# PROGRAM MANUAL
## 2016-2017

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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. Our basic goals are to train virtuous Psychiatrists that function as exemplary clinicians, capable teachers and knowledgeable managers of health care resources. Our Psychiatry Residency Program Manual outlines the key elements to achieve those goals.

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 recently implemented Next Accreditation System (NAS). Such is elaborated in more detail on pages 22-23 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. 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. The Milestones 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 9-17 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 Step III 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 dementia, delirium, headaches, traumatic brain injury, neoplasms, infectious diseases, movement disorders, multiple sclerosis, Parkinson's disease, seizure disorders, intractable pain, stroke and 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 for ALS, Parkinson’s Disease, multiple sclerosis, neuro-muscular disorders, epilepsy and memory disorders. 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 for Psychiatrists Seminar is offered during PGY-3 or PGY-4.

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. work hour 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 and even PGY-3 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 and PGY-3. Specific A.C.G.M.E. Milestone requirements regarding supervision are listed on pages 29-30. 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), mid-level (PGY-2), and advanced (PGY-3) 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 Skills Conferences and Inpatient PBL and I Conferences, 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 usually during PGY-1 or PGY-2 in the Substance Abuse Treatment Program (SATP) at the nearby V.A. Medical Center as
described in more detail on page 35. This is an intense, specialized rehabilitation program utilizing a multidisciplinary approach to evaluate and treat patients with significant chemical dependency problems. 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 SBP3 and PROF1.

Per the A.C.G.M.E. Specialty Specific Duty Hour requirements, PGY-1 Psychiatry Residents may progress to being supervised indirectly with direct supervision immediately 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 Level of Supervision Form: Indirect Supervision is included on page 65.

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 64-67.

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 telephonically to advance to PGY-2. The pertinent evaluation form in included on page 66.

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 19-20) and General Criteria for Advancement: PGY-2 to PGY-3 (pages 39-40) to be able to advance to PGY-3. An Evaluation for Supervisor Capability Form is included on page 67. [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 32. 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 are elaborated in subcompetencies MK1, MK2 and ICS2.

**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, long-term care and emergency settings and learn to diagnose and treat psychophysologic 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 and others. [PC, MK, SBP, ICS] Relevant Milestones are elaborated in subcompetencies SBP4, PBLI3, PROF1, ICS1, ICS2 and MK3.

**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. During the Community Psychiatry rotation there is exposure to forensics reports and assessment and treatment of patients on parole and probation. [MK, SBP] Relevant Milestones are elaborated in subcompetency MK6 and SBP4.

**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 Emergency Psychiatric Center at our affiliated Banner Behavioral Health Hospital in Scottsdale as well as during the PGY-2 and PGY-3 during Consultation – Liaison/Emergency Psychiatry Rotations at B-UMCP. These assignments involve crisis evaluation and management, telepsychiatry and triage. Similar Emergency Psychiatry experiences occur at B-UMCP during PGY-2, 3 and 4 on-call and during PGY-1 in concert with a more senior resident while taking evening extended duty hours. Essentially all of the ambulatory outpatient assignments 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.

**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, transference and countertransference phenomena as well as the value of family, group, interpersonal, cognitive and behavioral therapies and psychological insight and learn to use our webcam resources to facilitate outpatient supervision.

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. A minimum of 20% of the overall outpatient experience at B-UMCP is continuous for at least one year. 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 and V.A. Ambulatory Care assignments usually during PGY-3; and at the Employee Assistance Program at A.S.U during PGY-3 or 4. Our PGY-3 and PGY-4 residents also provide outpatient crisis evaluations and consultation to patients referred from the IM, Family Medicine, OB-GYN, Surgery 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 PC4, MK1, MK4, MK5, MK6, PBLI1, SBP2 and PROF2.

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 Clinic at B-UMCP, our Consultation-Liaison/Emergency Psychiatry Service at B-UMCP, and the outpatient experience at the V.A.M.C. during PGY-3. During PGY-3 there is also a part-time two month assignment at the Banner Alzheimer’s Institute and Memory Disorders Clinic on the B-UMCP Campus. There are also opportunities to understand the usefulness of neuropsychological testing and neuroimaging as it relates to cognitive functioning in the elderly. [PC, MK, SBP] Relevant Milestones are elaborated within subcompetencies MK1, MK3 and PROF1.

During PGY-3, our residents participate part-time over three months in a nearby 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 32-33. Several community psychiatry electives are also available during PGY-4 at various programs focusing on chemical dependent pregnant women, individuals with HIV/AIDS, minority groups and others. [MK, SBP] Relevant Milestones are elaborated within subcompetency SBP3.

**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, Journal Club and Career Options Conferences. The Senior residents participate in a variety of Medical Education and Departmental administrative meetings with faculty at B-UMCP and elsewhere involving experiences in utilization review, quality improvement, patient safety and performance improvement. [PC, PBL, IPC, SBP]

Senior residents also have a weekly experience over several months participating as a Psychiatric consultant and member of an interdisciplinary team at the Employee Assistance Program Outpatient Clinic at Arizona State University which is described in more detail on page 33. When available, Senior residents are also encouraged to take a variety of part-time Administrative Psychiatry electives [PC, SBP] including functioning as a Senior Inpatient Resident or Senior C-L Resident.

Qualified PGY-4s rotate as the Senior Outpatient Administrative Resident (SOAR) assisting with outpatient triage, organizing PBL and I outpatient case conferences, crisis supervision, etc. [ICS, PROF, SBP] and are expected to assume additional administrative and teaching responsibilities assisting the Program Director and Associate Program Director [ICS, PROF, SBP]. Relevant Milestones are elaborated within subcompetencies SBP1, SBP2, PBLI1 and ICS1 and ICS2.

**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 3-4 months during PGY-4. They must be based on specific written educational goals with assessable Milestone 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.

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 5 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: **supportive therapy, combined psychotherapy and psychopharmacology, cognitive-behavioral therapy, psychodynamic psychotherapy and brief therapy**. In addition to these required therapies, we have developed competency evaluations forms for interpersonal therapy and group therapy and encourage each resident to document competence in these areas as well. Detailed evaluation forms regarding these treatment competencies are included in this manual on pages 87-94. [PC, MK, PBLI] Relevant Milestones are elaborated within subcompetencies PC4 and MK4.
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. 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: http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf

Broadly, the GENERAL COMPETENCIES and SUBCOMPETENCIES include:

1. 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 are expected to:
   - Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
   - Gather essential and accurate information about their patients
   - Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
   - Develop and carry out patient management plans
   - Counsel and educate patients and their families
   - Use information technology to support patient care decisions and patient education
   - Perform competently all medical and invasive procedures considered essential for the area of practice
   - Provide health care services aimed at preventing health problems or maintaining health
   - Work with health care Professionals, including those from other disciplines, to provide patient-focused care

   Psychiatry specific subcompetencies include:
   a) Psychiatric Evaluation
   b) Psychiatric Formulation and Differential Diagnosis
   c) Treatment Planning and Management
   d) Psychotherapy
   e) Somatic Therapies

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. Residents must demonstrate competence in their knowledge of:
   - 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.
   - Laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing.
   - Reliability and validity of the generally-accepted diagnostic techniques, including physical examination of the patient.
   - 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 subcompetencies include:**
  a) Development through the life cycle  
  b) Psychopathology  
  c) Clinical Neuroscience  
  d) Somatic Therapies  
  e) Practice of Psychiatry

3. **PRACTICE-BASED LEARNING AND IMPROVEMENT (PBLI):** 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:

- 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 subcompetencies include:**
  a) Development and execution of lifelong learning through constant self-evaluation, including critical evaluation of research and clinical evidence  
  b) Formal practice-based quality improvement based on established and accepted methodologies  
  c) Teaching

4. **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 subcompetencies include:**
  a) Relationship development and conflict management with patients, families, colleagues, and members of the health care team  
  b) Information sharing and record keeping

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 subcompetencies include:
   a) Compassion, integrity, respect for others, sensitivity to diverse patient populations, adherence to ethical principles
   b) Accountability to self, patients, colleagues, and the profession

6. 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.
   • Advocate for the promotion of mental health and the prevention of mental disorders.

Psychiatry specific subcompetencies include:
   a) Patient Safety and the Health Care Team
   b) Resource Management (may include diagnostics, medications, level of care, other treatment providers, access to community assistance)
   c) Community-Based Care
   d) Consultation to non-psychiatric medical providers and non-medical systems (e.g., military, schools, business, forensic)

The A.C.G.M.E. Psychiatry Residency Review Committee has updated the General Competencies to be specialty specific and such are included verbatim below. Our program adheres to these requirements. Most all are described in narratives of our specific clinical and didactic experiences and objectives throughout this manual. We have also assigned several General Competencies to our Competency Based Skills and Milestones on pages 2-8 and our year-to-year Psychiatry Roles and Responsibilities on pages 18-21. 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.

1. Patient Care (what you do) that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health.
   a) Each resident must have supervised experience in the evaluation and treatment of patients. These patients should be of different ages and gender from across the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds.
   b) Residents should be familiar with physical conditions that can affect evaluation and care (e.g., CNS lesions, HIV/AIDS, and other medical conditions).
   c) Clinical education should be organized to provide experience so that residents develop competence in:
(1) formulating a clinical diagnosis for patients by conducting patient interviews, eliciting a clear and accurate history; performing physical, neurological, and mental status examination, including appropriate diagnostic studies; completing a systematic recording of findings; relating history and clinical findings to the relevant biological psychological, behavioral, and sociocultural issues associated with etiology and treatment;

(2) developing a differential diagnosis and treatment plan for all psychiatric disorders in the current standard nomenclature, i.e., DSM, taking into consideration all relevant data;

(3) using pharmacological regimens, including concurrent use of medications and psychotherapy;

(4) understanding the indications and uses of electroconvulsive therapy;

(5) applying supportive, psychodynamic, and cognitive-behavioral psychotherapies to both brief and long-term individual practice, as well as assuring exposure to family, couples, group and other individual evidence-based psychotherapies;

(6) providing psychiatric consultation in a variety of medical and surgical settings;

(7) providing care and treatment for the chronically mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;

(8) participating in psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance, performance improvement and patient safety;

(9) providing psychiatric care to patients who are receiving treatment from nonmedical therapists and coordinating such treatment; and

(10) 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.

d) Patient Care Requirements and Specific Experiences and Rotations must be organized to allow residents to have major responsibility for the care of a significant number of patients with acute and chronic psychiatric illnesses.

(1) Patient care assignments must permit residents to practice appropriate treatment, and to have sufficient time for other aspects of their educational program.

(2) 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.

(3) 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:

(a) limited to child and adolescent psychiatry patients;

(b) up to a maximum of 12 months that can be double counted;

(c) documentation by child and adolescent psychiatry program director for all areas for which credit is given in both programs;

(d) no reduction in total length of time devoted to education in child and adolescent psychiatry, which must remain at 2 years; and

(e) only the following experiences can be used to meet requirements in both general and child and adolescent psychiatry;

(i) 1 month FTE of child neurology;

(ii) 1 month FTE of pediatric consultation;

(iii) 1 month FTE of addiction psychiatry;

(iv) Forensic psychiatry experience;

(v) Community psychiatry experience; and
e) Required clinical experiences include the following:

(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, day hospital programs, research units, residential treatment programs, and other settings that meet the following criteria:

   (a) The patient population is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and gender; and,
   (b) Patient services are comprehensive and continuous and allied medical and ancillary staff is available for backup support at all times.

(3) Outpatient Psychiatry: 12-month FTE organized, continuous, and supervised clinical experience in the assessment, diagnosis, and treatment of outpatients with a wide variety of disorders and treatment modalities, with experience in both brief and long-term care of patients. Each resident must have significant experience treating outpatients longitudinally for at least one year. This longitudinal experience should include:

   (a) evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly under supervision;
   (b) exposure to multiple treatment modalities that emphasize developmental, biological, psychological and social approaches to outpatient treatment;
   (c) opportunities to apply psychosocial rehabilitation techniques, and to evaluate and treat 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 are:

   (a) supervised by child and adolescent psychiatrists who are certified by ABPN or judged by the RRC to have equivalent qualifications; and
   (b) provided opportunities to assess development and to evaluate and treat 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 the diagnosis and management of mental disorders in patients with multiple comorbid medical disorders, familiarity with the differential diagnosis and management (including management of the cognitive component) of the degenerative disorders, an understanding of neuropsychological testing as it relates to cognitive functioning in the elderly, and the unique pharmacokinetic and pharmacodynamic considerations encountered in the elderly, including 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 detoxification, management of overdose, maintenance pharmacotherapy, the use of psychological and social consequences of addiction in confronting and intervening in chronic addiction rehabilitation used in recovery stages from pre-contemplation to maintenance, and the use of self-help groups.

(7) Consultation-Liaison: minimum two month FTE organized where the residents consult under supervision on other medical and surgical services.
(8) Forensic Psychiatry: This experience must expose residents to the evaluation of patients potential to harm themselves or others, appropriateness for commitment decisional capacity, disability, and competency. This experience should include writing a forensic report. Giving testimony in court where feasible is highly desirable.

(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. Residents must be provided experiences in evaluation, 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 expose residents to 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 consult with, learn about, and use 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) Addiction, Community, Forensic, and Geriatric psychiatry requirements can be met as part of the inpatient requirements above the minimum six months, and/or as part of the outpatient requirement.

2. Medical Knowledge (what you know) about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care.

   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:

      (1) the major theoretical approaches to understanding the patient-doctor relationship;

      (2) the 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;

      (3) the 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, sociocultural, and iatrogenic factors that affect the prevention, incidence, prevalence and long-term course and treatment of psychiatric disorders and conditions;

      (4) comprehensive discussions of the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, such as neoplasms, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, seizure disorders, stroke, intractable pain, and other related disorders;

      (5) the use, reliability, and validity of the generally-accepted diagnostic techniques, including physical examination of the patient, laboratory testing, and psychological testing;

      (6) understand the indications and uses of electroconvulsive therapy;

      (7) the use and interpretation of psychological testing (under the supervision and guidance of a qualified clinical psychologist, residents should have experience with the interpretation of the psychological tests most commonly used, some of which experience should be with their own patients);

      (8) the history of psychiatry and its relationship to the evolution of medicine;

      (9) the legal aspects of psychiatric practice, and when and how to refer;

      (10) an understanding of American culture and subcultures, particularly those found in the patient community associated with the educational program, with specific focus for residents with cultural backgrounds that are different from those of their patients;

      (11) use of case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in the diagnosis and management of cases; and,
(12) 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. Practice-Based Learning and Improvement (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:

(1) 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;
(2) identify strengths, deficiencies and limits to one’s knowledge and expertise;
(3) set learning and improvement goals;
(4) identify and perform appropriate learning activities;
(5) systemically analyze practice using quality improvement methods and implement changes with the goal of practice improvement;
(6) include formative evaluation feedback into daily practice;
(7) using evaluations of performance provided by peers, patients, superiors, and junior colleagues to improve practice;
(8) locating, appraising, and assimilating evidence from scientific studies related to their patient’s health problems;
(9) using information technology to optimize lifelong learning; and
(10) actively participating in the education of patients, families, students, residents and other health Professionals. This should be documented by evaluations of a resident’s teaching abilities by faculty and/or learners.

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.

4. Interpersonal and Communication Skills (how you interact with others): Residents must demonstrate skills that result in the effective exchange of information and collaboration with patients, their families, and other health Professionals.
Specific knowledge, skills, and attitudes should include:

a) communicating effectively in a developmentally appropriate manner, and across a broad range of socioeconomic and cultural backgrounds, with patients, their families, and professional associates;
b) demonstrating sensitivity and responsiveness to a diverse patient population, including but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;
c) communicating effectively with physicians, other health Professionals, and health-related agencies;
d) working effectively as a member or leader of a health care team or other professional group;
e) acting in a consultative role to other physicians and health Professionals.
f) maintaining comprehensive, timely, and legible medical records; and
g) interviewing patients and family in an effective manner to facilitate accurate diagnosis and biological, psychological and social formulation.

5. **Professionalism (how you act):** Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds.

Specific knowledge, skills, and attitudes in professionalism should include demonstrating:

a) respect, compassion, integrity, and honesty;
b) a responsiveness to the needs of patients that supersedes self-interest; accountability to patients, society and profession;
c) respect for patients privacy and autonomy;
d) high standards of ethical behavior which include maintaining appropriate professional boundaries, and understanding the nuances specific to psychiatric practice.

Our program distributes to residents and operates 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 an integral part of the educational process;

1) sensitivity and responsiveness to a diverse patient population, including but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
2) timely completion of thorough and accurate medical records.

6. **Systems-Based Practice (how you work within the system):** 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.

Specific knowledge, skills, and attitudes in Systems-Based Practice should include:

a) work effectively in various health care delivery settings and systems relevant to Psychiatry;
b) coordinate patient care within the health care system relevant to Psychiatry;
c) incorporate considerations of cost awareness and risk benefit analysis as appropriate;
d) work in interprofessional teams to enhance patient safety and improve patient care quality;
e) participate in identifying system errors and implementing potential systems solutions;
f) knowing how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
g) practicing cost-effective health care and resource allocation that does not compromise 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;
h) advocating for quality patient care and assisting patients in dealing with system complexities, including disparity in mental health care;
i) working with health care managers and health care providers to assess, coordinate, and improve health care, particularly as it relates to access to mental health care;
j) knowing how to advocate for the promotion of mental health and the prevention of disease;
k) acknowledging the importance of medical errors and examining systems to prevent them;
l) maintaining a mechanism to ensure that charts are appropriately maintained and readily accessible for patient care and regular review for supervisory and educational purposes;
m) collaborating with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients; and
n) monitoring clinical records on major rotations to assess resident competencies to:
(1) document an adequate history and perform mental status, physical, and neurological examinations;
(2) organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues;
(3) proceed with appropriate laboratory and other diagnostic procedures;
(4) develop and implement an appropriate treatment plan followed by regular and relevant progress notes regarding both therapy and medication management; and
(5) timely preparation of an adequate discharge summary and plan.

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 18-21. 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, web-based learning modules, Clinical Skills Evaluations and other examinations, as well as utilizing extramural (e.g. U of A COM-Phoenix Campus evening symposia) 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 site to improve communication of patient care handoffs [IPC], Performance Improvement and Patient Safety Conference [PBL], the formalizing of a 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, videotapes 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, Columbia Psychodynamic Psychotherapy Exam, 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. Our ongoing quality improvement process of the Residency Program, referred to by the A.C.G.M.E. as “Phase III” of the Outcomes Project, is used to identify opportunities for improvement at the program level.

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.

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 hours:

- 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]
- **No later than the end of the third inpatient month, 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 from direct to indirect supervision 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, 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, PBLI, PROF]
- 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 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 Resident position, ASU Employee Assistance Program, 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 22 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. All Milestone threads (as indicated by the letter in each milestone reference number, the “A” in PC1, 1.1/A) should be formally evaluated and discussed by the CCC on at least two occasions during a resident’s educational program.

Thread names, preceded by their indicator letters, are listed in the top row of each Milestone table. Each thread describes a type of activity, behavior, skill, or knowledge, and typically consists of two-to-four Milestones at different levels. For example, the “B” thread for PC1, named “collateral information gathering and use,” consists of the set of progressively more advanced and comprehensive behaviors identified as 1.2/B, 2.3/B, 3.3/B, 4.2/B, 4.3/B and 5.2/A,B. The thread identifies the unit of observation and evaluation. For, PC1, thread “B,” faculty members would observe a resident’s evaluation of a patient to see whether he or she demonstrates the collateral information gathering and use behaviors described in that Milestone. Threads do not always have milestones at each level 1-5; some threads may consist of only one Milestone.

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): **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)

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

**PROFESSIONALISM**
- PROF1 Compassion, integrity, respect for others, sensitivity to diverse patient populations, adherence to ethical principles
- PROF2 Accountability to self, patients, colleagues and the profession

**INTERPERSONAL and COMMUNICATION SKILLS**
- ICS1 Relationship development and conflict management with patients, families, colleagues and members of the healthcare team
- ICS2 Information sharing and record keeping

**PRACTICE BASED LEARNING and IMPROVEMENT**
- PBLI1 Development and execution of life-long learning through constant self-evaluation, including critical evaluation of research and clinical evidence
- PBLI2 Formal practice-based quality improvement based on established and accepted methodologies.
- PBLI3 Teaching

**SYSTEM BASED PRACTICE**
- SBP1 Patient Safety and the Healthcare Team
- SBP2 Resource Management
- SBP3 Community Based Care
- SBP4 Consultation of non-psychiatric medical providers and non-medical systems e.g. military, schools, business, forensic, etc.
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

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**Competency Domain**  
Subcompetency  
Thread Names

**Thread for: Development as a teacher** (all milestones with “A”)

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| Competency Domain: PBL Teaching  
A: Development as a teacher  
B: Observable teaching skills |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Has not Achieved Level 1</td>
</tr>
<tr>
<td>1.1/A Recognizes role of physician as teacher</td>
</tr>
<tr>
<td>2.1/A Assumes a role in the clinical teaching of early learners</td>
</tr>
<tr>
<td>3.1/A Participates in activities designed to develop and improve teaching skills</td>
</tr>
<tr>
<td>4.1/A Gives formal didactic presentation to groups (e.g. Grand Rounds, case conference, journal club)</td>
</tr>
<tr>
<td>5.1/A Educates broader professional community and/or public (e.g. presents at regional or national meeting)</td>
</tr>
<tr>
<td>2.2/B Communicates goals and objectives for instruction of early learners</td>
</tr>
<tr>
<td>3.2/B Organizes content and methods for individual instruction for early learners</td>
</tr>
<tr>
<td>4.2/B Effectively uses feedback on teaching to improve teaching methods and approaches</td>
</tr>
<tr>
<td>5.2/B Organizes and develops curriculum materials</td>
</tr>
<tr>
<td>2.3/B Evaluates and provides feedback to early learners</td>
</tr>
</tbody>
</table>

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Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box in the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as some milestones in the higher level(s).
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 regards 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 98.

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 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.

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. Also, a Clinical Neurology for Psychiatrists Lecture Series and Advanced Clinical Neuroscience Seminar are part of the Psychiatry Residency curriculum and broaden the clinical neurology, neuropsychiatric and neurobehavioral experiences. Residents are also encouraged to attend the B-UMCP Neurology Grand Rounds with some regularity throughout the residency.

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 Interview Skills Conference as well. There are also daily inpatient teaching rounds, frequent 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. 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: 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,
videotapes 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.

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 1 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. PGY-2 residents are encouraged to attend the monthly PBLI Outpatient 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.

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 monthly PBLI Outpatient Case Conference. There is also a specific seminar for Group Therapy. There are several other required seminars for the advanced residents (Core Curriculum II) each of which address in depth the following areas: Consultation-Liaison/Emergency Psychiatry (PGY-2 and 3); Clinical Neurology for Psychiatrists; Advanced Clinical Neurosciences; Forensics; Administrative Psychiatry; Career Options and Practice Management; Psychiatric Ethics; Board Preparation, Research Library, Advanced EBM Psychopharmacology. New seminars are often developed reflecting the dynamic expansion of knowledge in Psychiatry and requests by our trainees and faculty. Again, attendance and active participation are expected at weekly Departmental Grand Rounds, the monthly Journal Club, and various Interdisciplinary Conferences sponsored by the Department of Graduate Medical Education.

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 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 health care financing, ethics, utilization review, quality improvement and patient safety, professionalism, medical humanities, etc. All of our residents 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 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. 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. Residents will participate in our Literacy Seminar where local Psychiatry researchers will discuss basic research principles and also present his or her research projects which residents are encouraged to consider joining. Our residents are also encouraged to participate in Academic Excellence Day which is open to residents and fellows throughout the 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 Quality Improvement and Patient Safety Projects 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, our 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.

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. The residents can also participate in our yearly Performance Improvement and Patient Safety Conference (former Morbidity and Mortality Conference) as well as the B-UMCP Graduate Medical Education and Safety Day Conference. Our residents also have an opportunity to participate in the Graduate Medical Education patient Safety and Quality Council.

**CLINICAL ROTATIONS: 2015 – 2016:** Typical required clinical assignments for each level of training include the following:

**PGY-1:** Internal Medicine (B-UMCP and V.A.M.C.; one month Pediatrics at P.C.H. may be substituted)
- Emergency Medicine (B-UMCP)
- Neurology (B-UMCP)
- Adult Inpatient Psychiatry (B-UMCP)
- Chemical Dependency (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)
- Emergency Psychiatry (Banner Psychiatric Center)
- Outpatient Psychiatry (B-UMCP Behavioral Health Center, continuous part-time extending through PGY-3 and PGY-4)
PGY-3: Consultation-Liaison/Emergency Psychiatry (B-UMCP)
Community Psychiatry (Southwest Network)
Geriatric Psychiatry (B.A.I.)
V.A. Outpatient Clinic (V.A.M.C.)
Outpatient Psychiatry (B-UMCP, continuous part-time extending through PGY-4)

PGY-4: Outpatient Psychiatry (B-UMCP, continuous part-time)
Employee Assistance Program (A.S.U.)
Senior Outpatient Administrative Resident (B-UMCP)
Clinical, Research, Quality Improvement and Patient Safety and Administrative Electives

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. Electives are part-time over 3-4 months allowing continuous care of ongoing outpatients and attendance at required lectures, conferences, seminars, etc. and supervision. 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
- Adolescent Psychiatry at Banner’s Scottsdale Behavioral Health Center
- Consultation-Liaison Psychiatry at B-UMCP and the V.A.M.C.
- Emergency Psychiatry
- Electroconvulsive Therapy
- Substance Abuse Programs
- Geropsychiatry
- Research Design and Methodology
- Psychopharmacology
- Toxicology
- Telepsychiatry
- Transcultural Community Psychiatry at various community sites
- Translational Genomics Research
- Banner Alzheimer’s Institute (BAI) at B-UMCP Campus
- Banner’s Memory Disorders Program
- Palliative Care
- Women’s Health
- Quality Improvement and Patient Safety Initiatives
- . . . and Others

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 duty hour 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 and III 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)
- Clinical Science Lecture Series (PC, MK)
- Diagnostic Interviewing Skills Conference (ICS, PROF, MK)
- Inpatient Clinical Case Conferences (PC, PBLI)
- Child and Adolescent Psychiatry Lecture Series (PC, MK, SBP)

**Core Curriculum II**
- Consultation - Liaison/Emergency Psychiatry Seminar (PC, MK, SBP)
- Clinical Neurology for Psychiatrists Seminar (PC, MK)
- Advanced Clinical Neuroscience Seminar (MK, PBLI)
- Forensic Psychiatry Seminar (MK, PROF, SBP)
- Quality Improvement and Patient Safety Seminar (PBLI, SBP)
- Career Options and Practice Management Conferences (PROF, SBP)
- Psychiatric Ethics and Professionalism Seminar (PROF, PC)
- Senior Residents’ Board Review Course (MK)

**Core Curriculum III**
- Psychiatric Ethics and Professionalism
- Administrative psychiatry
- Neurology for Psychiatric Seminar
- Forensic Psychiatry
- Research Library Seminar
- Advanced EBM Psychopharmacology

**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**
- Grand Rounds (weekly)
- Journal Club (monthly)
- Training Director's luncheons (monthly)

**CASE CONFERENCES**
- Consultation –Liaison Clinical Conferences (PC, MK)
- Outpatient PBLI Clinical Conferences (PC, PBLI)

**ELECTIVE DIDACTICS**
- Research Design and Methodology Seminar
- Biostatistics Seminar
- Medical Epidemiology Seminar
- University of Arizona College of Medicine – Phoenix Campus Clinical Educators Conferences
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. Emergency Psychiatry and Risk Assessment
4. Psychopharmacology
5. Schizophrenia Spectrum and other Psychotic Disorders
6. Bipolar, Depressive and Related Disorders
7. Anxiety Disorders
8. Personality Disorders
9. Mental Disorders due to Medical Conditions
10. Diagnostic Use of Laboratory
11. General Competencies and Milestones Subcompetencies Overview
12. Introduction to Ethics
13. Personal Stress and Fatigue Management
14. Transitions of Care
15. Basic Neuroscience

Clinical Science Lecture Topics (weekly lectures Fall through Spring)

1. Geriatric Psychiatry and Neurocognitive Disorders
2. Psychological and Neuropsychological Testing
3. Defense Mechanisms
4. Somatic Symptom and Related Disorders
5. Substance Related and Addictive Disorders
6. Eating Disorders
7. History of Psychiatry
8. Introduction to Psychiatry and the Law
9. Introduction to Supportive Psychotherapy
10. Introduction to Milieu and Group Therapies
11. Sleep-Wake Disorders
12. Community Psychiatry
13. Electroconvulsive Therapy and Neuromodulation Interventions
14. Transcultural Psychiatry
15. Trauma and Stressor Related Disorders
16. Epidemiology of Psychiatric Illness
17. Paraphilic Disorders
18. OCD and Related Disorders

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. 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. They 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 18-21) and Criteria for Advancement (pages 38-40) and Supervision Policies (pages 39-40) 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.

Additional Notes

Please note that most milestone sets include explanatory footnotes for selected concepts. These appear at the bottom of each milestone table. The footnotes are essential tools in Milestone evaluation. The Psychiatry Milestones, subcompetencies and threads are accessible at:

http://www.acgme.org/acgmeweb/tabid/433/ProgramandInstitutionalAccreditation/Milestones/Milestones-MedicalSpecialties.aspx

TRANSITIONS OF CARE
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 in Care face to face and not to rely only on phone calls, computer, or paper documentation. We utilize a secure form on our department Sharepoint site 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 similar form on the Sharepoint site 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 on West Tower 6. The Adult Inpatient Psychiatry residents and Senior Resident 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 senior 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 West Tower 6 patients were transferred to the medical floor while on call, this information will also be relayed to the senior c/l resident.

At the end of the workday, each resident on the Adult Inpatient Psychiatry unit will check out face to face with the resident on call. Check out sheets should be updated throughout the day 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 Sharepoint and review any issues with what 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 checkout sheet. 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.

**SPONSORING INSTITUTION**

**B-UMCP Medical Center** is the primary sponsoring institution for the Psychiatry Residency Program and serves as the main clinical and educational facility. B-UMCP abides by the Institutional Requirements expected from the A.C.G.M.E.

**PARTICIPATING CLINICAL SITES**

As the “sponsoring institution” the great majority, perhaps over 75% of clinical assignments and most of the didactics occur on the **B-UMCP campus**. 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, PC5, MK2, MK5, PROF2, ICS2
Mid-Level (PGY-2): PC5, MK2, MK5, SBT1, SBP2, PROF2, PBL13, ICS2
Advanced (PGY-3-4): PC5, MK2, MK5, SBP1, SBP2, PBL13, ICS1

Outpatient Clinic: Beginner (PGY-2): PC4, MK4
Mid-Level (PGY-3): PC4, MK1, MK4, MK5, MK6, PBL11
Advanced (PGY-4): PC4, MK4, MK5, MK6, SBP2, PBL11, PROF2

Consultation-Liaison: Beginner (PGY-2): SBP4, PBL13, PROF1, ICS2
Mid-Level (PGY-3): SBP4, PROF1, ICS1, ICS2, PBL13, MK3

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, geriatrics and elective programs); Phoenix Children's Hospital (pediatrics; child, adolescent and family psychiatry); Arizona State Hospital (forensics); Arizona State University's Employee Assistance Program; 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 one month assignment to the inpatient, outpatient and residential treatment substance abuse programs at the nearby Phoenix V.A. Medical Center during PGY-1 or PGY-2. Carlos Carrera, M.D. is the lead faculty supervisor 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 one-half day week for ongoing outpatients and supervision at B-UMCP if the resident is at the PGY-2 level. Milestone subcompetencies aligned with this experience include SBP3 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. The experience includes inpatient, outpatient and consultation experiences. Jacob Venter, M.D. is the Site Director. Milestone subcompetencies aligned with this experience include MK1, MK2 AND ICS2.

- 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 BGSMC-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 at PCH: Full-time faculty at PCH. Ongoing Adult Outpatients and Intakes: Assigned Primary Supervisor.

Community Psychiatry (CP) – this is a one-day per week assignment usually during PGY-3 over three months at a nearby 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. John Blunt, M.D. is the Clinical Site Director. Milestone subcompetencies aligned with this experience include PROF1, SBP1 and SBP2 and SBP3.

- Ongoing Adult Outpatients and Supervision: this schedule allows regular attendance for the PGYY-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 BGSMC-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 PTO to one five (5) day block to minimize days missed during this experience.

**V.A. Ambulatory Psychiatry (VAP)** – 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 Catellino, M.D. is the Site Director for this assignment and she will organize supervised training opportunities including brief psychotherapy, crisis assessments, PTSD and Gender Identify groups and involvement with their Interdisciplinary 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 and should discuss such with Dr. Catellino well in advance. Milestone subcompetencies aligned with this experience include SBP1, SBP2 and SBP3 and those selected for a mid-level (PGY-3) Outpatient experience.

**A.S.U. Employee Assistance Office (EAO)** – a several month part-time assignment to 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. 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 on-site oversight for the experience. Clinical supervision is provided by the B-UMCP full-time Primary Supervisor. This assignment is one-half day a week (Wednesdays, 1:00 p.m. – 5:00 p.m.). 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 PROF1 and SBP2.

**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 Senior Practice Manager or designee to develop and monitor PGY-2, 3 and 4 residents’ schedules for outpatient case loads and new patient intakes.
- Monitors caseloads and facilitates referrals to PGY-2, 3 and 4 residents to ensure each resident’s expected outpatient caseload is full, commensurate with his/her level of training and meeting the program’s accreditation requirements.
- Serves as a liaison to the support staff in the screening, triage and scheduling referrals from WT-6 and outpatient consultation requests and referrals from other hospital based outpatient clinics or off-campus agencies.
- Actively assists the PGY-2 residents regarding outpatient intake assessments, crisis evaluations, clinical emergencies, etc.
- Participates as an active clinician in the Outpatient Clinic maintaining an expected outpatient caseload.
- Serves as a consulting Psychiatrist to the Employee Assistance Office (EAO) at A.S.U. one-half day per week (Wednesday afternoons).
- Provides emergent coverage of post-call residents’ outpatients.
- Organizes a monthly PBLI Outpatient Clinic Case Conference.
- Attends the Department of Psychiatry Medical Staff Committee (noon, 1st Tuesday during September, December, March and June) West Tower 2 Administrative Conference Room.

Milestone subcompetencies aligned with this experience include ICS2, ICS2, PROF2 and PBLI1.

**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.
• 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.

Milestone subcompetencies aligned with this experience include PBL13, ICS1 and ICS2.

B-UMCP MEDICAL CENTER
PSYCHIATRY RESIDENCY PROGRAM

II. POLICIES

The B-UMCP Department of Graduate Medical Education provides each resident an on-line Housestaff Manual at the start of training which is revised and updated annually. Specific areas covered in that manual include basic duties and responsibilities; certification of residency or fellowship training; compliance education and training programs; compliance training overview; contract related items; delinquent records policy; disaster policy; disciplinary action policy for residents; resident impairment; drug testing policy; summary suspension; automatic suspension; resident duty work hours; evaluations of residents and fellows; eligibility and selection of residents; hospital staff relationships; international medical graduates; internal reviews; leave of absence for residents; personal leave; meal policy; miscellaneous requests from program directors; on-call rooms; on-call and holidays; on-call for residents rotating between departments; pagers; parking; patient relationships; 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; supervision of residents and medical students; autopsy policy; and other topics. Both the Department of Graduate Medical Education's Housestaff Manual and the B-UMCP Employee Manual (which are available on-line at www.BannerHealth.com) should be reviewed for specific information. 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/.

APPLICATION PROCESS

Upon receiving a request for information about the Psychiatry Residency a potential applicant is directed to information about our program on our website at www.BannerHealth.com/GoodSam-Psych-Residency.com.

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

- Completed Common Application Form (CAF)
- Personal Statement
- Dean's letter 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 –iii. Resident Appointments)

Applicants for the Psychiatry Residency Program at B-UMCP 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 October 1 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) 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.

The Program Director of the residency program should have an Educational Policy Committee 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. This committee should participate actively in: planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless there is a separate residency selection committee) determining curriculum goals and objectives; and evaluating both the teaching staff members and the residents. In its evaluation of residency programs, the Review Committee will take into consideration the information provided by the American Board of Psychiatry and Neurology regarding resident performance on the certifying examinations during the most recent five years.

CLINICAL COMPETENCY COMMITTEE

As required by the A.C.G.M.E. NAS, the Program Director appoints the Clinical Competency Committee (CCC). 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.

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.

**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.
- **Quality Improvement** – including how sponsoring institutions engage residents in the use of data to improve systems of care, reduce health care disparities and improve patient outcomes.
- **Transitions of Care** – including how sponsoring institutions demonstrate effective standardization and oversight of transitions of care.
- **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.
- **Duty Hours Oversight, Fatigue Management and Mitigation** – 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.

**RESIDENT SUPERVISION**

In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or approved licensed independent practitioner) who is ultimately responsible for that patient’s care. This information should be available to residents, faculty members, and patients. Residents and faculty members are expected to inform patients of their respective roles in each patient’s care.
Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. 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 or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

**LEVELS OF SUPERVISION:** To ensure oversight of resident supervision and 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. When available, evaluation should be guided by specific national standards-based criteria. Faculty members functioning as supervising physicians should 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 appropriate 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.

In particular, PGY-1 residents should 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 should 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.

**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. 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). The Columbia University **Psychodynamic Psychotherapy Competency Test** is required for all PGY-3 and PGY-4 residents. These types of examinations cross 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, 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 an ABPN certified Psychiatrist. 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 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 Department 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 the completion of training the Program Director provides a **Summative Evaluation** for each graduating resident. 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 Education Policy Committee and ultimately the Medical Center’s Graduate Medical Education Committee, 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, ability to practice independently without direct supervision and 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 specialities 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, Consultation-Liaison Psychiatry, Emergency Psychiatry, Outpatient Psychiatry, Child and Adolescent Psychiatry, 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 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, clinical knowledge, professionalism and scholarly activities. This evaluation includes annual written confidential evaluations by residents as well.

**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, B-UMCP, and our program are jointly responsible for the quality of education offered to residents for the duration of such a project.

**ASSISTING RESIDENTS**

A resident who feels he or she needs added professional supervision should contact the Director of Residency Education and every effort will be made to fulfill this need. A resident who needs help with a personal or emotional problem may contact the Program Director. If therapy is indicated either will assist the resident in finding an appropriate referral outside of the department. Both an Employee Assistance Program and mental health coverage are included in the health care benefits provided residents and their families.

**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 through the Crisis Prevention Institute 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 CPI 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, extended duty hours during PGY-1 and duty hours requirements, the routine weekday work hours are 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. Work Duty Hours Regulations. 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.

RESIDENT DUTY HOURS, STRESS, ALERTNESS MANAGEMENT, FATIGUE MITIGATION AND THE WORKING ENVIRONMENT

Our program is committed to promoting patient safety and resident well-being while providing a supportive educational environment. Appreciating that the crux of training involves patient contact and responsibility, the learning objectives must not be compromised by excessive reliance on residents to fulfill service obligations. Didactics and clinical education must have priority in the allotment of resident’s time and energy. Both residents and faculty collectively have responsibility for the safety and welfare of patients.

Our residents and faculty are educated to recognize the signs of fatigue and sleep deprivation and are expected to apply this knowledge to prevent and counteract its potential negative effects on patient care and learning.

The A.C.G.M.E. has established various regulations for all residencies regarding duty hours, stress, fatigue and the working environment which are included in the A.C.G.M.E. Psychiatry Program Requirements, a copy of which is provided each resident at the start of the academic year. It is the expectation of the Graduate Medical Education Department and our Psychiatry Residency that all aspects of these guidelines be firmly in place and regularly monitored. Residents are provided a monitoring form which is included in this manual at the end of each month to complete, sign as an accurate attestation and submit to the Program Director. An annual inservice on Alertness Management, Fatigue Mitigation and Sleep Deprivation is provided to the residents and faculty and all new trainees participate in a course on these topics. Residents are also expected to personally report any potential infractions of these regulations to the Program Director immediately. Both the A.C.G.M.E. and the B-UMCP Department of G.M.E. also survey residents periodically on these matters the results of which are reviewed by our program. A program specific tally of days off per month is reviewed by our Program Director. Individual clinical service schedules, including extended duty hours and on-call assignments, are required to develop a patient care and coverage mechanism ensuring that these guidelines are strictly followed. All patient care is supervised by qualified more senior residents and faculty approved by the Program Director. Please refer to the section labeled “Supervision and Lines of Responsibility” on page 33 for a more detailed description of this important topic. Our residents are provided individual sleep rooms when on-call. Taxi vouchers or reimbursement are available for transportation for residents who may be too fatigued to safely drive themselves home.

The A.C.G.M.E. guidelines are such: Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being including fatigue, stress and physical or emotional conditions which inhibit performance or learning. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents’ time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients. To assist with these efforts, personal well-being, signs of fatigue and methods to prevent and counteract its potential negative effects are discussed routinely in all facets of the program and a Departmental Grand Rounds for residents and faculty is devoted to the topic annually.

1. Supervision of Residents:
   a) All patient care must be supervised by qualified faculty or more senior residents. The program Director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
   b) Faculty schedules must be structured to provide residents with necessary supervision and consultation.
c) Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

2. **Duty Hours:**

   a) Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

   b) Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and any “moonlighting”.

   c) Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four week period, inclusive of call. One day is defined as one continuous 24 hour period free from all clinical, educational, and administrative activities.

   d) Adequate time for rest and personal activities must be provided. A 10 hour time period for rest and personal activities should be provided between all daily duty periods, and after in-house call.

3. **On-Call and Extended Work Hours Activities:**

   The objective of on-call activities is to provide residents with continuity of patient care experiences. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

   a) In-house call must occur no more frequently than every third night, averaged over a four-week period. On our psychiatry rotations, in-house call should not occur more frequently than every fourth night averaged over a four week period.

   b) Continuous on-site duty, including in-house call, must not exceed 16 consecutive hours for PGY-1 residents.

   c) Continuous on-site duty, including in-house call must not exceed 24 consecutive hours for PGY-2, 3 or 4 residents who may remain on duty for up to 4 additional hours to participate in didactic activities, maintain continuity of medical and surgical care or transfer care of patients.

   d) No new patients may be accepted after 24 hours of continuous duty for PGY-2, 3 or 4 residents.

   e) At-home call (pager call) is defined as call taken from outside the assigned institution.

   1. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

   2. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80 hour limit.

   3. The Program Director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

4. **Moonlighting:**

   a) Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

   b) The program director must comply with both the A.C.G.M.E. and the sponsoring institution’s written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements III.D.1.k.

   c) Moonlighting must be counted toward the 80-hour weekly limit on duty hours.

5. **Oversight:**

   a) Each program must have written policies and procedures consistent with the A.C.G.M.E. common and specific specialty Program Requirements for resident duty hours and the working environment. These
policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

b) Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

6. **Duty Hours Exception:**

An R.R.C. may grant exceptions for up to 10% of the 80-hour limit, to individual programs based on a sound educational rationale. However, prior permission of the institution’s GMEC is required.

**ON-CALL AND EXTENDED WORK HOURS**

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. Resident Work Duty Hours 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 duty hours through direct supervision or indirect supervision immediately available. PGY-1 residents are expected to be signed-off for indirect supervision telephonically 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 duty hours for PGY-1’s are typically 4:30 p.m. until no later than 9:00 p.m. weekdays and holidays, and 8:00 a.m. until no later than midnight on weekends. The PGY-1 residents’ work day should not exceed 16 hours and allow for no less than 10 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. Usually over the first six months in the academic year, PGY-1 residents will have their extended duty hours those evenings, weekends and holidays also assigned to PGY-3 and 4 residents. Later in the year, the PGY-1 may be assigned with a supervisor approved PGY-2. 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 equal approximately 18 months total from PGY-2 onward. 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. work duty hours 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 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 WT-6 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 WT-6.

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 WT-6 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 “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 “back-up” resident may be needed is unpredictable, the “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 p.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. During the first several months of the academic year (and similarly for any new resident joining the residency later in the year or at a more advanced level), the assigned senior (PGY-3 and 4) residents will also provide supervision to these new residents as they complete day-time admissions to WT-6. This back-up will initially include in-house direct supervision and assistance as described above.

9. For PGY-2 residents and the PGY-1 residents upon returning from medicine assignments typically in the Fall, the “back-up” resident will presumably come from the pool of available on-call residents. Expectedly, if a PGY-2 resident is on-call and requests a PGY-1 “back-up” resident to come in for assistance, the PGY-1 will be directed to take on the appropriate supervised responsibility consistent with their level of training.

10. The attending on-call always has the right to direct the designated “back-up” resident to come in and help.
11. The “back-up” on-call schedule must adhere to the Resident Physician Work Duty Guidelines and the designated resident under the supervision of the Program Director is responsible for developing the complete on-call schedule.

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 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, concerns about physical or mental fatigue, 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.

PAID TIME OFF POLICY (PTO)

Psychiatry residents are allowed a maximum of 21 days each academic year of Paid Time Off (PTO) when scheduling permits including the 6 Banner designated “holidays” unless on an assignment requiring their clinical coverage. Residents should not take PTO or educational leave while on medicine or pediatric rotations. Also keep in mind that it is Banner policy to consider “sick days” as PTO. When PGY-2, 3 or 4 residents or PGY-1 residents assigned to Psychiatry are working Banner holidays, the unused PTO can be allocated, if scheduling permits, to another date during the same month. PGY-1's are required to take 5 days PTO, preferably consecutively, during each of the following assignments: neurology, EM (the 5 days are built into the schedule) and CD. In the unlikely event there is remaining PTO it must be scheduled during AIP when there is a surplus of other residents and clinical coverage permits. PGY-2 and PGY-3 residents are expected to schedule their PTO, preferably in 5 consecutive day increments during any of the following assignments: Community Psychiatry, Geriatric Psychiatry at either the beginning or end of either month, Forensic Psychiatry at either the beginning or end of the month, VA Outpatient, Outpatient Psychiatry, Child and Adolescent Psychiatry, Psychological Dependency at either the beginning or end of the month, 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. It is possible that a Banner holiday will be preceded or followed by another Banner required PTO day. If assigned to the Outpatient Clinic or a service not requiring clinical coverage PTO will be required on those days. All PTO 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. PGY-1 residents are also off one week without pay but with benefits the week before starting PGY-2.

All outstanding medical records, treatment logs, evaluations and billing sheets must be completed and signed prior to the approval and taking of PTO or education leave. Once the PTO request form is completed, the resident will need to obtain the Program Coordinator’s signature and approval. That person will monitor the necessary compliance as the PTO approaches.

Neither PTO nor educational leave may be carried over into the next year of training. It is the resident’s responsibility to schedule his/her PTO 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 PTO 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 PTO must be discussed with the Program Director to ensure all accreditation and board eligibility requirements are satisfied.

**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 PTO. 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 PTO should be used for these activities.

**PATIENT LOGS**

An A.C.G.M.E. accreditation requirement is that each resident 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 taking extended duty hours or on-call, all Emergency Center Psychiatric on-call evaluations, on-call consultations in the Towers, Rehab Center, etc. and admissions to WT6 unless subsequently followed by you, should be logged on a **separate on-call log sheet** clearly marked “Emergency Psychiatry”. 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, extended duty hours or 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 PTO or educational leave. A delay in completing delinquent medical records is considered a breach of Professionalism and may result in disciplinary action.
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 the Medical Center, 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.

<table>
<thead>
<tr>
<th>Documentation Requirement</th>
<th>Timeframe</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Report</td>
<td>Documented within 24 hours of discharge/disposition from the ED</td>
<td></td>
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<tr>
<td>Admitting Progress Note</td>
<td>Documented within 24 hours of admission</td>
<td></td>
</tr>
<tr>
<td>History &amp; Physical</td>
<td>Documented within 24 hours of admission and before invasive procedure</td>
<td></td>
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<tr>
<td>Consultation Reports</td>
<td>Documented within 24 hours of consultation</td>
<td></td>
</tr>
<tr>
<td>Post op Progress Note</td>
<td>Documented immediately post-op when there is a delay in the availability of the full report</td>
<td></td>
</tr>
<tr>
<td>Provider Coding Clarification</td>
<td>Documented within 24 hours of notice</td>
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<tr>
<td>Operative Report</td>
<td>Documented immediately post-op and no later than 24 hours after the procedure.</td>
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<tr>
<td>Special Procedures Report</td>
<td>Documented within 24 hours of notice</td>
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</tr>
<tr>
<td>Discharge Summary Report</td>
<td>Documented at the time of discharge but no later than 24 hours after discharge</td>
<td>Not required on all admissions less than 48hrs, or for normal vaginal deliveries and normal newborns</td>
</tr>
<tr>
<td>Discharge Progress Note</td>
<td>Documented at the time of discharge but no later than 24 hours after discharge, all admissions less than 48hrs or for normal vaginal deliveries and normal newborns</td>
<td></td>
</tr>
<tr>
<td>Death Summary</td>
<td>Documented at the time of death/disposition but no later than 24 hours after death</td>
<td></td>
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<tr>
<td>Death Pronouncement Note</td>
<td>Completed at the time the patient is pronounced within 24 hours</td>
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<tr>
<td><strong>Home Health (Face to Face Documentation)</strong></td>
<td><strong>Completed within 30 days of discharge.</strong></td>
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<tr>
<td>Transfer Summary</td>
<td>Documented at the time of transfer no later than 24 hours</td>
<td></td>
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<tr>
<td>Signatures</td>
<td>Authentication of transcribed or scanned reports and progress notes, within 7 days from the date of notice</td>
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<tr>
<td>Verbal Orders</td>
<td>Dated, time and authenticated within the timeframe specified by state regulation Arizona = 72 hours</td>
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<tr>
<td>Psychiatric Evaluation</td>
<td>Documented within 24 hours of admission</td>
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III. 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. Example rotation evaluations follow and include a more comprehensive Milestones oriented template (Form A) to be used no less than semi-annually for each resident and a more generic General Competencies template (Form B). Rotation specific Milestone subcompetencies may be added to either template.

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

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Subcompetency</th>
<th>Thread Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBL Teaching</td>
<td>A: Development as a teacher</td>
<td>Thread for: Development as a teacher (all milestones with “A”)</td>
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<tr>
<td></td>
<td>B: Observable teaching skills</td>
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<table>
<thead>
<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1/A Recognizes role of physician as teacher</td>
<td>2.1/A Assumes a role in the clinical teaching of early learners</td>
<td>3.1/A Participates in activities designed to develop and improve teaching skills</td>
<td>4.1/A Gives formal didactic presentation to groups (e.g. Grand Rounds, case conference, journal club)</td>
<td>5.1/A Educates broader professional community and/or public (e.g. presents at regional or national meeting)</td>
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<tr>
<td>2.2/B Communicates goals and objectives for instruction of early learners</td>
<td>3.2/B Organizes content and methods for individual instruction for early learners</td>
<td>4.2/B Effectively uses feedback on teaching to improve teaching methods and approaches</td>
<td>5.2/B: Organizes and develops curriculum materials</td>
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<tr>
<td>2.3/B Evaluates and provides feedback to early learners</td>
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Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box in the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as some milestones in the higher level(s).
EVALUATION OF RESIDENT (Form A)  
PSYCHIATRY RESIDENCY PROGRAM

University of Arizona College of Medicine - Phoenix

These evaluations are based on the A.C.G.M.E. Milestones for Psychiatry which use descriptive anchors for each competency.

- Level 1 represents expected skills of an incoming resident.
- Level 2 resident advancing but not performing at midresidency level.
- Level 3 resident demonstrates majority of Milestones in this subcompetency.
- Level 4 resident substantially demonstrates majority of Milestones in this subcompetency; 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.

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. The evaluating faculty and resident should review and discuss this assessment. (PC1), etc. refer to the relevant subcompetency 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) Able to perform and document MSE (PC1)

<table>
<thead>
<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
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2) Able to develop biopsychosocial diagnostic plan (PC2)

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<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
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<th>Level 3</th>
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<th>Level 5</th>
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</table>
3) Able to develop biopsychosocial treatment plan (PC3)

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
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4) Able to provide psychotherapy during patient encounters (PC4)

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<tr>
<th>Level 1</th>
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<th>Level 3</th>
<th>Level 4</th>
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5) Able to prescribe medications appropriately and safely (PC5)

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6) Manages drug interactions effectively when using multiple medications concurrently (PC5)

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7) Comments (strengths and weaknesses)

Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

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

8) Knowledge of developmental determinants including impact of psychopathology (MK1)

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9) Able to formulate an accurate Differential Diagnosis (MK2)

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10) Knowledge of neurology, neuropsychiatry, neurodiagnostic testing and relevant neuroscience (MK3)

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11) Knowledge of psychotherapy theories, strategies, and applications (MK4)

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12) Knowledge of psychopharmacologic principles and agents (MK5)

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13) Knowledge of ECT techniques, as well as length and frequency of treatment (MK6)

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14) Knowledge of applicable laws, ethics, compliance and regulatory requirements (MK7)

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15) Comments (strengths and weaknesses)

Comments

Remaining Characters: 5,000

SYSTEMS BASED PRACTICE

Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide optimal health care.

16) Able to use appropriate QI and Patient Safety tools in order to prevent adverse events (SBP1)

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17) Appropriately utilizes diagnostic, medication formulary, level of care and consulting resources (SBP2)

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18) Able to coordinate care with other health care professionals, community agencies and physicians (SBP3)

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19) Able to provide consultation to non-psychiatric medical providers and non-medical systems (SBP4)

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20) Comments (strengths and weaknesses)

Comments

Remaining Characters: 5,000

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*

21) Applies Evidence Based Medicine to patient care (PBL11)

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22) Uses medical literature to answer questions regarding patient care (PBL11)

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23) Able to apply daily clinical practice to own learning and development (PBL12)

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24) Participated in ongoing QI project in this setting (PBL12)

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25) Ability to teach students and other health care professionals (PBL13)

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26) Comments (strengths and weaknesses)

Comments
PROFESSIONALISM

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

27) Demonstrates compassion, integrity and respect (PROF1)

Has not Achieved Level 1 Level 2 Level 3 Level 4 Level 5 N/A
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28) Adheres to ethical principles (PROF1)

Has not Achieved Level 1 Level 2 Level 3 Level 4 Level 5 N/A
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29) Demonstrates sensitivity to culture and diversity issues (PROF1)

Has not Achieved Level 1 Level 2 Level 3 Level 4 Level 5 N/A
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30) Demonstrates accountability to self, patients, colleagues and profession (PROF2)

Has not Achieved Level 1 Level 2 Level 3 Level 4 Level 5 N/A
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31) Comments (strengths and weaknesses)

Comments

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.

32) Ability to engage patient in interview and build rapport (ICS1)

Has not Achieved Level 1 Level 2 Level 3 Level 4 Level 5 N/A
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33) Ability to relate to families (ICS1)

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34) Ability to relate to health care team (ICS1)

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35) Ability to relate to colleagues (ICS1)

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36) Demonstrates effective information sharing (ICS2)

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37) Comments (strengths and weaknesses)

Comments

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GENERAL PROFESSIONALISM

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

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39) Did the resident attend at least 70% of scheduled supervision sessions?

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40) Has this resident performed sufficiently to be given credit for this required experience?

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Overall Comments:

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Subcompetency questions are generated based on the resident’s rotation.

Choose a rotation
**EVALUATION OF RESIDENT (Form B)**
**PSYCHIATRY RESIDENCY PROGRAM**

University of Arizona College of Medicine - Phoenix

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Please consider the resident's level of training and the specific roles and responsibilities, clinical skills and educational objectives outlined in the current Psychiatry Residency Manual for this rotation. It is important to document explicit impressions on overall progress, strengths, areas for improvement and if necessary recommendations for remediation when performance is unsatisfactory. The evaluating faculty and resident should review and discuss this assessment near the end of the rotation. (PCI), etc. refer to the relevant subcompetency 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](http://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) **Able to perform and document MSE (PC1)**
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A

2) **Able to develop biopsychosocial diagnostic plan (PC2)**
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A

3) **Able to develop biopsychosocial treatment plan (PC3)**
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A

4) **Able to provide psychotherapy during patient encounters (PC4)**
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A

5) **Able to prescribe medications appropriately and safely (PC5)**
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A
6) Manages drug interactions effectively when using multiple medications concurrently (PCS)
   Apparent  ○  Emerging  ○  Unsatisfactory  ○  N/A  ○

7) Comments (strengths and weaknesses)
   Comments

   Remaining Characters: 5,000

MEDICAL KNOWLEDGE

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

8) Knowledge of developmental determinants including impact of psychopathology (MK1)
   Apparent  ○  Emerging  ○  Unsatisfactory  ○  N/A  ○

9) Able to formulate an accurate Differential Diagnosis (MK2)
   Apparent  ○  Emerging  ○  Unsatisfactory  ○  N/A  ○

10) Knowledge of neurology, neuropsychiatry, neurodiagnostic testing and relevant neuroscience (MK3)
    Apparent  ○  Emerging  ○  Unsatisfactory  ○  N/A  ○

11) Knowledge of psychotherapy theories, strategies, and applications (MK4)
    Apparent  ○  Emerging  ○  Unsatisfactory  ○  N/A  ○

12) Knowledge of psychopharmacologic principles and agents (MK5)
    Apparent  ○  Emerging  ○  Unsatisfactory  ○  N/A  ○

13) Knowledge of ECT techniques, as well as length and frequency of treatment (MK5)
    Apparent  ○  Emerging  ○  Unsatisfactory  ○  N/A  ○

14) Knowledge of applicable laws, ethics, compliance and regulatory requirements (MK6)
    Apparent  ○  Emerging  ○  Unsatisfactory  ○  N/A  ○

15) Comments (strengths and weaknesses)
    Comments
SYSTEMS BASED PRACTICE

Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide optimal health care.

16) Able to use appropriate QI and Patient Safety tools in order to prevent adverse events (SBP1)
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A

17) Appropriately utilizes diagnostic, medication formulary, level of care and consulting resources (SBP2)
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A

18) Able to coordinate care with other health care professionals, community agencies and physicians (SBP3)
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A

19) Able to provide consultation to non-psychiatric medical providers and non-medical systems (SBP4)
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A

20) Comments (strengths and weaknesses)
   - Comments

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

21) Applies Evidence Based Medicine to patient care (PBLII)
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A

22) Uses medical literature to answer questions regarding patient care (PBLII)
   - Apparent
   - Emerging
   - Unsatisfactory
   - N/A
23) Able to apply daily clinical practice to own learning and development (PBL2)

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24) Participated in ongoing QI project in this setting (PBL2)

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25) Ability to teach students and other health care professionals (PBL3)

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26) Comments (strengths and weaknesses)

Comments

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PROFESSIONALISM

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

27) Demonstrates compassion, integrity and respect (PROF1)

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28) Adheres to ethical principles (PROF1)

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29) Demonstrates sensitivity to culture and diversity issues (PROF1)

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30) Demonstrates accountability to self, patients, colleagues and profession (PROF2)

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31) Comments (strengths and weaknesses)

Comments
### 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.**

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<th>33) Ability to relate to families (ICS1)</th>
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<th>34) Ability to relate to health care team (ICS1)</th>
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<td>Apparent</td>
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<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>35) Ability to relate to colleagues (ICS1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apparent</td>
</tr>
<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>36) Demonstrates effective information sharing (ICS2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apparent</td>
</tr>
<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>37) Comments (strengths and weaknesses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
</tr>
</tbody>
</table>

Remaining Characters: 5,000

### GENERAL PROFESSIONALISM

<table>
<thead>
<tr>
<th>38) Have you reviewed and co-signed the resident's patient treatment log for this rotation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>39) Did the resident attend at least 70% of scheduled supervision sessions?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>40) Has this resident performed sufficiently to be given credit for this required experience?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>
SUBCOMPETENCIES AND THREADS

Please click on the circle that represents the level the resident has demonstrated during the rotation or other specified training experience. You should click on the circle in between levels if the resident is approaching but not yet attained most of the threads of the next level.

These evaluations are based on the A.C.G.M.E. Milestones for Psychiatry which use descriptive anchors for each competency.

In general:
- Level 1 represents skills of early learners
- Level 2-3 are expected to be attained through residency
- Level 4 indicates ability to practice Psychiatry independently and without supervision
- Level 5 is aspirational and expected to be attained once in practice.

Overall Comments:

Remaining Characters: 5,000

Subcompetency questions are generated based on the resident’s rotation.

Choose a rotation
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:

<table>
<thead>
<tr>
<th>Submit Final</th>
<th>Save Draft</th>
<th>Save Draft and Print</th>
<th>Not Enough Time</th>
</tr>
</thead>
</table>

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 602-839-6880.

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 notification to complete a survey on Didactic seminars (called Conferences in New innovations). Please do all possible to complete in a timely manner.

Resident Log In procedures are exactly the same as faculty Log on. Refer to paragraph two (New innovations Log –In Procedures) under Faculty/Attending section above.
SUPERVISION STATUS SUMMARY
Psychiatry Residency Training Program

Resident’s Name: ____________________________________________

PGY-1:

Evaluation for Indirect Supervision: Immediately Available
Form A: Indirect, with Direct immediately available in-house
Form B: Indirect, with Direct available telephonically

Evaluating Resident: _________________________________________
Evaluating Attending: _________________________________________

Reviewed by Program Director: ___________________________ Date: ____________

PGY-2: Evaluation for Supervisory Capability

Form C Passed: ☐ Yes ☐ No

Evaluating Attending: ________________________________

Reviewed by Program Director: ___________________________ Date: ____________

PGY-3: Evaluation for Supervisory Capability
(If not passed during PGY-2)

Form C Passed: ☐ Yes ☐ No

Evaluating Attending: ________________________________

Reviewed by Program Director: ___________________________ Date: ____________
EVALUATION OF PGY-1 FOR INDIRECT SUPERVISION:
IMMEDIATELY AVAILABLE - Form A
University of Arizona College of Medicine - Phoenix
Psychiatry Residency Training Program

Resident’s Name: ___________________________  PGY Level: ______  Date: __________
Evaluator Name: ___________________________  Evaluator Status: ☐ Faculty  ☐ Resident

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: 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.

At the beginning of the residency, each PGY-1 must have Direct Supervision. A PGY-1 may progress to being supervised indirectly with direct supervision immediately available only after demonstrating competence in:

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

Based on your direct observation of this PGY-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):

Gathering an appropriate history  ☐ Y  ☐ NY  ☐ N
Ability to perform an emergent psychiatric assessment  ☐ Y  ☐ NY  ☐ N
Presenting patient findings and data accurately to a supervisor  ☐ Y  ☐ NY  ☐ 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: ________________
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 necessarily 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 expectedly will progress to this level of supervision before the end of the academic year as a prerequisite to advance to PGY-2.

---

### COMPETENCY

<table>
<thead>
<tr>
<th>MEDICAL KNOWLEDGE</th>
<th>PERFORMANCE</th>
<th>COMMENTS &amp; REMEDIATION PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The resident recognizes clinical signs and symptoms which necessitate immediate action to protect patient and coworker safety.</td>
<td>Met ☐ Not Met ☐</td>
<td>____________________________</td>
</tr>
<tr>
<td>2. The resident demonstrates knowledge of appropriate methods for managing patient agitation, violence and self-harm behaviors.</td>
<td>Met ☐ Not Met ☐</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT CARE</th>
<th>PERFORMANCE</th>
<th>COMMENTS &amp; REMEDIATION PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Met ☐ Not Met ☐</td>
<td>____________________________</td>
</tr>
<tr>
<td>2. The resident gathers a patient history adequate to guide appropriate diagnosis and treatment.</td>
<td>Met ☐ Not Met ☐</td>
<td>____________________________</td>
</tr>
<tr>
<td>3. The resident adequately performs an emergent evaluation, including assessment of drug withdrawal, suicide, violence and homicide risk as appropriate.</td>
<td>Met ☐ Not Met ☐</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERPERSONAL AND COMMUNICATION SKILLS</th>
<th>PERFORMANCE</th>
<th>COMMENTS &amp; REMEDIATION PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The resident accurately presents patient findings and data to a supervisor who has not yet seen the patient.</td>
<td>Met ☐ Not Met ☐</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROFESSIONALISM</th>
<th>PERFORMANCE</th>
<th>COMMENTS &amp; REMEDIATION PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Met ☐ Not Met ☐</td>
<td>____________________________</td>
</tr>
<tr>
<td>2. The resident is aware of supervisory lines and accesses them appropriately to obtain clinical supervision.</td>
<td>Met ☐ Not Met ☐</td>
<td>____________________________</td>
</tr>
<tr>
<td>3. The resident practices within his or her scope of expertise.</td>
<td>Met ☐ Not Met ☐</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

---

* **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 by phone).

---

Evaluating Faculty: __________________________ Date: ______________

Resident: __________________________ Date: ______________

Reviewed by Program Director: __________________________ Date: ______________
<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Knowledge:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The resident demonstrates level of medical and psychiatric knowledge sufficient to safely supervise fellow residents with less experience.</td>
<td>Met ☐ *Not Met ☐</td>
<td></td>
</tr>
<tr>
<td><strong>Interpersonal and Communication Skills:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The resident demonstrates capability to provide accurate and helpful feedback to peers and to subordinates.</td>
<td>Met ☐ *Not Met ☐</td>
<td></td>
</tr>
<tr>
<td><strong>Professionalism:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The resident supervises subordinates in a respectful and supportive manner.</td>
<td>Met ☐ *Not Met ☐</td>
<td></td>
</tr>
<tr>
<td>4. The resident informs patients appropriately of his/her role in their care.</td>
<td>Met ☐ *Not Met ☐</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

Print Name ____________________________ Signature ____________________________ Date: ________

**Residents’ Signature:** ____________________________ Date: ________

**Reviewed by Program Director:** ____________________________ Date: ________
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: | | |


### 8. Faculty Evaluation of Handoff Quality:

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has not achieved</td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
<td>Level 4</td>
</tr>
</tbody>
</table>

| SBP1 1.2/B Recognizes failure in teamwork and communication as leading cause of preventable patient harm | SBP1 2.2/B Consistently uses structured communication tools to prevent adverse events (e.g., checklists, safe hand off procedures, briefings) | ICS2 3.1/A, B Uses easy to understand language in all phases of communication, including working with interpreters | ICS2 4.1/A,B Demonstrates effective verbal communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent | ICS2 5.1/A Models continuous improvement in record keeping |
| ICS2 1.1/A Ensures transitions of Care are accurately documented, & Optimizes communication across Systems and continuums of care | ICS2 2.1/A, B Organizes both written and oral information to be shared with patient, family, team, and others | | | |
| ICS2 1.2/A Ensures that the written record (EMR, personal health records/patient portal, handoffs, discharge summaries, etc) are accurate and timely, with attention to preventing confusion and error, consistent with institutional policies | | | | |

- Faculty Signature/Date: _______________________________
Please complete and review with your Primary supervisor. Remember to sign and then return to Program Director when complete. Choose the bullet that best describes your performance.

<table>
<thead>
<tr>
<th></th>
<th>Falls below expectations</th>
<th>Approaches</th>
<th>Meets expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take handoff seriously</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrives on time for handoff meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keep check out sheet up to date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes anticipatory guidance on check out sheet “If … then…”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When passing on critical information I repeat myself and request read back</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I use the read back technique when receiving important information</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Resident (Print): ___________________________  Level of Training: ____________

Resident (Signature): ___________________________  Date: ____________

Supervisor (Print): ___________________________  Setting: ____________

Supervisor (Signature): ___________________________  Date: ____________

Program Director (Signature): ___________________________  Date: ____________
## SEMI-ANNUAL GENERAL COMPETENCIES RESIDENT SELF-ASSESSMENT

Name: ___________________________ Date: ___________________________

### Indicate the level of confidence you have in the following areas of patient care.

<table>
<thead>
<tr>
<th></th>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communicate effectively and demonstrate caring respectful behaviors when interacting with patients and their families</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Gather essential and accurate information about your patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Make informed decisions about diagnostic &amp; therapeutic interventions based upon patient information and preferences, up to date scientific evidence and clinical judgment</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Develop, carry out and modify management plans</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Counsel and educate patients and their families</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Use information technology to support patient care decisions and patient education</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Perform competently all medical and psychiatric procedures considered essential for your area of practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Provide health care services aimed at preventing health problems or maintaining health</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Work with health care Professionals including those from other disciplines to provide patient focused care</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### Indicate the level of confidence you have in the following areas of medical knowledge.

<table>
<thead>
<tr>
<th></th>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Demonstrate investigative &amp; analytic approaches to clinical situations</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Know and apply basic and clinical services appropriate to your discipline</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### Indicate the level of confidence you have in the following areas of practice based learning and improvement.

<table>
<thead>
<tr>
<th></th>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Analyze your clinical practice to identify important learning needs and construct goals/plans for improvement</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Locate, appraise, and assimilate evidence from scientific studies related to your patients' health problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Obtain information about your own population of patients and the larger population from which your patients are drawn</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Critically appraise the literature on diagnosis, prognosis, therapy, and harm</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Use information technology to manage information, access on-line medical information and support your learning needs</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Effectively teach students and other health care Professionals</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### Indicate the level of confidence you have in the following areas of interpersonal and communication skills.

<table>
<thead>
<tr>
<th></th>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Create and sustain therapeutic, ethically sound relationships with your patients, maintaining appropriate boundaries</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Use effective listening skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Elicit and provide information using effective verbal and nonverbal communications skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Use effective writing skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Work effectively with others as a member or leader of a health care team or other professional group</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

PLEASE COMPLETE SIDE 2
<table>
<thead>
<tr>
<th>Indicate the level of confidence you have in the following areas of Professionalism.</th>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Demonstrate sensitivity and responsiveness to patients’ culture, age, gender and disabilities</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicate the level of confidence you have in the following areas of systems based practice.</th>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Know how types of medical practice and delivery systems differ from one another including methods of controlling health care costs and allocating resources</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Practice cost-effective health care and resource utilization that does not compromise quality of care</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Advocate for quality patient care and assist patients in dealing with system complexities</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th>Date: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level (circle one):</td>
<td>PGY-1</td>
</tr>
<tr>
<td>Rater (circle one):</td>
<td>Attending</td>
</tr>
</tbody>
</table>

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

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

Resident: __________________________ Date: __________________________

Program Director: __________________________ Date: __________________________
ACGME General Competency:
Interpersonal & Communication Skills: Self-Assessment
360° Evaluation of Resident Performance

<table>
<thead>
<tr>
<th>Resident Name: ___________________________</th>
<th>Date: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level (circle one): PGY-1 PGY-2 PGY-3 PGY-4</td>
<td>Rotation: ________________</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>INTERPERSONAL AND COMMUNICATION SKILLS</th>
<th>Highly Characteristic</th>
<th>Not at all Characteristic</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communicates clearly</td>
<td>5 4 3 2 1 DK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Is willing to answer questions and provide explanations</td>
<td>5 4 3 2 1 DK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Seeks to understand others’ views</td>
<td>5 4 3 2 1 DK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Treats others with respect (e.g. does not demean, insult, or make others feel inferior)</td>
<td>5 4 3 2 1 DK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Provides equitable care, regardless patients’/decedents’ SES, ethnicity or gender</td>
<td>5 4 3 2 1 DK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Assists or fills-in for others when needed</td>
<td>5 4 3 2 1 DK</td>
<td></td>
<td></td>
</tr>
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<td>7. Negotiates and compromises when disagreements occur</td>
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<td>8. Tends to have disagreeable interactions with co-workers and support staff</td>
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<td></td>
<td></td>
</tr>
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<td></td>
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<tr>
<td>15. Responds poorly to feedback or suggestions from others</td>
<td>5 4 3 2 1 DK</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Resident: ___________________________ Date: ________________

Program Director: ___________________________ Date: ________________
### ACGME General Competency:
Practice Based Learning and Improvement
Part I: Analyze and Improve Own Practice

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level (circle one): PGY-1 PGY-2 PGY-3 PGY-4</td>
<td>Rotation:</td>
</tr>
<tr>
<td>Rater: Attending</td>
<td></td>
</tr>
</tbody>
</table>

- **For PGY-1 and PGY-2 Residents**

<table>
<thead>
<tr>
<th>Makes same mistakes again and again. Oblivious of context. No appreciation of ethnic or cultural variations.</th>
<th>Needs frequent prompting to adjust. Slow to learn from previous mistakes. Minimal appreciation of ethnic or cultural variations.</th>
<th>Improves and adds to own development by learning from day to day clinical practice. Adapts to cultural backgrounds and work situations without undue assumptions.</th>
<th>⊕ Learns quickly from practice. Anticipates and adapts to different cultural backgrounds and work situations. Assimilates and applies relevant literature.</th>
<th>⊕⊕ Excellent learning from practice. Rapidly acquires, assimilates and applies relevant literature. Recognizes and utilizes strengths and weaknesses of systems.</th>
</tr>
</thead>
<tbody>
<tr>
<td>⊕</td>
<td>⊕</td>
<td>⊗</td>
<td>⊕</td>
<td>⊗</td>
</tr>
</tbody>
</table>

- **For PGY-3 and PGY-4 Residents**

<table>
<thead>
<tr>
<th>Unable to incorporate his or her own experience. Limited to or no ability to use rounds or patient care as learning experiences.</th>
<th>Struggles to benefit from ward teaching. Erratic response to feedback from faculty and ancillary personnel.</th>
<th>Uses clinical examples to learn treatment planning, differential diagnoses, and follow-up. Steadily adds individual patient data to fund of knowledge.</th>
<th>⊕ Formulate treatment in response to expanded awareness of his or her experience. Uses rating scales and objective measures of efficacy.</th>
<th>⊕⊕ Consistently and accurately utilizes clinical experience to improve patient care. Readily gathers and applies current literature to his or her own patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>⊗</td>
<td>⊗</td>
<td>⊗</td>
<td>⊗</td>
<td>⊗</td>
</tr>
</tbody>
</table>

**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: 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

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

• For PGY-3 and PGY-4 Residents

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

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

Resident: ________________________________ Date: ____________________________
Program Director: ____________________________ Date: ____________________________
### EVIDENCE BASED MEDICINE

#### Indicate the level of confidence you have in formulating answerable clinical questions.

<table>
<thead>
<tr>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1. I am regularly curious about clinical problems in many of my clinical settings and identify foreground questions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Indicate the level of confidence you have in finding the best available evidence.

<table>
<thead>
<tr>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. I regularly perform electronic searches to answer my questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I have become efficient in my searching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I know the best sources for current evidence to answer my questions. I am becoming comfortable using a widening array of sources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I am skillful at using MeSH headings, limiters, thesaurus, EBM filters, and shortcuts when searching MEDLINE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. My searches compare favorably with those performed by research librarians or respected colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Effectively teach students and other health care Professionals searching skills</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Indicate the level of confidence you have in critically appraising the literature.

<table>
<thead>
<tr>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. I have a good understanding of basic statistical concepts, clinical epidemiology, and study design/methodology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I am comfortable applying critical appraisal guides to my evaluation of an article</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I am becoming more accurate and efficient in understanding and calculating some critical appraisal measures, such as NNT’s and likelihood ratios</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Indicate the level of confidence you have in applying the best evidence to your patient.

<table>
<thead>
<tr>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. I change my patient care practices based on best available evidence, my patients’ preferences and my clinical judgment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I am able to justify whether or not to apply critically appraised findings to an individual patient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Indicate the level of confidence you have in teaching EBM

<table>
<thead>
<tr>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Indicate the level of confidence you have in pursuing continued development in learning and teaching EBM

<table>
<thead>
<tr>
<th>Not Confident</th>
<th>Reasonably Confident</th>
<th>Extremely Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. I regularly seek out EBM supervision and learning opportunities to improve my skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I regularly identify my learning needs in EBM skill development and set personal goals and plans to achieve further competence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACGME General Competency:  
Practice Based Learning and Improvement  
Part III: Use of Information Technology  
*Self-Assessment*

Resident Name: ___________________________  Date: ________________

In a typical week, how many hours do you personally use a computer hands-on?  ___________________________

Hours

To what extent do you personally use a computer for each of the following professional tasks? *Please circle your answer.*

1. Never perform this task
   2. Perform this task but never use a computer
   3. Sometimes use a computer
   4. Often use a computer
   5. Always use a computer

<table>
<thead>
<tr>
<th>Task</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documenting patient information (e.g., history &amp; physicals, progress notes)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Accessing clinical data (e.g., laboratory data, EKGs, radiology reports)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Communicating with colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Obtaining advice on a specific patient’s diagnosis or therapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Scheduling patient appointments</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Writing (e.g., grants, research papers, teaching material)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Preparing presentation Powerpoint or overheads</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Performing statistical analysis on clinical or research data</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Searching the medical literature (e.g., MEDLINE)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Teaching students and residents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

On the whole, how sophisticated a computer user do you consider yourself?

☐ Very sophisticated
☐ Sophisticated
☐ Neither sophisticated nor unsophisticated
☐ Unsophisticated
☐ Very unsophisticated

Resident: ___________________________  Date: ________________

Program Director: ___________________________  Date: ________________
ACGME General Competency:
Practice Based Learning and Improvement/ Interpersonal and Communication Skills
Part IV: Facilitate Learning of Others
*Medical Student Evaluation of Resident Teaching*

Resident: ___________________________ (circle one)  AIP  C/L  Outpatient  Lecturer

Evaluator level of training (please circle):  MS3  MS4

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

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

Resident: ___________________________ Date: ____________________

Program Director: ___________________________ Date: ____________________
ACGME GENERAL COMPETENCIES: PROFESSIONALISM

Resident Name: ___________________________  Evaluator’s Name: ___________________________

Method of Evaluation: □ Clinical Teaching  □ Performance Feedback  □ Clinical Experiences

□ Departmental Conferences, Lectures or Discussions  □ Other Learning Activity

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

<table>
<thead>
<tr>
<th>MANAGEMENT OF CLINICAL RESPONSIBILITY</th>
<th>Inappropriate, antagonistic attitude. Late to clinical responsibilities with no regard to inconveniences of others. Unprepared. Often absent or unreachable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SKILLS</td>
<td>Usual present, but frequently disinterested. Rarely adequately prepared. Cannot keep up with clinical data. Difficult to track down.</td>
</tr>
<tr>
<td>PERSONAL QUALITIES</td>
<td>Adequately prepared and organized for clinical and educational activities. Delegates appropriately. Solid attendance and availability.</td>
</tr>
<tr>
<td>RESPONSIBILITY</td>
<td>Aby manages all patient responsibilities and educational experiences. Adapts at managing many complicated patients. Impeccable attendance.</td>
</tr>
<tr>
<td>SUPPLEMENTAL</td>
<td>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</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SKILLS</td>
<td>Unfocused notes with many omissions or marked over-inclusion. Many late and/or untimely entries.</td>
</tr>
<tr>
<td>RESPONSIBILITY</td>
<td>Complete documentation that includes all basic information and satisfies legal expectations.</td>
</tr>
<tr>
<td>SUPPLEMENTAL</td>
<td>Well organized and thorough. Precise charting that reflects appreciation for the medical record as a part of the patient’s care.</td>
</tr>
<tr>
<td></td>
<td>Concise without losing completeness. Always timely. Able to use the medical record as an important tool in both patient care and medicolegal affairs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TEACHING</th>
<th>Never teaches. Often ignores the students or only expects them to provide service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SKILLS</td>
<td>Rarely teaches and ineffective when the attempt is made. No active organization of educational endeavors.</td>
</tr>
<tr>
<td>RESPONSIBILITY</td>
<td>Solid clinical teacher who adds didactic sessions to the student’s and lower level resident’s workday.</td>
</tr>
<tr>
<td>SUPPLEMENTAL</td>
<td>Above average bedside teacher who conveys difficult aspects of psychiatric knowledge to learners of all levels.</td>
</tr>
<tr>
<td></td>
<td>Exceptional and enthusiastic teacher. Systematically covers many areas of psychiatry for all the members of the team. Regularly arranges educational experiences</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ETHICAL DECISION MAKING &amp; CULTURAL SENSITIVITY</th>
<th>Does not accept moral standards for decision making. Prejudiced. Dishonest. Attempts to cover up errors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SKILLS</td>
<td>Irregularly applies moral standards. Not always impartial. May try and minimize or camouflage mistakes and shortcomings.</td>
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<td>Applies moral standards to personal and clinical decisions that are relevant to the role of resident. Admits errors. Aware of cultural differences.</td>
</tr>
<tr>
<td>SUPPLEMENTAL</td>
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<td>Exceptional decision-maker who respects human dignity without bias. Utilizes cultural differences to maximize care delivery.</td>
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<table>
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<table>
<thead>
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<th>ADMINISTRATIVE SKILLS</th>
<th>Unable to supervise or inappropriately supervises. Cannot make decisions. Fails to accomplish paperwork and reports.</th>
</tr>
</thead>
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<tr>
<td>SKILLS</td>
<td>Marginally effective at supervision. Inconsistent appreciation for necessary documentation, standards and paperwork.</td>
</tr>
<tr>
<td>RESPONSIBILITY</td>
<td>Able to coordinate and supervise team. Good planner. Effective at ensuring that necessary documentation is complete and timely.</td>
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<tr>
<td>SUPPLEMENTAL</td>
<td>Easily adapts to the administrative and supervisory role. Independently coordinates team function.</td>
</tr>
<tr>
<td></td>
<td>Exemplary organizer, supervisor, and leader. Fosters excellence within the team and encourages compliance with documentation and Required paperwork.</td>
</tr>
</tbody>
</table>

Other comments: ____________________________

1. Was this evaluation reviewed with the resident?  □ Yes  □ No  2. Remedial plans discussed with Resident?  □ No  □ Yes; Discuss plan: ____________________________

Evaluator’s Signature ___________________________  Date ___________  Resident’s Signature ___________________________  Date ___________

Director of Residency Training ___________________________  Date ___________
ACGME GENERAL COMPETENCIES PROFESSIONALISM: SELF-ASSESSMENT

Resident Name: ___________________________  Evaluator’s Name: ___________________________

Method of Evaluation:  ☐ Clinical Teaching  ☐ Performance Feedback  ☐ Clinical Experiences
☐ Departmental Conferences, Lectures or Discussions  ☐ Other Learning Activity

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 ongoing 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

<table>
<thead>
<tr>
<th>Quality</th>
<th>Resident</th>
<th>Evaluator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate, antagonistic attitude. Late to clinical responsibilities with no regard to inconveniences of others. Unprepared. Often absent or unreachable.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Usually present, but frequently disinterested. Rarely adequately prepared. Cannot keep up with clinical data. Difficult to track down.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Adequately prepared and organized for clinical and educational activities. Delegates appropriately. Solid attendance and availability.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Ably manages all patient responsibilities and educational experiences. Adept at managing many complicated patients. Impecable attendance.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

DOCUMENTATION

<table>
<thead>
<tr>
<th>Quality</th>
<th>Resident</th>
<th>Evaluator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unfocused notes with many omissions or marked over-inclusion. Many late and/or untimed entries.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Complete documentation that includes all basic information and satisfies legal expectations.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Well organized and thorough. Precise charting that reflects appreciation for the medical record as a part of the patient’s care.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Concise without losing completeness. Always timely. Able to use the medical record as an important tool in both patient care and medicolegal affairs.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

TEACHING

<table>
<thead>
<tr>
<th>Quality</th>
<th>Resident</th>
<th>Evaluator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never teaches. Often ignores the students or only expects them to provide service.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Rarely teaches and ineffective when the attempt is made. No active organization of educational endeavors.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Solid clinical teacher who adds didactic sessions to the student’s and lower level resident’s workday.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Above average bedside teacher who conveys difficult aspects of psychiatric knowledge to learners of all levels.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Exceptional and enthusiastic teacher. Systematically covers many areas of psychiatry for all the members of the team. Regularly arranges educational experiences</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

ETHICAL DECISION MAKING & CULTURAL SENSITIVITY

<table>
<thead>
<tr>
<th>Quality</th>
<th>Resident</th>
<th>Evaluator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not accept moral standards for decision making. Prejudiced. Dishonest. Attempts to cover up errors.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Irregularly applies moral standards. Not always impartial. May try and minimize or camouflage mistakes and short-comings.</td>
<td>☐</td>
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<tr>
<td>Applies moral standards to personal and clinical decisions that are relevant to the role of resident. Admits errors. Aware of cultural differences</td>
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<td>Ethical and reasoned decision making process. Acknowledges equality of all people.</td>
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PERSONAL QUALITIES

<table>
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<tr>
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ADMINISTRATIVE SKILLS

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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 ___________________________
MEDICAL KNOWLEDGE COMPETENCY
Improvement Plans – 2016-2017

Resident’s Name: ______________________ Level: __________

Primary Supervisor’s Name: ______________________

Available Topics and example relevant Milestone sub-competencies (choose at least 2)

_____ Growth and Development (MK1)
_____ Adult Psychopathology (MK2, PC2)
_____ Emergency Psychiatry (MK2)
_____ Social Psychiatry (MK4)
_____ Psychosocial Therapies (MK4, PC4)
_____ Somatic Treatments (MK5, PC5)
_____ Patient Evaluation and Treatment Selection (PC1, PC2, PC3, PC4, PC5, MK2, MK4, MK5, ICS2, PROF1, SBP2, SPB3)
_____ Consultation-Liaison (SBP4)
_____ Child Psychiatry (MK2, PC2)
_____ Substance Abuse (MK2, PC2)
_____ Geriatric Psychiatry (MK3, MK5, PC5)
_____ Forensic Psychiatry (MK6, PBLI3, PROF1, PROF2, SBP1, SBP4)

Study Plans (be specific) _____________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Re-assessment Strategies (be specific) _______________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Resident Signature: ______________________ Date: __________

Supervisor Signature: ______________________ Date: __________

Reviewed: ______________________ Date: __________

Program Director
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:

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
     ○  ○  ○  ○  ○
• Can the resident devise a treatment plan that controls health costs in a cost-effective manner that does not compromise care?
  Never Sometimes Always
  ○ ○ ○ ○ ○

3. Delivery Systems
  • Does the resident have the knowledge of available services in the community both public and private for the patient?
  Never Sometimes Always
  ○ ○ ○ ○ ○
  • Does the resident consistently teach the patient and family how to use the system to the patient’s benefit?
  Never Sometimes Always
  ○ ○ ○ ○ ○
  • Does the resident understand how to improve patient compliance?
  Never Sometimes Always
  ○ ○ ○ ○ ○

4. Patient Advocacy
  • Does the resident know how to mobilize appropriate resources to overcome barriers and improve patient care?
  Never Sometimes Always
  ○ ○ ○ ○ ○
  • Does the resident understand and apply the following issues to patient care: capacity and consent, confidentiality and reporting, leaving against medical advice, refusal of care?
  Never Sometimes Always
  ○ ○ ○ ○ ○
  • Does the resident know how to advocate for the patient within multiple systems of care?
  Never Sometimes Always
  ○ ○ ○ ○ ○

5. Comments (Strengths, Areas for improvement):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Resident:______________________________________ Date_______________
Faculty:______________________________________ Date_______________
Program Director:______________________________ Date_______________
**PYCHIATRY CLINICAL SKILLS EVALUATION FORM (CSV)**

**Resident Name** [ ]  **Resident Signature** [ ]

**Level of Training** PG [ ]  **Date** [ ]

**Examiner Name** [ ]  **Examiner Signature** [ ]

**Patient Type** [ ]

<table>
<thead>
<tr>
<th>PHYSICIAN-PATIENT RELATIONSHIP (overall):</th>
<th>Unacceptable</th>
<th>Acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Opening and closing</td>
<td>Awkward strategies</td>
<td>Appropriate strategies</td>
</tr>
<tr>
<td>2. Informational cues</td>
<td>Ignored leads</td>
<td>Followed leads</td>
</tr>
<tr>
<td>3. Affective cues</td>
<td>Ignored</td>
<td>Explored appropriately</td>
</tr>
<tr>
<td>4. Communication style and rapport</td>
<td>Insensitivity interfered with data collection</td>
<td>Adequate language sensitivity</td>
</tr>
<tr>
<td>5. Questioning techniques</td>
<td>Abrupt and forced choice questions</td>
<td>Open-ended but appropriately structured</td>
</tr>
<tr>
<td>6. Control and direction of interview</td>
<td>Scattered and fragmented questions</td>
<td>Developed cohesive interview</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PSYCHIATRIC INTERVIEW (overall):</th>
<th>Unacceptable</th>
<th>Acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Presenting problems and history of present illness</td>
<td>Inadequately obtained or too vague</td>
<td>Obtained adequate data</td>
</tr>
<tr>
<td>8. Past history: Psychiatric</td>
<td>Ignored major issues</td>
<td>Gathered relevant data in at least brief form</td>
</tr>
<tr>
<td>Family</td>
<td>Ignored major issues</td>
<td>Gathered relevant data in at least brief form</td>
</tr>
<tr>
<td>Medical</td>
<td>Ignored major issues</td>
<td>Gathered relevant data in at least brief form</td>
</tr>
<tr>
<td>8. Past history (continued): Developmental</td>
<td>Ignored major issues</td>
<td>Gathered relevant data in at least brief form</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>9. History of drug and alcohol abuse</td>
<td>Ignored or too limited</td>
<td>Sensitively gathered</td>
</tr>
<tr>
<td>10. Assessment of suicidal risk</td>
<td>Ignored or too limited</td>
<td>Sensitively explored</td>
</tr>
<tr>
<td>11. Assessment of homicidal risk</td>
<td>Ignored or too limited</td>
<td>Sensitively explored</td>
</tr>
<tr>
<td>12. Mental status examination</td>
<td>Omitted or too limited</td>
<td>Organized approach and performed appropriately</td>
</tr>
</tbody>
</table>

**CASE PRESENTATION (overall):**

<table>
<thead>
<tr>
<th>13. Summary of important data</th>
<th>Unacceptable</th>
<th>Acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Mental status examination</td>
<td>Incomplete</td>
<td>Accurately summarized</td>
</tr>
<tr>
<td>15. Emergency issues: Suicide</td>
<td>Ignored</td>
<td>Considered</td>
</tr>
<tr>
<td>Violence / abuse</td>
<td>Ignored</td>
<td>Considered</td>
</tr>
<tr>
<td>Drugs / alcohol</td>
<td>Ignored</td>
<td>Considered</td>
</tr>
</tbody>
</table>

**Recognition of need for additional history and collateral information**

<table>
<thead>
<tr>
<th>Absent or no rationale</th>
<th>Appropriate</th>
</tr>
</thead>
</table>

**Comments:**
# Guidelines for Observed Clinical Interview

## DOCTOR-PATIENT RELATIONSHIP

<table>
<thead>
<tr>
<th>Adequately Performed</th>
<th>Comments/Documenting Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Adequately Performed</th>
<th>Adequately Documented</th>
<th>Comments/Documenting Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

## 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

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td></td>
</tr>
</tbody>
</table>

## CASE PRESENTATION

### Presents data in an 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 NAME: ____________________ SIGNATURE: ____________________ Date: ________________
# Evaluation for Competency in Supportive Psychotherapy

<table>
<thead>
<tr>
<th>Skills</th>
<th>Not Apparent*</th>
<th>Emerging+</th>
<th>Apparent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to initiate supportive therapy for appropriate patient/clinical issue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to assess ego strengths and make interventions to support patient’s ego functions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to take a non-interpretative stance in relation to a defensive operation in a patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to be directive: give advice, set limits, provide patient education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to take action on behalf of a patient or influence their environment</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ability to recognize transference &amp; countertransference but not interpret it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to maintain appropriate boundaries in supportive therapy setting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to understand and address issues of treatment compliance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to provide accurate, timely and rational medical documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to establish rapport and develop a therapeutic alliance with the patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to empathize with the patient and convey empathic understanding</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

+ **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: __________________________
**Evaluation for Competency in Combined Psychopharmacology and Psychotherapy**

Resident: ____________________________  PGY- ________
Evaluator: ____________________________
Setting: ____________________________  Dates of Evaluation: __________

<table>
<thead>
<tr>
<th>Skills</th>
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<th>Emerging+</th>
<th>Apparent*</th>
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<tbody>
<tr>
<td>Ability to integrate biological and psychological aspects of a patient’s history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to provide psychoeducation about psychiatric illness and commonly prescribed psychotropic medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
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<tr>
<td>Ability to demonstrate a basic understanding of diagnosis-specific psychotherapy and medication management</td>
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<tr>
<td>Ability to recognize and manage transference and countertransference in prescribing medications</td>
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<tr>
<td>Recognize how medication can positively or negatively effect psychotherapy and how psychotherapy can positively or negatively effect medication management</td>
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<tr>
<td>Identify psychological aspects of noncompliance</td>
<td></td>
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</tr>
</tbody>
</table>

+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: __________________
## Evaluation for Competency in Psychodynamic Psychotherapy

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

Page 1

CONTINUED ON 2ND PAGE
### Evaluation for Competency in Psychodynamic Psychotherapy

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

+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: ________________________________
## Evaluation for Competency in Cognitive-Behavioral Therapy

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

**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: ________________
### Evaluation for Competency in Brief Therapy

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

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•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: ________________________________
Evaluation for Competency in Interpersonal Psychotherapy

Resident: ___________________________ PGY- ______________
Evaluator: ___________________________
Setting: ___________________________ Dates of Evaluation: ___________

1. Designate focus areas for IPT
   _____ Depression   _____ Interpersonal Disputes   _____ Grief
   _____ Interpersonal Deficits   _____ Role Transition   _____ Other: ______

<table>
<thead>
<tr>
<th>Skills</th>
<th>Not Apparent*</th>
<th>Emerging+</th>
<th>Apparent●</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to articulate historical development, theoretical basis and appropriate applications and efficacy of IPT</td>
<td></td>
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<tr>
<td>Able to evaluate symptoms of patient</td>
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<tr>
<td>Able to review symptoms of patient</td>
<td></td>
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<tr>
<td>Able to review and establish goals of IPT with patient</td>
<td></td>
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<tr>
<td>Able to identify role of patient’s relationships and self-concept in affecting resolution of specified focus areas</td>
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<tr>
<td>Able to clarify and assist patient in focusing on current and past relationships</td>
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<tr>
<td>Assist patient in identifying what can be done to change relationships</td>
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<tr>
<td>Assist patient in improving communication skills</td>
<td></td>
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<tr>
<td>Appropriate use and scrutiny of patient-therapist relationship as part of therapy</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

Frequency of sessions: ___________________________
Length of treatment: ___________________________

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●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: ___________
Evaluation for Competency in Group Psychotherapy

Resident: ___________________________          PGY- __________________________
Evaluator: ___________________________
Setting: _____________________________          Dates of Evaluation: ____________

<table>
<thead>
<tr>
<th>Skills</th>
<th>Not Apparent*</th>
<th>Emerging+</th>
<th>Apparent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to present information, clearly and in detail</td>
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<tr>
<td>Ability to demonstrate an understanding of, indications for and appropriateness for group therapy</td>
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<tr>
<td>Ability to observe and describe group phenomena</td>
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<tr>
<td>Ability to demonstrate knowledge of the specific therapeutic principles involved in the technique of group psychotherapy</td>
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<tr>
<td>Ability to appropriately evaluate the effectiveness of the use of group therapies</td>
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<tr>
<td>Ability to work with and clarify the role of co-therapist</td>
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<tr>
<td>Ability to make good use of supervision</td>
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<tr>
<td>Ability to use constructive criticism to improve areas of weakness</td>
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</tbody>
</table>

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• 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: __________________________
**ECT and other Neuromodulation Techniques**  
**Education Module Checklist**

Resident Name ____________________________________________

<table>
<thead>
<tr>
<th>Experience</th>
<th>✓ = Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attended Core I Lecture</td>
<td></td>
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<tr>
<td>2. Completed recommended reading</td>
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<tr>
<td>3. Evaluated pre-ECT patient</td>
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<td>4. Participated in Sim Center experience</td>
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<tr>
<td>5. Observed ECT procedure</td>
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<td>6. Completed Quiz</td>
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<tr>
<td>Score</td>
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<tr>
<td>7. TMS (specify)</td>
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<tr>
<td>8. VNS (specify)</td>
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<td>9. Other (specify)</td>
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</tbody>
</table>
RESIDENTS’ MONTHLY EVALUATION OF CLINICAL AND DIDACTIC EXPERIENCES

Resident (optional): ________________________________ Primary Rotation: ________________________________

CLINICAL EXPERIENCES

Attending(s): ________________________________ Rotation Dates (optional): ________________________________

Please evaluate the educational quality of this rotation in the following areas.

1. Was the experience appropriate for a psychiatry resident at your level of training and did it satisfy the educational goals and objectives?

   SUPERIOR 1 2 3 4 5

   POOR

2. Quality of supervision & teaching. Informal and formal.

   SUPERIOR 1 2 3 4 5

   POOR

Comments regarding the strengths of this rotation:

__________________________________________________________________

__________________________________________________________________

Comments regarding the opportunities for improvement of this rotation:

__________________________________________________________________

__________________________________________________________________

Comments regarding how well this rotation met the goals and objectives. Please list any objectives that were not accomplished:

__________________________________________________________________

__________________________________________________________________

DIDACTIC EXPERIENCES

Lectures, Seminars, etc. Faculty Comments

__________________________________________________________________

__________________________________________________________________

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If hand-written, please fold and return to Andrea Waxman, M.D. upon completion
WORK DUTY HOURS ATTESTATION

Resident Name: ____________________________  Month/Year: ____________________
Primary Rotation: __________________________  Level of Training: ____________________

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td><strong>OVER THE PAST 4 WEEKS ON AVERAGE WERE YOU:</strong></td>
<td></td>
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<tr>
<td>Scheduled less than 80 duty hours per week?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Average # Hours/Week:</td>
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<tr>
<td>☐ 40-50</td>
<td>☐ 50-60</td>
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<tr>
<td>☐ 60-70</td>
<td>☐ 70-80</td>
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<tr>
<td>☐ &gt;80</td>
<td>☐ &gt;80</td>
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<tr>
<td>Provided 1 day in 7 free of patient care responsibilities on average over each month long rotation?</td>
<td>☐ Yes</td>
<td>☐ No*</td>
<td></td>
</tr>
<tr>
<td>Average # Days Off/Month:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ 40-50</td>
<td>☐ 50-60</td>
<td></td>
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<tr>
<td>☐ 60-70</td>
<td>☐ 70-80</td>
<td></td>
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<tr>
<td>☐ &gt;80</td>
<td>☐ &gt;80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-call no more than every fourth night?</td>
<td>☐ Yes</td>
<td>☐ No*</td>
<td>☐ N/A</td>
</tr>
<tr>
<td><strong>HAVE YOU ROUTINELY BEEN PROVIDED A 10 HOUR REST PERIOD BETWEEN DUTY PERIODS?</strong></td>
<td>☐ Yes</td>
<td>☐ No*</td>
<td></td>
</tr>
<tr>
<td>Minimum # Hours Off Between Shifts:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>☐ 40-50</td>
<td>☐ 50-60</td>
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<tr>
<td>☐ 60-70</td>
<td>☐ 70-80</td>
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<tr>
<td>☐ &gt;80</td>
<td>☐ &gt;80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-call no more than every fourth night?</td>
<td>☐ Yes</td>
<td>☐ No*</td>
<td>☐ N/A</td>
</tr>
<tr>
<td><strong>PGY-1: BEEN ROUTINELY EXCUSED FROM DUTY NO MORE THAN 16 HOURS FROM THE START OF YOUR WORK DAY?</strong></td>
<td>☐ Yes</td>
<td>☐ No*</td>
<td></td>
</tr>
<tr>
<td>#Times NOT over past 4 weeks:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ 40-50</td>
<td>☐ 50-60</td>
<td></td>
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<tr>
<td>☐ 60-70</td>
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<td>On-call no more than every fourth night?</td>
<td>☐ Yes</td>
<td>☐ No*</td>
<td>☐ N/A</td>
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<tr>
<td><strong>PGY-2, 3 &amp; 4: WHEN ON CALL FOR PSYCHIATRY OVERNIGHT HAVE YOU HAD 6 HOURS REST TIME?</strong></td>
<td>☐ Yes</td>
<td>☐ No*</td>
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<td>#Times Work &gt; 28 Hours Continuously the Past Month:</td>
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<td>☐ Yes</td>
<td>☐ No*</td>
<td>☐ N/A</td>
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<tr>
<td><strong>PGY-2, 3 &amp; 4: BEEN ROUTINELY EXCUSED FROM DUTY NO MORE THAN 4 HOURS AFTER A 24 HOUR ON-CALL DUTY?</strong></td>
<td>☐ Yes</td>
<td>☐ No*</td>
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<td>☐ Yes</td>
<td>☐ No*</td>
<td>☐ N/A</td>
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<tr>
<td><strong>HAVE THE 4 HOUR ADDED PERIODS BEEN LIMITED TO CONTINUITY AND TRANSFER OF CARE FOR ESTABLISHED PATIENTS, EDUCATIONAL DEBRIEFING AND DIDACTIC ACTIVITIES?</strong></td>
<td>☐ Yes</td>
<td>☐ No*</td>
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<td>☐ Yes</td>
<td>☐ No*</td>
<td>☐ N/A</td>
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<tr>
<td><strong>HAVE YOU NOTIFIED YOUR PROGRAM DIRECTOR OF ANY CONCERNS REGARDING STRESS AND FATIGUE OR DUTY HOURS COMPLIANCE?</strong></td>
<td>☐ Yes*</td>
<td>☐ No*</td>
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<td>Why Not?</td>
<td></td>
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<td><strong>ARE YOU MOONLIGHTING?</strong></td>
<td>☐ Yes</td>
<td>☐ No</td>
<td></td>
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<tr>
<td>Have you received written authorization to moonlight?</td>
<td>☐ Yes</td>
<td>☐ No*</td>
<td>☐ N/A</td>
</tr>
<tr>
<td>*If NO contact your Program Director</td>
<td></td>
<td></td>
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<tr>
<td>Has your moonlighting caused you to work more than 80 hours per week?</td>
<td>☐ Yes*</td>
<td>☐ No</td>
<td>☐ N/A</td>
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</tbody>
</table>

Resident’s signature attesting to the veracity of your answers: ____________________________ Date: ____________

Program Director’s Signature: ____________________________ Date: ____________
PSYCHIATRY RESIDENCY
University of Arizona
Psychiatry
College of Medicine – Phoenix Program
Psychiatry-BAI

- Child-Adolescent
- OP-B-UMCP

TREATMENT LOGS
- Emergency Psychiatry (On-Call, BPC)

RESIDENT’S NAME:  (PRINT)

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

Internal Medicine (GM)  VAM

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

SIGNATURE:__________________________

PGY: ________ MONTH/YEAR: ________

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

<table>
<thead>
<tr>
<th>PT INITIAL S</th>
<th>AGE</th>
<th>SEX</th>
<th>ETHNICITY</th>
<th>SETTING</th>
<th>DIAGNOSES</th>
<th>TREATMENTS (Medications and Psychotherapies)</th>
<th>FREQ (daily, etc.)</th>
</tr>
</thead>
</table>

Psychotherapy:  
- Supportive
- Combined
- Dynamic
- CBT
- Brief
- Other

Supervising Faculty: ___________________________ Service: ___________________________ Date: ___________________________
This form MUST be reviewed with the Program Director before submitted to the Residency Advisory Committee 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 Faculty Supervisor; please be specific): __________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Have you identified elective specific Milestone subcompetencies? 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 (regarding letters of agreements, contracts, ongoing outpatient hours, etc.): __________________________
Residency Program Director: __________________________
Approved by Education & Policy Committee: __________________________ Date: __________________________
PTO REQUEST FORM

Name of Resident: ___________________________ PGY- ________ Date: ____________
Requested Dates: From: ________________ Through: ________________ Total Days: ____________

Primary Rotation: ___________________________ Request type: ☐ Vacation/Personal ☐ Educational leave
☐ Holiday adjustment (Is this PTO request to compensate for a Banner holiday worked on Psychiatry in the same month?) ☐ NO
☐ YES (holiday) ____________________________

1st step: Resident consideration of adequate coverage of clinical service:

Date of initial request: ________________ Other residents requesting PTO at same time? ☐ Yes ☐ No
Same rotation? ☐ Yes ☐ No If YES, whom? Name ____________________________ PGY ________
(discussed PTO request with residents on same rotation?) Same PG year? ☐ Yes ☐ No If yes, whom?
Name ____________________________ PGY ________ Name(s) ____________________________

*Reviewed adequate coverage with Rotation Supervisor Preliminary approval? ☐ Yes ☐ No

Rotation Supervisor:
Print Name ____________________________ Signature ____________________________ Date ____________

*Review with Residency Program Coordinator

Preliminary approval? ☐ Yes ☐ No Placed on Department Outlook PTO Calendar? ☐ Yes ☐ No
Residency Program Coordinator ____________________________
Signature and Date ____________________________

2nd step: Resident verification after call schedule finalized for month of PTO request:

Call verification (attach final call schedule for month of request) On-call or back up responsibilities during PTO? ☐ Yes ☐ No
Outpatient coverage verification (PGY2-4 residents) Outpatients will be covered by: ____________________________

*Covering Resident
Print Name ____________________________ PGY ________
Signature and date ____________________________

Covering Resident is available to cover all days requested? ☐ Yes ☐ No
Covering Resident post-call on: ____________________________ If “No” indicate SOAR Resident available for post-call
coverage ____________________________

*SOAR Resident ____________________________
Print Name ____________________________ Signature and date ____________________________

3rd step: Resident agreement to update voicemail and Outlook Calendar prior to taking PTO

☐ Resident will change outpatient voice mail to reflect PTO dates and covering physician (day before departure)
☐ Resident will put PTO dates in Personal Outlook Calendar and indicate name of covering resident
☐ Resident will provide updated outpatient log to covering resident and have Transition Of Care meeting to discuss Outpatients and patients from C/L service.

Resident Signature ____________________________ Date ____________

4th step: Final Authorization by Residency Program Coordinator

ALL MEDICAL RECORDS, CASE LOGS, CHARGE SHEETS EVALUATIONS, SIGNATURES IN NEW INNOVATIONS, ARE CURRENT AND SUBMITTED BEFORE PTO OCCURS: ☐ Yes ☐ No

Residency Program Coordinator ____________________________ Signature ____________________________ Date ____________

cc: Resident ____________________________ Resident On Call Coordinator ____________________________ Office of Residency Training ____________________________ SOAR resident during PTO request ____________________________
Rotation Supervisor Melissa Hardy Residents on Primary Rotation ____________________________ Resident covering outpatients ____________________________
EDUCATIONAL LEAVE REQUEST

Submitted by: ______________________________ Level of Training: __________________

Dates of Educational Leave: __________________________ Total Days: _____________

Purpose (eg. meeting name*, licensing exam, etc.): ______________________________

(Please attach course description or statement from sponsoring group if applicable)

*How will you share what you learn at the meeting with our professional staff (be specific):

PLEASE COMPLETE AND ATTACH THIS FORM TO A COMPLETED PTO REQUEST FORM INDICATING COVERAGE, APPROVAL, ETC.
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, 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: ______________________ 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)

   Date: ______________________

Chief Academic Officer/DIO
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. IV 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
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 case was staffed with Signature

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 case was staffed with Signature
OUTPATIENT PSYCHIATRY

INITIAL ASSESSMENT AND PROGRESS NOTE OUTLINE: (completed within 24 hours after service is provided) – please use templates in NextGen Electronic Medical Record. Notes must include all elements below. Additional training on the use of NextGen 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”