and Time
4. Click Save



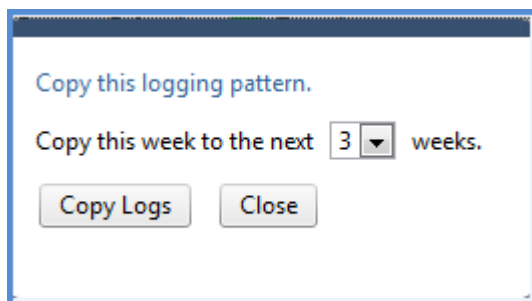
Copy a Log to Multiple Days

1. **Right+Click** the log you want to copy
2. **Select Copy Log**
3. **Click the days you want to copy the log to**
4. **Click Save**



Copy a Week of Duty Hour Logs to Other Weeks

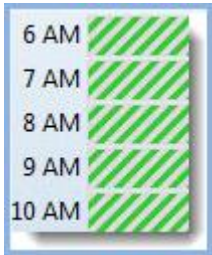
1. **Log a week of duty hours**
2. **Click Save & Copy**
3. **Select the number of weeks forward you want to copy this week to**
4. **Click Copy Logs**



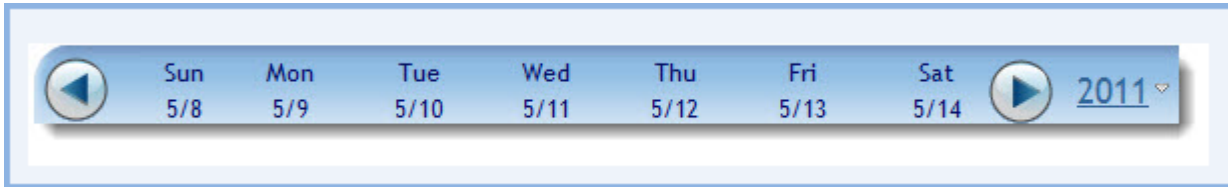
- **To erase an entry, click any active cell to delete the entry.**
- **To apply an entry to multiple dates, right-click it and select the appropriate days on the calendar.**

Navigation and Preferences

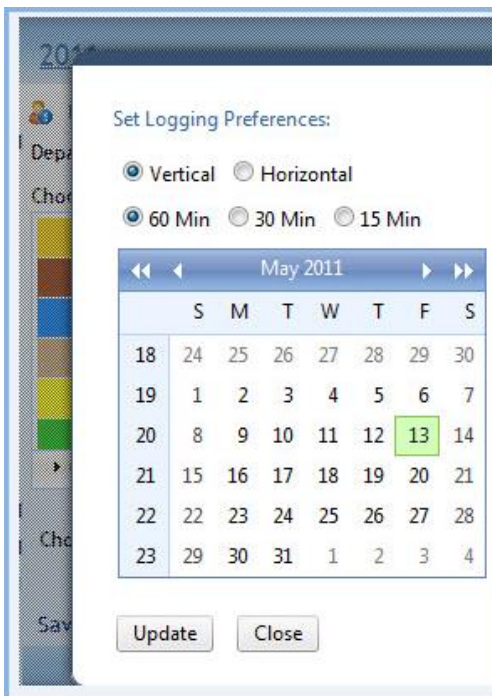
Previously saved logs are indicated with a hatch pattern and can be edited by right-clicking any cell that is part of the entry.



Click the navigation arrows in the corner of the timeline to advance to the next week or return to the prior week.



Click the year or Preferences to set logging preferences and use a calendar to navigate to a different date.



Resident's Monthly Evaluation of Clinical & Didactics Experience

SAMPLE: Evaluation of Rotation by a Resident



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by:

Evaluator Name

Status
Employer
Program

UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE - PHOENIX PSYCHIATRY RESIDENCY PROGRAM

Evaluation of Rotation by a Resident

Instructions:

Before you begin this evaluation, review the scale below, noting that Strongly Disagree begins the scale rating. Please rate questions 1 - 9 using the scale; comments are optional. Questions 10 - 12 are free text and comments are required to submit this evaluation. Feel comfortable in giving honest, meaningful feedback as your answers and comments will remain completely anonymous.

1 The Rotation achieved the intended outcome of learning skills, based on the rotation objectives.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

2 The Rotation achieved the intended outcome of knowledge, based on the rotation objectives.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

3 The expectations of this Rotation were clear.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

4 The expectations of this Rotation were achievable.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

5 The Rotation was efficient.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

6 The Rotation was organized.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

7 The criteria for evaluation was clearly stated.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

8 The overall quality of interactions with the Staff on this rotation was a positive experience.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

9 I feel competent in this clinical area after completing this rotation.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment

10* What advice would you give yourself if you had to go back and repeat this rotation?

11* If I could change something about this rotation it would be:

12* WELLNESS: HOW HAVE YOU ADDRESSED YOUR PERSONAL WELLNESS IN THE PAST MONTH?

Overall Comment

SAMPLE EVALUATION: Evaluation of Supervisor by Residents



Subject Name

Status
Employer
Program
Rotation
Evaluation Dates

Evaluated by:

Evaluator Name

Status
Employer
Program

UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE - PHOENIX PSYCHIATRY RESIDENCY PROGRAM

EVALUATION OF SUPERVISOR BY RESIDENTS

Instructions:

Please rate questions 1 - 7 using the scale; comments are optional. Questions 6 and 7 are free text and comments are required to submit this evaluation. Feel comfortable in giving honest, meaningful feedback as your answers and comments will remain completely anonymous.

N/A=Unable To Assess

1 Teaching Skills

Excellent	Very Good	Fair	Improvement Needed	N/A
-----------	-----------	------	--------------------	-----

Comment

2 Availability and Accessibility for Supervision

Excellent	Very Good	Fair	Improvement Needed	N/A
-----------	-----------	------	--------------------	-----

Comment

3 Knowledge Base

Excellent	Very Good	Fair	Improvement Needed	N/A
-----------	-----------	------	--------------------	-----

Comment

4 Motivation/Interest in Teaching

Excellent	Very Good	Fair	Improvement Needed	N/A
-----------	-----------	------	--------------------	-----

Comment

5 Feedback (timely and constructive)

Excellent	Very Good	Fair	Improvement Needed	N/A
-----------	-----------	------	--------------------	-----

Comment

6* Please share comments about the strengths of this faculty member:

7* Please share comments about possible areas of improvement for this faculty member:

Resident's Monthly Evaluation of Didactics Experience

SAMPLE: Evaluation of Seminars by a Resident

Conference Survey Designer

Seminar Evaluation AY2019-2020

Conference: {Conference Name}

Conference Date/Time: {Date/Time}

Evaluator: {Evaluator's Name}

Enter Survey Instructions here

The speaker facilitated relevant discussion about the topic.

Strongly Disagree Disagree Neutral Agree Strongly Agree

The speaker maintained professional behavior.

Strongly Disagree Disagree Neutral Agree Strongly Agree

The speaker provided information in a clear and understandable manner.

Strongly Disagree Disagree Neutral Agree Strongly Agree


The speaker paced session to support effective learning for time allotted.

Strongly Disagree Disagree Neutral Agree Strongly Agree

The speaker provided supportive learning environment that encourages discussion and questions.

Strongly Disagree Disagree Neutral Agree Strongly Agree

Please provide comments regarding this lecture using the W3 model. (W1: What worked well? W2: What did not work well? W3: What would you like to see in the future?)

 Add Question

Save

Cancel

CLINICAL SERVICE:

- AIP
- ASU EAO
- Chemical Dependency
- Child-Adolescent
- Community Psychiatry
- Geriatric Psychiatry-BAI and VAMC
- Forensic/Correctional LBJ
- Neurology
- OP-B-UMCP
- OP-VAMC
- Consult-Liaison

TREATMENT LOGS

2021-2022

- Emergency Psychiatry (On-Call, UPC)
- Elective (Specify) _____

RESIDENT'S NAME: (PRINT)

Required to Submit TREATMENT LOGS but not required to fill out**

- Emergency Medicine
- Pediatrics
- Internal Medicine (GM)
- VAM

**Mark above appropriate rotation; draw a diagonal line in the body of the log below; signature required

SIGNATURE: _____

PGY: _____

MONTH/YEAR: _____

PLEASE CLEARLY CIRCLE THE DATE OF 1st VISIT FOR EACH PATIENT SEEN OVER ONE YEAR. -----



PT INITIALS	AGE	SEX	ETHNICITY	SETTING	DIAGNOSES	TREATMENTS (Medications and Psychotherapies)	FREQUENCY (daily, weekly, etc.)	DATE OF 1 ST VISIT M/D/Y	TERMINATION M/D/Y

Psychotherapy: Supportive Combined Dynamic CBT Brief Other _____
 Supervising Faculty: _____ Service: _____ Date: _____

**University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program
ELECTIVE REQUEST FORM**

This form MUST be reviewed with the Program Director *before* submitted to the Education Policy Committee (EPC) for approval.
***Please submit this completed form to the BUMCP-BHC Practice Manager at least 3 months prior to the start of the elective so the necessary administrative paperwork can be processed.**
Previous Electives (Name and Dates): _____

Resident's Name: _____ Level of Training: _____

Elective Supervisor: _____ Phone: _____

Name of Elective: _____

Location: _____

Address: _____

Contact Name and Phone: _____

Contact E-mail Address: _____

Time Period: From: _____ To: _____

Days of week: _____ Hours/week: _____

Expected Ongoing Outpatient Hours/Week: _____

Educational Goals and Objectives (to be developed and approved by Elective Supervisor; please be specific):

Identified elective specific Milestone subcompetencies to be evaluated (please list): _____

If this is a research elective, what are your plans to develop a publishable paper or present your research as a poster at a regional or national meeting? _____

Other pertinent information: _____

Approvals:

Elective Faculty Supervisor: _____ Date: _____

*Practice Manager Approval: _____ Date: _____

(regarding letters of agreements, contracts, ongoing outpatient hours, etc.)

Residency Program Director: _____

Approved by Education Policy Committee: _____ Date: _____



Banner
University Medical Center
Phoenix

VACATION/TIME OFF

To request paid time off (PTO), please click on the link below and complete the form in formsite:

<https://fs4.formsite.com/c5mM4D/6zpvn8yhmj/index.html>

Per policy, residents are entitled to 20 PTO days and 6 Banner Holidays.

Reminder: If a rotation requires clinical coverage during a holiday, the resident must work on the holiday. When PGY2 - PGY4 residents are assigned to Psychiatry and are working on a Banner holiday, the resident gets a holiday adjustment day. Since the resident does not get the holiday off, this leaves an unused PTO day that can be allocated, if scheduling permits, to another day during the same month. This form must also be used to request the holiday adjustment. Residents who are on call the night prior to a holiday and are able to leave shortly after sign-out are considered to have the holiday off, and do not receive an additional PTO day as they are not technically working the holiday.

You will be notified and your time off will be placed on your outlook calendar if your request was approved.

MOONLIGHTING REQUEST

The decision regarding whether or not residents are permitted to "moonlight" is left up to the discretion of the Program Director. The general institutional and ACGME policies imply that at no time should "moonlighting" interfere with the resident's performance of his or her scheduled duties. This applies to either regular rotations or electives. "Moonlighting" should not interfere with the educational requirements of his or her particular residency or fellowship which often extend beyond the regularly scheduled hours of hospital or clinic duty. Expectedly, a resident's "moonlighting" activities will not be beyond his or her level of competence and occur in a setting with adequate supervision. Private practice settings are not acceptable "moonlighting" activities. Moonlighting residents must have passed the Step III licensing exam. If, at any time, in the judgment of the Program Director, the resident's "moonlighting" activities are considered inappropriate or the resident's performance, milestone assessments, concerns about physical or mental fatigue, undue stress, required work hours, expected caseloads (including outpatient) or educational achievements are compromised by "moonlighting", or unsatisfactory independent of "moonlighting" activities, he or she will be asked to either curtail or discontinue these outside activities. Poor performance on the PRITE or other standardized examinations will warrant remedial studying and preclude permission to moonlight. A resident's expected housestaff responsibilities plus "moonlighting" activities must be consistent with the A.C.G.M.E. Resident Work Duty Hours guidelines which must not exceed eighty hours per week when averaged over a particular month. To ensure compliance with these guidelines any employment outside the Residency Program must be explicitly approved in writing by the Program Director and the Chief Academic Officer of B-UMCP. The moonlighting resident will be expected to submit monthly work logs documenting adherence to the 80-hour rule. The approved written statement of permission will be included in the resident's file. The request to "moonlight" form is included in this manual. Any approved "moonlighting" activities must be periodically reviewed by the Program Director no less than semi-annually. Failure to follow these guidelines may constitute grounds for the resident's dismissal from the program.

- 1.) I have read the "Moonlighting Policy" for the Psychiatry Residency Program and agree to fully follow its stipulations including providing a monthly log of all work hours.
- 2.) I have a medical license independent of my residency license to engage in the above activity.
- 3.) I have a DEA number separate from the Medical Center's DEA number if writing prescriptions for controlled substances is expected of me.
- 4.) Proposed employment outside of the Residency Program includes (be specific): _____

- 5.) I authorize Dr. Waxman or designee to contact the responsible physician where I plan to moonlight.
His/her name is: _____ and phone number _____
Program Director comments: _____
- 6.) Expected hours per week (*No later than 8:00 a.m. and no earlier than 5 p.m. M-F*): _____
- 7.) Professional liability coverage will be provided by: _____
- 8.) My employment outside the Residency Program will not depend on the Medical Center's secretarial, hospital operators or other support staff.
- 9.) My outpatient hours are at the expected levels for my level of training and my case logs, medical records, compliance training, and competency worksheets are up to date and will remain so while moonlighting.

Resident's name: _____ Level of training: _____

Date: _____

Date: _____

Program Director (Signature implies above reviewed with resident and approval)

ADULT INPATIENT PSYCHIATRY

ADMISSION HISTORY AND EXAMINATION OUTLINE (completed within **12 hours**) - please use pre-printed form or format listed below (if dictated or written must include all elements below; if dictated a brief hand written note must be placed on the chart pending dictation arrival)**

Identifying Data (Age, sex, marital status, legal status, etc.)

Informants/Sources of Information

Chief Complaint

History of Present Illness (include time or age of onset; duration and course)

Psychiatric Review of Symptoms

Psychiatric Hospitalizations

Medication Trials/Response

History of Suicide Attempts (particular attention to the last 6 months)

History of Harming Self or Others (ask about behavior on an inpatient psychiatric unit)

History of Violence

Prior Court Ordered Treatment

History of Abuse/Trauma

Substance Abuse (include legal and illicit)

Family History

Medical

Psychiatric: including History of Suicide in any Family Member; Psychiatric Diagnosis and Psychiatric Treatment

Past Medical History

PCP Phone Number and Address; Illnesses; Surgeries; Head Trauma; Current Medications; Allergies; LMP (if applicable)

Social History

Birth and Development

Family Issues/Marriage/Children

Education

Military History

Occupation

Current Living Situation

Current Social Supports

Cultural/Ethnic/Spiritual Practices

Sexuality

Leisure Activities

Employment

Legal History

Inventory of Patient's Strengths (greater than 2 strengths)

Review of Systems (evaluate all 14)

Physical Examination including Neurological Examination

Mental Status Examination (include general fund of knowledge; highlight judgment and insight) with Mini-Mental Status Exam and AIMS scores

Formulation

Assessment (DSM-5)

List first admit Psychiatric diagnosis then medical

Risk Assessment/Prognosis

Initial Treatment Plan

Notation that you have evaluated patient's danger to self and others

Recommended Level of Precautions

Interventions (problem based)

Discharge Goals

Documentation of Informed Consent for Treatment Obtained

Resident's Name

Attending's Name who staffed with

****If a medical student completes an admission H&P or daily progress note, the resident must not only review and co-sign the student's notes but also see the patient, complete and document his/her own comprehensive examination, findings, impressions and treatment plans.**

PSYCHIATRIC DISCHARGE SUMMARY

The following format must be dictated at time of discharge:

- I. Identifying information, admission date and discharge date; also include name of referring clinic or psychiatrist, and his/her address and telephone number.
- II. Admit Diagnosis and Discharge Diagnosis.
- III. Chief complaint, brief clinical history, a brief narrative of the events leading up to this hospitalization, pertinent positive mental status and physical findings. Include sufficient data to support your discharge diagnosis. Also include a justification of the patient's admission (e.g., dangerousness to self or others, need for intensive inpatient therapy, etc.).
- IV. Significant laboratory, x-ray and other studies including pertinent consultation findings.
- V. Course in hospital, including specific treatment goals, interventions and achievement or lack of such and obstacles in the course of treatment. If special procedures were carried out, such as ECT, make a brief statement to justify these. List any complications (e.g. diabetic coma, suicide attempt in hospital, transfer to ICU, etc.) and indicate measures taken to manage these complications. Include a chronological review of the treatment offered, the patient's response or lack of response to that treatment.
- VI. Risk Assessment/Prognosis. Each patient at discharge should be formally assessed and the assessment documented as to risk for harm to self (or others if appropriate). Generally, patient is discharged only if risk for self-harm (or harm to others) is assessed as low due to ameliorating factors during the hospitalization, availability of follow-up, etc. Every discharge summary must include a section "Suicide Risk Assessment" specifically addressing the patient's risk of suicide at discharge.
- VII. Final diagnosis. Use D.S.M. 5 terminology. Include any other relevant diagnoses, either physical or psychiatric. Be certain that sufficient history and mental status material are included in the discharge summary to justify the diagnosis. Be specific - do not use single terms such as "Schizophrenia", "Depression" or "NOS" (not otherwise specified) diagnoses, unless no other diagnosis is appropriate.
- VIII. Condition on discharge and disposition: (improved, minimal improvement, guarded, unimproved, etc.); treatment completed on discharge or ongoing treatment referred to alternative provider in outpatient or transitional setting; include discharge medications and recommendation for future treatment needs if any; final disposition (home, nursing home, State Hospital, etc.), follow-up plans (e.g. place and date of appointments and follow-up physician if known); and prognosis. Include a description of what discharge information has been communicated to the next receiving provider or level of care (e.g. discharge medication, treatment recommendations).
- VIII. Resident Physician's Name
Attending Physician's Name

CONSULTATION-LIAISON PSYCHIATRY

Guidelines for Creating an Initial Consult Note & Follow-up Note

Initial consult must include:

- Date & Time seen
- Type of consult: (*Initial Psychiatric Consultation*)
- Requesting Physician
- Reason for consult
- History of Present Illness
 - Pertinent History
 - Psychiatric ROS if indicated
 - Collateral Information
- Past Psychiatric History
 - Pertinent history/dx, medications, history of suicide attempts, violence, substance abuse
- Review of Systems
- Past Medical History
- Social History
 - Tobacco Use and Substance Use
 - Living arrangements/support system/Employment
- Family History
 - Pertinent family psychiatric history
- Allergies
- Medications
- Vital Signs
- Mental Status Exam
 - Must be **complete exam**
 - Scan in MMSE if completed
- Lab Results (if pertinent)
- Interpretation of Results (if pertinent)
- Assessment
 - Risk Assessment
 - Diagnosis (*create a problem list that prioritizes diagnoses and include medical problems and psychosocial issues as indicated*)
- Plan
 - List problems and recommendations
 - Indicate if signing off or following patient
 - Indicate amount of time spent
 - Indicate which attending staffed case

Follow-up Psychiatry Consultation must include:

- Date & Time
- Type of Consult: (follow-up psychiatric consult)
- Requesting Physician
- Reason for initial consult or for follow-up
- History of Present Illness: note interval history since last note
- Vital Signs
- Mental Status Exam
 - Must be **complete exam**
 - Scan in MMSE if completed
- Lab Results (if pertinent to follow-up, results that were pending)
 - Diagnosis - (*create a problem list that prioritizes diagnoses and include medical problems and psychosocial issues as indicated*)
- Plan
 - List problems and recommendations
 - Indicate if signing off or following patient
 - Indicate amount of time spent
 - Indicate which attending staffed case

OUTPATIENT PSYCHIATRY

INITIAL ASSESSMENT AND PROGRESS NOTE OUTLINE: (completed within **24 hours** after service is provided) – please use templates in Electronic Medical Record. Notes must include all elements below. Additional training on the use of **Ambulatory EHR** takes place at the start of PGY-2.

INITIAL ASSESSMENT

Date
Identifying Data (*Age, sex, marital status, etc.*)
Visit Type
Session start and stop time (*only on psychotherapy notes*)
Chief Compliant
History of Present Illness
****Allergies**
Review of Systems
Past Psychiatric History
Medical History (*including medications*)
Family Psychiatric History
Family Medical History
Social History (e.g. ****tobacco** and alcohol use)
****Chronic Problem List** (*include medical problems*)
Mental Status Examination (*all 15 elements*)
****Medication List** (*Active and inactive, compliance as prescribed, medication response*)
Documentation of therapeutic intervention (*medication management, type of psychotherapy, e.g. insight, supportive, cognitive-behavioral, etc.*)
Impression (*1, 2, etc...*)
Plan (*1, 2, etc...*)
Treatment Plans including follow-up
****Patient Education**
****Patient Plan**
Patient's Decision-Making Capabilities

PROGRESS NOTE

Date
Identifying Data (*Age, sex, marital status, etc.*)
Visit Type
Session start and stop time (*only on psychotherapy notes*)
Chief Compliant
History of Present Illness
****Allergy Update**
Social History Update
****Chronic Problem List**
Medical/Surgical History Update
Mental Status Exam
****Medication List** (*Active and inactive, compliance as prescribed, medication response*)
Documentation of therapeutic intervention (*medication management, type of psychotherapy, e.g. insight, supportive, cognitive-behavioral, etc.*)
Impression (*1, 2, etc...*)
Treatment Plans including follow-up
****Patient Education**
****Patient Plan**
Patient's Decision-Making Capabilities
****Required documentation to meet “Meaningful Use”**