

# **PSYCHIATRY RESIDENTS HANDBOOK**

**2016-2017**



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**WAKE FOREST SCHOOL OF MEDICINE  
WAKE FOREST BAPTIST HEALTH**

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# **SECTION ONE: INTRODUCTORY MATERIAL**



# **THE COMMUNITY**

## **BEGINNINGS OF WINSTON-SALEM**

The Moravians, a Protestant communal sect, settled the town of Salem (meaning “peace”) in 1766. Their disciplined and pacifist lifestyle was fostered by a work ethic and an appreciation for music and the arts. In addition to cotton and wool manufacturing, they relied on trades and crafts to support their community. The Moravians established Salem College, one of the nation’s first colleges for women.

The county of Forsyth and the city of Winston, founded in 1849, were more industrially oriented and developed around the manufacture of textiles, furniture, and tobacco products. In 1913 the two cities of Winston and Salem were joined. This merging of economies, talents, and values reflected a cooperative spirit between the two original settlements that has remained until the present.

## **LOCATION**

In the Piedmont region of north central North Carolina, Winston-Salem is equidistant from Washington, D.C., and Atlanta, Georgia. Winston-Salem joins with Greensboro and High Point to form the Triad region of North Carolina. Residents enjoy proximity to the beautiful Blue Ridge Mountains to the west and relaxing beaches of the Atlantic to the east. The region is served by the Piedmont Triad International Airport, only 20 minutes away.

## **LOCAL ATTRACTIONS**

The Piedmont Triad contains numerous institutions of higher learning including Wake Forest University, Winston-Salem State University, Salem College, Forsyth Technical Community College, High Point University, The University of North Carolina in Greensboro, and the North Carolina School of the Arts. The arts are well represented by the Winston-Salem Symphony and Symphony Chorale, Wachovia Little Symphony, Piedmont Chamber Singers, Piedmont Opera, Southeastern Center for Contemporary Art (SECCA), Museum of Early Southern Decorative Arts (MESDA), Reynolda House Museum of Fine American Art, The Little Theater, The Stevens Center, Films on Fourth, and The Arts Council.

Winston–Salem is the home of African-American history programming celebrating Black History Month during February and The National Black Theatre Festival during August of every other year. It is also the new home of the River Run International Film Festival which takes place annually in April.

Local attractions include the beautiful Reynolda Gardens of Wake Forest University, Tanglewood Park, Old Salem, the single-A baseball team an affiliate of the Chicago White Sox, the Winston-Salem Dash, and Historic Bethabara.

The city is transitioning from an industrial to a research and technology center. Recent and planned developments include a \$20 million downtown research park, and several retail projects in the financial section of the inner city.

## **WAKE FOREST UNIVERSITY**

Wake Forest University was founded in 1834 by the Baptist State Convention of North Carolina. The school was opened as Wake Forest Institute, with Samuel Wait as principal. It was located in the Forest of Wake County, on the plantation of Dr. Calvin Jones, near which the village of Wake Forest later developed.

Re-chartered in 1838 as Wake Forest College, it is one of the oldest institutions of higher learning in the state. It was exclusively a men's college of liberal arts until 1894 when the School of Law was established. The School of Medicine, established in 1902, offered a two-year program.

In 1946 the trustees of Wake Forest College and the Baptist State Convention of North Carolina accepted a proposal by the Z. Smith Reynolds Foundation to relocate the college to Winston-Salem, where the medical school had moved five years earlier.

In 1967 Wake Forest College was granted full university status by the Southern Association of Schools and Colleges. Today the University has an undergraduate College of Arts and Sciences, School of Law, the Calloway School of Business and Accountancy, the Babcock Graduate School of Management, the Divinity School, and the Graduate School of Arts and Sciences. The total enrollment is approximately 6,500 students with over 850 full-time faculty. The university receives national recognition for its successful integration of computer and information technologies into all of its educational programs. Two nationally televised presidential debates have been hosted on the campus. Dr. Nathan O. Hatch was inaugurated as Wake Forest University's thirteenth president on October 20, 2005.

## **WAKE FOREST SCHOOL OF MEDICINE**

The School of Medicine of Wake Forest College, founded in 1902, was renamed the School of Medical Sciences in 1937 and operated as a two-year medical school until 1941.

It was in 1941 that the School of Medical Sciences was moved from its original college home in Wake Forest, North Carolina (near Raleigh) to Winston-Salem. Wake Forest College remained in the town of Wake Forest until 1956, when it was moved to Winston-Salem.

The 1941 move resulted in an expansion to four-year medical school status, the opening of the School of Medicine's Department of Clinics (DOC), renamed Wake Forest Physicians in 1991 and renaming of the school to Bowman Gray School of Medicine in recognition of the benefactor who made the expansion possible. In October of 1997, the Medical School was renamed the Wake Forest University School of Medicine at the Bowman Gray campus.

The four-year medical school opened with a faculty of 23 and a student body of 73. The Bowman Gray School of Medicine joined forces with North Carolina Baptist Hospital in forming an academic medical center, one of only 127 such centers nationwide today.

Today the medical school consists of 120 per class and has been a national leader in innovative medical education with its problem-based case study curriculum, "Prescription for Excellence: A Physician's Pathway to Lifelong Learning." In addition, our medical center is now recognized as Wake Forest Baptist Health after a merger between hospital and the medical school

## **NORTH CAROLINA BAPTIST HOSPITAL**

The hospital opened in 1923 by the Baptist State Convention of North Carolina as one of its missionary enterprises and originally was an 88-bed facility. Though it did serve some patients from across the state, North Carolina Baptist Hospital generally cared for patients from the immediate area of northwest North Carolina.

In preparation for the opening of Bowman Gray School of Medicine, North Carolina Baptist Hospital expanded to 300 beds. That was followed in 1946 by the opening of an outpatient department designed to handle 50,000 patients a year. In 1954 the hospital expanded to 450 beds.

In 1967 the hospital increased to 701 beds with the opening of the Reynolds Tower. With the addition of the North Tower in 1989, the hospital increased its number of beds to 806. Additionally, the Richard Janeway Clinical Sciences Tower opened in 1990 and serves as the outpatient surgery center and office building for the Wake Forest University Physicians. In 1996 Ardmore Tower opened, housing a state-of-the art Emergency Department and Level I trauma center and a 1,000-seat cafeteria. A new facility for the Brenner Children's Hospital and additional services opened in 2002. The Comprehensive Cancer Center moved into new quarters in 2004 and is currently under expansion.

Today the Medical Center boasts the most advanced technologies available including the positron emission tomography [PET] center, a magneto encephalography [MEG] suite and a gamma knife facility. The center has a strong commitment to quality patient care, education, and medical research, as well as a highly skilled and dedicated medical staff.

## **COY C. CARPENTER LIBRARY**

The Coy C. Carpenter Library of the Medical Center is located on the first floor of the School of Medicine's James A. Gray Building. The library contains extensive collections of all of the medical and surgical specialties and in the basic sciences, as well as collections in nursing and allied health. Wide selections of domestic and foreign periodicals, textbooks, monographs, archival materials and audiovisuals are also available.

In addition to its computerized catalog, the library offers free training in and use of web-based Medline as well as a computerized Drug Information Center, Tox-line, Psychological Abstracts, and other national and international databases. Remote access to library databases is also available at no charge to residents and faculty. The library maintains an advanced computer learning resource center with desktop computers. A variety of software is available as are short courses in software usage.

## **STANDARDS**

The School of Medicine is a member of the Association of American Medical Colleges and is accredited by the Liaison Committee on Medical Education (LCME), which represents the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges. The Residency Program in Psychiatry is accredited by the Accreditation Council for Graduate Medical Education (ACGME). The psychiatric residency program conforms to or exceeds the requirements of the ACGME. Our program was last reviewed in 2015 and was granted continued full accreditation.

## **SECTION TWO:**

# **WELCOME TO WAKE FOREST PSYCHIATRY RESIDENCY PROGRAM**



## HISTORY LINE

BGSM	YEAR	WFBMC
<i>Founding of School of Medicine</i>	1902	
	1923	NCBH (North Carolina Baptist Health) opens with 88 beds; Rev. Lumpkin, Super.
<i>Dr. Coy C. Carpenter, Dean</i>	1936	
<i>School moves to Winston-Salem and becomes four-year Bowman Gray School of Medicine; joins NCBH to form the medical center, Bowman Gray's Department of Clinics opens.</i>	1941	
	1942	Hospital expands - 300 beds
	1945	Reed Holmes – President
<i>Department of Neuropsychiatry opens</i>	1946	Outpatient department opened
<i>Department of Neuropsychiatry becomes the Department of Psychiatry and Neurology</i>	1953	
<i>Lloyd J. Thompson, M.D. (1953-1956) Chairman of the Department of Psychiatry and Neurology</i>	1953	
	1954	Hospital Expands-450 beds
<i>Angus C. Randolph, M.D. (1957-1959) Interim Chairman of the Department of Psychiatry and Neurology</i>	1957	
<i>Richard C. Proctor, M.D. (1960-1985) Chairman of the Department of Psychiatry and Neurology</i>	1960	
<i>Dr. Richard Janeway, Dean</i>	1971	
	1973	Hospital expands - 701 beds (Reynolds Tower)
	1974	Dr. Manson Meads becomes Director of the Medical Center
	1974	John Lynch – President

<b><i>The Department of Psychiatry and Neurology becomes the Department of Psychiatry and Behavioral Medicine</i></b>	1979	
<b><i>Jack M. Rogers, M.D. (1985-1986) Acting Chairman of the Department of Psychiatry and Behavioral Medicine</i></b>	1985	
<b><i>Burton V. Reifler, M.D., M.P.H. (1987-2001) Chairman of the Department of Psychiatry and Behavioral Medicine</i></b>	1987	
	1990	Clinical Sciences Building opens
	1992	PET Center opens
<b><i>Dr. James Thompson, Dean</i></b>	1995	
	1996	Ardmore Tower Opens (Emergency Department and Cafeteria)
	1996	Comp Rehab Plaza Opens
<b><i>W. Vaughn McCall, M.D. (2001-2012) Chairman of the Department of Psychiatry and Behavioral Medicine</i></b>	2001	
	2004	Comprehensive Cancer Center
	2011	Name change: Wake Forest Baptist Health
<b><i>Stephen I. Kramer, M.D. (2012-2013) Interim Chairman of the Department of Psychiatry and Behavioral Medicine</i></b>	2012	Outpatient Psychiatry moves from Janeway Tower to Jonestown Road Location.
<b><i>Tom Sibert, M.D. (2013-2014) Interim Chairman of the Department of Psychiatry and Behavioral Medicine</i></b>	2013	
<b><i>Allison Brashear, M.D. (2014-2015) Interim Chairman of the Department of Psychiatry and Behavioral Medicine</i></b>	2014	
<b><i>Rahn K. Bailey, M.D. (2015-Current) Chairman of the Department of Psychiatry and Behavioral Medicine</i></b>		

## CORE FACULTY AND THEIR SPECIALTIES/INTERESTS

**Elizabeth M. Arnold, Ph.D.**

Associate Professor  
Adolescent Health  
Mood Disorders  
Risk Behaviors  
HIV Prevention  
Suicidal Behavior

**Katherine Atala, M.D.**

Associate Professor  
Perinatal and Reproductive Psychiatry  
Women's Issues in Psychotherapy  
Psychiatry Disorders in relation to hormonal concerns

**Richard C. Blanks M.D., J.D.**

Assistant Professor  
Director, Adult Resident Education  
Director Forensic Psychiatry  
Adult Inpatient Psychiatry

**Gretchen Brenes, Ph.D.**

Associate Professor  
Geriatrics  
Behavioral Medicine  
Anxiety and Stress  
Psychotherapy  
Women's Health Issues  
Grief

**Tereia S. Cook, LCAS LPC CCS**

Addiction Counselor

**Larry W. Freeman, D.Min. LCAS**

Assistant Professor  
Continuing Education  
Area Health Education Center

**Predrag V. Gligorovic, M.D.**

Assistant Professor  
Director, Medical Student Education  
Director, Electroconvulsive Therapy  
Electroconvulsive Therapy  
Psychosomatic Medicine  
Mood Disorders  
Substance Abuse

**Karen Green, M.D.**

Assistant Professor  
Treatment Resistant Depression  
Cognitive-Behavioral Therapy

**Patrick Harmon, M.D.**

Assistant Professor  
First break psychosis  
Student Health  
rTMS

**Matthew G. Hough, D.O.**

Assistant Professor  
Director, Child/Adolescent Outpatient Services  
General Child Psychiatry

**Robin A. Hurley, M.D.**

Professor  
Neuropsychiatry  
Research

**Sebastian Kaplan, Ph.D.**

Assistant Professor  
Child/Adolescent Psychiatry  
Adult Psychiatry  
Family Therapy  
Trauma  
School-Based Mental Health

**James N. Kimball, M.D.**

Assistant Professor  
Director, Consultation-Liaison Services  
Director, Adult Outpatient Services  
Psychosomatic Medicine  
Mood Disorders  
Substance Abuse

**Tim King, M.D.**

Assistant Professor  
Child & Adolescent Psychiatry  
Pervasive Developmental Disorders  
Anxiety Disorders in children

**Stephen I. Kramer, M.D.**

Emeritus Professor  
General Adult Psychiatry  
Neuropsychiatry  
Forensic Psychiatry  
Psychiatry Education  
Research

**Naomi Leslie, M.D.**

Assistant Professor  
Director-Child & Adolescent Psychiatry  
Fellowship  
ADHD, Anxiety, Depression

**Josephine Mokonogho, M.D.**

Assistant Professor  
Assistant Director, Adult Resident Education  
Psychosomatic Medicine  
Psycho-oncology

**Dean Melton, LCAS**

Instructor  
Director of Addiction Programs

**Stephen Rapp, Ph.D.**

Professor

Chief of Psychology

Cognitive Disorders

Adult Psychology

Research

**Richard Patrick Smith, D.O.**

Assistant Professor

Behavioral Health Integration

Behavioral Economics

Evidence-based pharmacology

Neuromodulation technologies

Psychotherapy

**Charlie Suttentfield, Ph.D.**

Assistant Professor

Psychological Consultant to Burn Center and

Cardiac Transplantation Team

Rehabilitation Psychology

Chronic Pain Management

Trauma

Geriatric Psychology

Cognitive Behavioral Psychotherapy

Emergency Consultation/Liaison Services

## VOLUNTEER CLINICAL FACULTY

**Chris Aiken, MD**  
Clinical Instructor

**David Branyon, MD**  
Clinical Instructor

**Iverson Brooks Carter, MD**  
Clinical Instructor

**Stephanie Daniel, PhD**  
Adjunct Assistant Professor

**Palmer Edwards, MD**  
Clinical Associate Professor

**Anthony Frasca, MD**  
Clinical Associate Professor

**David Goldston, PhD**  
Adjunct Associate Professor

**Kim Hutchinson, EdD, APRN**  
Clinical Associate Professor

**J. Ray Israel, MD**  
Clinical Associate Professor

**Mary Jacobsen, PsyD**  
Clinical Associate Professor

**Ali Jarrahi, MD**  
Clinical Associate Professor

**Edward C. Jones, MD**  
Clinical Associate Professor

**Arthur Kelley, MD**  
Clinical Associate Professor

**Kevin A. Kilbride, MD**  
Clinical Assistant Professor

**Lea H. Kirkland, MD**  
Clinical Assistant Professor

**George Krebs, MD**  
Clinical Assistant Professor

**Saule E. Kulubekova**  
Adjunct Instructor

**Philip H. Lavine, MD**  
Clinical Assistant Professor

**Jessica U. Lay, MD**  
Clinical Assistant Professor

**Steven L. Mahorney, MD**  
Clinical Assistant Professor

**William L. Michielutte, PhD**  
Clinical Assistant Professor

**German Molina, MD**  
Clinical Assistant Professor

**Mary Patricia Moore, MD**  
Clinical Instructor

**Philip A. Nofal, MD**  
Clinical Instructor

**David Patterson, MBA**  
Adjunct Assistant Professor

**Frantz E. Pierre, MD**  
Clinical Assistant Professor

**Pamela Pittman, MD**  
Clinical Assistant Professor

**Rommel Ramos, MD**  
Clinical Assistant Professor

**Randy Readling, MD**  
Clinical Associate Professor

**Chris Rodriguez, MA**  
Clinical Instructor

**Jared A. Rowland, PhD**  
Adjunct Instructor

**Margaret Ruskstalis, MD**  
Clinical Faculty

**Steve N. Scoggin, Psy.D.,**  
Assistant Professor

**Jeff Smith, PhD**  
Clinical Assistant Professor

**Rebecca Valla, MD**  
Clinical Instructor

# RESIDENTS AND CHILD/ADOLESCENT FELLOWS 2016-2017

## CHILD AND ADOLESCENT PSYCHIATRY FELLOWS:

Ryan McQueen, M.D.	Virginia Commonwealth University School of Medicine
Kelechi Emereonye, M.B.B.S.	Abia State University
Raunak Khisty, M.B.B.S.	Krishna Institute of Medical Sciences
Nicholas Ladd, D.O.	Edward Via Virginia College of Osteopathic Medicine
Sheila Maurer, M.D.	Oceania University of Medicine

## FOURTH-YEAR GENERAL PSYCHIATRY RESIDENTS:

Derek Ayers, D.O.	Lincoln Memorial University of DeBusk College of Osteopathic Medicine
Emily Boothe, D.O.	West Virginia School of Osteopathic Medicine
Katherine Nguyen, D.O.	Lake Erie College of Osteopathic Medicine
Raj Patel, M.D.	The University of Toledo College of Medicine
Melisa Tyndall, M.D.	Ross University School of Medicine

## THIRD-YEAR GENERAL PSYCHIATRY RESIDENTS:

Letitia Bolds, M.D.	Medical University of South Carolina College of Medicine
Kateland Branch, M.D.	University of North Carolina School of Medicine
Kevin Carmen, M.D.	Northeastern Ohio Universities College of Medicine
Kelley Cyzeski Klein, M.D.	New York Medical College
Poonam Deshmukh, M.B.B.S.	Dr. D.Y. Patil Pratishthans Medical College, Pimpri
Heather Douglas, M.D.	University of Mississippi School of Medicine
Preston Gentry, M.D.	The Warren Alpert Medical School of Brown University
Luciana Giambarberi, M.D.	St. George's University School of Medicine

## SECOND-YEAR GENERAL PSYCHIATRY RESIDENTS:

Hammaad Alvi, M.B.B.S.	Allama Iqbal Medical College, Pakistan
John Bocock, M.D.	The Brody School of Medicine at East Carolina University
Adam Boiter, D.O.	Edward Via College of Medicine – Carolinas Campus
Caitlin Briggs, M.D.	University of Kentucky College of Medicine
Heather Ford, M.D.	Mercer University School of Medicine – Savannah
Matthew Kern, M.D.	University of Arkansas Medical Sciences College of Medicine
Muneeb Malik, M.D.	St. George's University School of Medicine, Grenada

## FIRST-YEAR GENERAL PSYCHIATRY RESIDENTS

Jonathan Allan, M.D.	Texas Tech University School of Medicine
William Tyler Cecil, D.O.	Edward Via College of Osteopathic Medicine
Brett Fornell, M.D.	University of South Carolina School of Medicine
Michael Marchese, M.D.	University of Arkansas College of Medicine
John Marigliano, M.D.	University of South Carolina School of Medicine
Marta Olenderek, M.D.	University of Florida College of Medicine
Phillip Smith, M.D.	Wake Forest School of Medicine

## LORETTA Y. SILVIA TEACHING AWARD

**Eligibility:** All clinical faculty members are eligible.

**Criteria:** This award is presented to a faculty member who teaches by example and possesses clinical excellence, empathy, courage and compassion. This award was begun in 2006 in honor and memory of Loretta Y. Silvia, Ph.D. Dr. Silvia was a beloved and respected faculty member in the Department of Psychiatry and Behavioral Medicine who spent many years teaching and mentoring resident physicians. She was known for her empathy, her courage, and for the compassion she showed for her patients.

**Note:** The award cannot be given to the same faculty member for two consecutive years.

**Election:** Recipient to be chosen yearly via elections by residents and child/adolescent fellows.

**Occurrence:** The award is presented at the Senior Graduation Banquet each spring.

### PREVIOUS AWARD RECIPIENTS:

2006: Loretta Silvia, Ph.D.  
2007: Harold Elliott, M.D.  
2008: Eugene Mindel, M.D.  
2009: Donald Peters, M.D.  
2010: Stephen I. Kramer, M.D.  
2011: Eugene Mindel, M.D.  
2012: Rommel Ramos, M.D.  
2013: David A. Brady, D.O.  
2014: Stephen I. Kramer, M.D.  
2015: James N. Kimball, M.D.  
2016: Donald Peters, M.D.

## Stephen I. Kramer, M.D., Resident Award for Academic Excellence

**Eligibility:** All residents are eligible.

**Criteria:** This award is presented to the resident who consistently demonstrates academic excellence throughout their residency. Dr. Kramer is known for teaching and having residents strive for academic excellence throughout their careers.

**Election:** Recipient to be chosen yearly via academic performance as indicated by the program director.

**Occurrence:** The award is presented at the Senior Graduation Banquet each spring.

**SECTION THREE:**

**OVERVIEW OF THE  
PSYCHIATRY RESIDENCY PROGRAM**



# OVERVIEW OF THE PSYCHIATRIC RESIDENCY PROGRAM

The house officer education program in psychiatry is accredited as a four-year program by the Accreditation Council for Graduate Medical Education. Applicants are considered for acceptance at the first postgraduate year after medical school graduation or second postgraduate year after satisfactory completion of an accredited clinical training program providing experience in general medical care of adults or children. The residency educational program of the Department of Psychiatry and Behavioral Medicine is designed to prepare the physician for the practice of general psychiatry or further subspecialty training, such as child/adolescent psychiatry, consultation-liaison psychiatry (psychosomatic medicine), substance abuse, geriatric psychiatry, forensic psychiatry, or neuropsychiatry. A Child/Adolescent Psychiatry Fellowship Program began in 1993.

## **Clinical rotations can include the following experiences:**

1. Inpatient adult psychiatry at Wake Forest Baptist Health
2. Inpatient psychiatry at the Veterans Administration Medical Center in Salisbury, NC
3. Outpatient primary care at the Veterans Administration in Kernersville and Salisbury, NC
4. Suboxone clinic at Wake Forest Baptist Health
5. Addiction Psychiatry at the Veterans Administration Medical Center in Salisbury, NC
6. Emergency medicine experience at Wake Forest Baptist Health
7. Outpatient pediatrics at Wake Forest Baptist Health
8. Outpatient neurology at Wake Forest Baptist Health and at the Veterans Administration in Salisbury, NC
9. College student mental health experience at Wake Forest University
10. Child/adolescent outpatient psychiatry at Wake Forest Baptist Health
11. Carenet outpatient psychiatry rotation
12. Assertive Community Treatment (ACTT) program
13. Medication management clinic at the Samaritan Homeless Shelter for at risk populations
14. Forensic psychiatry rotation at Wake Forest Baptist Health
15. Consult Liaison psychiatry and Emergency Psychiatry at Wake Forest Baptist Health
16. Neurobehavioral Psychiatry at Wake Forest Baptist Health
17. Geriatric outpatient psychiatry at Wake Forest Baptist Health
18. Adult outpatient psychiatry at Wake Forest Baptist Health and the Veterans Administration in Kernersville
19. Electives in rural mental health, inpatient child psychiatry, research, and inpatient psychiatry (adult or child) at Broughton Hospital in Morganton, NC (one of three state psychiatric institutions)
20. Selectives at the Veterans Administration Medical Center in Salisbury in a variety of outpatient and inpatient psychiatry experiences

Supervision while on rotations is designed to allow for increasing autonomy for the resident as clinical competence is gained in training. The rotations provide a broad base of clinical experiences reflecting the contemporary practice of psychiatry and preparing the resident for future developments in the field.

Two hours weekly of psychotherapy supervision are required for the PG-II, PG-III and PG-IV years of training. This may be a combination of individual or individual and group psychotherapy supervision. During this period, each resident follows his or her own outpatients in long-term and time-limited psychotherapy.

For first-year residents, the PG-I Seminar series provides weekly instruction in fundamentals of psychiatry, emergency psychiatry, psychopharmacology and ECT. For second and third year residents, weekly seminar tracks in psychotherapy and biological psychiatry are required. Other lectures include the Psychopharmacology Seminar, the Ethics and Professionalism Seminar, the Performance Improvement Conference series, and the Advanced Test-Taking Skills Seminar.

## DIRECTOR OF ADULT RESIDENCY EDUCATION

Richard C. Blanks, M.D. is the director of the adult residency training program and director of the forensic psychiatry service.

### Education & Training

- B.A., University of North Carolina-Chapel Hill, 1980
- J.D., Campbell University, 1983
- M.D., George Washington University School of Medicine, 2002
- Residency, Psychiatry, Cambridge Health Alliance, 2006
- Fellowship, Medical Ethics, Harvard Medical School, 2006
- Fellowship, University of Massachusetts, 2007

### Board Certifications

- American Board of Psychiatry & Neurology, Psychiatry
- American Board of Psychiatry & Neurology, Psychiatry, Forensic Psychiatry

### ADMINISTRATIVE LINE:

The Director of Resident Education is directly responsible to the Educational Policy Committee and Departmental Chair.

### RESPONSIBILITIES:

The Director of Resident Education is responsible for the maintenance of a comprehensive educational program for psychiatric residents of the highest quality. The following areas are his direct responsibility:

1. Selecting residents to maintain a critical nucleus of capable residents to ensure an optimal educational process and meet the needs of the department. This involves recruiting applicants from other institutions, cultivating medical students within our own institution who are interested in psychiatry, and fostering interest in psychiatry in graduating medical students. Duties also include interviewing all prospective applicants for the program and leading the residency selection committee.
2. Developing and maintaining a comprehensive training program of the highest quality, including:
  - a. Maintaining clinical rotations with excellent supervision and of a variety of clinical experiences to reflect psychiatry as it is practiced today
  - b. Acting as a liaison between Wake Forest and external rotation sites
  - c. Helping to assign faculty supervisors for residents
  - d. Performing exit interviews for graduating residents and signing off on letters for ABPN
  - e. Having weekly meetings with the assistant training director and the chief residents to foster program communication
  - f. Planning and overseeing educational seminars to ensure coverage of basic knowledge in the field of psychiatry and neurology – specifically responsible for biological seminar curriculum and content

- g. Developing and coordinating a comprehensive system of resident evaluation with sufficient feedback to facilitate remediation of perceived deficiencies. In the event of failure to achieve minimal standards, to initiate procedures for remediation and assisting in disciplinary issues
  - h. Being aware of and enforcing ACGME requirements for psychiatric residency education in the curriculum
  - i. Directly involving the residents in curriculum development and evaluation
  - j. Orienting new residents to the training program
  - k. Performing semi-annual reviews on PGY 2-4 residents
  - l. Organizing annual graduation dinner
3. Participating on the Program Evaluation Committee (PEC)
- a. Organizing the semi-annual retreat for PEC
4. Maintaining membership in the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry
- a. Attending the annual AADPRT meeting and participating in various committees

## **ASSOCIATE DIRECTOR OF ADULT RESIDENCY EDUCATION**

Josephine Mokonogho, M.D. is the assistant director of the adult residency training program Department of Psychiatry and Behavioral Medicine at Wake Forest University Health Sciences.

### Education & Training

- M.D., University of Ibadan Medical School-Nigeria, 2002
- Residency, Psychiatry, SUNY Health Science Center at Brooklyn, 2010
- Fellowship, Memorial Sloan-Kettering Cancer Center, 2011

### Board Certifications

- American Board of Psychiatry & Neurology, Psychiatry,
- American Board of Psychiatry & Neurology, Psychiatry, Psychosomatic Medicine

### **RESPONSIBILITIES:**

The following areas are the direct responsibilities of the Assistant Program Director:

1. Work with PEC to oversee and ensure the quality of the didactic and clinical education in all sites that participate in the program
2. Collaborate with local directors at each participating site who are responsible for resident education to assure that resident supervision is occurring. Handle issues that arise related to clinical site supervision
3. Oversee the evaluation process of clinical rotation sites and handle issues related to feedback about clinical sites
4. Participate in semiannual resident reviews for residents
5. Assist in applicant selection to determine which candidates are granted interviews and assist in conducting applicant interviews during interview season
6. Work with CCC for determining that resident promotion requirements are met
7. Work with chief residents for resolution of resident conflicts and disciplinary actions when needed
8. Work with FTC Outpatient Director, Residency Program Coordinator, PEC, and Chief Residents for creating resident schedules for each academic year
9. Oversee Performance Improvement Case Conference, Journal Club, Practical Life Seminar, CSV Case Conference, PGY4-5 Elective Rotations, and Intern Didactics

## CHIEF RESIDENT SELECTION PROCESS

**PURPOSE:** The position of Chief Resident is designed to provide the elected resident an experience in administrative psychiatry. The experience provides an opportunity to exercise leadership skills and act as a liaison between the residents and faculty.

### QUALIFICATIONS FOR CHIEF RESIDENT:

- A resident who wants to be considered for Chief should submit a brief statement as to why he or she is interested in the position and why they should be considered. The statement should include any administrative experience the resident may have had. The deadline for submission will be announced in advance.
- Only residents who wish to be considered for appointment will be candidates for Chief resident.
- A resident who wishes to be considered for Chief should have no active disciplinary actions or letters of concern in his/her file, should be caught up on documentation and clinical duties, and should be in good standing with moonlighting, supervision hours, and duty hour requirements.

### LETTER OF INTEREST AND APPOINTMENT PROCEDURE:

A resident who wishes to be considered for a Chief position must submit a letter of interest to the Program Directors and Coordinator specifying the desired Chief position. The Program Director may accept or deny the candidacy based on qualifications of the resident as described above. The resident body will vote via secret ballot for the Chief and Co-Chief candidates from the rising PGY4 and PGY5 classes. In the event that there is only 1 interested/eligible PGY 4-5 candidate for Chief, then a Co-Chief can be considered and voted on by the residents from the rising PGY3 class. If no PGY 4-5 residents are interested/eligible to serve as chief, then 2 rising PGY3 residents may be considered to serve in the positions. The Didactic Chief position may be a rising PGY 3-5 and preference not necessarily given based on seniority. The preference would be for the didactic chief to be a PGY-3.

Results from the secret ballot will then be submitted for consideration to the Director and Assistant Director of Psychiatry Resident Education for approval. The names will then be given to the PEC for approval and finally to the Department Chair for final approval and appointment.

The Department Chair will appoint the Chiefs in the spring of the academic year and the currently active chiefs will use this time for orientation of the new appointees. The currently appointed chiefs will end their duties June 30 of each year and the new chiefs will assume their roles July 1 of each academic year.

Child psychiatry residents (fellows) may not serve as the adult department's Chief Residents while actively participating in the fellowship program.

**COMPENSATION:** Chief residents receive an additional \$333.33 annually. The funds are distributed equally in his/her paycheck throughout the academic year.

## **CHIEF RESIDENT DUTIES:**

1. Assigns backup coverage for the unexpected absence of an assigned resident or for work load reduction where needed
2. Orients new residents or rotating residents from other departments or institutions
3. Oversees preparation of the call schedule for residents by the required date (one month before next quarter begins). This duty may be delegated to other residents for completion but requires approval of chief residents for final publication.
4. Prepares the clinical rotation assignments at the start of an academic year and when revisions are needed
5. Works with Department Chair or other designated faculty to schedule speakers for Ground Rounds.
6. Orients medical students on clinical rotations
7. Participates as a member of the Program Evaluation Committee.
8. Participates as a member of the Resident Selection Committee and participates in interviewing and selecting residency applicants
9. Is available by beeper or phone at all times during regular duty hours unless an acting chief resident is assigned during the chief resident's absence
10. Participates as a member of the institutional Chief Residents' Council
11. Works closely with associate chief or co-chief in dividing responsibilities
12. Provides appropriate/necessary yearly up-dates to the Resident Handbook
13. Functions as a mediator between residents, faculty and staff
14. Prepares the clinic on-call schedule one week prior to the first of every month and distributes a copy to those residents in clinic as well as secretaries, phone triage, and scheduling coordinators
15. Works with program directors on resident discipline issues
16. Meets weekly with program directors and runs resident meetings as needed
17. Additionally, the didactics chief resident selects topics and presenters for didactics. Works in tandem with program director/assistant program director to ensure scheduling of didactics. Ensures presenters present topics adequately and ensures resident attendance for didactics.

# **SECTION FOUR:**

## **SCHEDULING AND ROTATIONS**



# OVERVIEW OF CLINICAL ROTATIONS

**OBJECTIVES:** The clinical rotations are designed to provide supervised contact with a wide variety of psychiatric patients of varying diagnoses, ages, gender, sexual orientation, and racial and ethnic backgrounds. Patient exposure is monitored to ensure that a good spectrum of clinical material is encountered during training. Treatment settings are selected to provide a cross-section of psychiatry as currently practiced. Residents should be able to observe and practice a number of treatment techniques, including brief and long-term psychotherapy, supportive therapy, crisis intervention, pharmacotherapy, and ECT. Supervision at different levels of training allows greater responsibility in patient management with increased level of training and sophistication. In addition, an exposure to primary care including emergency medicine, internal medicine/family medicine, and pediatrics during the first year of training is designed to familiarize the resident with the diagnosis and treatment of common medical problems in ambulatory or inpatient settings. The inpatient units of Wake Forest Baptist Health, a tertiary care center, have a number of patients with complex medical as well as psychiatric problems. During the first year of training, a two-month rotation in neurology, with one block at Wake Forest Baptist Health and one at the VA Medical Center in Salisbury provides experience with both common and unusual neurological problems. Increased proficiency in performance of an extensive neurological examination is expected to be developed during this rotation.

Because of the more intensive emphasis on neurology and medical illness and co-morbidity in the first two years, we require that our residents pass step three of the USMLE or COMLEX board exam by the end of the PGY-2 year of the resident's training.

**EFFECTIVENESS EVALUATION:** Individual rotations are evaluated with feedback from resident evaluations of the rotation through Med Hub and direct observation. When a rotation is found to be below expectation, every effort will be made to work with the supervisor of the rotation to improve it. If this cannot be done, alternate equivalent experiences will be sought, and the deficient rotations will be dropped.

**\*The following page is a general reflection of the current training curriculum. As service needs change and individual needs arise year to year changes and mid-year changes can potentially occur.**

YEAR	ROTATION	DURATION
<b>First Year</b>	Outpatient Neurology at WFBMC or VAMC Salisbury	2 blocks*  *NOTE: If only one month is completed during PGY-1, the second month will be completed either PGY-4 or during the child & adolescent fellowship
	Primary Care: Outpatient Internal Medicine – VA Sites Emergency Medicine WFBMC Outpatient Pediatrics WFBMC	2 blocks 1 block 1 block
	WFBMC Adult Inpatient Services Salisbury VA Inpatient Services	6 blocks**  **NOTE: Occasionally a PGY-1 will complete 1-2 months of Inpatient psychiatry at the VAMC in Salisbury, NC
	Night Float	1 block
<b>SECOND YEAR</b>	Inpatient Child	1 block
	Telepsychiatry	1-2 blocks
	Consultation-Liaison & Emergency Psychiatry Service WFBMC	6 blocks
	Outpatient clinics in Child Psychiatry/Geriatric Psychiatry/Suboxone/ Neurobehavioral /ECT	3 blocks
	Addiction – VA Salisbury	1 block
	Night Float	1 block
<b>THIRD YEAR</b>	12 Month Outpatient Continuity Clinic Adult Outpatient Psychiatry, WFBMC, Student Health/HOT Project/VA Adult Outpatient Clinics – Salisbury or Kernersville	12 months
<b>FOURTH YEAR</b>	ESC	~0-2 months
	WFBMC Adult Inpatient Service-Junior Attending/Child Inpatient Unit	2 months
	VA Selectives	~1-3 months
	Forensic	1 month
	Electives	~6 months

# CLINICAL SUPERVISION

Supervision is provided in three basic formats:

- Faculty advisors
- Supervision of Psychotherapy
- Direct supervision during clinical rotations

**Faculty Advisors:** Each resident will be assigned a faculty advisor from the beginning of the residency. This is to be considered a permanent assignment for the duration of residency training, subject to change by mutual agreement and at the discretion of the Director of Residency Education. The role of the faculty advisor is expected to be primarily advisory, supportive, and non-evaluative. The advisor is expected to act primarily as an advocate for the resident as she sees fit with respect to interfacing with the residency program and personnel. Should the advisor feel that any material brought up in the context of the relation would seriously affect the performance of the resident, such as drug abuse, this material should be discussed (hopefully jointly) with the Director of Residency Education. The relationship is not confidential in the same sense as the therapeutic relationship. Frequency of contact is at the mutual discretion of the advisor and resident but expected to be more frequent during the initial months of residency and diminish as confidence grows. Certainly, extra time may be required during stressful periods for the resident.

The faculty advisor system is designed to provide support for the resident, particularly early in residency and during periods of stress, to advise the resident in terms of her present learning role as resident and future roles within psychiatry, to mediate and, if necessary, to advocate in conflicts with teaching hierarchy, and to facilitate the learning process with advice as to extra learning materials.

**Supervision of Psychotherapy:** Residents are assigned two supervisors for psychotherapy beginning with the second year of training, one of which may be group supervision. Residents must demonstrate core competency in a variety of psychotherapies, including dynamic, supportive, brief, cognitive-behavioral, and combined psychotherapy-psychopharmacology. Supervision with individual supervisors is expected to be 1 hour weekly per supervisor with a minimum of 9 hours quarterly and a minimum of 36 hours of supervision with each supervisor accumulated annually. These hours will carefully maintained and tracked to ensure compliant with this requirement. Some cancellation is inevitable on the part of both the supervisor and resident but excessive cancellation of supervision on the part of the resident will be subject to disciplinary action. Supervision should center on techniques of psychotherapy and suggestions for supplementary readings on the presented cases. Two hours of weekly supervision will continue through the fourth year of training. Supervision and movement towards demonstrating core competency will be documented through regular evaluations submitted by the supervisor.

Residents must complete a minimum of 200 hours of psychotherapy under supervision to graduate (or 150 for those who do a child & adolescent track and PGY-2 transfers).

## EVALUATION OF RESIDENT PERFORMANCE AND RESIDENCY PROGRAM

**Evaluation:** Feedback on resident performance should be both on a daily basis and at the end of each clinical rotation. Supervisors will write formal evaluations on Med Hub at the end of each rotation to include constructive criticism or feedback. Residents are expected to review all evaluations on Med Hub. In addition to supervisor/faculty evaluations, 360 evaluations will be compiled for interns. The 360 evaluations will occur twice yearly and residents will receive feedback from medical students, nursing supervisors, social workers, and psychologists. This will mainly occur while the resident is completing his requirements on the inpatient unit.

Residents are given the opportunity to evaluate, in writing through Med Hub, all rotations, services, educational experiences, and faculty. **ALL** evaluations completed on educators are anonymous. The educator is **NOT** able to see who completed his evaluation. Evaluations are designed not to be released until 3 are completed, hence ensuring anonymity. Written comments are summarized in an anonymous fashion prior to feedback to specific faculty to maintain individual resident confidentiality. Feedback is also solicited during resident semiannual reviews. In addition, the residents will complete an overall evaluation of the program annually.

**Semiannual Review:** At the end of each half year, the resident's overall performance based on written and oral evaluations will be compiled and discussed during 2 personal meetings with the Director of Adult Resident Education or the Assistant Director of Adult Resident Education. One meeting will be held at the conclusion of the first 6 months of the academic year, and the second meeting will be held at the conclusion of the academic year. The program is now using the more nuanced ACGME Milestones Guidelines as the platform for evaluations. Suggestions for improved performance, areas for more intensive study, and remedial work are integral to this discussion. Positive feedback for achievement is an expected part of this process.

**Program Evaluation Committee (PEC):** ACGME programs must have a Program Evaluation Committee (PEC) appointed by the program director that functions in compliance with both the common program and program specific requirements. The goal of the PEC is to oversee curriculum development and program evaluations for its respective graduate medical education training program. The program director may serve as the chair of the PEC or he/she may appoint another faculty member as chair. Each PEC must be composed of at least two program faculty members and one resident or clinical fellow from the program. See ACGME for detailed list of responsibilities of PEC.

**Clinical Competency Committee (CCC):** ACGME required body comprising three or more members of the active teaching faculty who is advisory to the program director and reviews the progress of all residents in the program. The CCC functions in an advisory role by meeting regularly to review all completed evaluations and providing consensus based recommendation to the program director as to the standing of each trainee in the program. The Committee will provide performance based assessments using program specified ACGME milestones that respect the personal privacy of the residents or clinical fellows in the program. The Committee must function objectively and in a manner that promotes the highest levels of professionalism and confidentiality. The program director has final responsibility for each trainee's evaluation and promotion decisions.

**Psychiatry Resident In-Training Examination (PRITE):** All residents will take the annual PRITE, which usually takes place on the first two Fridays in October. Each resident receives direct feedback on his/her performance. Cumulative data is given to the Director of Adult Resident Education during the first semiannual review.

## Program Requirements for 2016-2017

**\*It is the responsibility of the resident to understand and clarify any and all requirements that they do not understand.**

**Core Competency Exam** – One page exam shows the resident is performing at his/her level of training. See iShare or Sheila for correct form for adult/child core exam.

**Clinical Skills Examination aka CSE or CSV** – Multi-page exam which demonstrates upon successful completion that the resident is performing at the level of a performing psychiatrist. Residents must successfully complete three exams between PGY-3 and 5 in order to graduate and sit for the boards after graduation. **Per PEC, CSV.3 must be used to complete CSV exams.** See iShare or Sheila for correct CSV.3 form.

### **REQUIREMENTS FOR PGY-1 CHECKLIST**

- 
- Six of your best discharge summaries (*also see Showcase Portfolio below*)
    - First three due **10<sup>th</sup> of November** and the remaining three by the **10<sup>th</sup> of May**
    - All summaries must be signed off by the attending who staffed
  - Two successful adult core competency exams (*also see Showcase Portfolio below*)
    - complete one by the **10<sup>th</sup> of November**
    - complete the second exam by the **10<sup>th</sup> of May**

Additional cores given as required by the program or requested by the resident
  - Step 3 taken and passed on or before the end of PGY-2 training level
  - Patient Logs – Minimum of 50 entries per semester (6 months)/9 entries on a monthly basis
  - Duty hours – entered and submitted weekly
  - Charting – must be current adhering to departmental and institutional guidelines
  - Other requirements not listed (*See Resident Handbook or Residency Coordinator*)
  - Scholarly Activity/Showcase Portfolio (*submit copies of work and forms, if required, to coordinator*)

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#### **SHOWCASE PORTFOLIO**

Showcase of “best work”; “best qualities”

Demonstration of scholarly activity

Demonstration of competencies

Demonstration of ability for self-assessment and self-reflection

Demonstration of milestone acquisition

- One of your best core competency exams (passed or provisional) from the requirements noted above
  - One Inpatient Psychiatry Discharge summary/complete case write-up (**de-identified**) from the requirements noted above (discharge summaries must be signed off by the attending who staffed)
  - One psychiatry case conference presentations: PowerPoint slides, handouts with references, etc.
  - Materials from mandatory presentation completed during Primary Care/Neurology rotation
  - One additional entry of the resident’s choice (paper, poster submission, additional presentations done during various rotations, membership of professional organizations, demonstrates specific milestones, etc...)
  - Updated Curriculum Vitae
  - IRB Certification
  - APA Membership
-

## REQUIREMENTS FOR PGY-2 RESIDENTS CHECKLIST

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- Two successful “**Child**” Core Competency Exams (*also see Showcase Portfolio below*)
    - complete one by the **10<sup>th</sup> of November**
    - complete the second exam by the **10<sup>th</sup> of May**
      - Recommendation – complete while rotating on the child psychiatry outpatient service*
    - Additional cores given as required by the program or requested by the resident
  - Step 3 taken and passed on or before the end of PGY-2 training level
  - Patient Logs – Minimum of 50 entries per semester (6 months)/9 entries on a monthly basis
  - Duty hours – entered and submitted weekly
  - Charting – current and adheres to departmental and institutional guidelines
  - Psychotherapy Supervision Logs submitted monthly (Supervision with individual supervisors is expected to be 1 hour weekly per supervisor with a minimum of 9 hours quarterly and 36 hours of supervision with each supervisor accumulated annually)
  - 200 Psychotherapy Hours; 150 hours for PGY-2 Transfers
  - Other requirements not listed (*See Resident Handbook or Residency Coordinator*)
  - Scholarly Activity/Showcase Portfolio (*submit copies of work and forms, if required, to coordinator*)
- 

### SHOWCASE PORTFOLIO

Showcase of “best work”; “best qualities”

Demonstration of scholarly activity

Demonstration of competencies

Demonstration of ability for self-assessment and self-reflection

Demonstration of milestone acquisition

- One successful completion of a child core competency exam {part of requirements noted above}
  - One Journal Club presentation
  - Biopsychosocial formulation
  - Two case conference presentations one of which must involve a child/adolescent case
  - Medical student lectures
  - One additional entry of the resident’s choice (paper, poster submission, additional presentations done during various rotations, membership of professional organizations, demonstrates specific milestones, etc...)
  - Updated Curriculum Vitae
  - IRB Certification
  - APA Membership
-

## REQUIREMENTS FOR PGY-2 TRANSFER RESIDENTS CHECKLIST

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- Six of your best discharge summaries (*also see Showcase Portfolio below*)
    - First three due **10<sup>th</sup> of November** and the remaining three by the **10<sup>th</sup> of May**
    - All summaries must be signed off by the attending who staffed
  - Two successful adult core competency exams (*also see Showcase Portfolio below*)
    - complete one by the **10<sup>th</sup> of November**
    - complete the second exam by the **10<sup>th</sup> of May**

Additional cores given as required by the program or requested by the resident
  - Step 3 taken and passed on or before the end of PGY-2 training level
  - Patient Logs – Minimum of 50 entries per semester (6 months)/9 entries on a monthly basis
  - Duty hours – entered and submitted weekly
  - Charting – current and adheres to departmental and institutional guidelines
  - Psychotherapy Supervision Logs submitted monthly (Supervision with individual supervisors is expected to be 1 hour weekly per supervisor with a minimum of 9 hours quarterly and 36 hours of supervision with each supervisor accumulated annually)
  - 200 Psychotherapy Hours; 150 hours for PGY-2 Transfers
  - Other requirements not listed (*See Resident Handbook or Residency Coordinator*)
  - Scholarly Activity/Showcase Portfolio (*submit copies of work and forms, if required, to coordinator*)
- 

### SHOWCASE PORTFOLIO

Showcase of "best work"; "best qualities"

Demonstration of scholarly activity

Demonstration of competencies

Demonstration of ability for self-assessment and self-reflection

Demonstration of milestone acquisition

- One successful completion of a core competency exam {part of requirements noted above}
  - One Journal Club presentation
  - Biopsychosocial formulation
  - Two case conference presentations one of which must involve a child/adolescent case
  - Medical student lectures
  - One additional entry of the resident's choice (paper, poster submission, additional presentations done during various rotations, membership of professional organizations, demonstrates specific milestones, etc...)
  - Updated Curriculum Vitae
  - IRB Certification
  - APA Membership
-

## REQUIREMENTS FOR PGY-3 CHECKLIST

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- \*Two Clinical Skills Examination (CSE)/Verifications (CSV) - *also see ShowCase Portfolio below*
  - complete one by the **10<sup>th</sup> of November**
  - complete the second exam by the **10<sup>th</sup> of May**
- Must have passed Step 3 by the start of this training level
- Patient Logs – Minimum of 50 entries per semester (6 months)/9 entries on a monthly basis
- Duty hours – entered and submitted weekly
- Charting – current and adheres to departmental and institutional guidelines
- Psychotherapy Supervision Logs submitted monthly (Supervision with individual supervisors is expected to be 1 hour weekly per supervisor with a minimum of 9 hours quarterly and 36 hours of supervision with each supervisor accumulated annually)
- 200 Psychotherapy Hours; 150 hours for PGY-2 Transfers
- Other requirements not listed (*See Resident Handbook or Residency Coordinator*)
- Scholarly Activity/Showcase Portfolio (*submit copies of work and forms, if required, to coordinator*)

**\*Child Fellowship Resident Applicants:** Complete a minimum of two CSVs during the first and/or second quarter of the academic year. Child rank order list due in December with the Match in early January.

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### SHOWCASE PORTFOLIO

Showcase of “best work”; “best qualities”

Demonstration of scholarly activity

Demonstration of competencies

Demonstration of ability for self-assessment and self-reflection

Demonstration of milestone acquisition

- One successful CSV/CSE (part of requirements above)
  - Materials from Journal Club Presentation
  - One CBT formulation
  - One Psychodynamic formulation
  - One additional entry of the resident’s choice (paper, poster submission, additional presentations done during various rotations, membership of professional organizations, demonstrates specific milestones, etc...May include community psychiatry entry from HOT project)
  - Updated Curriculum Vitae
  - IRB Certification
  - APA Membership
-

## REQUIREMENTS FOR PGY-4 CHECKLIST

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- \*Two Clinical Skills Examination (CSE)/Verifications (CSV) - (*also see Showcase Portfolio below*)
  - complete one by the **10<sup>th</sup> of November**
  - complete the second exam by the **10<sup>th</sup> of May**
- Prepare and conduct a Grand Rounds Presentation
- Patient Logs – Minimum of 50 entries per semester (6 months)/9 entries on a monthly basis
- Duty hours – entered and submitted weekly
- Charting – current and adheres to departmental and institutional guidelines
- Psychotherapy Supervision Logs submitted monthly (Supervision with individual supervisors is expected to be 1 hour weekly per supervisor with a minimum of 9 hours quarterly and 36 hours of supervision with each supervisor accumulated annually)
- 200 Psychotherapy Hours; 150 hours for PGY-2 Transfers
- Other requirements not listed (*See Resident Handbook or Residency Coordinator*)
- Scholarly Activity/Showcase Portfolio (*submit copies of work and forms, if required, to coordinator*)

**\*Child Fellowship Resident Applicants:** Complete a minimum of two CSVs during the first and/or second quarter of the academic year. Child rank order list due in December with the Match in early January.

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### SHOWCASE PORTFOLIO

Showcase of “best work”; “best qualities”

Demonstration of scholarly activity

Demonstration of competencies

Demonstration of ability for self-assessment and self-reflection

Demonstration of milestone acquisition

- One successful CSV/CSE (part of requirements above)
  - Materials from Journal Club Presentation
  - Administrative Psychiatry Entry (from selective/mandatory rotation) Could be a description of your role as a junior attending on the unit, assessment of what you did and role you played.
  - One additional entry of the resident’s choice (paper, poster submission, additional presentations done during various rotations, membership of professional organizations, demonstrates specific milestones, etc...May include community psychiatry entry from HOT project)
  - Updated Curriculum Vitae
  - IRB Certification
  - APA Membership
-

## PGY-1 Schedule

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### WFBH ADULT INPATIENT PSYCHIATRY ROTATION

<b>Director:</b>	Dr. Richard Blanks
<b>Team Leaders:</b>	Dr. Richard Blanks Various Faculty
<b>Location:</b>	Sticht Center, Wake Forest Baptist Health Chronic Inpatient Unit VAMC, Salisbury, NC

#### Teaching Objectives:

- 1.To gain experience in inpatient psychiatric diagnosis and treatment.
- 2.To learn different treatment modalities.
- 3.To learn appropriate use of psychotropic medicines.
- 4.To gain experience and practice in the multidisciplinary team approach to comprehensive patient care.
- 5.To learn the indications, contraindications, and performance of ECT.
- 6.To learn to make proper referrals for consultation.
- 7.To gain experience in teaching medical student and the health care staff.
- 8.To learn to deal with difficult patients, including those with multiple medical problems and complex co-morbidities.
- 9.To gain experience in work with families and inpatients.
- 10.To learn to utilize psychological testing in the process of diagnosis and treatment planning.
- 11.To learn technique and formulation of psychiatric history and physical examination.
- 12.To gain experience in systems-based practice, including service delivery oversight.
- 13.To learn professional and ethical behavior in the care of their patients and in their interactions with other health care providers

**Responsibilities:** The residents perform preliminary evaluation of the newly admitted patient with a complete history and physical examination and subsequent suggestion of appropriate lab work and treatment plan. The residents make daily rounds on weekdays with the attending at 8:00 a.m. and attend team meetings twice weekly. Each inpatient team has up to 12 patients and is comprised of the attending psychiatrist, 1-2 PG1 residents, 2-4 medical students and/or an Acting Intern (AI), a nurse, a social worker, a recreational therapist and a faculty level PhD psychologist. Often, there will also be a senior level resident assigned to the inpatient team. The residents write orders and daily progress notes. Residents are encouraged to attend group therapy and family meetings when time permits. These responsibilities generally take up the whole of each weekday morning from 8am-12pm.

In the afternoon, the residents make appropriate follow-up plans, write prescriptions/orders and give instructions to the patient and family regarding medications and side effects and the follow-up plan. The residents coordinate and schedule family meetings. The residents have the additional responsibility for daily instruction of medical students in performance of history and physical exams and in general psychiatry. The patient caseload is generally 6 to 12 patients per resident.

**PLEASE REFER TO SECTION 5 MISC: MORNING REPORT / DAILY PATIENT CHECK OUT**

**Competency-Specific Objectives:**

**Patient Care:** Residents must be able to provide care of inpatients that is compassionate, appropriate and effective for the treatment of severe mental illness. Residents will:

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Gather accurate and complete information about their patients from the following sources: the patient; the patient's family, friends and health care providers; the patient's medical record.
3. Develop comprehensive bio-psychosocial assessments and differential diagnoses that incorporate genetic predisposition, developmental issues, co-morbid medical issues, substance use and abuse, ethnic/cultural/spiritual factors, economic issues, current relationships, psychosocial stressors and current mental status exam.
4. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgment.
5. Counsel and educate patients and their families and demonstrate the ability to participate in and lead family meetings.
6. Use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records and other computer-based resources.
7. Develop understanding of the use of psychotherapeutic strategies appropriate for an inpatient setting, including supportive techniques, cognitive-behavioral interventions and psychodynamic strategies.
8. Demonstrate competence to recommend the administration of electroconvulsive therapy (ECT). Specifically, residents will be able to:
  - a. Describe selection of appropriate patients for ECT, including psychiatric indications and medical/psychiatric contraindications
  - b. Educate patients and their families about the risks and benefits of and alternatives to ECT
  - c. Obtain informed consent for ECT from patients
9. Demonstrate competence in the management of behavioral emergencies, including verbal and behavioral de-escalation techniques and psychopharmacological management.
10. Work with mental health professionals of other disciplines and with physicians from other specialty services to provide patient focused care.
11. Demonstrate understanding of the mental health system and mental health resources available in the community and use this knowledge to participate in discharge planning and the development of appropriate aftercare plans.
12. Maintain the medical record appropriately, including dictated admission H&Ps, daily progress notes, consent forms and dictated discharge summaries.

**Medical Knowledge:** Residents must demonstrate knowledge about the neurobiological and psychological underpinnings of mental illness and will apply this knowledge to patient care. Residents will:

1. Demonstrate knowledge of the etiologies, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions most likely to affect psychiatric inpatients.
2. Demonstrate understanding of the psychopharmacological treatment of mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.
3. Demonstrate understanding of the indications for and limitations of psychological testing and neuropsychological testing in an inpatient setting.
4. Demonstrate an investigatory and analytic approach to thinking through clinical situations.

**Practice-Based Learning and Improvement:** Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents will:

1. Seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.
2. Use information technology to access on-line medical information and to support their education.
3. Locate, appraise and assimilate evidence from scientific studies related to their patients' health problems.
4. Apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.
5. Facilitate the learning of medical students and other health care providers.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families and other health care providers. Residents will:

1. Create and sustain a therapeutic and ethically sound relationship with patients, including the use of open and honest communication, the maintenance of empathic stance and the establishment of appropriate boundaries.
2. Use effective listening skills in interactions with patients, their family members and other health care providers.
3. Demonstrate competence in complex interviewing situations, such as interacting with patients with thought disorganization, cognitive impairment, paranoia, aggressiveness or inappropriate behavior.
4. Recognize and monitor their emotional responses to patients and adjust their practice accordingly.
5. Demonstrate proficiency in conveying difficult information to patients and their families.
6. Demonstrate an ability to work effectively with other health care providers as a member or leader of an interdisciplinary treatment team.

7. Effectively elicit information from and provide information to other health care providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators and consulting physicians.

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

1. Demonstrate respect, compassion and integrity in all their interactions with patients, families, medical students and other health care providers.
2. Demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersedes self-interest.
3. Appreciate the ethical issues that can arise in an inpatient psychiatric setting, including: patient autonomy; involuntary treatment; decisional capacity to accept or refuse psychiatric care; informed consent; the challenges imposed by financial constraints; confidentiality of patient information; and the potential for violation of appropriate boundaries.
4. Demonstrate sensitivity and responsiveness to patients' culture, age, sexual orientation, gender and disabilities

**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value. Residents will:

1. Demonstrate understanding of the way in which their patient care affects and is affected by other health care providers and the mental health care system
2. Demonstrate an understanding of Wake Forest Baptist Medical Center's mission to the community and to the State.
3. Practice cost-effective health care that does not compromise quality of care.
4. Collaborate with psychiatrists and other mental health providers in the community, medical consultants, and community organizations to provide for the best patient care.
5. Develop an understanding of the economics of inpatient psychiatric treatment and become aware of the impact of differences in health care financing strategies among the various governmental and private insurance programs.
6. Develop an understanding of regulations which affect inpatient psychiatric treatment, including: federal rules on seclusion and restraint.
7. Advocate for quality patient care and assist patients in dealing with the larger mental health system.

## GENERAL MEDICINE ROTATION AT SALISBURY VAMC

**Director:** Frank A. Labagnara, D.O., Internal Medicine/Family Medicine

**Location:** Internal Medicine/Family Medicine-Salisbury VAMC in Salisbury, NC or Kernersville VAMC

### Teaching Objectives:

1. Exposure to a diverse range of complex and singular medical problems/medical diagnoses that are likely to be encountered in a psychiatric population in the inpatient or outpatient setting.
2. To acquire the knowledge and the skill to use diagnostic criteria when performing assessments for patients utilizing the laboratory resources, imaging, etc.
3. To learn and practice the principles of medical management of common and complex medical problems.
4. To gain practical experience in the use and appropriateness of Medical and Surgical consultations in continuity of care regarding medical disorders.
5. To gain experience and practice with respect to professionalism, compassion, and empathy in a general medicine setting.
6. To work within a MEDICAL HOME Model (PACT) and learn its philosophy, advantages and goals.
7. To learn maintenance of confidentiality on patient's behalf in regards to Substance Abuse (including alcohol) and Specific Diagnoses (HIV, Hep C). They will do the VA Clinical Reminders which help in risk assessment, suicide prevention, and disease prevention/screening. They will become acquainted with "duty to report" and Americans with Disability Act during the rotation.

### Responsibilities:

1. The resident is assigned to the Salisbury VAMC or Kernersville VAMC for a 2 month rotation in the Primary Care Outpatient Clinic. The resident will work with a different preceptor each month to maximize the benefit of their clinical experience.
2. The resident will see the patient, review past records/notes, evaluate the pt by taking a pertinent history and do a thorough pertinent physical exam. For new patients a standard History & Physical is expected to be completed with assessment/plan.
3. The resident is responsible for assessing the patient and producing a plan of care based on this visit and available studies, then presenting his recommendations (including lab studies, 36  
consults, imaging, etc.) to her attending, who will confirm the findings and approve the plan.

4. The Resident will notify the attending/preceptor of his schedule, days s/he will be out due to post call or educational duties. The resident is required to attend the educational programs held at Wake on Fridays or if changed to another day, then that day. The resident is encouraged and has ample opportunity to present didactic and clinical cases on this service and attend educational programs pertinent to their discipline while on rotation.
5. The Resident will report to his preceptor any indication of domestic abuse, elder abuse/neglect for review.
6. Resident is responsible for confidentiality of patient's health information.
7. Resident will report any perceived errors or omissions of care that become evident as soon as possible to his preceptor for discussion and determination.
8. If resident arrives on service and finds that the preceptor is absent, he/she should report to Education either in person or by phone to receive an alternate assignment. Call x2965 (Tony Miller), x4397 (Virginia Jeffries) or x4156 (Dr. Labagnara). If able, the preceptor should make other arrangements for the resident in advance.

### **Competency Specific Objectives:**

- I. **Patient Care:** At the end of their training, residents are expected to exhibit competency in the following areas:

#### **A. Accumulation of data**

- i. Obtain and record a complete history, appropriate to clinical circumstances.
- ii. Make efficient use of both patient and family in gathering information.

#### **B. Performance of physical examination**

- i. Recognize clinical situations which require a focused examination and those which require a complete examination.
- ii. Describe ways to modify the approach to the examination when faced with an uncooperative patient.

#### **C. Diagnosis and management of patients**

- i. Establish a differential diagnosis and assessment plan with appropriate prioritization.
- ii. Arrive at a decision or conclusion when reasonable data are available.

- iii. Complete prescriptions, consider potential treatment options, document drug interactions, and provide patient education about medications.
- iv. Provide appropriate patient education regarding disease state, diagnostic and treatment modalities and expected courses or outcomes.

#### **D. Utilization of patient care resources**

- i. Identify the indications for referral.
- ii. Develop an understanding of community services when providing care to families in need.

II. **Medical Knowledge:** At the end of their months of training, residents are expected to demonstrate appropriate knowledge in the following areas:

#### **A. Health maintenance**

- i. Discuss knowledge of recommended periodicity schedules for routine health supervision visits and for the content of these visits.
- ii. Recognize normal and abnormal physiology causing the symptom(s).
- iii. Develop a differential diagnosis and plan with appropriate prioritization.
- iv. Understand of the pathophysiologic processes of a disease and its treatment.
- v. Use of laboratory, x-ray, and ancillary services for diagnostic evaluation.
- vi. Interpret results of common tests.

#### **B. Use of Educational Resources**

- i. Use literature, including national guidelines and practice parameters, to expand knowledge and to develop sound, evidence-based patient care plans.

III. **Practice-Based Learning and Improvement:** At the end of their months of training, residents are expected to be developing competence in the following areas:

#### **A. Utilization of Educational Resources**

- i. Initiate and facilitate group discussion and teaching. Each resident is responsible for presenting 1-2 morning talks. See the schedule for your assigned date.
- ii. Each resident is expected to attend and participate in all of the morning lectures.

IV. **Interpersonal and Communication Skills:** Throughout the month, residents are expected to be developing their skills in the following areas:

**A. Communication with Patients and Families**

- i. Learn how to appropriately use interpreters.
- ii. Recognize cultural differences and how they affect communication in health care.

**B. Communication with Members of the Health Care Team**

- i. Maintain medical records properly and in a timely fashion. All records should be completed by the end of each day if possible, and absolutely no later than one week following the patient visit. All records need to be completed no later than 1 week after finishing the rotation.

V. **Professionalism:** Throughout the month, residents are expected to develop and exhibit the following skills of medical professionalism:

- A. Evaluate and enhance performance based on self-assessment and feedback from others.
- B. Recognize one's own limits and accept accountability for actions and errors.
- C. Demonstrate respect for a patient's privacy.

VI. **System-Based Practice:** By the end of their month, residents are expected to develop competence in the following areas:

- A. Collaborate with other providers and staff to assess and improve clinic flow and quality of services.
- B. Develop awareness of financial and organizational structures in the practice of medicine.
- C. Consider cost-effectiveness and utilization of limited resources in development of care plans.

# EMERGENCY MEDICINE ROTATION

**Director:** Emergency Medicine

Dr. David Story

**Location:** Emergency Department

Wake Forest Baptist Medical Center

## Objectives and Responsibilities:

- 1. Patient Care:** The resident should become adept at performing a problem-focused history and physical examination based on the patient's chief complaint. The resident is expected to develop a list of potential diagnoses and an appropriate plan for sorting through that list, including laboratory analysis, imaging techniques, point-of-care testing, medical therapies, and consultation when indicated. Appropriate disposition (discharge, admit, observation, follow-up) is expected to be the final aspect of patient care.
- 2. Medical Knowledge:** The resident should develop the acumen of identifying an acutely ill patient (emergent vs. urgent complaints). Developing a broad set of possible differential diagnoses should follow the patient interaction. Formulation and initiation of a treatment plan that will aid in identifying the proper diagnoses and rule out potentially catastrophic maladies, while concurrently treating active medical issues. Interpretation of data results, both laboratory and radiographic, is expected in order to properly treat and disposition the patient.
- 3. Practice Based Learning and Improvement:** The resident should show evidence of self-directed learning with an ability to seek out proper sources of information for questions regarding patient care and management.
- 4. Interpersonal and Communication Skills:** Establishing rapport with patients to gain trust and provide a caring environment for treatment is a key to good patient care in the emergency department. Additionally, communication amongst members of the treatment team (nursing, physicians, techs, etc.) is paramount. All members of the team should know the basic plan regarding the treatment of the patient. This requires that the resident to effectively communicate what needs to be done for the patient, and in what order and with what urgency that those orders be performed.
- 5. Professionalism:** All residents are expected to act in a respectful and responsible manner during their rotation in the emergency department. Residents will report on time for shifts and missing or skipping shifts will be handled on an individual basis by the director, and will need to be re-scheduled. A courteous attitude towards all members of the patient care team is expected at all times. All should exhibit sensitivity towards the cultural, socioeconomic, and religious issues facing patients.
- 6. Systems based Practice:** Residents should understand the confines of working within the system present. A good assessment of an undifferentiated patient is required to generate a plan for that patient's medical work-up. That evaluation needs to include lab and imaging tests that are available in a timely fashion. Appropriate disposition also requires that the resident understand the options for patients that are under- or un-insured.

The majority of the instruction that occurs during the emergency medicine rotation is direct bedside teaching and discussion. The attending physician must see and evaluate all patients. The residents perform the initial history and physical, develop a differential diagnoses list and plan, and then present to the attending physician. This interaction is tailor made for educating the

resident. It also allows the supervising physician to identify specific strengths and weaknesses in the resident's performance, so that the instruction given will be most beneficial.

Performing emergency medical procedures is also part of the rotation, varying from peripheral intravenous access to lumbar punctures to endotracheal intubation. We welcome the desire of rotating residents to perform these procedures when necessary on their patients, and are eager to teach and/or supervise when needed. Didactic lectures are available for rotating residents, but are not required, and do not comprise the bulk of teaching during this rotation.

# **DOWNTOWN HEALTH PLAZA GENERAL PEDIATRIC CLINIC ROTATION**

**Director:** Dr. Anna Miller-Fitzwater

## **Goals and Objectives for Psychiatry Residents on Pediatric Rotation:**

### **I. Patient Care:**

#### **A. Accumulation of data**

1. Obtain and record a complete pediatric history, appropriate to clinical circumstances.
2. Make efficient use of both patient and family in gathering information.

#### **B. Performance of physical examination**

1. Recognize clinical situations which require a focused examination and those which require a complete examination.
2. Describe ways to modify the approach to the examination when faced with an uncooperative child.

#### **C. Diagnosis and management of patients**

1. Establish a differential diagnosis and assessment plan with appropriate prioritization.
2. Arrive at a decision or conclusion when reasonable data are available.
3. Complete prescriptions, consider potential drug interactions, and provide patient education about medications.
4. Provide appropriate patient education regarding anticipatory guidance, immunizations, development, diagnostic and treatment modalities, and expected courses or outcomes.

#### **D. Utilization of patient care resources**

1. Identify the indications for referral.

### **II. Medical Knowledge:**

#### **A. Health maintenance**

1. Describe normal patterns and variants of growth and development in infancy, childhood, and adolescence.
2. Discuss knowledge of recommended periodicity schedules for routine health supervision visits and for the content of these visits.
3. Utilization of screening tools, schedules, and guidelines to assure growth and developmental progress.
4. Discuss appropriate nutritional intake for children at various stages of development.

#### **B. Acute and Chronic Conditions**

1. Recognize normal and abnormal physiology causing the symptom(s).
2. Develop a differential diagnosis and plan with appropriate prioritization.
3. Understand the pathophysiologic processes of a disease and its treatment.
4. Use of laboratory, x-ray, and ancillary services for diagnostic evaluation.
5. Interpret results of common tests.

### **III. Practice-Based Learning and Improvement:**

#### **A. Utilization of Educational Resources**

1. Initiate and facilitate group discussion and teaching.
  - i. Each resident is responsible for presenting 1-2 morning talks.
2. Use literature, including AAP guidelines and practice parameters, to expand knowledge and to develop sound, evidence-based patient care plans.

**Each resident should check the schedule at the DHP for his/her assigned date. Each resident is expected to attend and participate in all of the morning lectures (8:00 a.m. — 8:30 a.m.).**

**IV. Interpersonal and Communication Skills:**

**A. Communication with Patients and Families**

1. Learn how to use interpreters appropriately.
2. Recognize cultural differences and how they affect communication in health care.

**B. Communication with Members of the Health Care Team**

1. Maintain medical records properly and in a timely fashion.

**All EPIC records should be completed by the end of each day if possible, and absolutely no later than one week following the patient visit. All records need to be completed no later than 1 week after finishing the rotation**

**V. Professionalism:**

- A. Evaluate and enhance performance based on self-assessment and feedback from others.
- B. Recognize one's own limits and accept accountability for actions and errors.
- C. Demonstrate respect for a patient's privacy.

**VI. System-Based Practice**

**A. Advocacy for Patients and for Children's Health Issues**

1. Access and utilize local, regional, national, and international information related to health care issues.
2. Develop awareness of policies and legal issues at each level of governance that may influence population health and patient care.

**B. Practice Management**

1. Develop an understanding of community services when providing care to families in need.
2. Collaborate with other providers and staff to assess and improve clinic flow and quality of services.
3. Develop awareness of financial and organizational structures in the practice of pediatric medicine.
4. Consider cost-effectiveness and utilization of limited resources in the development of care

# NEUROLOGY ROTATION

**Director:** Dr. Allison Brashear

**Supervisor:** Dr. Jane Boggs

**Location:** Wake Forest Baptist Health for one block with a second block at the VAMC in Salisbury, NC

## Teaching Objectives:

1. To learn to perform a competent and complete neurological history and examination.
2. To develop competence in diagnosis and treatment of common neurological disorders.
3. To perform laboratory and diagnostic procedures for the diagnosis and monitoring of common neurological disorders.
4. To summarize and present neurological findings in a lucid and coherent manner to support a differential diagnosis.

## Duties:

1. The resident works in the Neurology Outpatient Department primarily. This involves taking a complete history, reviewing records and referral information, performance of a complete physical and neurological examination and preparation of a differential diagnosis and a treatment and/or diagnostic plan.
2. The resident presents his findings to the assigned attending neurologist (this includes various Neurology faculty). The attending then comments, examines the patient, and supervises in the implementation of the plan.
3. The resident attends teaching rounds and conferences in the Department of Neurology and attends PG-1 level seminars and Grand Rounds in the Department of Psychiatry.
4. If rotating at with the VA and resident arrives on service and finds that the preceptor is absent, he/she should report to Education either in person or by phone to receive an alternate assignment. Call x2965 (Tony Miller), x4397 (Virginia Jeffries) or x4156 (Dr. Labagnara). If able, the preceptor should make other arrangement for the resident in advance.

## Competency Specific Objectives:

**Patient Care:** Residents must be able to provide care of patients that is compassionate, appropriate and effective for the treatment of neurological conditions.

1. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Residents will demonstrate the ability to perform a relevant history and physical exam on culturally diverse patients, including: chief complaint, history of present illness, past medical history, a comprehensive review of systems, a biological family history, a socio-cultural history, a developmental history and a germane general and neurological examination.

3. Residents will develop an understanding of how to determine if a patient's symptoms are the result of a disease affecting the central and/or peripheral nervous system or of another origin, e.g., somatoform.
4. Based on a comprehensive neurological assessment, residents will demonstrate the ability to determine a formulation, differential diagnosis, laboratory investigation, and management plan.
5. Residents will make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and sound clinical judgment.
6. Residents will demonstrate the ability to counsel and educate patients and their families.
7. Residents will participate in the administration and interpretation of neuropsychological tests and will correlate test findings with clinical data.
8. Residents will use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records and other computer-based resources.
9. Residents will work effectively with health care professionals, including those from other disciplines, to provide patient-focused care.

**Medical Knowledge:** Residents must demonstrate knowledge about the neurobiological underpinnings of neurological illness and will apply this knowledge to patient care.

1. Residents will demonstrate familiarity with the scientific basis of neurology, including neuroanatomy, neuropathology, neurochemistry, neurophysiology and neuroimaging.
2. Residents will demonstrate understanding of the pathophysiology, epidemiology, diagnostic criteria and clinical course for common neurological disorders including:
  - a. Dementia, including Alzheimer's disease, vascular dementia, mixed dementia, dementia with Lewy bodies and fronto-temporal dementia
  - b. Epilepsy and related disorders
  - c. Neuromuscular disorders
  - d. Demyelinating disorders of the central nervous system
  - e. Cerebrovascular disorders
  - f. Infectious diseases of the nervous system
  - g. Tumors of the nervous system
  - h. Nervous system trauma
  - i. Toxic and metabolic disorders of the nervous system
  - j. Acute and chronic pain
  - k. Sleep disorders
  - l. Critical care and emergency neurology
  - m. Coma and brain death
  - n. Headache and facial pain
  - o. Movement disorders including abnormalities caused by drugs
  - p. Neurological manifestations/complications of common psychiatric disorders
  - q. Psychiatric manifestations of common neurological disorders
3. Residents will demonstrate understanding of neuro-pharmacology, including major medications (e.g., anticonvulsant, anti-parkinsonian agents), side effects (hallucinations, mood changes) and neurological complications of psychotropic medications (e.g., movement disorders.)
4. Residents will be able to select appropriate treatment options, based on:

- a. The nature of patients' history and physical findings and the ability to correlate the findings with a likely localization for neurological dysfunction;
- b. Likely diagnoses and differential diagnoses; and,
- c. Risks and benefits of potential therapies

5. Residents will be able to describe the indications for and limitations of neuropsychological testing, as well as psychometric properties such as validity and reliability.

### **Practice Based Learning and Improvement**

1. Residents will seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.
2. Residents will apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.
3. Residents will use information technology to manage information, access on-line medical information and support their own education.
4. Residents will facilitate the learning of medical students and other health care providers.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients' families and other health care providers.

1. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
2. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.
3. Residents will demonstrate proficiency in conveying difficult information to patients and their families.
4. Residents will demonstrate an ability to work effectively with other health care providers.
5. Residents will effectively elicit information from and provide information to other health care providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators and consulting physicians.

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

1. Residents will demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers.
2. Residents will demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients.
3. Residents will demonstrate a commitment to excellence and on-going professional development as they prepare for the transition to independent practice.
4. Residents will appreciate the ethical issues that can arise in the care of patients with neurological illnesses, including: decision making capacity of patients with dementia; ability of patients with dementia and epilepsy to drive; end-of-life issues in patients with severe

neurological illness; pre-symptomatic genetic counseling for patients with family members with neurological illnesses such as Huntington's disease; discontinuation of treatment of brain-dead patients; the ethics of the persistent vegetative state.

5. Residents will demonstrate sensitivity and responsiveness to each patient's age, gender, sexual orientation, culture, ethnicity, religion and disabilities.

**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.

1. Residents will demonstrate understanding of how their patient care affects and is affected by other health care providers, the health care organization and the healthcare system.

2. Residents will know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

3. Residents will practice cost-effective health care that does not compromise quality of care.

4. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system.

5. Residents will 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.

#### **Evaluations:**

***Mandatory:*** To provide the psychiatry resident with an evaluation after completion of the neurology service, it is the resident's responsibility to submit to Neurology's Supervisor, Dr. Jane Boggs and the Academic Assistant, Debbie Singleton, their case log MR with the name of their attendings at the completion of the service. This information will be used to create the resident's evaluation which will then be entered into MedHub by the supervisor in Neurology.

## PGY-2 Schedule

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### ECT AND BRAIN STIMULATION ROTATION

**Director:** Predrag V. Gligorovic, M.D.

**Faculty:** James Kimball, M.D.

#### Core Competency Objectives:

##### Patient Care:

1. The resident shall demonstrate the ability to perform and document a relevant history and examination of the patient with a treatment-resistant affective disorder.
2. The resident shall be able to evaluate a patient for ECT while weighing the pros and cons and risks and benefits of treatment with ECT.

##### Medical Knowledge:

1. The resident shall demonstrate rigor in thinking about clinical situations in which ECT might be considered.
2. The resident shall demonstrate knowledge about the history of ECT, as well as the science behind ECT.
3. The resident shall be able to conduct ECT including patient preparation, device set-up, treatment delivery, and aftercare
4. The resident will become familiar with newer treatment modalities of brain stimulation such as RTMS, VNS, and DBS.

##### Interpersonal and Communication Skills:

1. The resident shall create and sustain a therapeutic relationship with patients undergoing ECT.

##### Practice Based Learning and Improvement:

1. The resident shall be able to manage information in an effort to support clinical care and patient education.

##### Professionalism:

1. The resident shall demonstrate a commitment to ethical principles pertaining to the provision of ECT related services.

##### Systems Based Practice:

1. The resident shall partner with other providers to coordinate effective care for the patient getting ECT.

##### Resident Responsibilities:

1. Residents are assigned to this rotation for a two-month block, 1-2 days per week, while assigned to the Child Outpatient Psychiatry half-time rotation.
2. Residents assist with ECT consultations, ECT procedures, and aftercare management. This includes treatment coordination, interagency liaison, and providing clinical data for insurance verification and authorization as necessary.
3. Residents will submit 5 completed consultation reports, including assessment and plan covering the following key somatic therapies:
  - 1) **Pharmacologic augmentation strategies**
  - 2) **ECT index course**
  - 3) **ECT continuation and maintenance therapies**
  - 4) **Vagal nerve stimulation (when available)**
  - 5) **Transcranial magnetic stimulation (research cases or when available)**
4. Each case report will be used as a stimulus for assessment consisting of either a 15 minute oral examination or a one page (single spaced, typed) case discussion. At least three relevant references, one being a recent journal article, must be included in either assessment form.

# VAMC Inpatient Geriatric Psychiatry

**Director:** German Molina, MD  
**Supervisor:** Lao Por Yang, MD  
**Location:** W.G. (Bill) Hefner VA Medical Center

## TEACHING OBJECTIVES:

- 1) To learn the assessment of chronically ill psychiatric patients and to recognize psychiatric illnesses in the context of multiple co-morbid conditions. Although this is not specifically a geriatric population, many of the patients are middle-aged and elderly. Therefore, an awareness of issues relating to older patients is important.
- 2) To develop diagnostic and treatment skills when assessing this population.
- 3) To become familiar with psychopharmacology in theory and clinical practice.
- 4) To learn how to work in a coordinated fashion with other disciplines gaining experience in the multidisciplinary team approach to comprehensive patient care

## RESPONSIBILITIES:

- 1) Resident will attend morning nurse report from the psychiatric inpatient unit.
- 2) Resident will be an intrinsic member of the treatment team meeting, and participate in interviewing, presenting, and discussing patient's clinical case.
- 3) Residents will write progress notes on their assigned patients, under the supervision of the attending physician.
- 4) Residents will follow consults, labs report; discuss patients' medical aspects with medical providers.
- 5) Residents will give a presentation on a relevant topic, to the Attending physicians of the inpatient units, other residents, medical students, nurses and clinical staff of the Chronically Ill inpatient unit.
- 6) If rotating at with the VA and resident arrives on service and finds that the preceptor is absent, he/she should report to Education either in person or by phone to receive an alternate assignment. Call x2965 (Tony Miller), x4397 (Virginia Jeffries) or x4156 (Dr. Labagnara). If able, the preceptor should make other arrangement for the resident in advance.

## Competency Specific Objectives:

### 1. Medical Knowledge

#### A. Identify the biopsychosocial concomitants of chronic mental illness, including:

1. Demographic changes in the population, (increased proportion of elderly persons) and their implications for health care
2. Sociocultural, legal, economic, cultural and ethnic aspects
3. Psychological and sociological models of adult development
4. Organ system specific biological changes with normal aging, and with common age associated diseases.

#### B. Describe each of the following aspects of each of the following disorders of later life:

##### 1. *Aspects*

- a. Epidemiology  
Known etiological factors or other contributors to biopsychosocial pathogenesis
- b. Clinical features (phenomenology)  
Differential diagnosis, with particular attention paid to how the probabilities are different in older persons as compared with younger adults, or in conditions of later age of onset as compared with younger age of onset
- c. Course and prognosis
- d. Basic approaches to treatment

##### 2. *Disorders*

- a. Delirium
- b. Dementia
- c. Secondary disorders, i.e., those due to general medical conditions or substance-induced
- d. Depressive disorders
- e. Bipolar disorder
- f. Psychotic disorders
- g. Anxiety disorders
- h. Substance use disorders
- i. Personality disorders/vulnerabilities
- j. Sleep disorders and sleep-related symptoms
- k. Somatoform disorders and unexplained somatic symptoms

## 2. Patient Care

- A. Demonstrate ability to successfully interview chronically ill and older patients, including:
  1. Adapting interview technique to account for:
    - a. Age-related cohort/cultural differences between the resident and the patient
    - b. Patient sensory impairments
    - c. Patient cognitive impairments
    - d. Other patient psychopathological phenomena, including mood, psychotic, or anxiety symptoms
  2. Using the interview to accomplish the following:
    - a. Build a treatment alliance
    - b. Obtain historical information
    - c. Conduct a mental status examination, including a detailed cognitive examination
    - d. Impart information to the patient
    - e. Negotiate a treatment plan
- B. Evaluate older patients with psychiatric symptoms and signs, taking into account factors #1-2 above as well as the following:
  1. Comorbid general medical illnesses
  2. Functional assessment
  3. Family and psychosocial assessment, including the role of culture and ethnicity
  4. Ethical issues
  5. Selection and use of clinical laboratory tests, radiological, and other imaging procedures; neuropsychological testing; and appropriate referrals to and consultations with other health care specialists
- C. Develop a treatment strategy for older patients with psychiatric symptoms and signs, taking into account the following:
  1. Psychotherapies
    - a. Use of psychodynamic, cognitive, behavioral, and other methods
    - b. Use of individual, family, and group modalities
  2. Pharmacotherapies
    - a. Impact of normal aging, and diseases associated with aging, on drug pharmacokinetics, and on drug choice and dosage

- b. Use of drugs including: traditional and typical antipsychotics; antidepressants; mood stabilizers; benzodiazepines; psycho-stimulants; cholinesterase inhibitors
  - 3. Electroconvulsive therapy
  - 4. Social treatments
- 3. Interpersonal and Communication Skills
  - A. Relate respectfully and effectively with team members
  - B. Relate respectfully and effectively with patients and families
- 4. Professionalism
  - A. Demonstrate high levels of professionalism at all times, consistently showing respect, compassion, integrity, and honesty, and teaching and role modeling responsible behavior, commitment to self-assessment (with willing acknowledgement of errors), and consideration for the needs of patients, families, and colleagues.
- 5. Practice Based Learning
  - A. Accept feedback and perform self-improvement
  - B. Incorporate feedback into future work
  - C. Teach more junior trainees in psychiatry and colleagues from other specialties and disciplines
  - D. Incorporate evidence-based approaches to patient care, including demonstration of skills in critically reviewing the literature and describing relevant research methodologies used in geriatric psychiatry.
- 6. Systems Based Practice
  - A. Describe the organizational and administrative aspects of long-term care, home health care, outreach, and crisis intervention services.
  - B. Care for patients in varied settings including inpatient psychiatry and general medicine, outpatient, and residential long-term care facilities, to include functioning as a consultant and as a member of the multidisciplinary health team.

# CONSULTATION-LIAISON ROTATION

**Directors:** Dr. James Kimball-Adult Psychiatry  
Dr. Josephine Mokonogho- Adult Psychiatry  
Dr. Matt Hough - Child and Adolescent Psychiatry

**Location:** 11 Ardmore West Safety Unit and throughout the hospital.

## Teaching Objectives:

1. To understand the nature of the consultative process and distinguish the responsibilities of a consultant from those of a primary physician
2. To understand medico-legal problems that present to the consultation-liaison services (e.g. commitment, capacity) and provide appropriate consultation for these problems
3. To distinguish the various types of consultations (patient centered, physician centered, program centered, and nurse centered), and observe and practice each type
4. To formulate and articulate psychosomatic problems in a biopsychosocial context meaningful to the non-psychiatric physician
5. To recognize the signs and symptoms and diagnose psychiatric conditions most commonly encountered in medical settings
6. To observe and practice crisis intervention, brief psychotherapy, brief family intervention, patient education, and appropriate referral in medically hospitalized patients
7. To perform an adequate psychiatric consultation and present it in an effective manner to the consultation-liaison team

## Competency Specific Objectives:

**Patient Care:** Residents must be able to provide consultative care of patients that is compassionate, appropriate and effective for the treatment of psychiatric conditions in a medical environment.

1. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Residents will quickly develop a therapeutic alliance with medically ill patients.
3. Residents will learn to interview patients in a variety of medical settings.
4. Residents will evaluate for psychopathologic processes in patients with concomitant medical and surgical conditions.
5. Residents will evaluate cognitive ability in medically ill patients.
6. Residents will demonstrate the ability to perform a relevant history on culturally diverse patients, including; chief complaint, history of present illness, past medical history, a comprehensive review of systems, a biological family history, a sociocultural history, a developmental history and a germane general and neurological examination. This will be done in a wide variety of medical and surgical patients.

7. Residents will gather data from appropriate sources, including chart, hospital staff, family, and other relevant individuals.
8. Residents will interact effectively with a variety of consultees, including determination of consultation questions, and reporting of findings and recommendations.
9. Residents will recognize the typical signs and symptoms of psychiatric disorders including substance abuse in medical and surgical patients.
10. Residents will assess and interpret laboratory and medical data as it relates to psychiatric illness.
11. Residents will understand the connections between medical and psychiatric illnesses and the special issues that arise in specific patient populations, including cancer, cardiac disease, HIV disease, organ transplantation, and dementia.
12. Residents will write pertinent and useful consultation notes.
13. Residents will monitor the patients' course during hospitalization and provide continuing input as needed.

**Medical Knowledge and Therapeutics:** Residents must demonstrate knowledge about the medical underpinnings of psychiatric illness in medically/ surgically ill patients and apply this to patient care.

1. Residents will demonstrate an understanding of the pathophysiology, epidemiology, diagnostic criteria and clinical course for common consultation conditions including:
  - a. dementia(s)
  - b. delirium of multiple etiologies
  - c. drug induced psychiatric state
  - d. affective change in the face of chronic or life threatening illness
  - e. factitious disorders
  - f. malingering
  - g. chronic pain
  - h. assessment of conversion disorders
  - i. assess drug-drug interactions germane to psychiatry
  - j. assist in competency assessments
  - k. anxiety disorders in a general medical population.
  - l. psychotic disorders in a general medical population.
2. The resident must be able to:
  - a. Advise and guide consultees about the role of the medical disease and medications in the patients' presenting symptoms
  - b. Understand the indications for a variety of somatic therapies in medical and surgical patients
  - c. Understand the use of psychotropic medications and ECT in medical/ surgical patients, and appreciate physiological effects, contraindications, drug interactions, and dosing concerns
  - d. Understand, utilize, and instruct regarding the use of non-organic treatments, including brief psychotherapy, behavioral management techniques, family therapy, and

psychoeducation

- e. Work as a member of a multidisciplinary team to maximize the care of complex medically ill patients

**Practice-Based Learning and Improvement:** Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

1. Residents will seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.
2. Residents will apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.
3. Residents will use information technology to manage information, access on-line medical information and support their own education.
4. Residents will facilitate the learning of medical students and other health care providers.

This will include, but not be limited to:

1. Seeking appropriate reference material pertinent to consultation/ physician duties.
2. Reading articles with critical assessment as recommended by faculty.
3. Continuing to learn to use modern informational systems to identify, information in reference to patient issues.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients' families and other health care providers:

1. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
2. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.
3. Residents will demonstrate proficiency in conveying difficult information to patients and their families.
4. Residents will demonstrate an ability to work as a member of a multidisciplinary patient care team.
5. Residents will effectively elicit information from and provide information to other health care providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators and consulting physicians.
6. Residents should be able to make a determination regarding the consultation questions, and report findings and recommendations about the role of the medical disease and medications in the patients' presenting psychiatric symptoms.

7. Residents should be able to advise and guide consultees regarding managing psychiatric disorders in a medical setting including the management of behavioral disorders.

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

1. Residents will demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers.

2. Residents will demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersedes self-interest.

3. Residents will demonstrate a commitment to excellence and on-going professional development as they prepare for the transition to independent practice.

4. Residents will appreciate the ethical issues that can arise in the care of patients with concomitant psychiatric and medical/ surgical conditions. Such issues include for example, transplant decisions in psychiatric patients and issues of capacity and consent.

5. Residents will demonstrate sensitivity and responsiveness to each patient's age, gender, culture, ethnicity, religion and disabilities.

**Systems-Based Practice:** Residents must demonstrate an awareness of a responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.

1. Residents will demonstrate understanding of how their patient care affects and is affected by other health care providers, the health care organization and the health care system.

2. Residents will know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

3. Residents will practice cost-effective health care that does not compromise quality of care.

4. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system.

5. Residents will 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.

**Resident Responsibilities:**

1. Covering all psychiatric consultations requested during the working day Monday – Thursday, 8:00 a.m. to 5:00 p.m. Coverage is provided by attending physicians on Fridays to allow residents to attend didactics. Many of the patients will be rounded on at 11 Ardmore West.

2. Present the case to the consult attending or the requested faculty member. The patient is then seen jointly by the resident and the attending physician to develop diagnostic and treatment recommendations. Areas of review are interpersonal and communication skills,

professionalism, and systems-based practice.

3. Initiating and maintaining appropriate follow-up with inpatient consults.
4. Supervising medical students rotating on the consultation-liaison service.
5. Residents will submit 5 typed Consultation Reports, complete with your own assessment and plan, illustrating each of the following key consultation issues:
  - 1) Delirium
  - 2) Medical decision-making capacity
  - 3) Depression in a medically ill patient
  - 4) Somatoform disorder
  - 5) Suicidality
6. For each of the reports in #5 above, complete either a 15 minute oral examination by the C-L attending or submit a one-page, single-spaced typed case discussion. In either case, submit at least 3 relevant references with at least one being a recent journal article in the area.
7. Consultations seen on the Emergency Psychiatry Service may be used for items 5 and 6 above.

**PLEASE REFER TO SECTION 5 MISC: MORNING REPORT / DAILY PATIENT CHECK OUT**

# EMERGENCY PSYCHIATRY ROTATION

**Director:** Dr. James Kimball

## **Goals and Objectives for Psychiatry Residents on Emergency Psychiatry Rotation:**

- I. **Patient Care** - At the end of the rotation, residents are expected to exhibit competencies in the following areas:
  - A. **Accumulation of Data**
    1. Obtain and record a complete psychiatric history appropriate to the clinical circumstances
      - i. Should include review of pertinent labs and imaging
    2. Make efficient use of patient, family, and collateral resources for obtaining information
      - i. This should include review of previous records that are available on site as well as attempts to obtain collateral records from outside resources
  - B. **Performance of Physical Exam and Mental Status Exam in Emergency Setting**
    1. Recognize clinical situations that require a focused versus complete examination
    2. Recognize potential safety issues that are possible with emergency psychiatry patients
      - i. This should include the identification and assessment of potentially suicidal, violent, or threatening patients
      - ii. Learn how to manage situations where imminent danger is present
      - iii. Describe ways to modify the approach to the exam when faced with the potentially violent patient
  - C. **Triage of Emergency Psychiatry Patients**
    1. Learn to triage emergency psychiatry patients to appropriate levels of care.
      - i. This includes learning to recognize non-urgent psychiatric conditions and make appropriate referrals to community resources as well as learning to recognize acute psychiatric conditions that require inpatient level of care

**D. Diagnosis and Management of an Emergent Psychiatry Patient**

1. Establish a differential diagnosis and treatment plan with appropriate prioritization of treatment options
  - i. Arrive at a decision when reasonable data is available
2. To understand and utilize the involuntary civil commitment process
3. Understand indications for and appropriate administration of emergency psychopharmacology including the use of antipsychotic, benzodiazepines, and mood stabilizers for psychiatric emergencies
4. Consider potential medication interactions
5. Provide patient with medication education and keep patient updated on treatment recommendations

**E. Utilization of Outpatient Patient Care Resources**

1. Develop an understanding of available outpatient treatment options for community support, drug rehab, ACTT services, mobile crisis services, therapy options, outpatient medication management options, long-term care services, and social work resources for patients who are discharged
2. Develop an understanding of resources available to families of patients with mental illness
3. Learn when to utilize community resources and agencies to prevent repetitive emergency department visits

**II. Medical Knowledge-** At the end of the rotation, residents are expected to exhibit competencies in the following areas:

- A. Be able to recognize classic presentations of psychiatric illnesses
- B. Be able to recognize psychiatric complications from or psychological reactions to general medical conditions
- C. To recognize medical complications related to psychiatric illness or psychotropic medications
- D. To recognize general medical conditions that may present as psychiatric emergencies
  1. Rule out life-threatening medical conditions that mimic psychiatric emergencies
- E. Use appropriate ancillary services, x-ray, and labs as needed for medical clearance of psychiatric patients and interpret results of common tests
- F. To utilize medical consultants appropriately

- G. To coordinate with the ER physicians in the management of co-morbid, non-psychiatric medical issues for patients awaiting psychiatric placement
- III. **Forensic Knowledge:** At the end of the rotation, residents are expected to exhibit competencies in the following areas:
- A. Risk assessment
  - B. Duty to report
  - C. Civil commitment
  - D. Forced medication
- IV. **Use of Education Resources**
- A. Use literature, APA guidelines and practice parameters to expand knowledge and develop evidence-based practice patterns.
  - B. To be able to utilize psychiatric screening tools and assessment scales
- V. **Professionalism**
- A. Communicate with patients and families
    - 1. Demonstrate respect for patient privacy
    - 2. Advocate for patients with mental illness
  - B. Communicate with transfer coordinators, ED psychiatry holding unit nurses and ED resident/attendings for coordination of services
  - C. Maximize efforts for peer to peer checkouts for continuity of patient care
  - D. Maintain medical records properly and in a timely fashion
  - E. Recognize one's own limits and accept accountability for actions and errors
- VI. **Resident Responsibilities:**
- A. One resident will be assigned to the Emergency Psychiatry Consultation-Liaison Service providing coverage for the academic year in 1 month blocks.
    - 1. The mid-level providers will be responsible for covering the duties from 7 am – 3 pm in the adult ED and from 8 am – 5 pm in the pediatric ED and the assigned resident will be responsible for covering from 3pm – 12am Monday through Thursday.
    - 2. Any consults called into the consult line by 11pm will fall to the ED CL residents and night float to work up.
    - 3. Any new consults called in after 11pm will fall to the night float resident to complete.

4. During their assigned months, these residents will be responsible for seeing NEW urgent ADULT AND PEDIATRIC consults in the emergency room.
  5. Adult consults are to be staffed via phone or in person with Dr. Kimball or Dr. Suttentfield until 5 PM
  6. Pediatric consults are to be staffed via phone with the designated child attending until 5 PM
    - i. The resident will need to contact Sandy Harris (6-9606) each day to see which child attending will be staffing for the day.
- B. In addition to seeing new consults, the residents will also be responsible for helping re-evaluate, manage, and disposition ADULT patients who are held over in the Emergency Room.
1. Daily notes will be written for ADULT patients in the ED 24 hours or more by the mid-level provider and/or Dr. Suttentfield.
    - i. The Pediatric ED mid-level provider will be responsible for writing daily notes on PEDIATRIC patients in the ER 24 hours or more
  2. Appended daily notes should be written for ADULT patients in the ED who have been held less than 24 hours.
    - i. These notes should outline treatment plan of care, updated mental status exam, and disposition plans.
- C. Dr. Suttentfield will be available in the ED 8am – Noon, Monday – Friday.
1. Dr. Suttentfield will primarily be responsible for re-evaluations and dispositions for patients held over in the ED. If no patients require re-assessment, he will be available for bed-side teaching as well as help seeing new ADULT consults.
- D. Dr. Kimball will be available by phone 8 am – 5 pm Monday – Thursday.
- E. Each morning, there will be a 30 minute treatment team meeting led by Dr. Suttentfield starting at 9am in the Pediatric ED Staff Lounge. The meeting will facilitate triage, delegate duties, and insure that all parties are in the loop of communication.
1. Those expected to be present at this meeting include Dr. Suttentfield, the ED mid-levels, transfer coordinator, unit manager for adult inpatient unit, referral coordinator (via phone), and ED nurse covering behavioral holding unit.
  2. On weekends, the night float/overnight call resident will meet with the on-coming resident or their back-up for sign out between 7:30-8 AM. Sign out will be face to face if possible and by telephone if not.

- F. The ED CL resident should receive updates from the mid-level provider prior to his departure for the day on any patients he was handling.
- G. Fridays from 12 PM-10 PM:
  - 1. An assigned rotating resident will cover floor consults and if needed, the NEW consults in the ED along with the mid-level provider
  - 2. Dr. Suttentfield will cover re-evaluations and some new ADULT consults on Friday 8am to 12pm.

**Points to Consider for the Emergency Psychiatry Patient:**

**Evaluation of Psychiatric Patients in the Emergency Department:** An emergency psychiatric evaluation generally occurs in response to thoughts, feelings, or urges to act that are intolerable to the patient, or to behavior that prompts urgent action by others, such as violent or self-injurious behavior, threats of harm to self or others, failure to care for oneself, bizarre or confused behavior, or intense expressions of distress.

**Specific Approaches to the Emergency Psychiatric Patient:**

1. It is expected that under ordinary circumstances patients needing a psychiatric consult in the ED should be seen for the initial assessment in 30 minutes. Children take longer because you will need to interview the parent(s) as well.
2. Discuss with the referring physician the specific question or issue to be answered.
3. Confirm with the physician requesting the consult that the patient is aware that a psychiatric consultation will be performed.
4. Carefully consider matters of safety of the patient and others in your assessment.
5. Establish a provisional diagnosis (or diagnoses) of the mental disorder(s) most likely to be responsible for the current emergency, including identification of any general medical condition(s) and/or substance use that might be causing or contributing to the patient's mental condition.
6. Identify family or other involved persons who can give information that will help determine the accuracy of reported history, particularly if the patient is cognitively impaired, agitated, uncooperative, or psychotic and has difficulty communicating a history of events. If the patient is to be discharged back to family members or other caretakers, their ability to care for the patient and their understanding of the patient's needs should be addressed.
7. Identify any current treatment providers who can give information relevant to the evaluation and obtain this information whenever possible.
8. Identify social, environmental, and cultural factors relevant to immediate treatment decisions.
9. Determine whether the patient is able and willing to form an alliance that will support further assessment and treatment. Determine what precautions are needed if there is a substantial risk of harm to self or others, and whether involuntary treatment is necessary.
10. Develop a specific plan for follow-up, including immediate treatment and disposition. Determine whether the patient requires treatment in a hospital or other supervised setting and what follow-up will be required if the patient is not placed in a supervised setting.

### **Specific Approaches to the Emergency Psychiatric Patient Who is Intoxicated:**

1. Discuss with the referring physician whether or not the patient is capable of providing a coherent history.
2. Discuss with the physician whether or not the patient can provide a reliable and consistent mental status exam, and whether or not the patient's symptoms are more closely related to an urgent medical condition (encephalopathy, BAC > 200, diabetic ketoacidosis, etc.). The presence or level of a specific intoxicant should not necessarily preclude a psychiatric consultation.
3. Proceed with the Psychiatric assessment of the patient when deemed appropriate and tailor the assessment to the reason for the consultation.
4. Reassessment of the patient may be necessary as the intoxicant begins to clear. Not infrequently, a patient's status with regard to "dangerousness" may change with clearing of his/her mental status.

### **Triage of Non-Psychiatric Emergencies:**

1. Consults for routine psychiatric issues that are not emergent and have no immediate safety concerns can be referred to an outpatient clinic or provider
2. Detoxification from substances without associated suicidality can be referred to ARCA or CenterPoint. The psychiatric social worker/transfer coordinator in the ED can assist with disposition and can be reached at 713-5747.
3. Patients who will be admitted to the medical floors for stabilization may not require emergent psychiatric consult unless there is an issue with acute management of agitation/delirium/safety. Generally, psychiatric consultations for patients being admitted to the general hospital should be done by the C/L Service during daytime business hours. **Place these persons on the floor C/L list and notify that team!**
4. Patients who are simply seeking to "expedite" an outpatient referral should be referred to an outpatient clinic or provider.

**Effectiveness Evaluation:** Effectiveness of the policy will be periodically evaluated by psychiatry and emergency department faculty, as well as periodic review by the Educational Policy Committee.

***Refer to Admission procedure from ED to Inpatient on page 136***

## CHILD & ADOLESCENT PSYCHIATRY ROTATION

**Director:** Dr. Timothy King

**Supervisors:** Dr. Matthew Hough

**Rotation days/hours:** Tuesday 8:00 am – 5:00 pm  
Thursday 1:00 pm – 5:00 pm

**Location:** 791 Jonestown Rd  
Winston-Salem, NC 27103  
**Report to Dr. King**

### Teaching Objectives:

1. To appropriately evaluate, diagnose and treat children and adolescents, under supervision of faculty child psychiatrists.
2. To participate in a multidisciplinary diagnostic and treatment team and synthesize information from various disciplines.

### Competency Specific Objectives:

**Patient Care:** Residents must be able to provide care that is compassionate, appropriate and effective for the treatment of mental illness.

1. Residents will demonstrate the ability to assess a wide variety of child and adolescent patients presenting with the full spectrum of psychiatric disorders commonly seen in outpatient settings with attention to developmental stage and to psychological, biological, social and cultural contributions to their illnesses.
2. Residents will appropriately assess safety issues including risk for suicide or homicide and risk of abuse or neglect, and will address these concerns in an ethical manner that is congruent with state law.
3. Residents will communicate effectively and demonstrate caring and respectful behavior when interacting with patients and their families.
4. Residents will counsel and educate patients and their families and demonstrate the ability to convey difficult information in a developmentally appropriate manner.
5. Residents will develop patient formulations that include the following elements:
  - a. DSM 5 diagnoses
  - b. Developmental aspects
  - c. Narrative/psychodynamic aspects
  - d. Psychosocial aspects
  - e. Biomedical/psychopharmacologic aspects
  - f. Genetic aspects

6. Residents will formulate and implement treatment plans based on their diagnostic formulation and define specific treatment goals, considering patient personal and psychosocial resources and ability to participate in the plan. Treatment paradigms will include:
  - a. Psychopharmacological treatment and management
  - b. Individual psychotherapy
  - c. Family and group therapies
  - d. Integrated, multidisciplinary treatment
7. Residents will implement biomedical treatment strategies, including psychopharmacological treatment and, when indicated, referral for electroconvulsive therapy.
8. Residents will appropriately and proficiently employ commonly used rating scales during the assessment and follow up of outpatients (e.g. Child Depression Inventory, Achenbach Child Behavior Checklist)
9. Residents will demonstrate the ability to conduct a variety of psychotherapeutic treatment modalities with children and adolescents, including at a minimum:
  - a. Cognitive behavioral therapy
  - b. Behavioral therapy
  - c. Supportive psychotherapy
  - d. Brief psychotherapy
  - e. Family therapy
10. Within the setting of a supervised clinical experience in the evaluation and treatment of families and groups, residents will demonstrate competence to:
  - a. Evaluate families to identify interpersonal and family processes affecting individual members of the relationship in maladaptive or illness causing ways;
  - b. Evaluate individuals to determine their appropriateness for participation in interpersonal group therapies;
  - c. Conduct treatment of families
11. Residents will demonstrate the ability to identify outpatients who should be referred for psychological and neuropsychological testing to aid with diagnostic assessment.
12. Residents will understand the risks and benefits of and indications for psychiatric hospitalization and will be able to evaluate patients with a view to determining their psychiatric risk (risk of suicide or otherwise) and need for hospitalization.
13. Residents will assess patients for initiation or continuation of outpatient commitment proceedings under the applicable laws of the state of NC, using knowledge of the law for youth of various ages.

14. Residents will demonstrate the ability to conduct and appropriate clinical evaluation and referrals relevant to criminal or civil law, including evaluation of children in custody cases and or will alleged abuse.
15. Residents will collaborate with other health professionals, such as primary care providers, psychotherapists, nurses and case managers, to provide patient focused care, especially in these situations:
  - a. Resident provides psychiatric care and another clinician provides primary medical care;
  - b. Resident provides medication management services and another clinician performs psychotherapy;
  - c. Resident provides medication management services (and perhaps psychotherapy) and another clinician provides case management.
16. Residents will collaborate with school personnel including teachers, counselors, principals, nurses, and other staff during assessment and treatment.
17. Residents will use information technology to support patient care decisions and patient education, including online literature searches, electronic medical records and other computer-based resources.

**Medical Knowledge:** Residents must demonstrate knowledge of the neurobiological, psychological and socio cultural underpinnings of mental illness and will apply this knowledge to the care of outpatients.

1. Residents will demonstrate advanced knowledge of the epidemiology, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions most likely to affect psychiatric outpatients.
2. Residents will demonstrate knowledge of the biological underpinnings and modern etiological theories of mental illness that integrate recent findings in neuroscience.
3. Residents will understand the psychopharmacological treatment of mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.
4. Residents will understand the indications for and limitations of psychological testing and neuropsychological testing, and will understand the nature of various commonly used instruments such as the MMPI-A, Rorschach, TAT/CAT, WISC.
5. Residents will demonstrate knowledge of general medical disorders that may mimic or complicate psychiatric disorders, and appropriately investigate when appropriate (e.g., blood lead level, TSH, or strep titers)
6. Psychiatry residents will conceptualize mental illness in terms of biological, psychological, and socio cultural factors that determine normal and disordered behavior.
7. Residents will appreciate that psychopharmacological treatment must take into account the wide variety of interactions with other pharmacologic agents, impact on other medical conditions, potential to impact development and full appreciation of all side effect problems including compliance, sleep, weight, cognition, and other organ system difficulties.

8. Residents will appreciate issues arising from the integration of psychopharmacology and psychotherapy, including: the opportunities and challenges presented by “split treatment” (psychotherapy by one provider, medication management by another provider) and the practice of medication management with awareness of psychotherapeutic issues, whether or not the resident is performing psychotherapy.

**Practice-Based Learning and Improvement:** Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

1. Residents will seek feedback from their supervising faculty about their own practice and will use this feedback to improve their performance.
2. Residents will locate, appraise and assimilate evidence from scientific studies related to child patients, including participation in “wrap-up” sessions.
3. Residents will demonstrate evidence-based thinking in their formulations and treatment plans.
4. Residents will facilitate the learning of other health care professionals, including psychotherapists and case managers providing services to the residents’ outpatients.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families and other health care providers.

1. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
2. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.
3. Residents will demonstrate competence in communicating with patients of all ages, including the use of projective modalities as indicated (using drawings or play to communicate with a five-year old).
4. Residents will recognize and monitor their emotional responses to patients and adjust their practice accordingly.

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

1. Residents will obtain informed consent for psychiatric treatment plans, including for the use of psychotropic medications, and will demonstrate understanding of the ethical principles underlying informed consent.
2. Residents will provide care to outpatients that take into account: (1) medical record keeping, (2) risk management and quality assurance issues, (3) confidentiality, (4) collaboration with other providers, agencies, schools and family members, (5) financial and health system issues, (6) legal and forensic issues and (7) other ethical concerns.
3. Residents will understand issues related to medical disability evaluations, including state regulations regarding such evaluations and the ethical principles involved.

4. Residents will demonstrate sensitivity and responsiveness to each patient's age, gender, sexual orientation, culture, ethnicity, religion and disabilities.

**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide optimal care to outpatients.

1. Residents will appreciate the model of community-based outpatient care employed at WFBMC and will understand the difference between this model and others, such as mental health centers, hospital-based practice, residential treatment, private practice group models and solo practice.
2. Residents will understand how their patient care affects and is affected by other health care providers, the health care organizations.
3. Residents will appreciate the economics of outpatient mental health care, including the value of services residents provide and to which they refer their patients; in turn, residents will practice cost-effective health care that does not compromise quality of care.
4. Residents will recognize issues that can arise in outpatient practice, including: (1) interaction with staff members; (2) management of patient records and other information systems; (3) scheduling; (4) cross-coverage among practitioners; (5) various treatments among practitioners; (6) billing and payers (including Medicare, Medicaid, HMO's and private insurance); (7) office and space management.
5. Residents will understand the regulation of outpatient psychiatric treatment, including: (1) patient confidentiality and HIPAA; (2) state regulations regarding involuntary treatment; (3) state regulations regarding custody and guardianship; (4) governmental and other regulation of outpatient clinics, including JCAHO and state inspectors; (5) other regulations specific to WFBMC.
6. Residents will know and, if necessary, utilize the mechanisms by which quality improvement occurs at WFBMC.
7. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system.

**Resident Responsibilities:**

1. Residents are assigned to the Child Psychiatry Outpatient Clinic for a day and a half for a five month period during their second year and a ½ day for two months fourth year.
2. Perform diagnostic evaluation and treatment assigned during the rotation under the supervision of the attending psychiatrists. Written initial evaluations with assessment and treatment plan will be reviewed each week, covering patients with each of the following issues for the Medical Knowledge core competency:
  - a. ADHD
  - b. Mood Disorders
  - c. Anxiety Disorders
  - d. PDD

e. Substance Use Disorders

f. Psychotic Disorders

Each disorder discussion should include 2 relevant references to demonstrate the Practice-based Learning and Improvement core competency.

3. Proper documentation of new patient evaluations, discharge summaries and progress notes.
4. Attending assigned seminars and clinics.
5. Performing supervised consultations for children in the pediatric units, and demonstrating appropriate interagency and family facilitation in all clinical venues for the Systems-Based Practice core competency
6. Successfully complete 2 new child evaluation interviews observed by child faculty to assess patient care and professionalism core competencies.

# TELE-PSYCHIATRY ROTATION

**Director:** Dr. Mokonogho

## **Objectives:**

During this rotation, the resident will provide psychiatric consultation to community Wake Forest psychiatric facilities. In this capacity, the resident will evaluate and assist with disposition of psychiatric patients and assist in the medical decision making for these patients.

## **Competency Specific Objectives:**

**Patient Care:** Residents must be able to provide consultative care of patients that is compassionate, appropriate and effective for the treatment of psychiatric conditions in a medical environment.

Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.

Residents will quickly develop a therapeutic alliance with medically ill patients.

Residents will learn to interview patients in a variety of medical settings.

Residents will evaluate for psychopathologic processes in patients with concomitant medical and surgical conditions.

Residents will evaluate cognitive ability in medically ill patients.

Residents will demonstrate the ability to perform a relevant history on culturally diverse patients, including; chief complaint, history of present illness, past medical history, a comprehensive review of systems, a biological family history, a sociocultural history, a developmental history and a germane general and neurological examination. This will be done in a wide variety of medical and surgical patients.

Residents will gather data from appropriate sources, including chart, hospital staff, family, and other relevant individuals.

Residents will interact effectively with a variety of consultees, including determination of consultation questions, and reporting of findings and recommendations.

Residents will recognize the typical signs and symptoms of psychiatric disorders including substance abuse in medical and surgical patients.

Residents will assess and interpret laboratory and medical data as it relates to psychiatric illness.

Residents will understand the connections between medical and psychiatric illnesses and the special issues that arise in specific patient populations, including cancer, cardiac disease, HIV disease, organ transplantation, and dementia.

Residents will write pertinent and useful consultation notes.

Residents will monitor the patient's course during hospitalization and provide continuing input as needed.

**Medical Knowledge and Therapeutics:** Residents must demonstrate knowledge about the medical underpinnings of psychiatric illness in medically/ surgically ill patients and apply this to patient care.

3. Residents will demonstrate an understanding of the pathophysiology, epidemiology, diagnostic criteria and clinical course for common consultation conditions including:

- a. dementia(s)
- b. delirium of multiple etiologies
- c. drug induced psychiatric state
- d. affective change in the face of chronic or life threatening illness
- e. factitious disorders
- f. malingering
- g. chronic pain
- h. assessment of conversion disorders
- i. assess drug-drug interactions germane to psychiatry
- j. assist in competency assessments
- k. anxiety disorders in a general medical population.
- l. psychotic disorders in a general medical population.

4. The resident must be able to:

Advise and guide consultees about the role of the medical disease and medications in the patients' presenting symptoms

Understand the indications for a variety of somatic therapies in medical and surgical patients

Understand the use of psychotropic medications and ECT in medical/ surgical patients, and appreciate physiological effects, contraindications, drug interactions, and dosing concerns

Understand, utilize, and instruct regarding the use of non-organic treatments, including brief psychotherapy, behavioral management techniques, family therapy, and psychoeducation

Work as a member of a multidisciplinary team to maximize the care of complex medically ill patients

**Practice-Based Learning and Improvement:** Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Residents will seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.

Residents will apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.

Residents will use information technology to manage information, access on-line medical information and support their own education.

Residents will facilitate the learning of medical students and other health care providers.

This will include, but not be limited to:

Seeking appropriate reference material pertinent to consultation/ physician duties.

Reading articles with critical assessment as recommended by faculty.

Continuing to learn to use modern informational systems to identify information in reference to patient issues.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients' families and other health care providers:

1. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
2. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.
3. Residents will demonstrate proficiency in conveying difficult information to patients and their families.
4. Residents will demonstrate an ability to work as a member of a multidisciplinary patient care team.
5. Residents will effectively elicit information from and provide information to other health care providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators and consulting physicians.
6. Residents should be able to make a determination regarding the consultation questions, and report findings and recommendations about the role of the medical disease and medications in the patients' presenting psychiatric symptoms.
7. Residents should be able to advise and guide consultees regarding managing psychiatric disorders in a medical setting including the management of behavioral disorders.

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

1. Residents will demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers.
2. Residents will demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersedes self-interest.
3. Residents will demonstrate a commitment to excellence and on-going professional development as they prepare for the transition to independent practice.
4. Residents will appreciate the ethical issues that can arise in the care of patients with concomitant psychiatric and medical/ surgical conditions. Such issues include for example, transplant decisions in psychiatric patients and issues of capacity and consent.
5. Residents will demonstrate sensitivity and responsiveness to each patient's age, gender, sexual<sup>73</sup> orientation, culture, ethnicity, religion and disabilities.

**Systems-Based Practice:** Residents must demonstrate an awareness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.

1. Residents will demonstrate understanding of how their patient care affects and is affected by other health care providers, the health care organization and the health care system.
2. Residents will know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
3. Residents will practice cost-effective health care that does not compromise quality of care.
4. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system.
5. Residents will 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.

**Resident Responsibilities:**

8. Covering all tele-psychiatric consultations requested during the working day Monday – Thursday, 8:00 a.m. to 5:00 p.m.
9. Present the case to the designated faculty member.
10. Recognize that ultimate disposition of patient is determined by the ED attending physician.

## PGY-3 Schedule

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### ADULT OUTPATIENT PSYCHIATRY CLINICAL ROTATION

**Co-Directors:** Dr. James Kimball & Dr. Karen Green

**Teaching Objectives:**

1. To improve and practice clinical interviewing, diagnostic, and formulation skills in the context of outpatient clinical settings
2. To observe and participate in a variety of outpatient treatment modalities, including individual psychotherapy, brief psychotherapy, pharmacotherapy and supportive therapy, outpatient group therapy, and neuropsychiatry
3. To provide a framework for supervised long-term psychotherapy cases
4. To supervise medical students in their initial evaluation of patients in the adult outpatient clinic

**Competency Specific Objectives:**

**Patient Care:** Residents must be able to provide care of outpatients that is compassionate, appropriate and effective for the treatment of mental illness.

1. Residents will demonstrate the ability to conduct assessments of a wide variety of patients presenting with the full spectrum of psychiatric disorders commonly seen in outpatient psychiatric settings and attending to development, psychological, biological, social and cultural contributions to their illnesses.
2. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
3. Residents will counsel and educate patients and their families and demonstrate the ability to convey difficult information.
4. Residents will develop patient formulations that include the following elements:
  - a. DSM 5 diagnoses
  - b. Developmental aspects
  - c. Narrative/psychodynamic aspects
  - d. Psychosocial aspects
  - e. Biomedical/ neuropharmacology aspects
  - f. Genetic aspects
5. Residents will formulate and carry out treatment plans based on the above diagnostic formulation and define a rationale for specific treatment goals, considering also patient personal and psychosocial resources and ability to participate in the plan. Treatment paradigms will include:
  - a. Psychopharmacological treatment and management
  - b. Individual psychotherapy

- c. Marital/couples, family and group therapies
  - d. Integrated, multidisciplinary treatment
6. Residents will implement biomedical treatment strategies, including psychopharmacological treatment with antidepressants, antipsychotics, sedative-hypnotics, mood stabilizing medications, stimulants and agents for treatment of sexual disorders and, when indicated, referral for electroconvulsive therapy.
7. Residents will appropriately and proficiently employ commonly used rating scales during the assessment and follow-up of outpatients, including anxiety and depression scales, cognitive measures (e.g., Folstein Mini-Mental State Examination) and neurological scale (e.g., Abnormal Involuntary Movement Scale).
8. Residents will demonstrate the ability to conduct a variety of psychotherapeutic treatment modalities, including:
  - a. Cognitive-behavioral therapy
  - b. Behavioral therapy
  - c. Dialectical behavioral therapy
  - d. Interpersonal psychotherapy
  - e. Supportive psychotherapy
  - f. Psychodynamic psychotherapy
  - g. Brief psychotherapy
9. Residents will conduct long-term psychotherapy with patients and will be able to manage issues that arise, including (a) establishing and maintaining a therapeutic relationship, (2) managing patient reactions to the therapist and the therapy in a developmental fashion, and (3) conduct psychological interpretation of patient issues in narrative, developmental and cognitive-behavioral terms.
10. Residents will demonstrate the ability to identify outpatients who should be referred for psychological and neuropsychological testing to aid with diagnostic assessment.
11. Residents will understand the risks and benefits of and indications for psychiatric hospitalization and will be able to evaluate patients with a view to determining their psychiatric risk (risk of suicide or otherwise) and need for hospitalization.
12. Residents will assess patients for initiation or continuation of outpatient commitment proceedings under the applicable laws of the State of NC, considering competency issues with regard to the impact mental illness has on the ability to conduct financial and personal decision-making.
13. Residents will demonstrate the ability to conduct a clinical evaluation relevant to the use of psychiatric testimony for the purposes of criminal or civil law.
14. Residents will collaborate with health professionals, in particular primary care providers, psychotherapists, nurses and case managers, to provide patient-focused care, especially in these situations:
  - a. Resident provides psychiatric care and another clinician provides primary medical care;
  - b. Resident provides medication management services and another clinician performs psychotherapy;

- c. Resident provides medication management services (and perhaps psychotherapy) and another clinician provides case management.

15. Residents will use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records and other computer-based resources.

**Medical Knowledge:** Residents must demonstrate knowledge of the neurobiological, psychological and socio-cultural underpinnings of mental illness and will apply this knowledge to the care of outpatients.

1. Psychiatry residents will conceptualize mental illness in terms of biological, psychological, and socio-cultural factors that determine normal and disordered behavior.
2. Residents will demonstrate knowledge of the epidemiology, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions most likely to affect psychiatric outpatients.
3. Residents will demonstrate knowledge of the biological underpinnings and modern etiological theories of mental illness that integrates recent findings in neuroscience.
4. Residents will understand the psychopharmacological treatment of mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.
5. Residents will appreciate that psychopharmacological treatment exposes the patient to interactions with other pharmacologic agents and affects other medical conditions, as well as causing many problematic side effects including sleep, weight, sexual problems, metabolic derangements, and other organ system difficulties. Residents will learn to assess for compliance and factors that interfere with it (finances, fears of adverse side effects, misunderstanding of medication purpose)
6. Residents will appreciate issues arising from the integration of psychopharmacology and psychotherapy, including:
  - a. The opportunities and challenges presented by "split treatment" (psychotherapy by one provider, medication management by another provider);
  - b. The practice of medication management with awareness of psychotherapeutic issues, whether or not the resident is performing psychotherapy.
7. Residents will understand the indications for and limitations of psychological testing and neuropsychological testing, and will understand the nature of various commonly used instruments such as the MMPI, Rorschach, Thematic Apperception Test, WAIS and Wechsler Memory Scale.

**Practice-Based Learning and Improvement:** Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

1. Residents will seek feedback from their supervising faculty, including clinic supervisors, general supervisors and psychotherapy supervisors, about their own practice and will use this feedback to improve their performance.
2. Residents will locate, appraise and assimilate evidence from scientific studies related to their patients' health problems, including attendance at the monthly Evidence-Based Medicine conferences.

3. Residents will gain and apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies, including attendance at the monthly Performance Improvement Conference.
4. Residents will facilitate the learning of other health care professionals, including psychotherapists and case managers providing services to the residents' outpatients.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families and other health care providers.

1. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
2. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.
3. Residents will recognize and monitor their emotional responses to patients and adjust their practice accordingly.

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

1. Residents will obtain informed consent for psychiatric treatment plans, including for the use of psychotropic medications, and will demonstrate understanding of the ethical principles underlying informed consent.
2. Residents will provide care to outpatients that takes into account (a) medical record keeping, (b) risk management and quality assurance issues, (c) confidentiality, (d) collaboration with other providers, agencies and family members, (e) financial and health system issues, (f) legal and forensic issues and (g) other ethical concerns.
3. Residents will understand issues related to medical disability evaluations, including state regulations regarding such evaluations and the ethical principles involved.
4. Residents will have appropriate interactions with representatives of the pharmaceutical industry and will appreciate the ways in which these interactions may affect their clinical practice.
5. Residents will demonstrate sensitivity and responsiveness to a patient's age, gender, culture, ethnicity, religion, sexual orientation, and disabilities.

**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide optimal care to outpatients.

1. Residents will appreciate the model of outpatient care employed at WFBMC and will understand the difference between this model and others, such as mental health centers, hospital-based practice, private practice group models and solo practice.
2. Residents will understand how their patient care affects and is affected by other health care providers, the health care organization and the mental health care system.

3. Residents will appreciate the economics of outpatient mental health care, including the value of services residents provide and of services to which they refer their patients; in turn, residents will practice cost-effective health care that does not compromise quality of care.
4. Residents will recognize issues that can arise in outpatient practice, including: (a) interaction with staff members; (b) management of patient records and other information systems; (c) scheduling; (d) cross-coverage among practitioners; (e) various practice styles among practitioners; (f) billing and payers (including Medicare, Medicaid, HMO's and private insurance) (g) office and space management.
5. Residents will understand the regulation of outpatient psychiatric treatment, including:
  - a. Patient confidentiality and HIPAA;
  - b. State regulations regarding involuntary treatment;
  - c. State regulations regarding guardianship;
  - d. Governmental and other regulation of outpatient clinics, including JCAHO and state inspectors;
  - e. Other regulations specific to WFBMC
6. Residents will know and, if necessary, utilize the mechanisms by which quality improvement occurs
7. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system.

**Resident Responsibilities:**

1. Residents will perform initial clinical evaluations of diagnostic cases. The attending will observe the residents' interview techniques, either directly or by one-way window. The cases will be presented and discussed with the attending and assigned to a resident for follow-up care.
2. Residents will teach medical students and supervise and critique their initial diagnostic evaluation.
3. Residents will participate in off-site and subspecialty clinics.
4. Residents will continue working at a more intensive level with long-term psychotherapy patients.
5. Residents will be regularly supervised by faculty members in the specialized areas of group therapy, brief, cognitive-behavioral, psychodynamic, and supportive psychotherapy.
- 6.
7. Residents will provide complete, accurate, and timely documentation of patient contacts and care provided. The attending will review all charts for completeness, accuracy, and quality of patient care.

## PSYCHIATRY FACULTY TEACHING (FT) CLINICS GENERAL INFORMATION FOR RESIDENTS

1. Each week, you (the residents) will be provided with one half-day during which time you will not be scheduled for off-site clinic duties or FT clinic duties. During this time, you are to:

- 1) See your private psychotherapy patients
- 2) Meet with your psychotherapy supervisors
- 3) Attend to clinic-related work, such as returning patient phone calls, charting, or preparing for upcoming clinic patients
- 4) Attend to other responsibilities, such as personal physician/dentist appointments or having the car serviced (non-work issues)
- 5) Perform scholarly activity such as research

During these times you are to have your pager on and with you at all times, since the department's secretaries may need to contact you. If you are planning to attend to an activity (like a dentist appointment) where it is not feasible to have your pager on, you need to let the FT clinic secretaries know, so that they are not needlessly paging you (they will page the clinic resident on call instead).

2. Every business day (not weekends or holidays) from 8 a.m. to 5 p.m., a resident will be assigned to cover clinic call. This call schedule is set up prior to the beginning of each month, and copies will be placed in your mailboxes and with the secretaries. The responsibilities of the resident on clinic call are as follows:

- 1) Review any prescription refill requests for residents who are off-site that day
- 2) Handle any issues involving clinic patients (whose resident providers are off-site or absent from work that day) who call the department with urgent questions or who are "in-crisis" (if this happens, one of the secretaries will page the resident on clinic call)
- 3) See emergency patients in the slots provided for emergency patient evaluation and stabilization

It is your responsibility to review the monthly clinic call schedule when it comes out and to arrange for a colleague to cover you if you are scheduled for vacation on a day you are assigned for clinic call. Be sure to let the FT clinic secretaries, scheduling coordinators, and phone triage know of any changes to this schedule.

3. It is important that you review the patient charts prior to the start of the clinic session, especially if the patient is new to you. Also, take the time to review any recent lab work for the patients

prior to the start of the FT clinic session.

4. Every FT clinic patient **must** be staffed by an attending psychiatrist. Be sure to budget the time needed to review the case with an attending so that you can remain (reasonably) on schedule in clinic. Patients that must be physically seen by an attending are those with the following insurance types: Medicare, Tri-Care (military insurance) and West Virginia Medicaid. Any patient the resident or attending feels uncertain about safety or other issues should also be physically seen by the attending.
5. Documentation must be made for every patient seen. It is important that you make sure that some type of medical record documentation is provided for each patient interaction.
6. Every time a medication prescription is written or called into a pharmacy, be sure to document this in the electronic medical record.
7. If the front desk or telephone triage pages you during clinic time (the call-back number will either be 6-6312 or 6-4551), call back immediately because they probably have a question regarding the check-out of the patient you just finished seeing or an urgent patient call, and it is not appropriate to wait 30 minutes before you return the secretary's page.
8. If you are scheduled to see a patient at a certain time, and it is past that time and no one has paged you to let you know that your patient has arrived, go to the front desk and double-check to make sure your patient has not arrived. The front desk secretaries often get very busy and occasionally are unable to page the resident for a patient. It is not appropriate to ask the front desk secretaries to bring patients back to you, It is your responsibility to go to the waiting area, greet your patient and accompany them back to your office.
9. If patients you have seen in FT clinic call and leave you an office voicemail message, return their calls at your earliest convenience, but do not wait days before doing so. Also, be sure to document your return call (with a telephone note) in the chart afterwards.
10. Whenever possible, be proactive in clinic. For instance, at the end of each week, check in with the medical record system and with the FT clinic secretaries to preview your clinic schedule for the upcoming week. Sometimes patients are mistakenly double-booked for you or scheduled during times when you are not supposed to be in FT clinic (i.e. post-call dates). By doing this, the secretaries will be able to call ahead and reschedule these patients, instead of having to deal with it on the day of the patient's appointment (or worse, when the patient has already shown up for clinic).

11. Generally, you should not schedule your patients for follow up with a different resident. There are exceptions, e.g., if you will be on vacation and someone else has agreed to cover your patients and you have a patient who will need to be seen in your absence. Also, if patients request a different clinician, the department may or may not grant that request, depending on what would be best for the patient. Generally, the FT clinic does not change residents unless there is a compelling clinical reason.
12. Your voicemail should be explicit in terms of when you will be at the office, when you are away from the office, and when you are on vacation. For example, "This is Dr. X from the Department of Psychiatry and Wake Forest Baptist Health. I am currently not able to take your call. I will attempt to return all calls within one business day. If this is an emergency, please call 911 or call the psychiatrist on call. If you are calling for a refill, please leave your pharmacy number. Please note I am not in the office on Tuesdays."
13. The termination policy should be followed in terminating patients from clinic. This includes sending a warning letter when a patient has not been seen in clinic for 90 days or has multiple no-shows. Check with your attending to see if they agree and forward these letters to the WMHS mailbox as staff members will keep track of when the patient needs to be terminated and will speak with risk management about their case. After 30 days, you will receive notice that the patient can be terminated from office staff personnel, and at that time you will print two termination letters and have the outpatient clinic director co-sign these. Risk management should be involved with complicated cases. Other terms of termination will be discussed directly with outpatient clinic director, the FTC Director.
14. If you are absent from FT clinic due to illness, it is necessary that you call or email the residency coordinator, Sheila Leach (saleach@wakehealth.edu), the scheduling coordinators, the chiefs, and program director. They will then inform others in the FT clinic of your absence.
15. If you order labs on a patient, make a note of it, follow up with the results of the labs and call or send a prompt letter to the patient with those results. Do NOT wait until the next scheduled appointment to review labs as this may be two to three months out.
16. Timely completion of all clinical documentation in compliance with institutional and departmental requirements.

## LEARNING OBJECTIVES OF THIS EXPERIENCE

By the end of this rotation you should feel comfortable with the following issues pertaining to outpatient practice:

### I. Issues of Confidentiality:

1) Phone calls from relatives

2) Communication with physicians/therapists:

Is it necessary to get authorization (written or verbal) from the patient?

What and how often do you get back to a referring physician: Phone call? Written note?

Getting in touch with a patient's other physicians: How much do you share/reveal?

3) How many notes and of what type do you keep for what purpose?

4) Do you ever audiotape sessions? Videotape sessions?

5) When and how do you tell a patient that you would like to see or phone a family member?

6) What can/should you say to a family member who is seeing you individually with your patient's permission? What do you reveal/not reveal?

7) When do you get a live consultation/second opinion for a long-term outpatient?

8) How do you handle a patient's request for either a second opinion or to be referred to another therapist?

### II. Financial Issues

1) When and how is it appropriate to charge for missed sessions?

2) Is it ever appropriate to lend a patient money?

3) How do you set or modify fees?

4) How do you deal with the patient who doesn't pay?

5) How do you deal with a patient who wants to bend the rules for insurance purposes?

6) What about seeing a family member? Whom do you charge?

### **III. Late/Missed Sessions**

1) When do you phone if a patient misses a session?

2) How do you deal with repeated lateness:

Extend the session?

“Demand” an explanation?

What is the therapeutic value in exploring this issue and if so, how is this done?

### **IV. Boundary Issues/Self-Disclosure**

1) When do you initiate a phone call to a patient at home or work? And how do you identify yourself?

2) Physical touching, handshakes, hugs, etc.: When are these appropriate?

3) Gifts, cards, invitations to special events: How do you handle these?

4) Pictures on your desk?

5) Seating arrangements?

6) Lighting in your office?

7) When you get sick or have a personal problem, do you ever share information about these events?

8) How much do you reveal about yourself (e.g., marital or parental status, age, specific vacation plans, etc.) and in what circumstances?

9) When do you ever extend sessions beyond your usual time (e.g., if a session is particularly “fruitful”, if you were late because of another emergency, etc.)?

### **V. Counseling vs. Psychotherapy**

1) Is there a difference? If so, what?

2) Giving “advice”: When, if ever, is it appropriate and how is it done?

### **VI. Therapeutic Style**

1) Use of affect by the clinician: Do you ever get angry, enthusiastic, express affection? 84

2) What do you say to a patient at the start of therapy?

Do you explain the nature of psychotherapy, about the role of the therapist, the patient?

Do you "educate the patient about the process of psychotherapy?

3) How do you select the appropriate mode of therapy for a given patient (e.g., brief or long-term psychodynamic, interpersonal, cognitive-behavioral, couple, family, group)?

How do you formulate a therapeutic contract?

4) How does a clinician dress?

5) How do you explain specific psychodynamic therapeutic techniques (if you use them) to a silent patient: Silences, refusal to answer direct questions, and other behaviors that on the surface look strange to the uninitiated?

6) Is there every any justification for expecting patients to figure out rules of psychotherapy on their own, or are they entitled to patient education and informed consent as in all other medical treatment?

7) How do you explain to a patient that you would like to do a mental status exam and the reasons for it?

8) Silence in psychodynamic psychotherapy: When, how long, who ends it?

## **VII. Medication Issues**

1) How do you incorporate pharmacotherapy into psychotherapy?

2) What strategies are used when the psychiatrist acts as a medical consultant for patients in psychotherapy with non-M.D. therapists?

3) What are the psychodynamic aspects of medication management?

4) How do you deal with issues related to medication consents in outpatient psychiatry?

- 5) What issues arise, and what strategies are used, with outpatients who are having medication side effects?
- 6) How do you deal with patients who are noncompliant with medications?

### **VIII. Suicide/Assault/Legal Issues**

- 1) How do you deal with suicidal threats in therapy: veiled and unveiled?
- 2) How do you deal with patients who are angry at you?
- 3) How do you deal with patients who make a veiled (or open) threat toward you or someone else?
- 4) What do you do when a patient reveals child abuse?
- 5) What do you do when a patient reveals illegal activities such as drug dealing, theft, fraud?
- 6) What do you do when you learn that a patient is using or abusing substances or alcohol?

### **IX. Countertransference/Transference Issues**

- 1) What is your understanding of the terms "transference" and "countertransference"?
- 2) How you handle your own hostility to patients?
- 3) How are you affected by and how do you respond to patients considered boring, kvetchy, selfish, immature, abrasive, oppositional, condescending, controlling?
- 4) Borderline rage in the therapy hour:  
  
How much destruction or abuse do you tolerate?  
  
How do you respond?
- 5) How do you handle your own attraction to patients, and patients' attraction to you?

- 6) How do you handle countertransference to patients with characterological/personality problems?
- 7) How do you handle the exhibitionistic patient?
- 8) What do you say (do) when a patient reveals sexual thoughts about you?

**X. Dreams**

- 1) Do you make use of dreams in psychotherapy? If so, what?

**XI. Termination**

- 1) Planned or Abrupt?
- 2) Patient-initiated or therapist-initiated?
- 3) When do you try to talk an ambivalent patient into staying in therapy?  
When don't you?

## COMMUNITY PSYCHIATRY: STUDENT HEALTH

<b>Director:</b>	Guy Palmes, M.D.
<b>Coordinator:</b>	Carolyn Potts
<b>Rotation Day/Hours:</b>	½ to full day shifts based on semester
<b>Location:</b>	Wake Forest Student Health Clinic, Reynolda Campus Report to Carolyn Potts, Office Manager

**Description:** Third year adult residents will rotate through the Wake Forest University Student Health Clinic one-half day per week per semester. The resident will interact with the Medical Director of the Clinic, as well as, participate in multidisciplinary team meetings. Residents will provide direct patient care to college-age patients.

### Goals and Objectives of the Rotation

#### Patient Care:

##### Knowledge:

1. Learn to evaluate older adolescents/young adults in a college setting.
2. Become acquainted with assessment tools utilized in a student health setting.

##### Skills:

1. Learn to function in a college setting using a co-location model.
2. Become familiar with college specific regulations: including athlete medication forms and class withdrawal forms.

##### Attitude:

1. Demonstrate a commitment to mastering the knowledge base and skills necessary to provide care in a college setting.

### Medical Knowledge

##### Knowledge:

1. Learn disorders most commonly encountered in a college-age population.
2. Become familiar with "leaving the nest" issues as described in the text "*Your Adolescent*".

##### Skills:

1. Become familiar with the Learning Assistance Center and the University Counseling Center.
2. Become familiar with resources available to help college students succeed.

##### Attitude:

1. Demonstrate motivation to learn to become an effective psychiatrist in the college setting.

## **Systems based practice**

### Knowledge:

1. Work effectively in consultation with professionals from other disciplines including nurses, primary care physicians and counselors.

### Skills:

1. Understand group assessment measures of academic performance for students.
2. Gain clinical experience in a wide variety of psychiatric problems in school settings.

### Attitude:

1. Demonstrate a commitment to becoming familiar with resources available in the college setting.

## **Interpersonal and Communication Skills**

### Knowledge:

1. Learn how to approach university personnel regarding educational problems that surface in psychiatric diagnostic interviews.

### Skills:

1. Become familiar with the documentation system used in a student health setting.
2. Provide education to university personnel on particular psychiatric conditions that affect student learning.

### Attitude:

1. Demonstrate a commitment to enhancing communication skills in a student health service.

## **Professionalism**

### Knowledge:

1. Understand and appreciate input from other health care professionals and university staff.

### Skills:

1. Demonstrate appropriate interactions with patient and school personnel to reflect a respectful attitude towards others and their needs.

### Attitude:

1. Exemplify personal and intellectual integrity and demonstrate an understanding of ethical values and codes of a member of the medical profession.

## **Practice Based Learning**

### Knowledge:

1. Recognize that the scientific literature is constantly evolving, that no one report or idea is necessarily true for all situations, and that the literature should be critically judged for its methodology and applicability.

### Skills:

1. Locate, appraise, and assimilate the best practices relevant to student health.

### Attitude:

1. Obtain appropriate supervision.

# COMMUNITY HEALTH SETTINGS IN PSYCHIATRY

**Directors:** Dr. Liz Arnold: Homeless Opportunities and Treatment Project  
Dr. Rommel Ramos: VA Outpatient Clinic – Kernersville  
Dr. James Kimball; Carenet

**Teaching Objectives:** The teaching programs at each community health setting are unique. The following is a generic description of the expected experience.

1. To develop an understanding of the psychiatric and psychosocial problems encountered in a community health setting population
2. To participate in a multidisciplinary treatment team consisting of physicians, social workers, psychologists, and other mental health professionals
3. To manage chronically ill patients in community or structured placement situations through appropriate pharmacotherapy, judicious outpatient follow-up and psychotherapeutic interventions when deemed necessary
4. To collaborate with professionals from other disciplines on appropriate patient management
5. To perform education as to medication therapeutic value, side effects, dosage and problems with patients and their families

## **Competency-Specific Objectives:**

**Patient Care:** Residents must be able to provide care that is compassionate, appropriate and effective for the treatment of severe and persistent mental illness in a community setting.

Specifically, residents will:

### **SKILLS**

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Cooperate with other members of the Assertive Community Treatment Team (ACT, also known as a Community Support Program) in joining with patients to develop collaborative, comprehensive, recovery oriented treatment plans that integrate psychopharmacology, skill training, case management, emotional support and help with concrete needs of living in the community.
3. Practice in a variety of community settings, including patient's apartments, community-based residential facilities, public settings such as restaurants, homeless shelters, and the jail.
4. Participate in all aspects of the required treatment plan, including help with housing, shopping, money management, transportation, time management, disability, employment, and obtaining medical care. Residents should become comfortable addressing issues related to disability and the other aforementioned aspects in this setting.
5. Make informed decisions about diagnostic and therapeutic interventions based on patient information, preferences, up-to-date scientific evidence and clinical judgment, in collaboration with the treatment team.

6. Provide psychopharmacologic management for patients that may require complicated interventions, often complicated by co-morbid substance use and medical illness.
7. Integrate the use of medication with skill training, concrete life supports and other interventions to ensure that patients maintain housing, work, structure and social support within the community.
8. Utilize appropriately designed interpersonal support and counseling, skills training, psychoeducational and cognitive-behavioral interventions for psychosis.
9. Be involved in the decision when and how to use the hospital when necessary,

#### **ATTITUDES**

1. Appreciate how modern concepts of recovery can aid in more effective treatment of persons with serious mental illness.
2. Practice in a manner consistent with an appreciation of the Stages of Change Model, utilizing motivational interviewing strategies where appropriate.
3. Demonstrate an awareness and appreciation of diversity issues, particularly regarding race, cultural, socio-economic status, and sexual orientation.

**MEDICAL KNOWLEDGE:** Residents must demonstrate knowledge about the neurobiological, psychosocial, cultural and economic underpinnings of severe and persistent mental illness and will apply this knowledge to patient care. Specifically, residents will:

#### **KNOWLEDGE**

1. Conceptualize severe and persistent mental illness in terms of the biological, psychological, psychosocial, cultural and economic factors that are thought to be relevant.
2. Demonstrate knowledge of the etiologies, prevalence, diagnosis, treatment, prevention and outcome of the psychiatric conditions most likely to affect patients with severe and persistent mental illness.
3. Understand the significance of co-morbidity, (i.e., the interactions among chronic mental illness, substance use disorders and medical illness.)
4. Understand state-of-the-art psychopharmacology of person with chronic schizophrenia and mood disorders, including:
  - a. Atypical and typical antipsychotics (administration and monitoring of clozapine, in particular)
  - b. Depot antipsychotics
  - c. Monitoring for antipsychotic side effects using tools such as the AIMS and monitoring of metabolic parameters
  - d. Antidepressants
  - e. Lithium and anticonvulsants
  - f. Rational poly-pharmacy
  - g. Algorithms for the treatment of psychotic and mood disorders
5. Describe the recovery model of treating persons with severe mental illness.
6. Describe psychosocial treatment strategies, (e.g., cognitive-behavioral therapy for psychosis.)

#### **ATTITUDES**

1. Demonstrate an investigatory and analytic approach to thinking through clinical situations. 91

**PRACTICE-BASED LEARNING AND IMPROVEMENT:** Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Specifically, residents will:

**SKILLS**

1. Seek feedback from MHC (mental health clinic) staff and their MHC attendings about their own practice and use this feedback to improve their performance.
2. Locate, appraise and assimilate evidence from scientific studies related to their patients' health problems, especially studies pertaining to:
  - a. Mental health services research
  - b. Clinical trials involving subjects with severe mental illness, e.g., the CATIE trial
3. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies; this should occur in the context of regular meetings with MHC staff.
4. Use information technology to manage information (i.e., clinical logs), access on-line medical information and to support their own education.
5. Facilitate the learning of other health care professionals, in particular other members of the treatment team.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families and other health care providers. Specifically, residents will:

**SKILLS**

1. Create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
2. Use effective listening skills in interactions with patients, their family members and other health care providers.
3. Demonstrate proficiency in complex interpersonal situations, such as interacting with patients with severe mental illness in non-medical settings.
4. Demonstrate proficiency in conveying difficult information to patients and their families.
5. Work effectively with other health care providers as a psychiatric member of an interdisciplinary treatment team.
6. Effectively elicit information from and provide information to other members of the treatment team.

**ATTITUDES**

1. Recognize and monitor their emotional responses to patients and adjust their practice accordingly.

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

Specifically, residents will:

## **KNOWLEDGE**

1. Appreciate the ethical issues that can arise in a community psychiatry setting, including:
  - a. Informed consent
  - b. Confidentiality of patient information
  - c. Involuntary treatment
  - d. Establishing and maintaining appropriate boundaries, and monitoring for and addressing violations of boundaries
  - e. The challenges imposed by financial and systems constraints

## **ATTITUDES**

1. Demonstrate respect, compassion and integrity in all their interactions with patients, families and MHC staff.
2. Demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients.
3. Understand that effective treatment requires that the clinician learn to be culturally competent, taking into account each patient's values, beliefs, cultural background and communication style.

**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively use system resources to provide care that is of optimal value. Specifically, residents will:

## **KNOWLEDGE**

1. Understand how their patient care affects and is affected by other health care providers, the public mental health care system, organizations (such as NAMI) and governmental agencies.
2. Understand the mission, function, economics and organization of the program.
3. Describe the model of Assertive Community Treatment of persons with severe and persistent mental illness.

## **SKILLS**

1. Practice cost-effective health care that does not compromise the quality of care.
2. Collaborate with members of various MHC programs, other mental health care providers and governmental agencies to provide for the best patient care possible.

## **ATTITUDES**

1. Appreciate the need for advocacy for patients seen in the community mental health system.

## **Resident Responsibilities**

1. Hours at the programs vary. Some programs are one day per week, typically from 9:00 a.m. to 5:00p.m. excluding travel time. Others are arranged differently and may involve half-day rotations.
2. Individual cases generally are assigned to the resident for new patient evaluation and longitudinal follow-up, which involves pharmacotherapy and may include supportive psychotherapy.

3. New diagnostic evaluations and follow-up cases will be evaluated and presented by the resident and then with the attending psychiatrist. In some instances, the attending may review the case at a later time.
4. Typically, 30 minutes are allowed for follow-up visits and 60 minutes are allowed for initial diagnostic interviews. Exceptions may be made depending on the individual program.
5. The attending physician or site supervisor will provide regular supervision for all patients and is available on call for emergency consultation.
6. The resident is responsible for dictation or written notes of a complete diagnostic evaluation, progress notes and treatment plans as per the program requirements.

# VAMC HIGH INTENSITY ACUTE INPATIENT PSYCHIATRIC UNIT

**Director:** German Molina, MD

**Supervisor:** Rajendra Daniel, MD

**Location:** W.G. (Bill) Hefner VA Medical Center.  
1601 Brenner Ave, Salisbury, NC 28144

## Teaching Objectives

1. To gain experience in evaluating and treating acute mentally ill patients on the High Intensity inpatient unit.
2. To participate in and lead a multidisciplinary treatment team.
3. To observe evaluation for dangerousness and commitment proceedings.
4. To gain experience in group leadership in therapy of acute inpatients.
5. To perform a comprehensive initial psychiatric evaluation, history, review of laboratory findings, medications interactions, and discuss treatment plans for newly admitted patients.

## Competency-Specific Objectives:

**Patient Care:** Residents must be able to provide care of inpatients that is compassionate, appropriate and effective for the treatment of severe mental illness.

Residents will:

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Gather accurate and complete information about their patients from the following sources: the patient; the patient's family, friends and health care providers; the patient's medical record.
3. Develop comprehensive bio-psychosocial assessments that take into account the veteran's military experience and formulate differential diagnoses that incorporate genetic predisposition, developmental issues, co-morbid medical issues, substance use and abuse, ethnic/cultural/spiritual factors, economic issues, current relationships, psychosocial stressors and current mental status exam.
4. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgment.
5. Counsel and educate patients and their families and demonstrate the ability to participate in and lead family meetings.
6. Use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records and other computer-based resources.
7. Develop understanding of the use of psychotherapeutic strategies appropriate for an inpatient setting, including supportive techniques, cognitive-behavioral interventions and psychodynamic strategies.

8. Demonstrate competence to recommend the administration of electroconvulsive therapy (ECT). Specifically, residents will be able to:
  - a. Describe selection of appropriate patients for ECT, including psychiatric indications and medical/psychiatric contraindications.
  - b. Educate patients and their families about the risks and benefits of and alternatives to ECT.
  - c. Obtain informed consent for ECT from patients.
9. Demonstrate competence in the management of behavioral emergencies, including verbal and behavioral de-escalation techniques and psychopharmacological management.
10. Work with mental health professionals of other disciplines and with physicians from other specialty services to provide patient focused care.
11. Demonstrate understanding of the mental health system and mental health resources available in the community and use this knowledge to participate in discharge planning and the development of appropriate aftercare plans.
12. Maintain the medical record appropriately, including dictated admission H&Ps, daily progress notes, consent forms and dictated discharge summaries.

**Medical Knowledge:** Residents must demonstrate knowledge about the neurobiological and psychological underpinnings of mental illness and will apply this knowledge to patient care. Residents will:

1. Demonstrate knowledge of the etiologies, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions most likely to affect psychiatric inpatients.
2. Demonstrate understanding of the psychopharmacological treatment of mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.
3. Demonstrate understanding of the indications for and limitations of psychological testing and neuropsychological testing in an inpatient setting.
4. Demonstrate an investigatory and analytic approach to thinking through clinical situations.

**Practice-Based Learning and Improvement:** Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents will:

1. Seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.
2. Use information technology to access on-line medical information and to support their education.
3. Locate, appraise and assimilate evidence from scientific studies related to their patients' health problems.
4. Apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.

5. Facilitate the learning of medical students and other health care providers.

**Interpersonal and Communication Skills:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families and other health care providers. Residents will:

1. Create and sustain a therapeutic and ethically sound relationship with patients, including the use of open and honest communication, the maintenance of empathic stance and the establishment of appropriate boundaries.
2. Use effective listening skills in interactions with patients, their family members and other health care providers.
3. Demonstrate competence in complex interviewing situations, such as interacting with patients with thought disorganization, cognitive impairment, paranoia, aggressiveness or inappropriate behavior.
4. Recognize their emotional responses to patients and adjust their practice accordingly.
5. Demonstrate proficiency in conveying difficult information to patients and their families.
6. Demonstrate an ability to work effectively with other health care providers as a member or leader of an interdisciplinary treatment team.
7. Effectively elicit information from and provide information to other health care providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators and consulting physicians.

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

1. Demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers.
2. Demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersedes self-interest.
3. Appreciate the ethical issues that can arise in an inpatient psychiatric setting, including: patient autonomy; involuntary treatment; decisional capacity to accept or refuse psychiatric care; informed consent; the challenges imposed by financial constraints; confidentiality of patient information; and the potential for violation of appropriate boundaries.
4. Demonstrate sensitivity and responsiveness to patients' culture, age, gender sexual orientation, and disabilities

**Systems-Based Practice:** Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.

Residents will:

1. Demonstrate understanding of the way in which their patient care affects and is affected by other health care providers and the mental health care system

2. Demonstrate an understanding of Wake Forest Baptist Medical Center's mission to the community and to the State.
3. Practice cost-effective health care that does not compromise quality of care.
4. Collaborate with psychiatrists and other mental health providers in the community, medical consultants, and community organizations to provide for the best patient care.
5. Develop an understanding of the economics of inpatient psychiatric treatment and become aware of the impact of differences in health care financing strategies among the various governmental and private insurance programs.
6. Develop an understanding of regulations which affect inpatient psychiatric treatment, including: federal rules on seclusion and restraint; NC State Law regarding mental health commitment and guardianship; patient confidentiality and HIPAA regulations; and policies and procedures specific to University of Wisconsin Hospital and Clinics.
7. Advocate for quality patient care and assist patients in dealing with the larger mental health system.

### **Resident Responsibilities**

1. The Inpatient psychiatric rotation requires that the resident spend time with the treatment teams during working days Monday through Thursday.
2. The resident is required to be available in the hospital from 8:00 a.m. - 4:30 p.m. Monday through Thursday.
3. The resident is required to complete discharge summaries, maintain current progress notes, and administer treatment of all assigned patients.
4. The resident is to assume active team leadership of a multidisciplinary treatment team.
5. The resident will participate in teaching medical and physician assistant students and do at least 1-2 presentations on a subject related to inpatient acute psychiatric morbidity of their choice.
6. If resident arrives on service and finds that the preceptor is absent, he/she should report to Education either in person or by phone to receive an alternate assignment. Call x2965 (Tony Miller), x4397 (Virginia Jeffries) or x4156 (Dr. Labagnara). If able, the preceptor should make other arrangement for the resident in advance.

## PGY-4 Schedule

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### STICHT CENTER ADULT INPATIENT PSYCHIATRY ROTATION UPPER LEVEL RESIDENTS

**Director:** Dr. Rahn Bailey

**Supervisors:** Dr. Richard Blanks, Dr. Karen Green, Dr. James Kimball, Dr. Patrick Smith

#### Teaching Objectives

1. Demonstrate higher order PGY4/5 ACGME core competencies as well as participate on the team in a more supervisory capacity, both demonstrating leadership and educating fellow residents.

#### Patient Care:

1. Depending on case load, responsible for 3-5 more complex patients from one team, including crisis-oriented and brief psychotherapy techniques.
2. Maintain reduced psychotherapy (outpatient) caseload and supervision.

#### Administration:

1. Assist attending faculty in monitoring patient admissions, acuity level, and team distribution, and learning objectives for trainees.
2. Participate in monthly Inpatient Staff Conference.

#### Teaching:

1. Supervise PG-1 residents on unit regarding general procedural and clinical issues.
2. Provide weekly PG-1 case conference to assist PG-1 residents in preparation for their core competency examinations.
3. Participate in daily check-out rounds, including relevant literature reviews and principles of evidence-based patient management.

#### Didactic Program

1. Participate in Senior Seminar, Grand Rounds, and other educational requirements of the department.

**PLEASE REFER TO SECTION 5 MISC: MORNING REPORT / DAILY PATIENT CHECK OUT**

# **SUBSTANCE ABUSE INTENSIVE OUTPATIENT PROGRAM**

**Director:** Dean Melton, MA, CCAS

**Location:** 791 Jonestown Road  
Winston Salem, NC 27103

**Objectives:** Psychiatry residents will have a supervised clinical experience in the assessment, diagnosis and treatment of addiction psychiatry patients that emphasizes a developmental, bio-psycho-social and culturally sensitive approach to addiction psychiatric practice.

Residents will have an addiction psychiatric experience that includes a wide variety of disorders, patients and treatment modalities, including biological treatments, psychotherapy and psychosocial rehabilitation.

Residents will demonstrate the ability to gather and organize data, integrate these data with a comprehensive formulation of the problem to support well-reasoned differential diagnosis, formulate a treatment plan, and implement treatment care follow-up in an addiction setting.

Residents will demonstrate competence in various pharmacological, psychotherapeutic and behavioral interventions including psychodynamic, cognitive, behavioral, supportive care appropriate for addiction psychiatry.

Residents will demonstrate professional and ethical behavior in the care of their patients and in their interactions with other health care providers and other administrative staff and demonstrate understanding of the various legal and regulations and risk management practices involved in addiction psychiatric care.

Residents are expected to gradually develop higher levels of understanding and skills as they proceed developmentally through this experience.

## **Competency-Specific Objectives:**

### **Patient Care:**

1. Residents must be able to provide care of addiction patients that is compassionate, appropriate and effective for the treatment of mental illness.
2. Residents will demonstrate the ability to conduct assessments of a wide variety of patients presenting with the full spectrum of psychiatric disorders commonly seen in addiction psychiatric settings and attending to developmental, psychological, biological, social and cultural contributions to their illnesses.
3. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families and other care providers.
4. Residents will counsel and educate patients and their families and demonstrate the ability to convey difficult information.
5. Residents will demonstrate the ability to conduct a variety of psychotherapeutic treatment modalities in an addiction setting, including group therapy and supportive therapy.
6. Residents will understand the risks and benefits of and indications for psychiatric hospitalization and will be able to evaluate patients with a view to determining their

psychiatric risk (risk of suicide or otherwise) and need for hospitalization in addiction patients.

7. Residents will collaborate with health professionals to provide patient-focused care.

### **Medical Knowledge:**

1. Residents must demonstrate knowledge of the neurobiological, psychological and socio-cultural underpinnings of addiction and will apply this knowledge to the care of psychiatric issues and emergencies in persons under treatment for addiction.
2. Psychiatry residents will conceptualize mental illness in terms of biological, psychological, and socio-cultural factors that determine normal and disordered behavior.
3. Residents will demonstrate advanced knowledge of the epidemiology, prevalence, diagnosis, treatment, and prevention of the psychiatric conditions most likely to affect addiction patients.
4. Residents will demonstrate knowledge of the biological underpinnings and modern etiological theories of addiction mental illness that integrate recent findings in neuroscience.
5. Residents will understand the psychopharmacological treatment of addiction and mental illness, including treatment algorithms, the management of treatment-resistant illness, augmentation strategies and combination therapies.
6. Residents will appreciate that psychopharmacological treatment must take into account the wide variety of interactions with other pharmacologic agents, impact on other medical conditions, and full appreciation of all side effect problems including compliance, sleep, weight, sexual problems, and other organ system difficulties.

### **Practice-Based Learning and Improvement:**

1. Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
2. Residents will locate, appraise and assimilate evidence from scientific studies related to their patients' health problems in addiction psychiatric practice.
3. Residents will gain and apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies into addiction psychiatric practice
4. Residents will use information technology to support patient care decisions and patient education, including on-line literature searches, electronic medical records and other computer-based resources.

### **Interpersonal and Communication Skills:**

1. Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families and other health care providers.
2. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
3. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.

4. Residents will recognize and monitor their emotional responses to patients and adjust their practice accordingly.

### **Professionalism:**

1. Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.
2. Residents will obtain informed consent for psychiatric treatment plans, including for the use of psychotropic medications, and will demonstrate understanding of the ethical principles underlying informed consent and the need for intervention in the addiction psychiatry patient.
3. Residents will provide care to patients that takes into account (a) medical recordkeeping, (b) risk management and quality assurance issues, (c) confidentiality, (d) collaboration with other providers, agencies and family members, (e) financial and health system issues, (f) legal and forensic issues and (g) other ethical concerns.
4. Residents will demonstrate sensitivity and responsiveness to each patient's age, gender, sexual orientation, culture, ethnicity, religion and disabilities.

### **Systems-Based Practice:**

1. Residents must demonstrate an awareness of and responsiveness to the larger context of the addiction mental health care system and the ability to effectively call on system resources to provide optimal care to addiction psychiatric patients.
2. Residents will appreciate the model of community-based addiction treatment and long-term care addiction practice and will understand the difference between this model and others, such as mental health centers, hospital-based practice, private practice group models and solo practice.
3. Residents will understand how their patient care affects and is affected by other health care providers, and the health care organization. Residents will appreciate the economics of addiction mental health care, including the value of services residents provide and of services to which they refer their patients; in turn, residents will practice cost-effective health care that does not compromise quality of care.
4. Residents will recognize issues that can arise in addiction practice, including: (a) interaction with staff members; (b) management of patient records and other information systems; (c) scheduling; (d) cross-coverage among practitioners; (e) various practice styles among practitioners; (f) billing and payers (including Medicare, Medicaid, HMOs and private insurance); (g) office and space management.
5. Residents will understand the regulation of addiction psychiatric treatment, including: (a) patient confidentiality and HIPAA; (b) state regulations regarding involuntary treatment; (c) state regulations regarding guardianship; and (d) governmental and other regulation of addiction clinics, including JCAHO and state inspectors.
6. Residents will advocate for quality patient care and assist patients in dealing with the complex addiction mental health system.

### **Resident Responsibilities:**

1. During the time of the rotation, residents are expected to attend AA meetings on Monday nights before the group begins.

2. Residents are expected to be an integral part of the group, helping to co-lead with the group leader.
3. Residents are expected to deliver at least one lecture per week while on the rotation.

## ELECTIVE ROTATIONS

**Director:** Josephine Mokonogho MD Assistant Director, Adult Psychiatry Education

**Supervisor:** Resident Choice

The elective rotation is designed by the resident in cooperation with the Assistant Director of Residency Education. It should be compatible with the education goals of both the individual resident and the Department.

### Elective Submission:

- Approved Wake Forest/VA Selectives:
  - o Residents must notify the program coordinator of the desired rotation at least 60 days prior to the scheduled start date.
- Non-Approved Wake Forest/VA Selectives:
  - o Residents must complete an elective request form and have supervisor approval prior to submission to the program coordinator.
  - o Residents must submit a completed elective request form to the program coordinator at least 90 days prior to the scheduled start date for approval.
  - o Residents must notify the program coordinator of the desired start date of the rotation at least 60 days prior to the scheduled start date.
- Non-approved Non-Wake Forest/VA Selectives
  - o Residents must submit a request form to the program coordinator at least 180 days prior to the scheduled start date

Please see iShare or Sheila Leach for the elective request form.

### Elective Examples:

1. Sleep Medicine
2. ECT
3. Utilization of Psychiatric Rating Scales
4. PTSD Unit
5. Emergency Psychiatry
6. Inpatient Psychiatry
7. Medical Student Psychiatry
8. Geriatric Psychiatry
9. Neuropsychiatry: Neuroimaging, Neuropsychological Testing, TBI, Seizure Disorders
10. Addiction Psychiatry
11. Genetics
12. Private Practice Management
13. Pain Medicine
14. Administrative Psychiatry
15. Research

# **ADVANCED INPATIENT EXPERIENCE AT BROUGHTON STATE HOSPITAL**

*(Elective Rotation)*

**Director:** Dr. George Krebs

**Supervisors:** Dr. Anthony Frasca  
Dr. George Krebs

## **General Goals:**

1. To gain experience in evaluating and treating chronically ill patients in a public hospital
2. To participate in and lead a multidisciplinary treatment team
3. To participate in forensic evaluation of dangerousness in commitment proceedings and potential testimony in commitment proceedings
4. To gain experience in group leadership in therapy of inpatients, often chronically mentally ill.
5. To perform initial evaluation, history, physical exam and laboratory evaluation, and prepare treatment plans for newly admitted patients

## **Competency Specific Objectives (see Inpatient Rotation Core Competencies)**

### **Resident Responsibilities**

1. Given the distance from Winston-Salem, a comfortable apartment is provided for the resident to use during the rotation if needed.
2. The resident is required to be available in the hospital from 8:30 a.m. -5:00 p.m. Monday through Thursday, Fridays are spent at WFBMC for didactic seminars and long-term psychotherapy cases.
3. The resident is required to dictate discharge summaries, maintain current and legible progress notes, and administer treatment of all assigned patients.
4. The resident is to assume active team leadership of a multidisciplinary treatment team.

## SELECTIVES FOR VAMC – SALISBURY

**Director:** Dr. German Molina

Below you will find a list of possible rotations from which you may choose to participate for your time in the VAMC. If you choose to participate in the group process format, we ask that you commit to at least a 3-month rotation block (a 2-month rotation may be possible under some circumstances). It is difficult for patients to have a new therapist that leaves in shorter periods of time. Elective experiences can be combined in a variety of ways to meet your educational and professional development requirements.

### **Core Electives:**

#### **1) PTSD**

Salisbury: outpatient PTSD clinics providing group therapy and medication management, as well as one of the nation's leading inpatient programs (20 beds).

This unit provides a 45-day intensive program to treat combat-induced PTSD. The program provides medication management, state-of-the-art psychotherapies that include intense process groups, psychodrama, art, and specific therapies. The resident would follow a group of patients from the beginning of their admission until discharge. The resident would participate as a co-leader of groups, evaluate patients in 1:1 therapy, and participate in treatment team conferences. You may select either 60 or 90-day rotations for this experience. If you choose a 60-day rotation, you would finish the rotation with outpatient PTSD clinics after the 45-day program is completed or do screenings for future admissions.

#### **2) Addiction Psychiatry (Substance Abuse Residential Rehabilitation Program (SAR RTP))**

Salisbury: substance abuse residential program. This 35 bed unit functions as a 30-35 day residential program for patients with substance dependence. You may function as co-therapist for the group therapies, serve as a case manager, follow patients from start-to-finish in the program, and address any medication-related issues. Supervision is provided by the Attending psychiatrist; and admission evaluation, as well as discharge process are part of this experience.

#### **3) Salisbury VAMC Inpatient Psychiatry Units**

The Salisbury VAMC has 2 acute inpatient units with an approximate 9-day length of stay. Residents will function as a "junior attending" with supervision on the inpatient unit of your choice.

**a) High Intensity General Acute inpatient psychiatry (4-3B):** This unit provides services to 23 veterans, 2 fulltime attending psychiatrists provide resident's supervision during their rotation. Experience provides completion of comprehensive psychiatric evaluations, discharges dictation, medication management, participation in daily morning multidisciplinary treatment team meeting is expected. Residents will be exposed to the involuntary commitment process in some cases.

**b) Chronic inpatient psychiatry (4-3A):** This ward is a 20 bed unit, providing mental health services for patients beyond their acute phase, pending discharge due to a variety of reasons. Guardianship, legal history, lack of resources, or lack of family involvement are some of the barriers/challenges that the treatment team may need to resolve to accomplish a successful discharge.

#### 4) Research

Salisbury: brain imaging research. You could do any elective that focuses on the writing of a brain injury case report or brain imaging paper. You will learn how to write an academic paper, submit it to a journal, and follow the process until publication. You will also gain a deeper knowledge of imaging tools in psychiatry and visit the Wake Forest radiology department's vast neuroimaging resources.

In addition to the core electives, you may select from the following clinical opportunities at the Salisbury facility:

##### Outpatient Rotations:

- General mental health medication clinics
- ACT team (assertive community treatment)
- Homeless program
- Brain Injury Clinic
- Primary care psychiatry clinic
- Psychiatric emergency service
- Group therapy

##### Inpatient psychiatry:

- Psychiatric Intensive Care Unit
- General inpatient psychiatry (acute)
- Chronic inpatient psychiatry

#### **Brief Description of Additional Rotations and Programs:**

Mental Health Clinic provides medication and group therapy for patients with mood, psychotic, or cognitive disorders. Patient may have dual diagnosis or PTSD in some cases. Clozaril as well as long-acting depot medication clinics are available. The resident could design the rotation for the proportion of med check visits vs. group therapy to fill the work week.

Mental Health Intensive Case Management (MHICM) (a.k.a. "ACT" team): The program provides case management, medication management, and social interventions for chronically mentally ill psychiatric patients in their homes. The MHICM team members travel to the patient's homes together as a team and provide services that include evaluation, medications, decanoate injections, etc. You will travel with other team members to evaluate chronically ill patients in their homes.

Homeless Program: This program provides initial visits and screenings for homeless veterans in the community. The team members go to shelters to screen patients. An additional part of the program includes placement into housing services with support to assist in the rehabilitation of the homeless veteran. You will be a full member of the team traveling to the shelters and placements for screening and evaluations.

Brain Injury Clinic: At the time of this printing, this clinic only meets 1 day per week and would need to be combined with another rotation to meet a full work-week schedule. This clinic evaluates and treats patients with psychiatric symptoms following brain injury. The clinic can be tied to the brain imaging research rotation.

Psychiatric Primary Care Clinic: This clinic (staffed by 2 psychologists and 1 psychiatrist) evaluates and treats patients with milder psychiatric illnesses. The goal for this program is to serve as a consultative service to the primary care practitioner in order to maintain treatment in the primary care setting. Clinicians diagnose, treat, and make recommendations for future

interventions – both to the patients and to the providers. You will serve as a full treatment team member.

Psychiatric Emergency Service: The emergency room at the Salisbury VAMC provides psychiatric services on a full-time basis from 8:00AM to 4:30PM. A full-time psychiatrist attending is assigned to this unit physically located in the Emergency Department. Residents will evaluate patients in the E.R. setting during regular business hours under supervision. This rotation could be combined with another to complete a full-time work-week.

Psychiatric Intensive Care Unit (PICU): The PICU is an 8-bed intensive care unit for the most acutely ill patients. The unit has a higher level of nursing care than acute psychiatric units and provides rapid stabilization in a safe environment. You will function as a “junior attending” on the unit with supervision.

Salisbury VAMC Campus: located on Brenner Ave. – off Innes Street. The VAMC has resident sleeping quarters/dorms. You are welcome to reserve these rooms, if you want to stay overnight in Salisbury. The contact person is Anita Demitry at 704-638-9000 – ext. 3338. You will have to contact Ms. Demitry as early as possible, if you want to reserve quarters, as they fill to capacity quickly.

**Please Note:** If rotating at the VA and resident arrives on service and finds that the preceptor is absent, he/she should report to Education either in person or by phone to receive an alternate assignment. Call x2965 (Tony Miller), x4397 (Virginia Jeffries) or x4156 (Dr. Labagnara). If able, the preceptor should make other arrangement for the resident in advance.

# FORENSIC PSYCHIATRY EXPERIENCE

**Director:** Dr. Richard Blanks, Esq.

**Objective:** Provide a forensic psychiatry experience for the general psychiatrist

## **Resident Responsibilities:**

1. Review IVC paperwork for petitioned patients and attend judicial review hearings
2. Review directed readings in forensic topics
3. Assist in open cases involving civil and/or criminal matters
4. Attend selected class sessions at Wake Forest University School of Law when scheduling permits

## **Description:**

This PG-4 level experience is typically done in conjunction with an alternative rotation for the duration of 1 month in compliance with ACGME requirements. It may provide a variety of didactic and practical experiences relevant to the general psychiatrist. Directed readings in the regulation of medical practice, involuntary civil commitment, medical malpractice, duty to warn and protect, decisional capacity, disability evaluations and criminal competences are reviewed in weekly individual supervisory sessions. Practical experiences, depending on the resident's interest and available active cases at the time of each rotation, include liaison work with the medical center's Elder Law Clinic, attendance at guardianship hearings, attendance and participation in involuntary commitment hearings, case review, analysis, and research on a variety of civil and criminal actions, participation in relevant Wake Forest University School of Law classes including the Law-Medicine-Bioethics program, assistance in deposition and trial expert witness preparation, and assistance in Forsyth county's new Mental Health Court.

## **Core Competencies**

### **Professionalism**

- Understand the state Medical Practice Act and Medico-Legal Guidelines
- Demonstrate the expected behaviors in legal consultation conferences, depositions, and trial appearances.

### **Patient Care/Procedural Skills**

- Achieve the ability to perform competent and comprehensive commitment, capacity, and dangerousness evaluations.

### **Medical Knowledge**

- Become aware of resources for identifying statutory regulation, case law, and legal consultation for clinical practice.
- Develop facility in applying evidence-based practice resources to standard of care questions.
- Understand the various definitions and criteria for disability due to a mental disorder.

### **Interpersonal and Communication Skills**

- Communicate effectively with the subject in an informed consent, commitment, or criminal capacity assessment, with special attention to the limits on confidentiality

-Effectively communicate verbally and in written documents the clinical findings relevant to a forensic question.

**Systems-based Practice**

-Appreciate the difference between clinical and forensic practice, including the conflicting roles of treating clinician (fact witness) and forensic reviewer (expert witness).

**Practice-based Learning and Improvement**

-Achieve a degree of comfort in dealing with attorneys and the legal system.

# HOMELESS OPPORTUNITIES AND TREATMENT PROJECT CLINICAL ROTATION

**Director:** Dr. Liz Arnold, Project Director

**Supervision:** Dr. Liz Arnold – General Supervision  
Drs. Thomas Brown and Marcus Gulley – Medication Management Supervision

**Coordinator:** Sharnita Duren, MS

**Location:** Samaritan Ministries  
414 E. Northwest Blvd  
Winston-Salem, NC 27105  
336-748-1962

**Report to Dr. Arnold**

## Teaching Objectives

1. To improve and practice clinical interviewing, diagnostic, and formulation skills in the context of a community-based outpatient clinical setting with individuals who are homeless
2. To observe and participate in a variety of outpatient treatment modalities, including medication management and individual psychotherapy

## Resident Responsibilities

1. Residents will perform initial clinical evaluations of diagnostic cases. The cases will be presented and discussed with the project director or the attending psychiatrist. Evaluations will include information on relevant psychosocial stressors unique to the homeless population.
2. Residents will follow patients for medication management and/or psychotherapy. They will arrange for clinically appropriate referrals for those needing additional services.
3. Residents will provide complete, accurate, and timely documentation of patient contacts and care provided. The project director and/or attending psychiatrist will review all charts for completeness, accuracy, and quality of patient care.
4. Residents will participate in team meetings for the clinic as scheduled during the rotation. Residents will be responsible for presenting their cases to the team and incorporating any feedback into the treatment plan.

# **SECTION FIVE: SEMINARS AND CONFERENCES**



# GENERAL TEACHING OBJECTIVES OF PSYCHIATRY DEPARTMENT SEMINARS & CONFERENCES

## A. Knowledge Objectives

1. Thorough knowledge of medical disorders having psychiatric presentations and psychiatric disorders presenting as medical problems.
2. Knowledge of clinical and laboratory diagnostic techniques for diagnosis of common medical and surgical problems.
3. Thorough knowledge of the currently applicable (DSM 5) diagnostic system, clinical criteria, and the system of multi-axial diagnosis (from DSM-IV and used in the WFBH inpatient psychiatry settings and possibly on the consultation and liaison rotations for educational purposes) with knowledge of the presumed etiology, prevalence, differential diagnosis and treatment of these conditions.
4. Awareness of the major theoretical systems in psychiatry, their theories of disease causation and treatment techniques.
5. Knowledge of the interaction of biological, psychological, sociocultural, and familial factors on development from infancy to late adulthood, with particular reference to disease production.
6. Knowledge of the diagnosis and treatment of common neurologic disorders.
7. Critical appreciation and knowledge of commonly used psychological assessment techniques, their utility and limitations.
8. Familiarity with the existing systems of financing and regulating psychiatric practice, public policy that influences psychiatric care and current problems in these areas.
9. Familiarity with the ethics underlying psychiatric practice, their rationale, and their application to common clinical situations.
10. Appreciation of the history of psychiatry in the broader context of the evolution of modern medicine.
11. Familiarity with common legal procedures related to psychiatry, such as commitment, competency, liability, and determination of criminal responsibility.
12. Familiarity with self-limitation necessitating the process of referral for psychiatric or medical intervention.
13. Knowledge of research methods and experimental design in psychiatry and the behavioral sciences sufficient to critically read new literature, including critical knowledge of the commonly read psychiatric journals and an appreciation of their relative accuracy.

## B. Skills

1. Ability to evaluate and diagnose psychiatric and neurological disorders through the clinical interview, history taking, mental status examination, and the physical and neurological exam, including the knowledgeable application of DSM 5 diagnostic criteria—this proficiency should exist for all age groups of patients, including children.

2. Ability to deal effectively with difficult patients who may be frightened, angry, seductive, or provocative.
3. Ability to synthesize biological, psychological, and social factors derived from the clinical examination and other data into an acceptable formulation, differential diagnosis and treatment plan.
4. Demonstrate clinical competence in providing major therapies, including short- and long term individual psychotherapy, psychodynamic and cognitive-behavioral psychotherapies, family therapy, group therapy, crisis intervention, pharmacotherapy, ECT, and drug and alcohol detoxification.
5. Capacity to provide ongoing care for a variety of patients of all age groups through a variety of treatment modalities, including the chronically mentally ill.
6. Ability to perform adequate psychiatric consultation in the medical-surgical setting and effectively communicate these findings to medical peers.
7. Demonstrate competence in psychiatric administration, especially the experience of managing an interdisciplinary treatment team.
8. Ability to apply in a selective manner commonly available psychological testing, including clinical assessment scales in the diagnosis and treatment of psychiatric and neurological disorders.
9. Ability to read the professional and scientific literature critically.
10. Ability to teach basic psychiatry to students in the health professions.

### **C. Attitudes**

1. Development of a sense of responsibility for the optimal care of patients.
2. Development of an awareness of self-limitation and the ability to get help for difficult cases by appropriate referral.
3. Development of a desire for continued self-instruction in the fields of medicine, neurology, and psychiatry.
4. Development of an awareness of how physicians' attitudes may influence patient response in the treatment situation.

## SEMINARS

Interns are required to attend seminars while on the inpatient unit that cover a variety of the core topics in general psychiatry. Interns rotating on the inpatient service will also attend a weekly ECT Conference. Other learning/teaching functions include Grand Rounds, Journal Club, Performance Improvement Conference, Advanced Test-Taking Skills Seminar, Ethics and Professionalism Seminar, Forensic Seminar and rotation-specific conferences. The first-year seminars are designed to provide a basic background of general psychiatry for the starting resident, to expose the residents to senior faculty in areas of their expertise, and to build a foundation for later didactic material.

PGY-2 and PGY-3 seminars are intermediate in difficulty with attention to supplementary reference reading. There are two areas of learning running continuously over the course of two years:

- 1) The Psychotherapy Case Conference and the Psychotherapy Didactic include an introduction to psychoanalytic theory and individual psychotherapy, cognitive-behavioral therapies, group psychotherapy, marital and family therapy and a practicum in writing case formulations.
- 2) The Biological Psychiatry Seminar includes modules in genetic and biological factors in psychiatric disorders, research methods and design, substance abuse, neuropsychiatry, and cognitive neuroscience. These seminars run concurrently on a weekly basis and are required of all PGY-2 and PGY-3 residents. These seminars are based on the model curriculum of the American Society of Clinical Psychopharmacology and will run throughout the year.

A course on Ethics and Professionalism will alternate with the Advanced Test-Taking Skills Seminar and the Performance Improvement Conference. The Psychopharmacology Seminar is based on the model curriculum of the American Society of Clinical Psychopharmacology and will run throughout the year.

### **Attendance:**

Attendance at these seminars is taken regularly via hard copy sign in. Attendance of 100% is expected and at least 70% attendance record is required for each seminar assigned to year in training. It is the responsibility of the resident to ensure attendance is appropriately logged in order to ensure proper credit is given. Residents alternate coverage in the ED on Fridays so that this is protected didactic time for the remainder of the residents. Morning hours are dedicated to didactics while the afternoon is used to see psychotherapy patients.

## **SCHOLARLY ACTIVITY GUIDELINES**

### **Description of Educational Experience:**

Another requirement of the ACGME is that General psychiatry residents will become competent consumers of scholarly material. In attaining this competency, residents are encouraged to produce and disseminate scholarly material prior to graduation from the program.

Friday didactics and Friday afternoons are reserved for scholarly activity and therapy/supervision for PGY2's and above. One-half day during the week (in addition to Friday Didactics) will be reserved for independent Scholarly Activity as well as administrative duties and psychotherapy patients for PGY3s. In addition, the clinic float week should be used for reading/study/work on research projects.

### **Suggestions:**

1. Residents will participate in department and consult liaison journal club presentations and monthly Performance Improvement case conferences.
2. Residents are encouraged to produce scholarly work suitable for publication, poster presentation, or departmental Grand Rounds.
3. Residents are expected to present their scholarly activity at the annual department research symposium.

## **PSYCHIATRY SEMINARS AND RESIDENT ACTIVITIES**

Psychotherapy Case Conference

Psychotherapy Didactic

Psychotherapy Patient Supervision

Biological Seminar

PG-1 Seminar

Psychopharmacology Seminar

Spirituality

Forensic Psychiatry Seminar

Psychiatry Grand Rounds

Psychiatry Journal Club

Ethics and Professionalism Seminar

Advanced Test-Taking Skills Seminar

Performance Improvement (Formerly Morbidity and Mortality) Conference

Resident Meeting

Miscellaneous/Guest Lectures

**SECTION SIX:  
RESIDENT FUNDAMENTALS  
AND POLICIES**

## MEDICAL RECORDS REQUIREMENTS

Medical records are critical for the proper documentation of the provision of medical care. They facilitate communication among different staff working with the same patient. Patient records are an increasingly important means of validating patient treatment and progress, as they are often used to justify admission and determine allowed hospital days. Residents play a central role in record keeping for patient care. Resident records will be inspected by attendings, and residents will receive feedback as to their adequacy. All of our current templates for inpatient and outpatient care are DSM-5 compliant. You may add items you find useful but may not delete sections. The following are helpful guides:

### A. Admission Note

When a new patient is admitted, the resident on duty (either on call or assigned) performs a psychiatric history (utilizing information from family members and other collateral sources, whenever possible), a medical history and a physical examination. For adult and child/adolescent inpatients, this information is recorded in WakeOne templates for History and Physical.

### B. Progress Notes

Daily progress notes must be written for each patient. These are done electronically in WakeOne. Notes should reflect changes in patient condition (psychiatric or physical), achievement of treatment plan goals, results of testing, laboratory results, consults, changes in treatment, and any new information gained regarding the patient.

Progress notes are completed by filling out all of the appropriate information in the electronic note template for each patient. This includes providing information on the presenting complaint, HPI (including nursing report), pertinent social history and family history, current precautions, mental status examination, labs and imaging, an updated assessment, and a daily plan.

### C. Discharge Summary

**Discharge summaries should be completed on the day of discharge and in no event later than 24 hours after discharge.** You must complete each summary in WakeOne.

# GUIDELINES FOR COMPOSING PSYCHIATRY NOTES

## All notes should include the following elements:

1. Identification of the encounter being documented.

### *Examples:*

- i. Psychiatric diagnostic interview
- ii. Admission note
- iii. Progress note
- iv. Psychotherapy note

2. Identification of the supervising attending physician.

*Example:* Patient's case was discussed with Dr. Kimball, Psychiatry attending.

3. **DO NOT** copy and paste whole notes. This is considered fraud.

4. **DO NOT** copy and paste Mental Status Exams. This is the same as copying a physical exam from a previous note and is also considered fraud.

5. Abnormal lab tests and/or imaging studies should be discussed and a follow-up plan should be outlined.

6. Consult responses should be acknowledged.

## All psychotherapy notes should include the following specific elements:

1. A statement about the specific psychotherapy procedure performed, and whether it included medication management or not

*Example:* Patient was seen for supportive psychotherapy (or insight-oriented, or cognitive-behavioral, etc.) and medication management.

2. A statement about the time spent with the patient. In general, there are two types of psychotherapy intervention used - the shorter one used for supportive therapy with/without medication management (90833) and the longer one used for insight-oriented or at times cognitive therapy (90836). This is also pertinent to the procedure code.

*Example of an opening statement:* Patient was seen for 30 minutes, for supportive psychotherapy and medication management.

3. A short Mental Status Exam (MSE). This is required for clinical and billing purposes and should at least include elements of: alertness, orientation, speech pattern, affect, mood, thought process, perception, suicidal/homicidal ideations, insight and judgment
4. A statement about medication tolerance, side-effects and medication changes
5. A statement about patient education in regard to their medications and their understanding of their medications
6. An impression as to their progress in therapy and their current psychiatric diagnoses/status

7. A follow-up plan, including lab tests, medication changes, individual and group therapy attendance, and medical referrals, as needed

# FACULTY ADVISOR PROGRAM

## **DESCRIPTION:**

Each resident will be assigned a faculty advisor from the beginning of the residency. This is to be considered a permanent assignment for the duration of residency training, subject to change by mutual agreement and at the discretion of the director of residency training. The role of the faculty advisor is expected to be advisory, supportive, and non-evaluative. The advisor is expected to act primarily as an advocate for the resident with respect to interfacing with residency programs and personnel. Should the advisor feel that any material brought up in the context of the relationship would seriously affect the performance of the resident, such as drug abuse, this material should be discussed (hopefully jointly) with the director of residency training. The relationship is not confidential in the same sense as the therapeutic relationship. Frequency of contact is at least once every 3 months, but is expected to be more frequent during the initial months of residency and diminish as confidence grows. Certainly, extra time may be required during stressful periods for the resident.

## **OBJECTIVES:**

1. To provide support for the resident, particularly early in residency and during periods of stress.
2. To advise the resident in terms of her present learning role as resident and future roles within psychiatry.
3. To mediate and, if necessary, advocate in conflicts with the teaching hierarchy.
4. To facilitate the learning process with advice as to extra learning materials.

## **IMPLEMENTATION:**

Faculty advisors will be assigned annually as new interns or transfer residents enter the program. Assignments will be made by the director of residency education. Changes may be requested either by the advisor or resident and should be presented to the director of residency education.

The program faculty advisor will be evaluated via the resident survey every year.

## **RESIDENT PROFESSIONALISM AND TEAM WORK**

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- Compassion
- Integrity
- 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, sexual orientation, age, culture, race, religion, disabilities, and sexual orientation.

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in the specialty.

## **DUTY HOURS & CALL**

**Notes:** As of July 2011, the ACGME has instituted new duty hour policy for interns and residents. Interns are not permitted to work more than 16 hours in a shift. Please refer to page 134 for maximum duty hours.

### **NIGHT FLOAT**

The night float system was developed to decrease service hours for residents. It provides a 4 week period where an intern or second year resident will cover psychiatry consultations from the emergency department (pediatric and adult) and hospital inpatient units as well as responding to outside patient calls and calls from nurses on the inpatient psychiatric units.

The night float resident shift on Monday through Thursday begins at 8:00pm. On Friday evenings it starts at 5:00pm. The night float period will end the following day at 8:00am. (e.g: if the night float resident begins their Monday night shift at 8:00pm, that shift ends Tuesday morning at 8:00am.) The night float resident is expected to complete all notes and other documentation prior to leaving the hospital.

The PGY-1 and PGY-2 academic years are divided into thirteen 4 week blocks. All PGY-1 residents and a majority of PGY-2 residents will have night float. The first three night float blocks of each academic year will be covered by a PGY-2. After this time period, the night float will be covered by the PGY-1 and PGY-2 residents.

Night float resident will be expected to cover the PAL pager for outside admissions once the secondary in house resident leaves for the night.

### **NIGHT CALL AND BEEPER COVERAGE**

Weekend (Saturday and Sunday) are divided into four 12 hour shifts:

Saturday 8:00am – 8:00pm  
Saturday 8:00pm to Sunday 8:00am  
Sunday 8:00am – 8:00pm and  
Sunday 8:00pm to Monday 8:00am.

Weekend primary call is covered by a PGY-1. One “primary” resident will cover the Saturday day call shift while another, “the rounding resident”, rounds with the attending on the adult and child units assisting with interviews, orders, and notes. Once the Rounding Resident has completed all responsibilities on both units, he/she may return home and has no other clinical duties that day. Two other residents will cover the Sunday day call shift in the same way. The same PGY-1/transitioning PGY-2 resident will cover both Saturday and Sunday night call shifts. The resident who covers the double night shifts will be post-call as of 8:00am Monday morning.

Occasionally on the weekends, some attendings may wish to round earlier than 8:00am and the resident on call that day is obligated to attend.

During the first three blocks of intern year, the intern will have an upper level resident in house during the duration of call (In-house back-up). At the end of the third block in September, interns will have the opportunity to demonstrate their competence to take call without direct upper level supervision by means of an observed patient encounter by a faculty member. The intern will interview a new patient with a faculty member present. After the interview they will present key historical facts, mental status exam findings, and case formulation to the faculty

member. If the faculty member agrees that the intern gathered an appropriate history, has the ability to perform an emergent psychiatric assessment, and can present patient findings accurately to a supervisor who would not have been present, and would be willing to ask for help when indicated, he will grant the intern the privilege of taking call without direct supervision. At this time the intern will still have a back-up resident that s/he can call for help, along with a faculty member who is present via phone to discuss cases and answer questions.

The interns covering the inpatient units are responsible for all on-campus admissions during the week that they are notified of before 5 pm on Monday through Friday. If the patient does not arrive to the unit before 6 pm on Monday through Friday then the new admission goes to the resident on-call. It is the responsibility of the intern on the inpatient unit to complete admissions for patients who are located at WFUBMC (i.e.: in the ED or on the floor) and may mean the unit intern presents to those locations to collect further history and do a physical exam. For admissions coming from outside the hospital, residents on the inpatient unit are responsible for completing these admissions if they make it to the unit by 6 pm Monday through Friday. Any admissions that come after the times mentioned above are the responsibility of the on-call resident.

A separate call system is in place for Fridays. From 8 AM -12 PM a psychiatry intern will cover Floor Consults and ED Consults as needed. From 12 PM to 10 PM, a PGY-2 resident is on duty to assist with floor and ED consults. When the ED based mid-level practitioner leaves at 3-4 PM, the resident's priority becomes the ED. When the night float resident arrives, they become primary call. The 12-10 resident is expected to continue seeing consults and also serves as the jeopardy back-up call. The 12-10 residents may go home at 10 pm as the work load allows, but continues to be available by phone and prepared to return to the ED if needed until 8 AM on Saturday morning.

Third year residents, fourth year residents, and Fellows are assigned to take a short call week (Monday through Thursday). They will complete clinical duties by 4:30pm, travel to the hospital, receive check out from the inpatient psychiatric units then report to the ED by 5:00pm. They will help to cover consultations, floor calls etc. during the 5:00-8:00 pm time period. At 8:00 pm, the third year resident will leave as they are assigned clinical duties the following day. As per ACGME requirements, a backup resident is required at all times, therefore, the third year resident assigned to the short call week, will serve as jeopardy back up call from 8:00pm to 8:00am Monday through Thursday. Jeopardy call ends for the third year resident at 8:00 am on Friday.

Residents on call are responsible for coverage of the Emergency Department, psychiatry floors, general floor consult requests and phone calls. **All admissions and discharges to and from the ED, any hospital consults, and any significant occurrences on the psychiatry floors are to be staffed with the attending on call.** If the attending cannot be contacted in a timely manner, the resident on call should contact the residency training director for advice and direction.

The back-up PGY2 on the weekends is responsible for coverage of tele-psychiatry during their backup shift in addition to coverage of the PAL pager from 8am-8pm at which time PAL coverage transitions to the overnight in-house resident.

## **PAL pager**

2 pager system

Pager 1: Weekday 8am-5pm pager is covered by adult inpatient interns

Pager 2: After hours and weekend pager – Should remain in the ED with in house providers at all times

PAL pager is covered by short call resident from 5p-8p M-Th. The pager is then passed off to the 3p-midnight ED resident. PAL pager is then passed to the night float resident at midnight, who covers the pager until the end of the shift at 8am. PAL pager should then remain in the ED until it is collected by the short call resident the following day. PAL pager is covered by the Friday 12p-10p resident from 3p-10p on Friday. The pager will then be monitored by the night float resident until the following morning. Weekend coverage is done by the in-house primary resident. The PAL pager should be left in the ED Monday morning in order for the short call resident to obtain it in the afternoon.

## **Back-up Call**

The general recommendation is for the primary weekend call resident to call in the back up resident after there are 4 or more consultations that have not been evaluated (this includes ED consults, floor consults, and direct admissions to the inpatient units). During night float, the parameter is for the night float resident to call in the jeopardy call back up resident is less stringent as the backup resident has clinical duties the following morning. Patient care is our top priority, and as such, any instance where patient care is compromised by workload should lead to the back-up resident being called in. The backup should also be called if the workload becomes heavy, preventing timely response to patient needs. If the primary resident feels overwhelmed or fatigued, he is encouraged to call in the back-up at that time. Residents on back-up call may take call from their homes, provided they can be physically present at the scene of emergency calls within 30 minutes.

**Emergency Call Protocol - *In the event the primary on-call resident is unable to take call due to sudden serious illness, accident, bereavement, or other unforeseen circumstances, then the back-up resident is obligated to take primary call. It is not acceptable for the back-up resident to refuse to cover primary call. It is also not acceptable for the back-up resident to delay coming in when called by the primary resident. The back-up call resident should be able to get to the hospital within 30 minutes of being called. If a backup resident does have to take the primary call, then a new back-up resident will be chosen from a master list.***

## SUPERVISION OF RESIDENTS DURING CALL

- In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.
- Residents and faculty members should 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 telephone 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.
- 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 telephone and/or electronic modalities, and is available to provide Direct Supervision.
- 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 must be 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.

- Residents must communicate major patient events with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.
- 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.
  - Each PGY-1 resident will perform a core competency exam in order to progress to the next level of supervision.
- 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.

## **POST CALL POLICY**

Post call days are not automatic comp days. The duty hour rule was designed to protect patients from fatigued doctors making decisions and to protect residents driving home after call. It isn't a mechanism by which residents get to leave work as soon as call is over. The ACGME limits the total number of hours worked to 24 hours for PGY2 and above and you may remain in-house up to an additional 4 hours to complete transition of care for patients. In summary, the ACGME standards as of July 2011, now limit a resident work shift to a total of 28 hours.

If you are the back-up resident and are called in for a substantial number of hours (not just to go in and see one or two patients) and/or are too fatigued to see patients the following day, you should contact the program director, program coordinator, and all chief residents to notify everyone regarding the situation and mutually discuss a plan for coverage.

If you don't make adequate arrangements and contact your supervisor, the day could be counted as a sick or vacation day.

**Reference:**

[http://www.acgme.org/acWebsite/home/Common\\_Program\\_Requirements\\_07012011.pdf](http://www.acgme.org/acWebsite/home/Common_Program_Requirements_07012011.pdf)

## ON-CALL COORDINATION/CONTINUITY OF CARE

### I. At the beginning of the shift, the on call resident will:

- Check WakeOne to verify the correct information is in the system. If it is not, they will contact the hospital operator to correct this.
- Verify the attending and back-up resident to verify how they want to be contacted
- Check with the admissions coordinator to verify bed status and any issues such as potential or pending admissions
- At the change of shift sign out, inpatient residents will notify the on-call resident if there are pressing issues or concerns on the inpatient unit that need to be relayed.

### II. Coordination of care:

- All consult notes (ED and inpatient) are to be signed in the electronic system at the end of each shift (before leaving for the day).
- If any department clinicians' patients are seen on call, that clinician should be electronically routed a copy of the note or notified via email.

### III. Weekend call:

- **Inpatient residents** (adult and child) will leave brief summaries in the attending weekend note file or through email for each patient on the inpatient service. Notes should include labs to check, medical issues to monitor, behavior to monitor, and recommendations for management. In addition, each unit has an EPIC list which must be updated to reflect admissions, discharges, medications, labs, and other concerns
- **Consult residents** will leave for the Friday on call resident a list of consults seen during the week and any pressing issues or possible complications with patients still in the hospital or likely to come back to the ED. This information is contained in a shared list on EPIC that must be updated over the weekend to reflect new consults, discharges, and admissions.
- **On-call residents** will pass the consult list to the next resident on call in a face-to-face checkout. They will check out to each other concerning any pressing issues with inpatients, consults, and/or ED patients.
- **Sunday evening on call resident (8:00pm-8am shift)** will have a face-to-face checkout with the primary inpatient team at 7:30 am Monday morning. At 8:00 am the resident will check-out with the primary Child and Adolescent Team, and will then check-out with the consult team. This process will involve a summary of issues with **consults (floor or ED) seen, any consults called in but not seen, and updates on current/new patients in the ED or Inpatient Units**. Specific information will include labs to check, medical issues to monitor, summary of psychiatric condition over the weekend, behavior to monitor, medication changes made with rationale, and recommendations for managing behavioral changes.

## THE ACGME STANDARDS OF DUTY HOURS AS OF JULY 2011

- Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.
- The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.
- Residents must demonstrate ability for recognition of impairment, including illness and fatigue, in themselves and in their peers; and also show honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
- All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.
- The program must educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. The program must adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
- Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

### Maximum Hours of Work per Week:

- Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.
- Duty Hour Exceptions: A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.
  - In preparing a request for an exception, the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.
- **Moonlighting** must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
  - PGY-1 residents are *not* permitted to moonlight.
  - Residents who are permitted to moonlight must be in good academic standing within the department.
  - Residents must seek and obtain explicit approval from RTD to moonlight.
- **Mandatory Time Free of Duty:** Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

- **Maximum Duty Period Length:**

- Duty periods of PGY-1 residents must not exceed 16 hours in duration.
- Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
- Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
- It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours if the resident has worked a maximum duty period based on PGY level.
- Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
- In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
  - Under those circumstances, the resident must: appropriately hand over the care of all other patients to the team responsible for their continuing care; and, document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
  - The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

- **Minimum Time Off between Scheduled Duty Periods:**

- PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
- Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
- Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
  - This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education

must be monitored by the program director.

- **Maximum In-House On-Call Frequency:**

- PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

- **At-Home Call:**

- Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
- At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."

## POLICIES

Please see MedHub and iShare for all GME policies governing residents. There is also a notebook located in the office of the Program Coordinator containing hard copies of all department and institution policies which may be reviewed at any time upon resident's request.

## BOOK FUND

All residents receive \$300 each year in "book money" from the department, which may be spent in any academically related manner. Unspent funds accumulate annually, but funds unspent at the end of the residency remit back to the department.

## MEDICAL STUDENT TEACHING

Medical student teaching is an integral part of all inpatient and outpatient rotations. Third year medical students are assigned to both inpatient services and the consultation-liaison service (emergency department and floors). They will work on each service for approximately 1 week. Senior medical students may select from several electives offered in the department. The education of medical students is a vital part of the residency experience. Being the closest in training to the medical student, the resident stands in a unique position to provide a quality teaching experience to assigned medical students during their psychiatric rotation. Clinical learning is very much an apprenticeship experience. Whenever possible, the medical student should follow the residents, gaining "hands on" experience in history taking, physical examination, neurological examination, talking with patients, and dealing with other staff members. When a resident is on call, he/she should make every effort to get the medical student out to see patients. Where it is possible, the resident should observe the medical student interviewing patients and then give feedback. Residents must read all medical student work-ups and progress notes, review them with the student and critique the efforts. Residents are clearly the role model for the medical students, especially in the process of diagnosis and treatment planning. The residents play a major role in evaluation of medical student performance at the end of each rotation. This is done via an online student evaluation that is reviewed by the Director of Medical Student Education. Resident input is absolutely necessary for accurate evaluation of student performance.

PGY-2 and 3 residents may also participate in the delivery of medical student lectures throughout the year. Typically, the PGY 2-3 will choose a topic from the following: mental status examination, mood disorders, psychotic disorders, anxiety disorders, substance abuse, personality disorders, factitious/somatiform, and psychopharmacology to lecture on throughout the year. Residents with interest in providing formal medication student lectures should coordinate scheduling with the Director of Medical Student Education within the Psychiatry Department. It is the responsibility of the resident to ensure that his/her clinical responsibilities are not impacted and are adequately covered with appropriate sign out to the resident or attending who will provide patient care during the lecture. Residents who provide lectures to medical students will be expected to return to regularly scheduled clinical duties immediately following conclusion of the lecture.

## INSTITUTIONAL EMAIL ACCOUNTS

Each resident will be given an institutional email account. Information is communicated to the residents by the hospital and department through email. **The resident will be expected to check emails daily.** The resident can access email from an off campus site by going to: <https://outlook.wakehealth.edu>.

# EDUCATIONAL LEAVE

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## Required Documentation Checklist

### 1) Notice of Leave Form

Legibly completed with all required signatures including the name of the conference or reason for educational leave

### 2) Conference/Educational Leave

Conference - a brochure or internet copy of the conference providing location and dates of conference

Board exam - a copy of the registration confirmation

Fellowship scholarship - please see coordinator for direction

### 3) Travel Authorization (TA) Form

Signed and legibly completed to include a total of estimated expenses regardless of utilization of institutional funds (please leave chart field blank)

### 4) Business Trip Budget (BTB) Form

Calculation of planned utilization of departmental and/or book fund monies - break down of estimated expenses personal funding - write "None" on the document but be sure to include your name and trip on the document

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## Procedure

### 1. Resident

- Obtain and complete legibly all required documents
- Maintain a copy of all materials to be submitted
- Submit completed documentation and in whole to Program Coordinator a minimum of **50 days prior to the first day of requested leave** (partial packets or incomplete documentation will be returned to the resident in its entirety)

### 2. Coordinator's Office

- Log the date the entire packet is received
- Contact Cindy Martin for book fund money balance
- Make a notation of other resident's scheduled to take leave within the same time frame
- Enter preliminary leave onto calendars
- Forward entire packet to chief residents for leave approval

### 3. Chief Residents

- Expedite processing (analyzing appropriate coverage, etc...) of leave within 2 business days and return entire packet to the Coordinator's Office

### 4. Coordinator's office

- Copy full packet including leave approval for resident attendance file
- Copy TA and BTB forms to Cindy Martin
- Email copy of approved notice of leave to pertinent staff
- Remove "preliminary" status to approved status on calendars
- Submit the complete packet to the Administrative Office, Dalena Childress

### 5. Administrative Office

- Review all documentation is in order
- Submit to Business Manager for funding approval
- Inform the residency program and resident regarding approval of funds, if warranted

## 6. Resident

- If funds are approved, maintain original receipts and submit to Coordinator's Office, Sheila Leach, within 3 business days upon return from travel
- If funds are being utilized for airfare, only the amount of funds approved can be used to purchase a ticket and the ticket must be purchased through the institution's vendor (please see Sheila Leach)

**Please note:** If funds approved for this trip come from book money and the balance is less than what is reported on the BTB form any time after the packet is submitted, the resident may be responsible for the difference.

## 7. Coordinator's Office

- Create a Travel Expense Voucher (TEV) based on the resident traveler's trip package and receipts
- Submit TEV and supporting materials to resident for signature; who in turn signs the packet and forwards back to the coordinator's office
- Copy to Cindy Martin for Book Fund, if appropriate.
- Submit originals to the Administrative Office, Dalena Childress and David Officer, for final approval and submission for payment.

**Please note:** Once materials are submitted to the Administrative Office, resident reimbursement, if any, may take up to six weeks.

**IMPORTANT NOTICE:** If the resident decides he/she is not able to attend educational leave before or during leave, it is the resident's responsibility to immediately notify the program in writing of the circumstances and seek direction from the program director. Unless otherwise arranged with the program director, the resident is expected to return to his/her normally scheduled responsibilities.

## DEPARTMENTAL LEAVE ALLOWANCES

### *Administrative Leave*

PGY4 residents and PGY3 residents planning to pursue fellowship training are allowed up to 5 days administrative leave to attend interviews. **Other trainees may be allowed administrative leave by the training director for legitimate absence from the training program. All administrative leave requests must be approved in writing in advance.**

## Vacation

Residents are allowed 3 weeks of vacation yearly. Residents are expected to take vacation during the contract year in which it is accrued. Every effort should be made to take leave throughout the academic year and not saved for the end of the year absent extenuating circumstances.

## GUIDELINES FOR DEPARTMENTAL LEAVE REQUESTS

- Requests for Departmental leave time should routinely be submitted at least 30 days in advance. Exceptions will be allowed when unforeseeable events or circumstances preclude the 30 day notification and adequate coverage for clinical assignments can be arranged. Exceptions will be reviewed on a case by case basis by the Chief Resident and the Residency Training Director.
- The resident requesting Departmental Leave Time should obtain a Resident Notice of Leave form from the Chief Resident. It is the individual resident's responsibility to complete this form including making arrangements for coverage of clinical responsibilities, obtaining the signature of the covering resident, and obtaining the approval (and signature) of the service attendings. Completed forms should be returned to the Chief Resident for final approval.
- Any conflicts or concerns (raised by a resident, faculty member, service attending, or the Chief Resident) about Departmental Leave, will be brought to the attention of the Residency Training Director for review and a final decision.
- Residents may not take leave while they are rotating on adult inpatient, night float, consultation / liaison, telepsychiatry, or emergency psychiatry services.
- Generally, no more than 5 consecutive week days should be taken for Departmental Leave. This will be the rule for all inpatient assignments (including VAMC) and the Consultation/Liaison service. Exceptions will be considered on a case by case basis by the Chief Resident.
- Generally, only one week of Departmental Leave should be taken per academic quarter. Exceptions will be considered on a case by case basis by the Chief Resident.
- Because of the arrival of new residents and the need to transition responsibilities, *vacation will not be granted during the last two weeks of June* (with the exception of residents who are leaving for fellowship beginning on July 1 or will be completing their training at the end of June) *or the first two weeks of July*. No resident may take more than 5 days of leave in the month (for any reason) of June because of transition responsibilities.
- Residents graduating or leaving the institution for a July 1 fellowship may be granted 5 days of terminal leave, provided the resident has leave available to use, and coverage arranged. The residency training coordinator will maintain records of Departmental Leave for all residents.

# SICK AND EMERGENCY LEAVE POLICY

Each resident is allowed ten (5) paid sick days per fiscal year (July – June). Sick time as determined by institution is when a resident is unable to perform their duties. Please see GME policy, which may include:

- Personal illness;
- Accident or illness in the immediate family;
- Pregnancy or childbirth;
- Medical and dental appointments;
- Additional days required in the event of a death in the family;
- An emergency situation where no vacation leave is available. *(The program director has the authority to decide validity of the emergency.)*

Unused sick time cannot be rolled over into the next fiscal period and cannot be borrowed. Sick time is not to be used as additional vacation days. Abuse of sick leave could result in serious consequences.

## **Procedure**

Should a resident require sick or emergency leave, the following is expected:

- 1) No later than 8:00am on the day of sick or emergency leave, the resident should contact the following personnel depending upon his/her schedule:
  - a. Onsite Clinics: the front desk at 716-6312 and Clinic Central at 716-4551
  - b. Offsite rotations: the site supervisor, site coordinator and/or point of contact. Contact information for offsite rotations is located on iShare <http://ishare.wakehealth.edu/Psychiatry/Pages/Home.aspx> under your program.
  - c. Outpatient Child rotation: Sandy at 716-9606.
- 2) Direct conversation with the chief resident or his/her designee of the impending leave, such that the chief resident can arrange clinical and/or call coverage.
- 3) Contact the training director, the service chief and the Administrative Secretary who coordinates the medical student rotation schedules, if appropriate.
- 4) Email the residency program coordinator, Sheila Leach, at [saleach@wakehealth.edu](mailto:saleach@wakehealth.edu) and list in the subject line "Sick". All leave, in partial or in whole, taken during the normal work week of Monday thru Friday should be reported to the coordinator. *(It is mandatory to notify the program coordinator of all leaves even in the event of the coordinator's absence. Failure to notify the coordinator of your absence may result in your leave being attributed as vacation and/or brought forth to the residency training director.*

## **BEREAVEMENT**

Each resident is allowed five (5) paid bereavement days per fiscal year for immediate family members. Immediate family members are defined as a spouse, parents, stepparents, siblings, children, stepchildren, grandparent, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, or grandchild. *(The Program Director has the authority to decide bereavement pay for extended family members).*

**Note:** Residents should follow the procedure as outlined above when taking bereavement leave

***FMLA (Family and Medical Leave Act)***

FMLA leave must be approved by the Program Director. Information and forms on FMLA are located on iShare <http://ishare.wakehealth.edu/Psychiatry/Pages/Home.aspx> under Documents/Forms/Policies.