
Resident Manual of Policies and Procedures



*Department of Psychiatry
Residency Education Program
Michigan State University*

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Policy Guidelines

The Michigan State University Psychiatry Residency Education Program is accredited by the ACGME. The Program will adhere to and follow all ACGME program requirements.

- ACGME program requirements: www.acgme.org

The Michigan State University Psychiatry Residency Education Program will follow the following policy guidelines in addition to the department policy and procedures:

- Graduate Medical Education, Inc. (GMEI) policies and guidelines (www.gmei.msu.edu)
- Michigan State University College of Human Medicine Educational Policies (<http://gme.chm.msu.edu/oversight.aspx>)
- Michigan State University College of Osteopathic Medicine Policy Manual (<http://scs.msu.edu/careerpath/policies/pdf/Resident%20Policy%20Manual.pdf>)

Residents in the MSU Department of Psychiatry Residency Program are bound by all of the proceeding guidelines and policies.

POLICY ON RESIDENT ELIGIBILITY AND SELECTION

- Resident Selection
 - Must have completed and obtained medical degree (DO/MD/MBBS) from an accredited medical program.
 - Applicants must demonstrate academic, clinical and interpersonal skills, motivation and integrity, through examination scores, personal interviews, and recommendations from previous supervisors or other sources.
 - Sex, race, age, religion, color, national origin, non-restricting disabilities, sexual orientation, and/or veteran status, shall have no part in the selection or evaluation of candidates
 - Candidates will be accepted preferentially who have enrolled in the National Residency Matching Program (NRMP) and abided by NRMP rules.
 - Non-eligible candidates will not be accepted into MSU Graduate Medical Education Residencies.
- Requirements to begin Training Program
 - Graduate of an accredited medical school
 - Licensed in Michigan with either an education limited or permanent physician license and have a Michigan controlled substance license.
 - Have current ACLS certification by the beginning of the residency training.
 - Have appropriate immigration or citizenship status.
 - *If issues arise concerning a licensing or ACLS certification delay, or immigration status, the Residency Program Director and the DME will make the decisions about whether and under which conditions the resident may begin training.
- Requirements for Fellowship Applicants
 - All of the same requirements for general resident selection and requirements to begin a training program
 - Guidelines as outlined in the ACGME program requirements section III.A.2.
 - Verification from ACGME accredited (for non-ACGME accredited programs see ACGME program requirements section III.A.2.b regarding exceptions) of the training completed and the last milestone assessments.
 - For Geriatric Fellowship: documentation that resident has completed an accredited General Psychiatry residency.
 - For Child and Adolescent Fellowship: at least one year of General Psychiatry training from an accredited residency must be completed.
- Transfer in and out of program
 - For applicants transferring into the program from ACGME accredited programs will be required to provide written documentation of the training successfully completed prior to starting the residency. The previous program will also be required to provide verification of the applicant's level of competency in the required clinical field using ACGME milestone assessments.
 - For applicants from a non-ACGME accredited program, the MSU Psychiatry Residency and fellowship programs will follow the guidelines in the ACGME program specific requirements outlined in section III.A.2 and III.A.2.b. The

documentation required will be the same as applicants transferring from an ACGME accredited program and additionally a milestone review of the new resident must be completed within six weeks of matriculation.

- All applicants transferring in will need to complete a Clinical Skills Evaluation within their first three months of training. This may or may not be counted as their required CSE.
- For residents transferring out of the residency to a different accredited residency or fellowship, the residency will provide the Final verification form (for completed training) or the Transfer form (when transferring from one program to another). The program will also provide verification of the applicant's level of competency in the required clinical field using ACGME milestone assessments.

SALARIES AND BENEFITS

Salaries are determined by the MSU Department of Psychiatry. Benefits are determined by GMEI. Professional liability insurance is provided by MSU for all activities assigned as part of the residency. Residents observe GMEI and Residency established holidays within the limits of on-call and other clinical responsibilities.

Food

Meals and some lunches are provided by Sparrow when on duty.

Parking

Parking is provided free of charge at Sparrow hospital. You will be issued a sticker and/or gate cards by the security department.

You will need to purchase parking permits for parking at MSU. PGY I residents are on campus usually only one afternoon a week and may therefore purchase a short-term parking pass from the Residency Office. Beginning PGY II it is recommended that residents register their vehicle at the Department of Public Safety on campus and purchase the parking permit/sticker. (Rates can be found at dpps.msu.edu and this can be payroll deducted or paid up front through GMEI). Residents will be bound by the parking office requirements related to their permit purchased. ***Do not park in patient/visitor lots at the MSU Clinical Center or Fee Hall Patient lot.***

Educational Fund

Residents receive \$1000/year, which may be used for: books, journals, medical software, professional equipment, USMLE Step III, ABPN or AOBPN exam registration, or other professional and educational costs. These funds may also be used for attendance at educational meetings and conferences, including associated costs for transportation, housing, meals, and registration. It is possible to receive an advance for certain expenses if prior approved. Cash purchases are reimbursable with an appropriate receipt. A reimbursement form (found on New Innovations, in the residency office or the department website) must be filled out and if traveling, the resident must speak with residency office regarding any requirements prior to booking any travel.

Clinical Faculty Appointment at Michigan State University

As a university-based medical resident, you are appointed as a Michigan State University clinical faculty member. Faculty status provides numerous benefits for you and your family, as the vast facilities at MSU are available to you at low or no cost. Your faculty/staff ID card can be used to obtain athletic tickets, lecture or concert series tickets, library privileges, and use of recreational facilities (pools, IM buildings, golf, and tennis). The University Library is available to you both online and on campus, with its science component in the basement. This is a good source of medical literature, and a health services librarian is available. To obtain your ID, please visit the ID Office in the International Center.

ABSENCES, VACATION, EDUCATIONAL LEAVE

Paid Vacation

Vacation must be approved by the Residency Director or Associate Residency Director and the clinical service chief. The resident is responsible for submitting vacation absence requests (form found in residency office and on New Innovations) to the Residency Director at a minimum of 6-8 weeks prior to planned departure. If you fail to do so, your absence request may be rejected without further explanation. Failure to notify the residency office of an absence prior to departure will result in time-off without pay that may affect your training schedule and may also result in disciplinary action. (See PROCEDURE II for a description of how to complete the form). It is the resident's responsibility to ensure the vacation has been approved prior to taking the time off.

Residents receive 20 working days' vacation. Vacation time should be distributed proportionally to the time spent on each service. No more than one week of vacation time may be taken during rotations of one block without having to make up the rotation time missed, vacation must be taken proportional to the time on the service, one day a week vacation for several weeks in a row will not be approved. Exceptions to this must be approved by the REC. Residents may not forego vacation time to make up a deficit in training time. ***Failure to obtain approval from the residency office 6-8 weeks prior to departure will result in time-off without pay that may affect your training schedule and may also result in disciplinary action.***

The resident is responsible for referring to the seminar schedule and list of NO VACATION DAYS that are published at the beginning of each program year before planning their leave. These days will not be granted unless by approval from the program director.

Paid Holidays

The Residency Program recognizes the holiday schedule of Michigan State University faculty and staff :

- New Years (two days)
- Memorial Day
- Independence Day
- Labor Day

- Thanksgiving Day
- Friday after Thanksgiving
- Christmas (two days) [religious holidays]

A resident preferring an alternative religious holiday should notify the residency office of their preference at the start of the academic year. Since religious holidays fall at various times throughout the year, requesting religious holidays other than the default holidays requires completion of the residency Absence Form. These days will be considered the individual resident's religious holidays and are limited to two per academic year. Requesting a religious holiday does not guarantee that you will be able to have that day free from duty.

Paid Educational Time

Educational leave, a maximum of 5 working days with pay, will be allowed per year when pre-approved by the Program Director, Service Director, and Residency Office. Educational leave is not considered vacation and is approved for only specific high-quality educational and professional opportunities. The residency office must receive a copy of the meeting schedule and the CME form must be filled out (see PROCEDURE XI).

Illness

When a resident is unable to perform their duties due to an acute illness, the resident must inform their supervising attending physician, outpatient clinic (must call patients when able), individual supervisor, and the program director and administrator as soon as they know they will not be able to attend required duties. (Email and phone communication are both required). If there are more than **3** (consecutive or cumulative) days of illness or injury the sick resident **must** be examined by a physician and provide a written note documenting the illness. If a resident accumulates 5 or more sick days in their academic year the time missed may be added to the end of their program year to meet accreditation and board requirements. Sick days will not be excused for seminar and didactic attendance purposes. (Procedure II)

Leaves of Absences

In accordance with the ACGME Institutional and Common Program requirements our leave policy is as follows. Educational requirements of the residency must be met irrespective of leaves. Such leaves may result in an extension of the time necessary to complete the residency. The program will make every attempt to meet individual needs created by pregnancy or illness, including arranging part-time positions. Part-time training may be available upon entry into the program or during the program. Arrangements must be made through the Residency Education Director.

Paid Medical Leave

Paid medical leave is available for significant medical care as documented by a physician. This also includes paid leave for pregnancy, childbirth, adoption, and subsequent newborn care. Vacation time cannot be forfeited to meet training requirements. Medical leave may require an extension of the training program to meet accreditation and board standards as determined by the Program Director and Residency Education Committee.

Family/Medical/Caregiver Leave

Residents may request maternity/paternity/family emergency leave in addition to their normally allotted vacation and educational leave. Vacation time does not have to be utilized for these leaves of absences. However, cumulative absences that exceed vacation and CME time in a single training year may result in an extension of that training year.

SEE GMEI Policy and PROCEDURE Manual for FMLA details.

Paid Bereavement Leave

In the unfortunate event of the death of an immediate family member, a resident is eligible for up to three days of paid bereavement leave. The bereavement leave must be requested and taken within two weeks of the death of an immediate family member. This requirement may be waived after review by the Program Director. If a resident wishes to take time off due to the death of an immediate family member, the resident should notify the Residency Program Coordinator. Approval of bereavement leave will occur in the absence of unusual departmental requirements. A resident may, with Program Administrator approval, use accrued paid time off benefits for additional time off as necessary.

Immediate family members are defined as follows:

- Spouse or person occupying the place of a spouse in the household
- Resident's and/or spouse's child
- Resident's and/or spouse's parent
- Resident's and/or spouse's grandparent
- Resident's and/or spouse's brother or sister

A miscarriage or pregnancy complication resulting in the death of the embryo or fetus will be covered under this policy.

- Bereavement pay will be granted to the parent(s).

Leaves of Absence without Pay

A leave of absence without pay may be granted with the approval of the program director. Since only up to one month of credit may be granted in any one year for vacation time or illness, a leave of absence will generally delay advancement to the next training level and/or completion of the residency training. Time off without pay is only available with the Program Director's approval after all accrued paid time off benefits have been exhausted.

Residents who are determined to be absent from assigned duty without prior permission may be determined to be absent without pay, and their payroll will be appropriately reduced. Other administrative actions up to and including dismissal will be taken as determined appropriate by the Program Director and/or Residency Education Committee (REC).

Jury Duty

In the event a resident is summoned for jury duty, the resident shall notify the residency office, clinic staff and their rotation supervisor. Should the resident have to report for their

jury duty, they will notify the clinic and/or their attending so the patients/duties they have that day will be canceled.

Extramural Work

Extramural work is not allowed during the PGY I or PGYII year. In PGY III – PGY VI, extramural work is generally permitted as long as the work is within their medical scope of practice and the resident is in good standing. Such work shall be limited to 8 hours per week and shall not occur during regular residency assigned responsibilities or interfere with program requirements. The resident must have their full medical license and DEA. The resident must provide his or her own professional liability insurance. (See PROCEDURE III).

All extramural work must be approved by the Residency Director in advance. The resident must provide information on extramural work to the residency office. Refer to the CHM GME Manual Section XIV Policy on Outside Professional Activities (Moonlighting) for additional policy guidelines.

RESPONSIBILITIES AND ATTENDANCE

Duty Hours

In accordance to ACGME regulations, continuous on-site duty, including in-house call, must not exceed 24 consecutive hours (PGY1 is 16 hours). Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care. No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the resident has not previously provided care. Refer to the CHM GME Manual Section XIII Policy on Hours of Duty for additional policy guidelines and specific duty hour's criteria and limits. (See PROCEDURE IV).

Residents will meet the clinical responsibilities of the services to which they are assigned. Resident duty hours, as defined by the ACGME, will not exceed the ACGME standard of 80 hours per week averaged over four weeks. Residents are responsible for continued development of their academic knowledge of psychiatry, their clinical skills and their continued adherence to ethical standards as stipulated by the American Psychiatric Association.

Residency Requirements Regarding Passing of National Board Exams

Residents are required to pass the Licensure Board Exams, either USMLE Step I, II, or COMLEX Part I, II, and before entering the residency program. Residents must **take** and **pass** Part/Step III of the National Board Exam by January 1 (or 6 months into) their PGY II year of training. Residents will not be promoted to PGY III without passing National Boards Part III. Please see PROCEDURE V for further information.

Rotation Goals and Objectives

Each rotation has written guidelines outlining responsibilities, expectations, and patient load for residents. This information will be sent to the resident prior to each rotation and will be available in the Resources section of New Innovations. It will also be kept on file in the Residency Education Office.

The program utilizes Goals and Objectives for each year of Training (see PROCEDURE XVII) along with the milestone evaluations (available at: <http://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf>) and Core Competency by program year (see PROCEDURE XVIII) to assess resident readiness to advance to the next program year.

Attendance

Attendance at all seminars is required. Residents are expected to meet the objectives of the seminars. When there are no seminars, residents are to be at their regular assignments. When illness or other extenuating circumstances prevent attendance at seminars, the Residency Office is to be notified in accordance with the absence policies stated above. In the case of unexpected absence from seminars, residents are to notify instructors and the residency office. It is understood that seminars may be missed because of vacations. The resident is responsible for material covered during missed seminars. All residents are expected to have a 100% attendance for seminars/lectures

Seminar attendance for all residency educational events (Thursday seminars, Journal Club, Grand Rounds, and Wednesday Morning Clinic) shall at a minimum be 70% per year for a resident to successfully graduate from the MSU Psychiatry Residency Program. Attendance shall be averaged on a 6- month basis and residents will be informed of their attendance status at their semiannual review. Residents who fail to meet this requirement will be asked to complete the seminars that they have missed before advancing in the program or graduating.

Psychotherapy Supervision

All residents will receive two hours of supervision in addition to supervision on clinical rotations. Attendance at supervision is required. When vacations or illness prevent supervision, the resident is responsible for notifying the supervisor. See PROCEDURE VI for further information regarding supervision.

Direct to Indirect Clinical Supervision

Residents will follow ACGME guidelines in regards to direct versus indirect supervision. Please see PROCEDURE VII for more information about the process.

Evaluations

All residents will participate in clinical skills evaluations (CSEs) as mandated by the ABPN and ACGME. Residents must pass this exam to move to the next year of training. (See PROCEDURE VIII)

Residents will take the Psychiatry Resident In-Training Exam (PRITE) yearly. Residents review the results with the training director and if remediation is needed, a plan may be put into place for: a) a low score b) a significant decrease in the current year's score from the previous year(s). (See PROCEDURE IX)

All supervisors' complete evaluations of resident performance. Residents' complete evaluations of seminars, services, and supervisors. All evaluation forms must be submitted by the specified deadlines.

Faculty are responsible for organizing and distributing seminar and psychotherapy supervisory assignments. These responsibilities include the preparation and distribution of objectives, reading lists, and reading material for all seminars. Responsibilities include the timely completion of evaluation forms and other requested material distributed by the residency program.

Resident After Hour Call Responsibilities

- On weeknights, call starts at 5:00 p.m. and ends at 8:00 a.m. the next morning.
- On weekends, call is from 5:00 p.m. Friday until to 8:00 a.m. Saturday; and then from 8:00 a.m. Saturday until 8:00 a.m. Sunday and then from 8:00 a.m. Sunday until Monday at 8:00 a.m. Holiday call begins at 8:00 a.m.

All call in the Psychiatry department is "home call." On weeknights call begins at 5pm and ends at 8am the next morning. PGY 2-4 residents are assigned to call. PGY 1 residents are not permitted by the ACGME or program to do home call and are therefore not included in the assignment of call. On the weekends, the PGY 2-4 resident assigned to home call also rounds on the patients starting at 8:00 a.m. on Saturday and Sunday. After finishing rounds on the weekend and duties on the unit the resident resumes home call.

PGY 1 residents are assigned to weekend/holiday rounding and work with the PGY 2-4 residents and the attending physician during weekend rounds. The PGY 1 resident is under the direct supervision of the attending physician throughout weekend rounding. When rounds are complete the PGY 1 resident is done with their duties for the day. PGY 1 residents round on the weekends during the time they are on the inpatient rotations. (See PROCEDURE XVI for more details).

Residency Management System (New Innovations)

The residency office utilizes New Innovations software to manage the residency. The following items are required information to be viewed/completed by the resident in New Innovations:

- Maintaining duty hour report

- Evaluations
- Seminar schedules and surveys
- Logs (MSU outpatient clinic logs not included)
- Scholarly activity
- Rotation Schedules
- Goals and Objectives (under assigned rotation curriculum)
- Rotation Information
- Compliance Notifications
- Forms and Residency Manual

Please see PROCEDURE X for more instructions on how to utilize the New Innovations functions.

Semi- Annual Review with Training Director

Two times during the academic year, in January & June, residents will have a review with the training director. Progress and concerns are discussed at this time. See PROCEDURE XI for more information on the Semi-Annual Review guidelines.

COMPLIANCE

Universal Precautions and Bloodborne Pathogens

All residents are required to maintain current training certification through the MSU Health Team's online training programs in universal precautions and bloodborne pathogens. The training program is maintained by the MSU Office of Radiation, Chemical, and Biological Safety and tracked at ora.msu.edu. All residents must obtain a passing score on the quiz at the completion of the online tutorial. Residents are notified when annual refresher recertification is required, and residents must respond promptly to notices for retraining. All portions of training, both the online modules and the worksite orientation and checklist, must be completed as assigned annually.

At all times residents should use the risk reduction strategies and materials available both in the clinic and in the hospitals. If at any time any person, no matter their specific role, detects a resident or other provider engaging in practices that do not meet safety standards, that person must bring their concerns immediately to the clinic supervisor, the nurse manager, the supervising attending, or the Program Director. At minimum, remediation of safe practices will be required.

Needle Stick or High Risk Exposure Policy

Any person potentially exposed to a blood borne pathogen (through cut/puncture injury, open wound exposure, mucus membrane exposure, prolonged skin contact, or any other exposure of concern to the affected person) should first attempt to wash/flush the area for 15 minutes (with soap and water for skin contact, water or normal saline for mucous membrane exposure), then immediately report the incident to your supervisor if available, go to the nearest urgent care center for evaluation and treatment. On arrival clearly state that you are an MSU resident and you have had a bloodborne pathogen exposure:

- At Sparrow, call the nursing supervisor on call. He/She will bring information/instructions to you. If the nursing supervisor is not available, go to Sparrow ER.
- Olin Urgent Care Clinic (business hours only; report to Sparrow ER after hours) At the urgent care facility you will have medical evaluation and laboratory follow up. If at any time you have concerns or questions, promptly notify your supervising attending, your chief resident, the program office, or all of the above. The program and the resources of the occupational health centers at each training center are designed to serve your health needs.

YOU MUST NOTIFY GMEI Central office and the psychiatry residency office immediately after treatment at (517)432-4421.

Updated information regarding HIV occupational exposure guidelines can be accessed through www.dcd.gov/hiv/treatment.htm or <http://aidsinfo.nih.gov>

HIPAA Compliance

You will be required to complete an on-line training session on the Health Insurance Portability and Accountability Act (HIPAA) and the associated HIPAA privacy rules. You must complete full MSU HIPAA compliance training, and may also be required to complete separate HIPAA training PROCEDURES at other training sites.

Vaccinations

Routine immunization records are required for most site's credentialing processes. Annual Flu shots and TB tests are also required by Sparrow/Community Mental Health/MSU Health Team. Hepatitis B vaccination is required. Initial vaccination may be given at the time of your physical examination and is the responsibility of the resident to keep track of and complete the vaccination series. If you had hepatitis B vaccination prior to entering the residency, you must provide written proof. COVID19 vaccination is also required to be up-to-date as per the CDCs current recommendation. Those wishing to decline any vaccines will need to complete the waiver process.

Current vaccination documentation must be submitted to the residency office, where it will be kept secure and utilized for credentialing purposes only.

Drug Testing Policy

At various times throughout residency/fellowship the resident will be expected to complete physicals and/or drug screening. Should a resident be on any substance that would cause a positive drug test, the resident must provide documentation from their physician to the entity administering and/or requesting the drug screen. Failure to do so may prevent the resident's eligibility to be credentialed and may result in dismissal from the residency.

BLS/ACLS Certification

Certification in BCLS and ACLS are required to begin the residency. The residency office must have a copy of your current certification cards. The department pays for this certification for new residents.

Medical Licenses

All residents are required to maintain a current Michigan Physician License and Michigan Board of Pharmacy license. Your initial license will be an educational limited license. It is recommended to apply for a permanent Michigan license after passing Step III of the USMLE/COMLEX and following satisfactory completion of two years of residency training (allopathic), or 1 year (osteopathic).

You cannot be involved in patient care without a valid medical license.

- **Federal DEA License:** Residents can get a federal DEA license on an education license, but the address on the DEA application **MUST** match the address on your MI license. Residents will need the DEA license when working in the outpatient clinic. Residents can apply for their own personal DEA license upon receiving their full Michigan license.

The address to use for licensing during training is:

MSU & Affiliated Hospitals
Psychiatry Residency Program
965 Wilson Road, Room A-233
East Lansing MI 48824

Professional Memberships

All residents in the general program are encouraged to join the APA both at the National and State level. The department will help subsidize the cost of the national membership and the resident can use their CME funds for the state membership. First year residents do not have to pay dues. Being an APA member provides educational, leadership and many other wonderful benefits that can be found on the APA website (www.psychiatry.org). Relevant information regarding APA guidelines can be found in the residency education office or on New Innovations under resources.

AOA membership is required by the licensing board to verify credentials so residents will need ensure their membership is current. The resident can use CME funds to pay for this membership.

Hand-Offs

Each rotation and site has specific hand-off procedure that residents are required to comply with. The rotation specific handoffs are listed under PROCEDURE XII.

PROFESSIONALISM

Correspondence

You must keep program records current by notifying the office in writing by completing the Address/Information form OR providing the residency office of any change in address or phone number or relevant status (i.e name change).

Email

An MSU e-mail account is provided to all residents. You are given an @msu.edu email through the university with your NETID. This is what you will use to log into computers and all university systems. All residents are expected to check their e-mail regularly, as important and sometimes vital information is communicated in this manner. You are responsible for the information in e-mail messages sent from the residency office. Not being able to check your e-mail is not an acceptable excuse for failure to respond to instructions in e-mail communications from the residency office staff. Resident clinics are set up to allow residents to check their e-mail as needed, and the e-mail is accessible over the Internet from remote sites. We can also help you set up a University e-mail account on your home computer, mobile device or access it from a web browser. Please contact the residency office for assistance. Please ensure if you are forwarding your emails to another account it is up-to-date to ensure you are getting your emails.

On your msu account you will have an “Outlook” calendar. The residency office and clinic will be responsible for adding items to your schedule, if you have an event that needs to be blocked please contact the appropriate person. This includes your scheduled supervision times and other special events. If you have a personal appointment you do not want others to see that requires taking time off, please submit a vacation request or speak to the residency office. It is critical to keep schedules up to date.

Mail

Mail for the PGY1 residents will be placed in a mailbox in the residency office in East Fee and PGY2 and above will have a mailbox both in the residency office and the West Fee clinic. It is the resident’s responsibility to check at least weekly to see if you have received any mail or notices. Additional hard copies of vacation forms, extramural practice forms, change of address forms, research guide and mentor lists, local therapist list, etc. can be requested by the residency office.

Appearance/Dress

Professional appearance is important at all times. Residents are expected to always dress in a professional way when seeing patients. The hospitals also have picture ID badges that you must wear at the hospitals.

Pager Policy/Availability

It is the resident's responsibility to ensure that he/she can be reached during on-duty hours and on-call. Residents have the option of having a pager assigned to them that is paid for by the department. Residents are able to use a reliable personal telephone but no compensation will be provided. If you leave your pager at home or your phone is inoperable, immediately notify your clinic, hospital and the residency office. If pager is lost or damaged, there is a \$75 replacement fee.

Medical Records Policy for Clinic/Hospital

Residents are responsible for completing all notes, charts, and logs each day they are on a service. Residents may be suspended without pay if patient logs or evaluations become delinquent. Upon notification from a medical record department that a resident has been placed on the "warning" list for delinquent records, the residency office will notify the resident that all delinquent records must be completed within the next 24 hours. Upon notification from a medical record department that a resident has been placed on the "suspended: list for delinquent records, the Program Administrator will notify the resident that they must immediately telephone the medical records and clear the records within the next two days. The resident must then notify the Program Administrator via e-mail or telephone when cleared by the medical records department. If the resident has not been cleared by the medical records department within 2 days of being notified (unless post-call), the Program Administrator will inform the resident that they are suspended without pay from the residency program until all delinquent records are complete and cleared by the medical records department. Residents are exempt from the delinquent records policy if during the time a record becomes delinquent the resident is on an excused absence.

Social Networking Policy

This policy applies to MSU psychiatry residents when they are engaging in social networking activity online. Social networking includes email, blogging, micro-blogging, Facebook and similar services, and other online portals that focus on free exchange of information across networks of individuals and organizations.

Social networking is a standard part of social interaction. In addition to personal uses, such networking can help extend the reach of the department and residency and can enhance learning and values. In some situations, it may contribute to particular projects. (See PROCEDURE XIII for further guidelines and instruction)

Rules of Personal Conduct

MSU residents are bound by policies outlined in the GMEi handbook as well as the MSU University Policy on Relationship Violence and Sexual Misconduct. Further information regarding professional conduct guidelines can be found in the CHM handbook as well as the MSU University Policy on Relationship Violence and Sexual Misconduct https://www.hr.msu.edu/documents/uwidepolproc/RVSM_Policy.htm.

A faculty or academic staff member who has educational responsibility for a graduate student enrolled at the University may not begin or enter a consensual relationship with a

graduate student when they have educational responsibilities over the graduate student. If a resident has a prior relationship with a student not at the graduate level, they must fill out the amorous relationship form. Please contact the residency office to get more information.

Liability

If you become aware of a situation in which a patient has been or feels to have been injured or not adequately cared for, report this immediately to your attending physician. No student or resident should give solicited statements or testimony to anyone (attorneys, insurance companies, the press, TV, radio). Report requests for such statements to your attending and the Program Director, who will arrange appropriate legal counsel.

Residents are provided professional liability insurance for program-required rotations (See Appendix 1 for liability statement). To comply with the liability policy, any “away” elective must have prior program approval. The Program Director must sign an official form for this purpose at least two months prior to the onset of the elective. Failure to meet this requirement will mean that the resident will not be insured for that period.

Residents must contact the Program Director when a risk is perceived, or legal counsel is felt to be needed for activities performed in the scope of resident activities. The Program Director (or Director of Medical Education) will arrange appropriate follow up.

Mental Health Code

Act 258 of 1974

“AN ACT to codify, revise, consolidate, and classify the laws relating to mental health; to prescribe the powers and duties of certain state and local agencies and officials and certain private agencies and individuals; to regulate certain agencies and facilities providing mental health or substance use disorder services; to provide for certain charges and fees; to establish civil admission procedures for individuals with mental illness, substance use disorder, or developmental disability; to establish guardianship procedures for individuals with developmental disability; to establish procedures regarding individuals with mental illness, substance use disorder, or developmental disability who are in the criminal justice system; to provide for penalties and remedies; and to repeal acts and parts of acts.” (Source: <http://legislature.mi.gov/doc.aspx?mcl-act-258-of-1974>)

Involuntary Admissions guidelines are covered under the mental health code. See PROCEDURE XIX.

Psychiatric Treatment for Department of Psychiatry Employees

In general, Department of Psychiatry faculty and residents should not provide treatment for employees of the Department of Psychiatry or their close family members.

Rationale for this policy: Providing psychiatric care to individuals or close relatives of individuals with whom we work creates potential conflicts and issues that are difficult to

keep separate from the work relationship. Such care can be suboptimal and in the interest of providing the best care possible is problematic.

Exceptions to this policy: We recognize that there may at times be exceptional circumstances that make an exception to this policy reasonable. Any such potential situation must be reviewed with and approved by the clinic director before treatment is initiated.

Impairment

In the event of impairment due to health-related matters, the Residency Education Committee (REC) will attempt to help the resident obtain appropriate care. The REC may request medical information and evaluation to guide it in making recommendations about the resident's ability to continue in the program. Refer to the GME Manual Section XVI Resident Impairment for additional policy guidelines.

Electives

Elective rotations generally occur during the PGY IV year. The Residency Director will meet with PGY III residents to discuss electives. Residents must submit a description of the elective including broad objectives, supervision, special readings or experiences and any other relevant material about the experience to the Residency Education Director for approval. This description of the elective must be signed by the faculty member who will be supervising the experience. For electives outside of the MSU system, similar documentation must be provided. All electives must be approved in advance by the Residency Director.

CHIEF RESIDENT

The Chief Resident/s shall ordinarily serve from January - December of the PGY III/IV/V Year. The Chief Resident/s will assist the Director in the administration of the program and serve on the REC. The residents will elect the Chief Resident/s who will be presented to the REC for approval.

Chief residents serve as the liaison between the faculty and residents. They attend meetings, conferences, and educational seminars to strengthen their administrative skills while advocating for the residency majority. It is expected that the Chief Resident(s) will delegate tasks as indicated, and focus on those tasks that are of highest priority. (See procedure XIV for chief resident duties).

CONFIDENTIAL CONCERNS

Residents are encouraged to address their concerns with the training director. These may be academic, personal or ethical concerns that arise throughout the course of their training period. Concerns may be over individual or group issues.

For a detailed guideline of how to address concerns please see PROCEDURE I.

GRADUATION REQUIREMENTS

Please see PROCEDURE XV for items needed to graduate from the residency.

Resident Dismissal Procedure

Resident Dismissal

The MSU Psychiatry Residency follows the MSU/CHM, as the Institutional Sponsor for ACGME Accredited Programs, policy for Resident dismissal. A resident may be dismissed for the following:

- Unsatisfactory academic or clinical performance.
- Failure to appear for duty when scheduled, without notification to the program.
- Failure to comply with the rules and regulations of the Program, the College, the University, or the Hospitals, in which training takes place.
- Revocation, suspension, or restriction of license to practice medicine.
- Theft.
- Unprofessional behavior.
- Insubordination.
- Use of professional authority to exploit others.
- Conduct that is detrimental to patient care.
- Falsification of information in patient charts or other documents of the residency program.

Process

The program director who is considering dismissing a resident shall consult with the chairperson of the academic department and Assistant Dean for Graduate Medical Education. The process for dismissal shall be:

1. The resident will be notified in writing that the program is considering dismissal. The reasons dismissal is being considered must be included.
2. Upon notification, the resident will have an opportunity to meet with the program director and members of the TEC to present oral and written support for his/her position in response to the reasons for the action set forth by the program director.
3. If after the meeting (or, if after the opportunity to meet is declined) the program director determines that dismissal is still recommended, the resident will then be offered a hearing prior to dismissal.

Resident Hearing Prior to Dismissal

1. A resident has a right to a hearing prior to dismissal. The resident may request, in writing, the hearing. Such a written request must be made to the Chair of the GMEC within fifteen calendar days from the date of receipt of the document informing the resident of the intention of the program director to dismiss, and his/her right to a hearing. Residents must be provided with the name and address of the Chair of the GMEC. The Chair of the GMEC shall impanel a hearing panel.
 - a. The members of the hearing panel shall consist of five members including: two physician faculty members from the involved clinical department, one faculty member from the GMEC from a

clinical department not involved in the action, one resident from the involved program or its related specialty program, and one resident or fellow from another MSU/CHM sponsored residency program.

- b. The hearing panel shall select a member who will chair the meeting(s) and draft the report of findings.
 - c. The resident will have the right to challenge any member of the hearing panel for bias. The panel, excluding any challenged member, shall confer and decide the validity of a challenge. The panel's finding shall be final.
2. The hearing panel shall attempt to maintain a collegial atmosphere. The hearing is not a court of law, and court rules and the rules of evidence are not binding. The resident or the program director may choose to invite an advisor to be present during the hearings. The presence of an attorney or other advisor is permitted; however, during the hearing itself, only the panel, the program director and the resident may speak. The resident may bring others who support his/her position and question others brought by the program director, if any.
 3. At the close of the hearing, the panel will overturn or uphold the decision of the program director to dismiss the resident. The panel's decision will be reported in writing to the resident, the Assistant Dean for Graduate Medical Education, the program director, and the chairperson of the academic department, within fifteen calendar days.

Policy on Final Payroll Date for Residents who Resign or are Dismissed

It is the policy of MSU GME that when a resident resigns or is dismissed, the resident will be paid through the effective date of the dismissal or resignation (effective date being defined as the date of the letter of resignation, or the date of the College Appeal Hearing at which the intent of the program director to dismiss was upheld). Additionally, all MSU GME residents will be paid for their allotted/accrued vacation. Other benefits, i.e., maternity, will be paid as stated in the resident contract.

RESIDENT GRIEVANCE POLICY (GME XIX)

- A resident in a MSU/CHM sponsored program initiating a grievance is required to use the MSU/CHM grievance process.
- Good faith efforts shall be made to resolve problems through informal means between the parties. The program director should be included as part of this informal process
- In the event that the matter cannot be resolved at the level of the program director, the resident may file a written grievance and seek relief with the chairperson of the affected academic department, and request a review of the issue. A grievance must be initiated within 90 days of the action that is being grieved.
 - The chairperson shall attempt to mediate a resolution to the complaint.
 - The chairperson will put his/her proposed resolution in writing to the resident with copies to the program director and the Assistant Dean for GME.

- It shall be assumed that the resident accepts the chairperson's resolution of the complaint if the chairperson is not informed to the contrary within fifteen calendar days of communicating a resolution to the concerned parties.
 - In the event that the resolution instituted by the chairperson of the affected academic department is not acceptable to the resident, s/he may request, in writing, a formal hearing of the grievance. The resident must state the basis for the grievance, and the request must be received by the chairperson no later than fifteen calendar days after the date the resident is informed by the chairperson of his/her suggested resolution.
 - The chairperson and the Assistant Dean for GME shall impanel a grievance hearing committee within fifteen calendar days of the receipt of the grievance letter.
 - The members of the hearing panel shall consist of five members including: two physician faculty members from the involved clinical department, one faculty member from the GMEC from a clinical department not involved in the action, one senior resident from the involved program and one senior resident from another MSU/CHM sponsored residency program.
 - The hearing panel shall select a panel chair who will chair the meeting(s) and draft the report of findings and the recommendation of the panel.
 - The panel shall first meet to hear the resident's complaint within fifteen calendar days of being impaneled.
 - The resident and the individual grieved against (respondent) will have the right to challenge any member of the hearing panel for bias. The challenge must be in writing. The panel shall confer and decide the validity of a challenge. The panel's finding shall be final.
 - The hearing panel shall endeavor to establish a collegial atmosphere in the hearing. The resident or the respondent may choose to invite an advisor to be present during the hearing. Either the resident or the respondent may choose to have an attorney as an advisor. However, during the course of the hearing, only members of the hearing panel, the resident, and the respondent have the right to address the panel members, the respondent, the resident, or other persons brought before the panel. An advisor shall not present the resident's nor the respondent's case.
 - The report and recommendation of the grievance hearing panel shall be submitted to the Dean of the College of Human Medicine.
 - The Dean will inform the resident, the respondent, and the chairperson of the academic department, of his/her disposition on the hearing panel's recommendation within fifteen calendar days of the last hearing.

NON-RENEWAL OF AGREEMENTS OF APPOINTMENTS

A resident will be provided with a written notice of intent not to renew his/her agreement of appointment no later than four months prior to the end of the resident's current agreement of appointment. However, if the primary reason(s) for the non-renewal occurs within the four months prior to the end of the agreement of appointment, the Program will provide the resident with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement of appointment. Residents must be allowed to implement the institution's grievance procedures when they have received a written notice of intent not to renew their agreements of appointment.

RESIDENCY CLOSURE/REDUCTION

If the Residency Program intends to reduce the size of the program or close the residency program, the Program must inform the residents as soon as possible. In the event of such a reduction or closure, the Program must allow residents already in the program to complete their education or be assisted by the Program in enrolling in an ACGME-accredited program in which they can continue their education.

RESIDENT FILE CONTENT AND ACCESS

The Residency Education Program will maintain a training file on each resident. Training files are considered confidential, will contain evaluations, review summaries, correspondence, and record of disciplinary actions. Access to resident files is limited to the Program Director, Associate Program Director, Residency Administrator, Associate Dean for Graduate Medical Education in COM, or the Designated Institutional Official for MSU/CHM. Refer to GME Manual Section IV Policy on Resident File Content and Access for additional policy guidelines

PHARMACEUTICAL REPRESENTATIVE POLICY

An important part of residency training is learning to interact in an ethical and fact-based manner with pharmaceutical representatives. This has several components:

- 1) understanding and evaluating the consequences of accepting gifts and the ways in which gifts may influence behavior, specifically prescribing
- 2) understanding and evaluating pharmaceutical representatives presentations for bias, and distortions
- 3) understanding and evaluating pharmaceutical company literature for bias and distortions

Please see Procedure XX for more information on interacting with pharmaceutical representatives.

MSU Psychiatry Residency Procedures

I. PROCEDURES FOR RESIDENTS TO CONFIDENTIALLY ADDRESS CONCERNS

The resident has the option to address any concerns with any of the following approaches:

1. Directly with the training director
 - The resident will request a meeting with the training director or may communicate their concern in writing. If an individual meeting is desired, the resident will arrange a consistent time with the residency coordinator.
 - The resident and training director will meet in a private office. The resident may wish to bring the chief resident or supervisor(s) if the concern warrants their involvement.
 - The resident and training director will discuss the concerns. Confidentiality will be maintained unless the issue pertains to the safety and welfare of the resident, the residency program or director. They will develop an action plan, depending upon the issue at hand. The residency training director may also document the meeting in a written memo back to the resident. Confidential follow-up meetings may also be scheduled.
2. Confidential Forms
 - We appreciate your comments and welcome your feedback. We have created a confidential concerns form on Google Drive. You may submit comments and concerns regarding the psychiatry residency education program. Submissions will be received by the residency office and forwarded to the program directors and chair. No identifying information is gathered for this form.
 - o For access, please visit <https://forms.gle/F31ZrCFnPVRnd2G7A>.
 - Concerns may be addressed to residentvoice@hc.msu.edu. This is an anonymous and confidential e-mail through the Graduate Medical Education Office.
 - Sparrow also has a line for confidential reporting, please call (517) 364-3996 or email a patient concern to GMEpatientsafety@sparrow.org.

II. VACATION AND CONFERENCE ATTENDANCE PROCEDURES AND EXPECTATIONS

Policy Summary:

1. Residents are expected to be on all psychiatry rotations from 8:00a.m.-5:00p.m. Monday, Tuesday, Wednesday and Friday or follow the assigned schedule of the off-service rotation.
2. Residents are expected to be on all rotations on Thursdays from 8:00 a.m.-11:30a.m.; seminars begin at 12:00 p.m. Residents are expected to attend all lectures and didactics as assigned. If the resident's lectures are complete prior to 5:00p.m. it is expected that the resident will return to their assigned rotation and complete clinical duties until 5:00p.m.

Vacations and conference time off is to be obtained 6-8 weeks prior to the date of vacation or conference:

1. The resident must fill out the vacation request form.
2. The resident needs to obtain resident coverage for their patients if they have outpatients.
3. The resident must obtain approval from their rotation supervisor.
4. If the resident is in the clinic, they must also obtain approval from the front office staff (coverage section complete) and clinic director.
5. The vacation request form is then given to the residency coordinator who checks to make sure all proper signatures have been obtained and the request is within the time allotted for vacation or conference.
6. If any paperwork (patient notes, evaluations, paperwork, etc.) is incomplete then the request is denied by their Residency Director.
7. Residents are allowed only one week off per four-week rotation and only 5 days per subspecialty (C/L, Addictions, Forensics, Child and Adolescent, Olin, Emergency Psychiatry, GEMS). On out medicine rotation, the resident is bound by their policies and procedures.
8. On inpatient rotations (GEMS and APU) the residents are responsible for ensuring there is only one resident off at a time. The senior resident will work with the attending to ensure there will be appropriate coverage.

Sick / personal days/emergency:

If a resident is unable to report for assigned duties for the day they need to notify the following individuals:

1. Rotation supervisor and/or senior resident on the rotation
2. Residency Coordinator(s) and Program Director (DO NOT call the answering service to leave a message). Please include all information, including times you will be out, reason, where you will be and how you can be reached if necessary.
3. Psychiatry Outpatient Clinic front office staff and medical director if patients are scheduled that day
4. Supervisor; if supervision scheduled that day (The residency office will not take responsibility for contacting your supervisors).

All absences are recorded. The program director determines if the absence is excused or unexcused. Failure to notify the above individuals automatically results in an unexcused absence. All unexcused absences, for any reason need to be made up. The resident is

also required to meet with the Program Director to discuss if further remediation is needed.

The following outlines the expectation on a resident's standard working day (not applicable to medicine rotations), any time taken that is during this schedule will need to have a vacation or conference request completed.

- Outpatient Schedule:
 - The resident is expected to be in the clinic from 8:00 a.m.-5:00p.m. (as above-see attendance policy) regardless of the number of patients scheduled.
 - Residents are to present to the clinic several minutes before 8:00 a.m. to check in with their attending physician, set up Zoom, check room availability etc.
 - Group sign-out takes place each morning at 11:30 and each afternoon at 4:30 (unless otherwise directed by the supervising physician).
 - Residents are expected to attend and participate in sign-out.
 - All notes should be completed by the end of the clinic block (noon or 5:00 p.m.) the same day. Followup notes must be complete within 24 hours and initial evaluations within 48 hours of the patient appointment or the resident will be considered delinquent and in violation of Department and MSU Health Care policies which may warrant reprimand or suspension of clinical duties.
 - Residents can only leave the clinic early or arrive late if given permission to do so by the resident clinic supervisor of the day-arranged ahead of time. They must then notify the residency office (Residency Coordinator(s) or Program Director) of any alternative plans made with their supervisor. All notes and patient care matters must be complete prior to the resident leaving the clinic.
- Inpatient Schedule:
 - APU Safety Team/Morning Report:Daily: Resident meets with MSW and nursing to discuss patient management and disposition. Residentpresents an interval history of their patient(s) noting improvement and including any pertinent details to nursing staff and utilization review on a daily basis.
 - Rounds: Daily; usually between 8:00a.m. and noon- at the attending's discretion
 - Afternoon activities: Residents should see every new patient, who arrives after rounds and before 5:00pm, and a cursory evaluation should be done and a progress note should be documented in the EMR.
 - Residents participate in treatment team meetings approximatley twice a week. During these meetings, the resident should be discussing goals for treatment, barriers to success, prognosis, as well as estimated length of stay.

- Residents have **DAILY** teaching seminars with alternating presentations between residents and medical students. The Admin Senior is in charge of scheduling presenters and topics.
- Residents meet with patients assigned to them after rounds and to update them on plans or changes. They should be addressing any new concerns that have arisen since the last meeting.
- Residents should be finishing notes, calling patient's families/doctors/therapists prior to leaving the units for the day.
- Residents participate in afternoon verbal sign-out and update the online hand-off together daily.
- Supervision should be scheduled to accommodate these requirements to the best of the residents and supervisor's ability. Individual psychotherapy supervision should be virtual when possible. If in person, returning to the unit after supervision is required between the hours of 8:00 a.m.-5:00 p.m.
- All residents are expected to be present on the unit from 8:00 am until 5:00 pm; if a resident needs to leave for supervision or to pursue other academic endeavors prior to 5:00 pm they must obtain permission from their attending physician, and notify fellow residents, unit staff/clerk and nursing.
- The residents may obtain permission to assign another resident to cover and be physically present on the unit while they are pursuing other approved academic endeavors off the unit.
 **On didactic days, the resident should be anticipating tasks and prioritizing according to the patient's needs. Residents are expected to return calls to the unit between seminars and to return to clinical duties once didactics are completed, if prior to 5:00p.m. The Admin senior is responsible for ensuring that the unit staff know who is covering admissions and access while they are in didactics and seminars.
- Supervision:
 - PGY I residents have one supervisor for one hour per week. The resident is to schedule supervision with the supervisor-during the PGY I year it is usually optimal to do so in the afternoons.
 - PGY II-V residents have two supervisors (2 hours per week total supervision). During out rotations; rotation schedule may need to vary based on the schedule of the resident and the supervisor.

Residents are expected to return to their assigned duties after supervision if it occurs between the hours of 8:00 a.m. and 5:00 p.m

III. EXTRAMURAL WORK (MOONLIGHTING)

In order to be approved for moonlighting the fully licensed (full state and DEA) resident must complete the following steps:

1. Meet with Program Director and Program Administrator to discuss the opportunity, obtain permission (verify resident is in good standing) and review ACGME, AOA, program and university requirements. No credentialing paperwork will be completed until after this step is done and signed off by program director.
 - a. The extramural practice form will be provided to the resident and the resident will need the following information for Part 1 of the form:
 - Facility/organization name and address
 - Phone number, fax and email for administrative contact person.
 - Physician Site supervisor
 - Proposed responsibilities during extramural work
2. Obtain Malpractice Insurance
3. Go through credentialing process at the extramural institution
4. Prior to starting the extramural work, meet again with the program director and administrator to ensure all paperwork has been completed. For this meeting the following must be provided:
 - a. Completed Extramural Practice Form
 - b. Copy of schedule
 - c. Proof of malpractice insurance
 - d. Agreement to abide by the following:
 - adherence to ACGME, AOA duty hour rules which will include any extramural work as well as required residency work
 - no more than 8 hours per week
 - at least one 24 hour period off per week averaged over 4 weeks. At home call cannot be done on free days.
 - will not work more than 80 hours per week when averaged over 4 weeks
 - will not participate in call more often than once every 3 nights when averaged over 4 weeks
 - adhere to all residency program training required documentation and duties.
 - Residents cannot engage in any extramural practice between the regular work hours of Monday – Friday 8-5pm, which includes scheduled vacation time
 - e. Physician Site Supervisor Signature

The Extramural Practice agreement must be renewed every year or anytime there is any change.

IV. DUTY HOURS

- Duty hours are **limited to 80 hours per week** averaged over a 4 week period inclusive of all in-house duties (ACGME)(anytime residents are in the hospital)and in-house call activities for DO residents this is **averaged over 2 weeks** (AOA).
- PGY I residents are **not permitted to do home call** (ACGME).
- Residents must be scheduled for a minimum of one day free of duty every week averaged over 4 weeks (MD) or **two weeks** (DO). At home call cannot be done on free days.
- Residents must have 8 hours free of duty between scheduled duty periods.
(AOA)
- Time spent in the hospital by a resident on at-home call must count toward the 80 hour maximum weekly hour limit.
- The frequency of at-home call must satisfy the requirement of 1 day off in 7 (averaged over 4 or 2 weeks).
- Duty hours **must not exceed 24 hours.**
- Residents must have **at least 14 hours free of duty after 24 hours** (ACGME) (AOA 12 hours) of in-house call.
- PGY II and more senior residents must be scheduled for in-house call no more frequently than every third night.
- The moonlighting experience(s) is counted toward total duty hours and cannot exceed those requirements.
 - o Moonlighting is elective and cannot interfere with program requirements. Our residents are limited to 8 hours of moonlighting per week; all moonlighting experience in total.

V. PROCEDURE FOR PASSING STEP 3

- If a resident has not passed COMLEX 3/Step 3 by the first of January in their PGY2 year, then they will be placed on probation at their January Semi-Annual Review. They will be required to sign up for a board review course and instructed that they will be expected to pass by June of the PGY 2 year, or they will not be advanced to PGY 3 Status in July. If they have not passed by the end of the PGY 2 year (June), then they will need to take an unpaid LOA in order to pass the examination. Probationary status will be lifted when they have passed COMLEX 3/Step 3 at which point they may rejoin the program. Probationary status may result in dismissal from the program.
- Three or more failures of Step 3/COMLEX 3 may result in dismissal from the program.
- A systematic approach will be undertaken to ensure that all residents stay on schedule with respect to the National Board Examinations. Board status will be reviewed at each semi-annual review and residents cannot progress to the PGY 3 level until they have passed.
- We will review the policy at the new resident orientation and at each Semi-annual review.
- Each year, the residents are required to sign that they agree to the terms of the manual as written, thus acknowledging that they agree to this procedure and policy.

VI. INDIVIDUAL PSYCHOTHERAPY SUPERVISION

Individual Psychotherapy Supervision

Supervision provides residents with a unique opportunity to develop and refine their clinical skills and to discuss their professional career development with an experienced faculty member. Supervisors also help the program evaluate residents in terms of the ACGME core competencies. This policy covers (a) clinical supervision of residents seeing patients and (b) the required two hours per week of supervision.

Each resident is required to have two hours of formal individual supervision per week. (PGY I residents receive one hour of such supervision per week). Residents and supervisors must make an effort to meet regularly, with exceptions only of vacation and illness. If either the resident or the supervisor is concerned that the weekly supervision requirement is not being met, s/he should notify the Program Director.

Goals of Individual Psychotherapy Supervision

Resident and supervisors should consider incorporating each of the following over the course of their supervision:

1. Practice management/Practice Habits – Residents follow a large number of patients with diverse diagnoses and treatment plans. Residents should seek guidance to continually refine their clinical skills including formulation of outpatient cases, treatment selection, realistic goal setting, monitoring of outcome and adjustment of treatment plan. In addition to providing supervision on individual cases, supervisors can help residents view their outpatient practice in terms of case load as well.
 - a. Review of case load – It is required that each resident review every patient in his/her case load with his/her supervisor during the first few weeks of the supervision assignment. The purpose of the review is to determine the goals of treatment for each patient and what course of action will be required to achieve those goals. For on-site supervisors, the residents may bring in the patient charts along with the case load list and for off-site supervisors; the residents should bring the case load list.
 - b. Termination of patient care – Termination/completion of patient care should not be limited to the months prior to graduation, but rather, actively addressed throughout each resident's training. As each patient progress toward meeting their treatment goals, the resident should prepare the patient for termination of that treatment episode. Supervisors play a key role in helping residents address termination issues. Additional termination of cases may occur at the time of graduation from the program or while getting ready to leave the outpatient clinic. It is recommended that the residents begin reviewing their caseloads with their supervisors 3-6 months prior to graduation to determine which

patients should be transferred to new residents and which patients should be discharged from the clinic.

- c. Professional and ethical issues in outpatient psychiatry – Potential topics include informed consent for psychiatric treatment, the appropriateness of the use of sample medications, interactions with pharmaceutical representatives. Balancing patient confidentiality with family concerns and so on.
2. Transference and Counter transference – Understanding patients’ reactions to residents and residents’ reactions to patients is a central component of clinical development. Residents should be open to discussing their transference and countertransference experiences with their supervisors and supervisors should help guide residents to respond correctly.
3. Educational Instruction – Supervision provides a good opportunity for learning and reviewing psychiatric knowledge in the context of specific clinical situations. Residents and supervisors are encouraged to use an evidence based approach to exploring treatment options and developing treatment plans. Review of the relevant psychiatric literature can happen prior to or during supervision sessions. Supervisors should be familiar with:
 - a. informational technology to explore the psychiatric evidence base e.g., web based PubMed search
 - b. practice guidelines such as those published by the American Psychiatric Association and the American academy of child and Adolescent Psychiatry
 - c. treatment algorithms that have been developed for specific psychiatric diagnoses
 - d. Discuss and analyze practice habits.
4. Miscellaneous topics – General supervision sessions may also include other topics as they arise for each resident. These may include discussion of key clinical research topics, writing, documentation/records, career planning, etc.

Individual Psychotherapy Supervision Objectives

In addition to providing residents with close guidance on psychotherapy cases, psychotherapy supervision helps the program assess the competency of residents to perform psychotherapy. Individual psychotherapy supervisors are asked to:

1. Monitor their supervisees’ exposure to patient and notify the Program Director of any problems with access to psychiatric and/or psychotherapy cases
2. Review residents’ patient caseload to ensure adequate experience in all psychiatric modalities, including different types of both short and long term psychotherapies.
3. Ensure the residents are tracking outcome measures (symptom rating scales, global functioning scales, patient satisfaction surveys etc) on their medication management and psychotherapy cases.

4. Review and provide information on practice habits.
5. Informally assess residents' psychiatry and psychotherapy knowledge base
6. Directly supervise psychotherapy sessions if possible
7. Address ethical issues that arise in psychotherapy, e.g., potential for boundary violations, accepting gifts from patients and so on
8. Assist with any remediation efforts as directed by the residency office

Residents are expected to:

1. Maintain an adequate caseloads. Multiple psychotherapy patients need to be seen at least weekly.
2. Select psychotherapy patients for both, short term and long term psychotherapy treatments
3. Bring in audio tapes or videotapes or process notes for review during supervision
4. Review the psychotherapeutic literature relevant to the cases they are reviewing in supervision
5. It is the resident's responsibility to contact the assigned supervisor(s) and work out a time to meet weekly. Residents are required to turn in a monthly log (green sheet) to the residency office that serves as a record of the supervision.

Assignment of Psychotherapy Supervisors

1. Each academic year the resident is assigned 2.
2. Assignments are made at the discretion of the program director taking into account the resident's requests and preferences, year of training and faculty area of expertise.
3. Residents will be assigned a new supervisor(s) each academic year, no resident will have the same supervisor twice unless extenuating circumstances exist and at the discretion of the program director.
4. Supervision is required and shall take place on a weekly basis with the exception of vacations and holidays. Residents will receive a green supervisor log sheet for supervisors to sign each time you meet for supervision. The resident is responsible to turn the log sheet in to the Residency Office at the end of each month.
5. All PGY I residents are assigned a supervisor/mentor. We hope that this supervision will provide a mentor to help to keep you connected with the residency program during your PGY I year and process thoughts and issues on your rotations.
6. Supervision in the PGY2 year will help making the transition from a more medically oriented PGY I year to the rest of your residency which is more psychiatrically oriented.

7. All PGY III & IV and CAP 1 and 2 residents will discuss patients with both psychotherapy supervisors. All resident outpatients should be followed by one of their two outpatient supervisors. Residents seeing outpatients must select two patients for more intensive supervision. These patients should be audio taped and/or one followed via process notes at the discretion of your supervisor. All other patients should be followed by a designated supervisor as well.

VII. CLINICAL RESIDENT SUPERVISION

Lines of Clinical Responsibility in Supervision of Patients

Resident care of patients is always under the direct clinical responsibility and supervision of the attending psychiatrist seeing the patient that day with the resident. When the attending does not directly supervise patient care, supervisors are immediately available by phone or in person. Please see each rotation's Goals and objectives for specific instructions about supervision on that rotation and for a description of progressive responsibilities for patient management

Advancing Direct to Indirect Clinical Supervision

According to the ACGME Specialty-specific Duty Hour Definitions-Psychiatry article VI.A.2.c). (1) a PGY 1 resident must be **directly** supervised (the supervising physician is physically present with the resident and patient) and can move to **indirect** supervision with direct supervision available when they demonstrate competence in:

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

At the conclusion of the PGY1 resident's first month on the Adult Psychiatric Unit the Supervising Attending physician will receive an evaluation through New Innovations listing the criteria as above. A final item stating "the resident is competent in the four stated areas and is competent to be indirectly supervised with direct supervision available" will be included. If the above criteria are checked off as competent the resident may move to indirect supervision, if not, the resident will be re-evaluated at the end of their second month on the Adult Psychiatric Unit. A PGY 1 cannot progress to the level of PGY 2 resident until they are competent in the four areas listed above.

Residents as Supervisors – PGY 2-4

At the conclusion of the PGY1 resident's year the semiannual review committee will discuss the resident's ability to serve as a supervisor starting their PGY 2 year. The Evaluation For Level of Supervision and Supervisory Capability form will be completed by the PD at the final PGY 1 year-end review. If a resident does not meet criteria, as listed above, they will be reassessed in January of the PGY 2 year, and finally in June of the PGY 2 year at their semi-annual review. All residents will be expected to meet the supervisory requirements in order to be advanced to the PGY 3 year –when they will be providing supervision to the PGY 1s-PGY 2s. All residents will be asked to complete and pass the STEP 3/COMLEX 3 by the conclusion of their PGY 2 year and they cannot progress to the PGY 3 year until they have passed. According to the ACGME Specialty-specific Duty Hour Definitions-Psychiatry article PGY 2-4 Residents may provide direct or indirect supervision for more junior residents as long as the following requirements are met:

- a. Both the junior resident and supervising resident should inform the patients of their respective roles in that patients care

- b. Assignment is based on the needs of each patient and the skill (demonstrated competency in medical expertise and supervisory capacity) of the individual supervising resident.
- c. This includes the supervision of PGY 1 residents by PGY 2 residents
- d. An attending physician must always be available to provide back-up supervision, which may be by phone.

VIII. CLINICAL SKILLS EXAMINATIONS (BOARD STYLE DIAGNOSTIC AND INTERVIEW ASSESSMENT)

- a. Guidelines:
 - i. Training programs are required to credential residents in the area of clinical interviewing skills in order for residents to be eligible to take the ABPN Board examination.
 - ii. There are three components of clinical skills that will be assessed are: 1) the doctor-patient relationship, 2) interviewing and data collection, including the mental status exam, and 3) case presentation.
 - iii. During your training, you are required to complete and pass a minimum of 3 Clinical Skills Evaluation (CSE) Assessments, scheduled individually with a patient in the outpatient clinic and a Board Certified faculty reviewer. You may complete more than one Board qualified CSE in a year. The ACGME requires a minimum of one clinical skills assessment during each year of your training.
- b. Annual Interview Assessment exams will take place in the West Fee Psychiatry Clinic for PGY2, PGY3, PGY4, C-1 and C-2 residents. (PGY1 residents will be given an interview assessment at St. Lawrence APU during their in-patient rotation.)
 - i. Forty-five minutes (thirty minutes for PGY1) will be reserved for this exam. The first hour will be devoted to patient interview. The remaining time will be for case presentation and feedback.
 - ii. One board-certified psychiatrist will be assigned to evaluate your interview and case presentation.
 - iii. Residents may bring in paper and a pen to take notes during the assessment. No outlines or prewritten materials will be allowed to be used during the assessment.
 - iv. CSE forms can be found in the clinic, residency office, on New Innovations and on the department website.
 - v. If you do not pass this exercise, you will be given time to remediate with your supervisor after which you will retake the exam. You will retake the exam until you pass.
 - vi. Patient Guidelines:
 - PGY 1,2, 4s will complete their CSE while on the inpatient units. PGY 3s and child fellow will complete their CSEs in the outpatient clinic. ,.
 - General program residents. Your patient will either be an adult or teenager.
 - Other patient options: Volunteer patients will be sought if new patients cannot be scheduled.

- You should disclose to the patient who you are, your level of training and that you are being observed by a faculty member for evaluation purposes.

IX. IN-SERVICE TRAINING EXAM: PRITE

Each year the PSYCHIATRY RESIDENT IN-TRAINING EXAMINATION (PRITE) is taken in the fall. ALL psychiatry interns and residents must take this exam. The PRITE provides a reasonably objective external criterion used by training programs to scrutinize curriculum content, goals and effectiveness. The content of this examination and the policies governing its use are determined by democratic processes that seek to incorporate a broad segment of the educational community. These policies include specific safeguards, such as firm guarantees of confidentiality for individual residents and training program, and prohibitions on the use of results for certification or pass-fail purposes.

This in-training examination is taken by residents in all stages of training (including beginners), and substantial performance data are provided to participating training programs. The primary objective is to provide educationally useful feedback for individuals and groups in the form of comparisons with peers in specific areas of knowledge.

Each resident receives a detailed computer and analysis of his or her test performance in comparison with other residents at a similar level of training. Each training director receives statistical summary data comparing his or her training program with other groups of participants. In addition, each training director receives copies of test results of individual residents.

Representatives of The American College of Psychiatrists, American Academy of Child and Adolescent Psychiatry, American Association of Directors of Psychiatric Residency Training, American Psychiatric Association, Association for Academic Psychiatry, and a neurology consultant comprise the PRITE Editorial Board who develop the examination.

Content Categories for the PRITE Titles of the 14 categories are in capital letters; the outlines are clarifications and conventions, but are not meant to be full definitions. PRITE consists of 300 questions and is administered in two parts. The content areas covered in the PRITE are:

- I. NEUROLOGY AND NEUROSCIENCES
 - A. Clinical neurology
 - B. Neurologic diagnostic procedures
 - C. Neuropathology
 - D. Neuropharmacology and neurochemistry, except if item is a good fit for the Somatic Treatment Methods category below
 - E. Sleep physiology
- II. PSYCHIATRY
 - A. GROWTH AND DEVELOPMENT
 - 1. Normal development (biological, cognitive, psychodynamic, personality)
 - 2. Death and mourning
 - 3. Most of analytic theory except therapy and psychopathology
 - 4. Normal psychosexual functioning and behavior

- B. ADULT PSYCHOPATHOLOGY
 1. All psychiatric disorders except "Disorders Usually First Evident in Infancy, Childhood, or Adolescence" as classified by DSM IV
 2. All psychiatric disorders not classified by DSM IV
 3. Sleep and arousal disorders
 4. Differential diagnosis
 5. Symptoms and descriptive terminology
 6. Biological, dynamic, and other descriptive or etiologic models
 7. Family pathology, child abuse, spouse abuse
- C. EMERGENCY PSYCHIATRY
 1. All items about suicide
 2. Crisis interventions
 3. Differential diagnosis in emergency situations
 4. Treatment methods in emergency situations
 5. Homicide, rape, other violent behavior
- D. BEHAVIORAL SCIENCE AND SOCIAL PSYCHIATRY
 1. Learning theory
 2. Psychology not elsewhere classified
 3. Theories of normal family organization, dynamics, communication
 4. Theories of group dynamics and process
 5. Ethology, anthropology, sociology, etc.
 6. Transcultural psychiatry
 7. Community mental health
 8. Epidemiology (including epidemiology of suicide)
 9. Research methodology and statistics
- E. PSYCHOSOCIAL THERAPIES
 1. All forms of psychotherapies (group, individual, family, behavioral; theory and practice)
 2. Treatments of psychosexual dysfunctions
 3. Hypnosis
 4. Doctor-patient relationship
- F. SOMATIC TREATMENT METHODS
 1. Pharmacotherapy of mental disorders (including indications, technique of prescribing, side effects, complications, pharmacokinetics, etc.)
 2. Pharmacology of psychotherapeutic drugs
 3. Mechanism of action
 4. ECT and other somatic therapies
 5. Biofeedback
- G. PATIENT EVALUATION AND TREATMENT SELECTION
 1. Psychological testing
 2. Laboratory methods used in psychiatry (biological markers of functional disorders, work-up for organic mental disorders, etc.)

- 3. Mental status examination
- 4. Diagnostic interviewing
- 5. Treatment comparisons and selection
- H. CONSULTATION-LIAISON PSYCHIATRY
 - 1. Specific syndromes (such as stress reactions, post-partum disorders, pain syndromes, post-surgical and ICU reactions, etc.)
 - 2. Psychiatric aspects of nonpsychiatric illness
 - 3. Psychiatric complications of nonpsychiatric treatments
 - 4. Psychosomatic and somatopsychic disorders
 - 5. Models of consultation-liaison psychiatry
- I. CHILD PSYCHIATRY
 - 1. Assessment and treatment of children and adolescents
 - 2. Disorders usually first evident in infancy, childhood, or adolescence
 - 3. Other disorders in children and adolescents
 - 4. Mental retardation and developmental disabilities (except if item is exclusively neurological)
- J. ALCOHOLISM AND SUBSTANCE ABUSE
- K. GERIATRIC PSYCHIATRY
- L. FORENSIC PSYCHIATRY

X. NEW INNOVATIONS PROCEDURES

- a. Logging In
 - i. Visit www.new-innov.com
 - ii. Institution: lansing
 - iii. username: firstinitiallastname (ie ASMITH)
 - iv. password: same as log in for first time, please change your password after initial log-in
 - v. Note: residency office can reset your password at anytime
- b. Duty Hours
 - i. You must log your hours worked every day. Do not include lunches as it will create a short break violation. Overnight home call can be documented as well
- c. Evaluations
 - i. You will receive notification that you have an evaluation to complete, either log-in to New Innovations to complete or follow the link in the email
 - ii. Complete the evaluation; some evaluations are automatically anonymous while others are elective anonymity. Please choose which you would prefer.
 - iii. You also have to sign off on evaluations completed on you by attending physicians and your program director's semi-annual review. This counts in your overall compliance.
- d. Seminar Schedules/Surveys
 - i. Your seminar schedule will show up on a calendar and in a list. This will show the most up-to-date schedule for seminars, presentations and other required times
 - ii. Many seminars will include a survey which you are required to complete. A notification should be sent out after the seminar is over to complete the survey. Please do this right away. These are anonymous as well.
- e. Patient Logging
 - i. You are required to log any patient not seen in the Outpatient clinic every day. Please choose from the appropriate diagnosis and attending and identify the patient by initials.
- f. Scholarly Activity
 - i. On the New Innovations top toolbar click on Portfolio>Scholarly Activities
 - ii. Click the link that says "New" to add an item

- iii. Choose the type of Scholarly Activity you would like to log
- iv. Certifications/Trainings: Any certificate of completion for a training or certification that you complete (could be from a conference or online training). *Note: some trainings/certifications (ACLS/BLS/HIPAA etc) are maintained and tracked in another place. This is for anything extraneous. Feel free to double check if you have any questions.
- v. Chapters/textbooks: if you want to record any interesting thing you have read.
- vi. CME credit: This is just to log any “CME credits” you may have earned doing an online webinar or other conference that wouldn’t be covered under another category.
- vii. Conference Presentation: any non-department related presentation.
- viii. Grand Rounds Presentation: please upload your presentation for each grand rounds you complete.
- ix. Internal presentation: for any journal club or other presentation you do that is department-related.
- x. Medical Student Teaching: any time/materials used in teaching medical students.
- xi. Senior research: please upload your senior research here.
- xii. Put in the required information and pick the core competencies you feel it covers. Upload any related documents (not always required, but this way you will always have quick access to them) and add any other contributors that you would like.
- xiii. You can go back and edit your activity at a later time and the coordinator has access to add/edit items as well.

g. Resources

- i. All forms, schedules, manuals and required documents will be included in this section. Please check here or the residency office prior to emailing about a form.

XI. PROCEDURE FOR SEMI-ANNUAL REVIEW WITH THE TRAINING DIRECTOR

- a. Scheduling
 - i. Occur in January and June.
 - ii. Residency office will schedule a block of time and excuse the resident from their rotation.
 - iii. Review form will be completed in New Innovations and resident will be required to sign off on the form.
- b. Items that must be completed for review
 - i. Self-assessment
 - ii. Evaluations of rotation attendings
 - iii. Evaluations of rotation
 - iv. Scholarly Activity
 - v. Patient Logs
 - vi. Seminar Surveys
 - vii. Duty Hours
 - viii. Psychotherapy supervisor logs and evaluation (must be done, not reviewed)
- c. Discussion items
 - i. Evaluations from attending supervisors on rotations
 - ii. Psychotherapy Supervision
 - iii. Attendance
 - iv. PRITE/Board Scores
 - v. Psychotherapy patients
 - vi. Duty Hours/Sleep Deprivation
 - vii. CSEs
 - viii. CQI projects
 - ix. Scholarly Activity
 - x. Patient Logs
 - xi. Student/Patient Evaluations

XII. HAND-OFF PROCEDURES

| 2011 ACGME Common Program Requirements: Handoffs | Joint Commission: National Patient Safety Goal, Handoffs |
|---|---|
| <ul style="list-style-type: none"> • Programs must design clinical assignments to minimize the number of transitions in patient care. • Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes that facilitate both continuity of care and patient safety. • Programs must ensure that residents are competent in communicating with team members in the hand-over process. • The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care. | <ul style="list-style-type: none"> • Implement a standardized approach to "handoff" communications including an opportunity to ask and respond to questions <p>Expectations:</p> <ul style="list-style-type: none"> • Interactive communications: opportunity for questions • Minimum content: Up-to-date information <ul style="list-style-type: none"> • Interruptions are limited • Process for verification: "read-back" • Opportunity to review prior care • Allocation of schedule for handoffs |

General guidelines:

1. The goal is to train residents in close collaboration with clinical service/system in safe and effective patient handoffs. Handoff training will be synchronize with the processes that will be used by each specific service.
2. Resident handoff competence will be assessed during the rotation by their supervisor. Assessment of competence in giving and receiving sign-out will be assessed for each resident at the conclusion of the rotation through New Innovations.
3. Addition measurement including; audit of written transfer summaries, direct observation with structured feedback and multi-source feedback will be used in the varied settings. Standardize both written and verbal sign-out will be used in the inpatient psychiatric setting.
4. The primary responsibility will lie with each clinical service and the supervisor of that service.

Index of Rotations:

1. Adult Inpatient Psychiatry/Administrative Psychiatry – St Lawrence APU/GEMs
 2. Geriatric Psychiatry
 3. Child and Adolescent Outpatient Psychiatry
 4. MSU Psychiatry Clinics – Outpatient Psychiatry
 5. Community Mental Health Psychiatry
 6. Emergency Psychiatry/Forensics
 7. Addiction Medicine Psychiatry
 8. Consultation/Liaison Psychiatry
- Electives

Adult Inpatient Psychiatry /Administrative Psychiatry

St. Lawrence APU:

Weekly Schedule:

AM Monday-Friday: Multidisciplinary Team Meeting (Safety Huddle) and nursing report attended by residents and supervising physician.

8:00 AM Monday: The administrative APU resident will use morning report to inform all residents on the rotation of what changes were made during the weekend.

8:00 AM Tuesday-Friday: The resident who was on call during the previous night will inform the admin resident of any patient updates prior to morning report. The admin resident will use morning report to inform all the residents of changes that occurred overnight. The residents will then takeover responsibility for their assigned patients until sign-out that day.

Daily Rounds: All residents who are rotating on the psychiatric unit along with the supervising physician will meet daily. All patients will be reviewed. The discussion will be led by the administrative APU resident. Any changes that were done that morning and any potential issues for the afternoon will be reported to the resident on call that evening prior to 5pm. Once sign out is complete, the residents and medical students will update the computer based patient sign out program.

- Residents should be on the unit in the afternoons, unless they are scheduled for other resident activities (clinic, supervision, lectures).

Weekday Sign-out:

5:00 PM Monday-Thursday: The admin resident will sign-out to the resident taking call from 5pm-8am.

8:00 AM Tues.-Friday: The weekday on call resident will sign-out to the Admin APU resident prior to 8:00 AM morning report.

Weekend Sign-out:

5:00 PM Friday: The administrative APU resident will contact the resident who is scheduled to be on call for the weekend in order to fully sign out all patients under the care of Team 1.

8:00 AM Monday: The resident who was on call during the weekend will contact the administrative APU resident in order to formally sign out all patients under the care of Team 1.

Information to be included in sign out:

1. Name MR
2. Gender
3. Age
4. Diagnosis
5. Length of stay (Approx)
6. Reason for admission
7. Current meds, therapeutic response, side effects
8. Effective emergency meds
9. Medication allergies, intolerance
10. Compliance
11. Significant safety issues while hospitalized: aggression, agitation, suicidal threats/behavior, falls, refusal of food, stealing, seductiveness/sexual predation, etc
12. Vulnerability due to cognitive impairment, medical condition, severe psychiatric conditions. This refers to inpatients at risk for victimization by others due to these conditions. Adults needing legal guardians often fall into this category.
13. Psychiatric goal(s): symptom improvement required for discharge.
14. Current psychiatric condition
15. Disposition, Barriers to discharge
16. Medical problems & pending tests
17. Legal status, significant legal issues (capacity, guardianship, mediation over objection, AOT, etc)
18. Communication/therapeutic alliance/counter transference issues
19. Significant collateral information & contact information

Assessment of Handoffs:

1. The supervising physician will be present during the daily sign-out. They will provide direct observation with structured feedback that will be given immediately. The weekday and weekend supervising physicians will review the written sign-out sheet daily.
2. The supervising physician will assess the interactive communication including: Opportunity for questions, up-to-date information, interruptions, “read-back” verification, review of prior care
3. Allocation of schedule for handoffs will be completed by the Admin APU Resident and monitored by the supervising physician.
4. Resident’s initial evaluations, progress notes and discharge summaries will be reviewed by the Admin APU resident and reviewed and signed by the supervising physician.

5. At the conclusion of the rotation the supervising physician will receive an evaluation through New Innovations which will include an assessment of the resident's competence in giving and receiving handoffs.

Geriatric Outpatient Psychiatry:

During the rotation on Geriatric psychiatry, the resident will be working directly with the supervising physician and will be under direct supervision throughout, in every treatment venue. Patient treatment is provided by the resident who is being supervised by the attending physician throughout. The attending physician will discuss all patients with the resident on a daily basis and provide direct feedback regarding patient issues. Patient will not be transferred between residents or supervising faculty. When the resident leaves the service the attending physician will continue to care for the patient. Residents do not provide call or coverage for the unit after normal business hours. The supervising physician will provide the resident with direct observation and structured feedback will be given throughout the rotation.

Child and Adolescent Psychiatry:

During the child and adolescent psychiatry rotation the resident will be working directly with the supervising physician and will be under direct supervision throughout, in every treatment venue. Patient treatment is provided by the resident who is being supervised by the attending physician throughout. The attending physician will discuss all patients with the resident on a daily basis and provide direct feedback regarding patient issues. Patient will not be transferred between residents or supervising faculty. When the resident leaves the service the attending physician will continue to care for the patient. Residents do not provide call or coverage for the unit after normal business hours. The supervising physician will provide the resident with direct observation and structured feedback will be given throughout the rotation.

Community Mental Health:

During the OP/CMH rotation (1.5 days per week) at CEI-CMH the resident will be working directly with the supervising physician and will be under direct/indirect supervision with the supervising physician immediately available. Patient treatment is provided by the resident who is being supervised by the attending physician throughout. The attending physician will discuss all patients with the resident on a daily basis and provide direct feedback regarding patient issues. Patient will not be transferred between residents or supervising faculty. When the resident leaves the service the attending physician will continue to care for the patient. Residents do not provide call or coverage for the service after normal business hours. The supervising physician will provide the resident with direct observation and structured feedback will be given throughout the rotation.

Outpatient Clinic Patient –MSU Department of Psychiatry:

During the 12-15 month rotation on outpatient psychiatry the resident will be working directly with the supervising physician and will be under direct/indirect supervision with the supervising physician immediately available. Patient treatment is provided by the resident

who is supervised by the attending physician. The attending physician will discuss all patients with the resident on a daily basis at group checkout (11:30am and 4:30pm) and will provide direct feedback regarding patient issues. The supervising physician will provide the resident with structured feedback.

Termination and Transfers:

Beginning approximately 3 months prior to the end of the outpatient rotation each resident is given a patient list to begin planning for each patient's continuing care after they leave the outpatient clinic. The resident may transfer the patient to another resident, community psychiatrist or back to the PCP. Prior to the end of the rotation the resident reviews their cases with the clinic director and other residents at the Monday Morning Clinic Conference supervised by the clinic director. Patient dispositions are decided. A Termination/Transfer Form is completed on every patient the resident has seen during the rotation.

- If the patient is stable on medication, and is not receiving psychotherapy services from the clinic, the resident discusses the possibility of transferring ongoing care to the patient's primary care physician or community psychiatrist. The resident then contacts the primary care physician/psychiatrist and makes arrangements for the transfer of care and forward of documentation as appropriate. The resident then completes the transfer/termination summary form and forwards it to the clinic director. The clinic director reviews the documentation and signs to confirm all necessary information are included and the disposition is appropriate.
- In the event that the patient will be requiring continued services within the clinic, either medication, psychotherapy, or both services, the resident discuss with the patient the possibility of a transfer to another resident. The treating resident consults with other residents in the clinic who are available to accept a new patient. Both the treating resident and the accepting resident should sign the form and forward it to the clinic director. The treating resident provides the accepting resident with the following:
 1. A verbal report on the history and current status of the case.
 2. A completed Transfer/Termination Summary form which includes
 - Name, age, DOB, MRN
 - Date of initial evaluation
 - Date of transfer
 - Diagnosis
 - Treatment summary
 - Therapy summary
 - Progress toward goals
 - Medications, doses, side effects
 - Special considerations
 - Compliance

- The Transfer/Termination Summary form is also completed for patients who have completed treatment, or who have dropped out of treatment. The form should be signed by the resident and forwarded to the clinic director.

Assessment of Handoffs:

1. The clinic director will supervise handoffs/transfers of care during the Monday Morning Clinic Conference. He will provide direct, immediate feedback.
2. The clinic director will assess the interactive communication including: opportunity for questions, up-to-date information, interruptions, “read-back” verification, review of prior care.
3. Resident’s initial evaluations, progress notes and discharge summaries will be reviewed and signed by the supervising physician.
4. At the conclusion of the rotation the clinic director will receive an evaluation through New Innovations which will include an assessment of the resident’s competence in giving and receiving handoffs.

Emergency Psychiatry/Forensics:

During the rotation at the CEI-CMH ES the resident will be working directly with the supervising physician/psychologist and will be under direct supervision throughout. Patient treatment is provided by the resident who is being supervised throughout. The supervisor will discuss all patients with the resident on a daily basis and provide direct feedback regarding patient issues. The patient will not be transferred between residents or supervising faculty. The acute nature of the setting does not necessitate transfer between residents or other physicians. Residents do not provide call or coverage for the unit after normal business hours. The supervisor will provide the resident with direct observation with structured feedback will be given throughout the rotation.

Consultation Liaison:

During this rotation at Sparrow Hospital the resident will be working directly with the supervising physician and will be under direct supervision/indirect supervision with direct supervision immediately available. Patient treatment is provided by the resident who is being supervised throughout. The supervisor will discuss all patients with the resident on a daily basis and provide direct feedback regarding patient issues. The patient will not be transferred between residents. Residents do not provide call or coverage for the service. The supervisor will provide the resident with direct observation and structured feedback will be given throughout the rotation.

Elective Rotations:

Hospice and Palliative Care

Hope Network

Dialectical Behavioral Therapy

During the elective rotations the resident will be working directly with the supervising physician and will be under direct supervision throughout. Patient treatment is provided by the resident who is being supervised by the attending physician throughout. The attending

physician will discuss all patients with the resident on a daily basis and provide direct feedback regarding patient issues. Patients will not be transferred between residents or supervising faculty. When the resident leaves the service the attending physician will continue to care for the patient. Residents do not provide call or coverage for elective rotations. The supervising physician will provide the resident with direct observation and structured feedback will be given throughout the rotation.

Elective Rotation:

Olin Health Center

During the rotation at Olin Student Health Center the resident will be working directly with the supervising physician and will be under direct/indirect supervision with the supervising physician immediately available. Patient treatment is provided by the resident who is being supervised by the attending physician throughout. The attending physician will discuss all patients with the resident on a daily basis and provide direct feedback regarding patient issues. Patients will not be transferred between residents or supervising faculty. When the resident leaves the service the attending physician will continue to care for the patient. Residents do not provide call or coverage for the service after normal business hours. The supervising physician will provide the resident with direct observation and structured feedback will be given throughout the rotation.

Addictions Psychiatry:

During this rotation on the Addictions Service at Sparrow Hospital the resident will be working directly with the supervising physician and will be under direct/indirect supervision with direct supervision immediately available throughout the week days M-F from 8am-5pm. Patient treatment is provided by the resident who is being supervised by the attending physician throughout. The attending physician will discuss all patients with the resident on a daily basis and provide direct feedback regarding patient issues. When the resident leaves the service the attending physician will continue to care for the patients. During regular business hours M-F, the supervising physician will provide the resident with direct observation with structured feedback will be given throughout the rotation.

Home Call Unit(s) Coverage:

Monday-Friday 5pm-8am: APU ONLY: By 5pm each evening the admin resident will call the on-call resident and hand-off the patients. Prior to 8am the on-call resident, will call the day resident and provided verbal sign-out. Verbal Sign-out will be monitored by the supervising physician. The Attending physician will maintain ultimate responsibility throughout.

5:00 PM Friday: The resident taking over weekend coverage will contact the Admin APU resident (APU)/Attending physician (GEMs) to complete sign-out under the supervision of the attending physician.

8:00 AM Monday: The resident who was on call during the weekend will contact the Admin APU resident/Attending physician in order to formally sign out all patients under their care.

Information to be included in sign out:

1. Name MR
2. Gender
3. Age
4. Diagnosis)
5. Length of stay (Approx)
6. Reason for admission
7. Current meds, therapeutic response, side effects
8. Effective emergency meds
9. Medication allergies, intolerance
10. Compliance
11. Significant safety issues while hospitalized: aggression, agitation, suicidal threats/behavior, falls, refusal of food, stealing, seductiveness/sexual predation, etc
12. Vulnerability due to cognitive impairment, medical condition, severe psychiatric conditions. This refers to inpatients at risk for victimization by others due to these conditions. Adults needing legal guardians often fall into this category.
13. Psychiatric goal(s): symptom improvement required for discharge.
14. Current psychiatric condition
15. Disposition, Barriers to discharge
16. Medical problems & pending tests
17. Legal status, significant legal issues (capacity, guardianship, mediation over objection, AOT, etc)
18. Communication/therapeutic alliance/counter transference issues
19. Significant collateral information & contact information

Assessment of Handoffs:

1. The supervising physician will be present during the daily rounds. They will provide direct observation with structured feedback that will be given immediately. The weekday and weekend supervising physicians will review the written sign-out sheet daily.
2. The supervising physician will assess the interactive communication during the rotation including:
3. Opportunity for questions, up-to-date information, interruptions, “read-back” verification, review of prior care
4. Allocation of schedule for handoffs will be completed and monitored by the supervising physician.
5. Resident’s initial evaluations, progress notes and discharge summaries will be reviewed and signed by the supervising physician.
6. At the conclusion of the rotation the supervising physician will receive an evaluation through New Innovations which will include an assessment of the resident’s competence in giving and receiving handoffs.

XIII. GUIDELINES AND POLICY ON SOCIAL NETWORKING FOR MSU PSYCHIATRY RESIDENCY PROGRAMS

This policy applies to MSU psychiatry residents when they are engaging in social networking activity online. Social networking includes email, blogging, micro-blogging, Facebook and similar services, and other online portals that focus on free exchange of information across networks of individuals and organizations.

Social networking is a standard part of social interaction. In addition to personal uses, such networking can help extend the reach of the department and residency and can enhance learning and values. In some situations, it may contribute to particular projects.

Psychiatrists have a particular responsibility when engaging with others socially in whatever setting to act in ways that promote professionalism, to never cross professional boundaries and to maintain absolute patient confidentiality. The following are a set of principles for using the potential of social networking:

Be Transparent:

Always be honest. Use your real name, only. If you wish, information about your profession and place of employment may be placed on social networking sites but you should identify yourself as a psychiatry resident. It is important to identify any vested interest you have in what you are discussing.

Please refrain from giving medical or psychiatric advice through a social network. This applies to “expert opinions” because you are residents and not medical/psychiatric content experts yet. As well, any opinions you give will inevitably be linked with the department.

NEVER comment on patients or your day to day work/job on social media, in any capacity.

Do NOT communicate with patients through social media.

Be Judicious:

Everything you post in a social networking environment will live forever. Simply deleting material from a site is no guarantee that others have not copied conversations, pictures or other material or that these are not on another site. This includes your words, music, and videos. Do not report on any private conversations without the permission of everyone who participated. Do not write critical material about individuals or organizations. Don't write about what you don't know about without a disclaimer. Any comments you do make are not to be considered an opinion of the Dept of Psychiatry at MSU. Never the less even with these qualifications, we strongly recommend that you refrain from giving medical or psychiatric advice through a social network.

Remember that potential employers now often check Facebook and other sites as they review potential employees. A good standard is to never put anything in writing that you would not like to see in a newspaper.

It's a Conversation:

Talk to other people as though you were in the same room with them. Harsh comments and any suggestions of bullying or racial or ethnic prejudice has absolutely no place in these conversations. Avoid preaching and lectures. Feel comfortable talking about personal experience as long as you don't mind everyone in the world knowing. Cite others whose public comments bear on the issue.

Confidentiality is an important issue and you should consider whether you wish to allow your content to be shared or not. Even if you believe your comments are not public, never put anything on the internet you do not wish to have viewed by others, as there is no perfect confidentiality, and in a legal situation, any material you have produced may be obtained by a friendly or unfriendly attorney.

XIV. CHIEF RESIDENT DUTIES

- Chief residents serve as the liaison between the faculty and residents. They attend meetings, conferences and educational seminars to strengthen their administrative skills while advocating for the residency majority. It is expected that the Chief Resident(s) will delegate tasks as indicated, and focus on those tasks that are of highest priority. The following is a list of duties for the Chief Resident(s) and a description of the selection process. This list is not all-inclusive. This list should expand and contract as indicated.
- **Chief Resident(s) Selection Process:**
 - The Chief Resident(s) will be elected yearly.
 - The Chief Resident(s) will be elected each year in November
 - Term of service begins January 1st and terminates on December 31st of the following year
 - Residents may nominate any PGY 3 resident in good standing to become Chief Resident
 - The residents will submit their nominee choices to the Residency Education Director
 - The REC must approve of the nominees prior to the election
 - The election is completed by formal secret ballot with each resident allowed one vote. Votes are tallied by the residency coordinator and then submitted to the Residency Director and REC for final approval
- **Meetings:**
 - Attend REC meetings (monthly)
 - Attend GMEC (Graduate Medical Education Committee) meetings
 - Attend Residency Education Director/Chief Resident Meetings (monthly)
 - Attend Outpatient Clinic meetings with Dr. Giuliano and staff (2x month)
 - Attend residency applicant ranking committee meetings
 - Receive a \$1500 stipend to attend Terry Town Chief Resident Leadership Conference.
- **Scheduling:**
 - Maintain MSU/APU call schedule
 - Maintain Holiday MSU call schedule
 - Assist with Journal Club scheduling and review of articles
 - Assist residency coordinator in planning of residency events
 - Assist residency coordinator with "Drill and Grill."
 - Create the monthly residency newsletter/reminder of dates
- **Miscellaneous:**
 - Serve as liaison between residents and faculty/administration
 - Interview prospective applicants
 - Organize resident retreat (once per year) and resident gatherings
 - Find coverage or fill in when other residents are unavailable for duties
 - Answer rotation questions and orient other residents to New Innovations
 - Orient 1st year residents to the APU, OP and residency

- Mentor 1st year residents
- **Teaching:**
 - Give lectures, seminars, and clinical instruction to medical students and residents
 - The chief resident(s) should help residents organize large projects
 - Chief residents are responsible for the creation, assignment and scheduling of the IM/FM/Psych lectures
 - SHELF Review monthly: split between chiefs

XV. PROCEDURE FOR COMPLETING GRADUATION REQUIREMENTS

- The resident must have a "Pass" evaluation for each rotation within the training program.
- The resident must "Pass" diagnostic Clinical Skills Evaluations (CSE) each year. Three of these assessments must meet Board requirements.
- The resident must have successfully completed four PRITE examinations (given yearly from PGY 1-4).
- The resident must have a "Pass" evaluation from each psychotherapy supervisor for PGY 1-4.
- The resident must successfully complete all charting and hospital/rotation paperwork associated with each rotation in a timely manner.
- The resident must complete all seminar evaluations in a timely manner prior to graduation.
- The resident must complete a log for each rotation throughout the residency prior to graduation.
- The MSU Psychiatry Residency Program requires a scholarly project to be completed and presented at graduation prior to the end of the PGY IV year. The project must be written in journal submission format.
- The resident must demonstrate ethical professional behavior both inside and outside all work settings.
- The resident must complete all final checklists distributed by the residency office through the New Innovations system.

XVI. ON-CALL PROCEDURES

Telephone Coverage

1. The Resident On-Call (ROC) does not need to be "in-house" so long as he or she is available by telephone or beeper.
2. The on-call resident covers all university service patients at St. Lawrence Adult/McLaren GEMs Psychiatric Unit. The resident should not cover any non-university patients.
3. The resident also covers any resident university outpatients. These calls typically come through the answering service.
4. For resident patients who are out of medications, the ROC should try to get in touch with the prescribing resident if possible. If this is not possible, and the medication request seems reasonable, the ROC may phone in a one or two day supply of the medication. If the resident is not comfortable or licensed for this, he or she should contact the faculty backup. The resident then remotely accesses the EMR and created a phone note in the patient's chart and e-prescribe as necessary.
5. The on-call resident will notify and update the treating resident that they spoke with their patient while on call.
6. **All FACULTY outpatients should be referred to the faculty backup by the answering service.** If faculty are unavailable the resident is to call the Residency Education Director the next working day. The resident should not be contacted about these cases unless the faculty backup cannot be reached.
7. For outpatients who are in crisis, but not having an emergency, the resident may try to contact their treating doctor, either resident or faculty. If the ROC needs assistance to deal with the situation, he or she should get the faculty back-up involved as soon as possible.
8. If the patient is experiencing an emergency the patient should immediately be referred to the emergency room/call 911. Or 911 should be called on their behalf to ensure safety

APU Coverage Overview

1. The St. Lawrence Adult Psychiatric Unit (APU) will be covered by the psychiatric and rotating residents assigned to the unit on a monthly basis. These residents are responsible for covering the unit from 8am until 5pm, Monday thru Friday.
 - a. Admissions
 - b. Discharges
 - c. Calls from nursing and staff
 - d. Seclusions and restraints
 - e. Medication questions and medical emergencies
2. From 5pm until 8am every weekday and weekends the resident on call is to cover the APU.
 - a. Admissions
 - b. Discharges
 - c. Calls from nursing and staff
 - d. Seclusions and restraints

- e. Medication questions and medical emergencies
- 3. On Thursdays from 12pm until 5:00pm ALL residents are to attend the resident lunch meeting and seminars. This is protected time and all calls will be taken by the attending physician.
- 4. PGY 2 and 4's have a required continuity clinic one ½ day per week, from 1pm until 5pm. During that time they will answer calls when paged. The other residents on the unit can cross-cover their patients and should be available for the following:
 - a. Admissions
 - b. Discharges
 - c. Calls from nursing and staff
 - d. Seclusions and restraints
 - e. Medication questions and medical emergencies
- 5. PGY I residents are required to have 1 hour of supervision per week. During their supervision time the other residents assigned to the unit are to provide coverage.
- 6. PGY II – IV residents are required to have 2 hours of supervision per week. During their supervision time the other residents assigned to the unit are to provide coverage.
- 7. All residents are responsible for coverage of the unit when they are not in supervision, clinic or seminars between the hours of 8am-5pm Monday thru Friday.
- 8. Admission that present to the unit between 8am and 5pm are to be seen by a resident that same day.
 - a. The resident may need to return to the unit after seminars, supervision or clinic to complete the admissions that presented between 1pm and 5pm.

APU/GEMs Call Overview

1. ACGME rules mandate that only PGY 2-4 residents are eligible for at home call.
2. Close attention is being paid to physician handoffs. Handoffs of patients must be completed in an accurate and systematic fashion from resident to resident and from resident to attending when transferring patient care.
3. PGY 2 residents are considered to be at the intermediate level with respect to a supervisory role.
4. Residents at the PGY 3 level or beyond are considered to be in the final years of education.

Monday- Friday from 5pm-8am (APU only) a PGY 2-4 will be assigned to home call with an attending physician having primary responsibility, indirectly supervising and available by phone.

Saturday 8am-8am Sunday a PGY 2-4 will be assigned to round in the hospital with an attending physician having primary responsibility and directly supervising/or indirectly supervising but immediately available. After rounding, a PGY 2-4 will be assigned to home call with an attending physician having primary responsibility, indirectly supervising and available by phone. A PGY 1 may be assigned to accompany the PGY 3-4 and attending on rounds and will be directly supervised throughout.

Sunday 8am-Monday 8am a PGY 2-4 will be assigned to round in the hospital with an attending physician having primary responsibility and directly supervising/or indirectly supervising but immediately available. After rounding, a PGY 2-4 will be assigned to home call with an attending physician having primary responsibility; indirectly supervising and available by phone. A PGY 1 may be assigned to accompany the PGY 3-4 and attending on rounds and will be directly supervised throughout.

APU Admissions

1. Residents are not required to go in for every admission unless individual patient circumstances require them to be seen by a psychiatrist. Admission orders must be Promptly entered into the EMR.

2. The admission procedure is as follows:
 - a. Complete psychiatric evaluation
 - b. Added data from collaborative sources if needed.
 - c. Documentation of evaluation
 - d. On Saturdays and Sundays, do a history and physical examination (if not done in the ED within the last 24 hours), which must be placed in the EMR within 24 hours.
 - e. Enter orders into EMR.
 - f. Obtain necessary consent forms.

APU/GEMs Rounds On Weekends/Holidays

1. Take place at Sparrow Hospital St. Lawrence Campus/McLaren Greater Lansing GEMs
2. Faculty will round with the ROC (and a PGY 1 resident when assigned) on weekends. Please call the faculty on back-up to arrange the time to meet.
3. Notes are to be completed on all university patients after being seen by the resident and weekend attending physician.
4. All patients must have a history and physical exam on the chart within 24 hours of admission.
5. All patients are seen by the faculty on call, and the ROC on the weekend and holidays.
6. Rounds on Thursday (seminar days) are required for SLH-APU prior to seminars.
7. Residents are expected to return to the SL-APU/GEMs after Thursday seminars to complete admissions of patients that arrived before 5:00 p.m.

Resident Backup

Formal resident backup (Buddy System) is assigned for the first month a PGY 2 is on call. Traditionally, the senior residents and chiefs are available for informal back-up at any given time. This means that the ROC is encouraged to call one of the PGY 3 or 4's any time they feel the need and without hesitation. There is always a faculty member on call and supervising the resident on call. A resident should never hesitate to call the faculty on call with any questions or concerns.

Emergencies/Seclusion Restraint at the APU/GEMs

The St. Lawrence ED is located on the first floor of the St. Lawrence campus. Patients will be admitted to the GEMs unit from local ED or hospital facilities. Patients with medical emergencies can be immediately transferred to the respective ED by faculty, residents or nurses. If the patient has an urgent issue the resident can call the faculty on call and request that the psychiatry attending speak with the ED physician regarding evaluation in the ED. All urgent medical concerns (non-emergencies) should be evaluated by the resident in person on the unit. If a patient needs seclusion/restraint the resident must report to the unit and evaluate the patient within one hour of the call from nursing.

Duty Hours/Home Call Time Off

1. Duty hours are limited to 80 hours per week averaged over a 4 week period inclusive of all in-house duties (anytime they are in the hospital) and in-house call activities.
2. Residents must be scheduled for a minimum of one day free of duty every week. At home call cannot be done on free days.
3. The ACGME requires 8 hours free of duty between scheduled duty periods.
4. Time spent in the hospital by a resident on at-home call must count toward 80 hour maximum weekly hour limit.
5. The frequency of at-home call must satisfy the requirement of 1 day off in 7 (averaged over 4 weeks).
6. Residents cannot do call or moonlight during regularly scheduled work hours 8:00 a.m.-5:00 p.m. M-F.
7. Our residents are limited to 8 hours of moonlighting per week; all moonlighting experiences in total.
8. If the ROC needs to go into the hospital they must have at least 8 hours free of hospital duty prior to returning to the unit the next morning. If they have less than 8 hours the ROC is to call their APU supervisor and residency director in the morning and arrangement will be made for the resident to arrive on the unit late ensuring that the ROC has at least 8 hours free of duty.
9. Resident must have 14 hours free of clinical work and education after a 24 hour in house call.

XVII. GOALS AND OBJECTIVES BY YEARS OF TRAINING

PGY-1 Goals and Objectives

General Medical and Neurological Services

- Residents learn general medical diagnosis and treatment and are able to localize pathology.
- Residents learn the pathophysiology of common medical and neurological disorders.
- Residents develop an understanding of common diagnostic procedures.
- Residents gain understanding of the behavioral manifestations of various disorders, especially those related to the central nervous system.
- Residents accurately perform a physical and neurological examination.
- Residents diagnose and manage common medical disorders

General Psychiatry

- Residents demonstrate knowledge of major mental illness including psychotic disorders, affective disorders, anxiety disorders and preliminary understanding of personality disorders.
- Residents demonstrate a working knowledge base of DSM-V diagnostic criteria for common adult mental disorders treated on an inpatient unit.
- Residents develop a beginning understanding of psychopharmacologic strategies used to treat major mental illness.
- Residents understand the indications for and precautions associated electroconvulsive therapy.
- Residents demonstrate the ability to do a complete psychiatric history and examination on the adult inpatient.
- Residents are able to formulate a case and administer an appropriate five axis DSM-V diagnosis on all patients they assess/treat.
- Under attending supervision, residents are able to use pharmacological agents such as antipsychotics, anxiolytics, and mood stabilizing medications and antidepressants effectively.
- Residents participate in individual, marital and group therapy for those patients assigned. Special effort is made to provide a group psychotherapy experience during the inpatient experience.
- Residents are able to participate in the administration of electroconvulsive therapy.
- Residents are able to triage psychiatric emergencies associated with on-call experience and on-service patients including but not limited to suicidality, medication reactions, discharge issues, behavioral disturbance and milieu issues.
- Residents demonstrate knowledge of late life major mental illness including psychotic disorders, affective disorders, dementia, anxiety disorders and personality disorders. This knowledge extends to an appreciation of how medical illness may affect behavior and psychiatric disorders in older adults
- Residents demonstrate a working knowledge base of DSM-IV diagnostic criteria for common late life psychiatric disorders treated in a geropsychiatric inpatient unit.

- Residents understand the psychopharmacologic strategies used to treat late life major mental illness in this setting, with an appreciation for altered pharmacokinetics and drug interactions in the elderly.
- Residents are able to describe supportive psychotherapy and understand its role in patient treatment.
- Residents understand the indications for and precautions associated with electroconvulsive therapy.

PGY-2 Goals and Objectives

General Psychiatry

- Residents demonstrate an understanding of the indications for individual, marital, milieu and group psychotherapy. They understand supportive psychotherapy and its role in patient treatment.
- Residents supervise and provide didactics for medical students rotating on the inpatient psychiatry service.
- Residents appreciate the variety of psychotherapies available to treat psychiatric disorders and are able to distinguish between them as well as to decide which approach would be most helpful for an individual patient. These therapies include short-term psychotherapies, long-term psychotherapies and individual/group/marital and family therapies.
- Residents learn to conceptualize a biopsychosocial formulation for all patients evaluated and treated.
- Residents understand the impact of managed care upon treatment and are able to effectively work with third party payers.
- Residents gain increased knowledge of pharmacotherapy in the outpatient setting.
- Residents demonstrate competence in the comprehensive interview and assessment of outpatients including a thorough history, DSM-V diagnosis, biopsychosocial formulation, diagnosis/prognosis and psychological testing if indicated.
- Residents develop a treatment plan including short and long-term goals.
- Residents use appropriate psychotherapy skills and techniques with each patient and is able to follow patients throughout the course of their illness.
- Residents use laboratory data in the management of outpatients.
- Residents use medication alone or in combination with psychotherapy in an outpatient setting.
- Residents are able to monitor physical signs and symptoms in outpatients on medication
- Residents work collaboratively with community professionals/resources/third party payers in a collaborative mode.
- Residents become familiar with the variety of settings in which chronic patients reside and receive care.
- Residents learn how to make a comprehensive biopsychosocial assessment of a patient, including identifying specific needs that must be met in order for the patient to live a stable life in the community.

- Residents develop knowledge of disability assessment, both for treatment planning purposes and to help the patient obtain needed financial support services.
- Residents develop increased knowledge of psychosocial interventions including skill training and environmental supports. This knowledge base includes both traditional and nontraditional approaches, for individuals or groups.
- Residents improve knowledge of psychopharmacology including the indications, side-effects and costs of psychotropic medications, with an emphasis on using them effectively in an outpatient setting.

Geriatric Psychiatry

- Residents demonstrate the ability to do a complete psychiatric history and examination on the older adult with special attention to mental status changes seen in late life psychiatric disorders.
- Residents are able to formulate a case and administer an appropriate five axis DSM-IV diagnosis on all patients evaluated and treated. The resident appreciates the interface between medical illness and psychiatric disorders in this population.
- Under attending supervision, the residents are able to use pharmacologic agents such as antipsychotics, anxiolytics, mood stabilizing medications and antidepressants effectively, titrating dosage and administration for the altered physiological needs of older adults.
- Residents participate in individual, marital and group therapy for those patients assigned.
- Residents are able to triage psychiatric emergencies in older patients including suicidality, medication reactions, acute medical assessment and appropriate consultation, discharge issues, competency issues, behavioral disturbance and milieu issues.
- Residents obtain exposure to psychological testing and outcomes as part of the older adult's treatment plan.

Child and Adolescent Psychiatry

- Residents learn about child and adolescent psychopathology with a focus on DSM-V diagnosis.
- Residents gain knowledge of the process and importance of consultation and liaison with other mental health and community professionals.
- Residents develop an increased knowledge base in childhood psychopharmacology with an appreciation for the unique application of medications in this population. The resident knows the indications for and use of antipsychotic, stimulant, selective serotonin uptake inhibitor, anticonvulsant and anxiolytic medications.
- Residents gain an understanding of the therapeutic relationship with each patient and is able to identify developmentally appropriate assessment and therapeutic strategies for each age group.
- Residents gain an understanding of the importance of family relationships in the assessment and treatment of psychiatric disorders in children and adolescents.
- Residents demonstrate proficiency with child and adolescent interviewing skills.

- Residents demonstrate the ability to evaluate children and adolescents and determine an appropriate five-axis DSM-V differential diagnosis.
- Residents demonstrate an understanding of appropriate treatment plans in collaboration with a multidisciplinary treatment team, patient and family.
- Residents demonstrate the ability to communicate the treatment plan to the patient, family and community support system.
- Residents demonstrate beginning understanding of psychotherapy techniques (e.g. CBT, Problem Solving) with selected children, adolescents and families.
- Residents demonstrate effective consultation and liaison skills with mental health professionals, health professionals and other community resources.
- Residents read scholarly literature in child and adolescent psychiatry and demonstrates understanding of the application of scientific literature to clinical problems.

Addictions Medicine

- Residents will understand the prevalence of alcohol and drug disorders in general population.
- Residents will understand the effectiveness of treatment for alcohol and drug disorders in general population
- Residents will understand the mechanisms of action for pharmacological treatments of alcohol and drug disorders
- Residents will understand the psychosocial justifications for treatment of alcohol and drug disorders
- Residents will understand the assessment and treatments for comorbid medical and psychiatric disorders
- Resident will explain the effectiveness of group and individual therapies for alcohol and drug disorders
- Residents will explain the likely effect of a physician's recommendation for a patient to abstain from alcohol or drugs
- Residents will explain the multiple roles of personnel in addiction treatment
- Residents will explain the characteristics and time course for withdrawal from alcohol and drugs
- Residents will explain the role of a physician in a multidisciplinary approach to addiction treatment.

PGY 3 Goals and Objectives

- Residents understanding the legal concepts of and processes involved in involuntary commitment of adults.
- Residents improve their knowledge base regarding patient dangerousness and are able to list risk factors associated with assault.
- Residents improve their knowledge base regarding patient dangerousness to others and are able to list risk factors associated with harm to others.

- Residents gain increased knowledge of community resources for crisis resolution and appropriate triage of patients.
- Residents improve their skill in triage of patients to inpatient/ partial hospitalization so that patients receive the appropriate level of care.
- Residents assess dangerousness, including suicidality and homicidality, and make appropriate interventions.
- Residents properly triage patients.
- Residents carry out short-term crisis intervention for individuals and families in 2-3 sessions.
- Residents initiate short-term medication treatment for patients in crisis or who are decompensating and transfers care appropriately.
- Residents use community resources appropriately and are able to make direct referral when needed.
- Residents gain skill in dealing with emergency services staff in triaging cases and case consultation.

PGY 4 Goals and Objectives

- Residents develop more extensive knowledge of the psychopathology of psychosomatic disorders, their DSM-IV criteria, appropriate differential diagnosis and diagnostic formulation.
- Residents gain more specific understanding of and ability to work in collaborative relationships with primary care physicians, specialists, nursing and ancillary health care professions.
- Residents gain more specific understanding of and ability to treat behavioral aspects of organic disease processes including delirium, dementia, seizure disorders and cardiopulmonary disease.
- Residents gain an understanding of the psychiatric side effects and drug interactions of many medications used to treat multisystem disease.
- Residents gain greater understanding of the psychodynamics of illness, grief and loss and coping strategies.
- Residents improve their understanding of judgment and the issue of competency to refuse/accept medical treatment.
- Residents develop comprehensive biopsychosocial evaluation skills including an effective psychiatric history and interview.
- Residents are able to create a reasonable differential diagnosis, formulation and treatment plan for each patient, taking into account the impact of their medical illness, coping strategies and environmental supports.
- Residents are able to effectively use pharmacologic agents to manage common consultation/liaison behavioral and symptomatic problems.
- Residents coordinate interaction with other physicians involved in the patient's care and respond to concerns in an effort to coordinate treatment.
- Residents identify psychiatric emergencies within the hospital and are able to appropriately triage cases to maximize effective interventions in a timely manner.

- Residents provide short-term therapies to patients and families in crisis within the inpatient medical setting.
- Residents gain understanding of the issues involved with competence to stand trial.
- Residents develop knowledge of severe personality disorder presenting in jail settings.
- Residents obtain increased understanding of diagnostic techniques useful in differentiating malingering from other psychiatric disorders.
- Residents learn about the link between violent crime and psychiatric disorders.
- Residents develop skills needed to evaluate patients for commitment hearings
- Resident gain skills in working with a chronically psychiatrically ill prison population.
- Residents improve diagnostic techniques to assess malingering from other psychiatric problems.
- Residents evaluate individuals in the jail setting with new onset of psychiatric disorders.
- Residents learn how to provide testimony in court settings.

XVIII. GENERAL PSYCHIATRY RESIDENCY COMPETENCIES BY PROGRAM YEAR

PGY-1 Resident

Goals: *By the end of the PG-1 year, the resident will obtain the knowledge, skills, and attitudes to foster confidence and competence in the basic skills of medical, neurological, and psychiatric assessment; diagnosis and treatment of patients; and in the six areas of the general competencies.*

Medical Knowledge:

- Diagnostic and treatment approaches to common medical and surgical disorders
- Diagnosis and management of common neurological disorders
- Interpretation of diagnostic studies, including laboratory tests and electrocardiograms
- Ethical practice standards
- Principles of psychiatric interviewing that is sensitive and HIPAA-compatible, psychiatric history-gathering, and mental status examination
- Understanding of common psychiatric emergencies
- Psychiatric symptoms and differential diagnosis of the major psychiatric disorders, including mental disorders related to general medical conditions
- Indications for and alternatives to psychiatric hospitalization
- Civil commitment procedures in Michigan
- Indications, usual doses, and side effects of the major psychotropic medications
- Community linkages to services for chronically mentally ill patients
- Basic principles of psychodynamic theory and psychological assessment
- Understanding of the relevance of cultural diversity, gender, race, ethnicity, socioeconomic status, religion, spirituality, and sexual orientation in biopsychosocial assessment
- Principles of psychiatric formulation

Skills:

- Conducts a thorough physical examination, including a comprehensive neurological exam
- Initiates and directs initial treatment plans for patients with common medical and neurological disorders
- Provides limited, but appropriate, continuous care of patients with medical illnesses and makes appropriate referrals as needed
- Conducts a thorough psychiatric interview
- Assesses mental status and reports it in an organized manner
- Documents clinical work clearly and in a timely manner that meets institutional policies
- Assesses patient dangerousness to self and others and manages appropriately

- Initiates and directs the diagnostic assessment and evaluation of psychiatric inpatients
- Develops a preliminary treatment plan, including pharmacological, supportive, social, and behavioral interventions
- Demonstrates the safe and competent use of psychopharmacologic agents
- Participates as an effective member of a multidisciplinary inpatient treatment team
- Conducts supportive psychotherapy with psychiatric inpatients
- Prepares adequate discharge summaries and after-care plans
- Teaches medical students

Attitudes:

- Internalization of certain values, including professionalism, conscientiousness, honesty, and reliability
- Maintenance of a professional presentation in speech, attire, and demeanor
- Interest in learning and regular attendance at teaching activities
- A high regard for the principles of ethical behavior, confidentiality, and cultural sensitivity in the physician-patient relationship
- Caring and compassion for patients and awareness of the negative stigma attached to psychiatric illness
- Respect for the contributions made by other medical and mental health professionals

PGY 1 General Competencies (Assessed through Milestone Evaluations)

Patient Care:

- Demonstrates the ability to utilize appropriate interviewing techniques
- Demonstrates the ability to conduct a thorough physical and neurological examination
- Performs and documents a psychiatric history and mental status examination
- Demonstrates the ability to assess potential for self-harm and harm to others, as well as how to intervene appropriately
- Develops and documents a *DSM* differential diagnosis
- Develops and documents a basic case formulation
- Develops and documents an appropriate evaluation plan, e.g., labs; imaging; physical, neurological, and psychological assessment
- Develops and documents a biopsychosocial treatment plan
- Demonstrates a beginning ability to conduct individual psychotherapy

Medical Knowledge:

- Demonstrates knowledge of the signs, symptoms, and epidemiology of the major psychiatric disorders

- Demonstrates knowledge of patient evaluation, including psychological testing, lab methods, mental status examination, diagnostic interviewing, and treatment planning
- Demonstrates knowledge of psychotropic medications and psychosocial therapies

Practice-Based Learning and Improvement:

- Accepts limitations in his/her knowledge base
- Demonstrates how to obtain up-to-date information from the scientific literature and other sources to assist in patient care, e.g., Medline, medical libraries, drug information databases
- Maintains patient logs and reviews patient records
- Obtains, accepts, and utilizes supervision

Interpersonal and Communications Skills:

- Develops and maintains constructive and ethical therapeutic relationships with patients
- Works collaboratively with professional colleagues and patients' families members
- Transmits information to patients and families in a clear and constructive fashion
- Maintains psychiatric medical records that are legible, timely, and capture essential information while protecting confidentiality
- Understands, with assistance, his/her own affects and countertransference that may influence treatment

Professionalism:

- Demonstrates responsibility for patient care, including appropriate transfer or referral if necessary
- Responds to communications from patients and health professionals in a timely manner
- Exhibits professional, ethically sound behavior and attitudes in patient and professional interactions
- Demonstrates respect for culturally diverse patients and colleagues

Systems-Based Practice:

- Has a working knowledge of some of the systems used in treating adults
- Has knowledge of available community resources
- Assists patients in accessing appropriate psychiatric care and supportive services
- Demonstrates knowledge of behavioral health systems, including how to educate patients in their use, participate in utilization review activities, and advocate for necessary patient care with a supervisor's assistance

PGY2 Resident

Goals: *By the end of the PG-2 year, the resident will obtain the knowledge, skills, and attitudes to provide psychiatric care to adults, adolescents, and children in a variety of settings. The resident will demonstrate continued personal and professional growth in the six areas of the general competencies and will begin to address the need to become competent in five specific types of psychotherapy.*

Additional Knowledge:

- Human growth and development through the life cycle
- Relevance of family systems in the evaluation and treatment of both the elderly and minors
- Diagnostic and treatment approaches to patients of varying ages and clinical presentations in a variety of clinical settings
- Interactions between medical illnesses with symptoms likely to be regarded as psychiatric, as well as psychiatric disorders likely to be regarded as due to general medical conditions
- Models of consultation, including the difference between consultation and liaison
- Recognition of psychiatric emergencies
- Application of triage and crisis intervention in patients in the emergency psychiatry setting
- Psychiatric diagnosis and differential diagnosis of the major psychiatric disorders, including those that are substance-induced
- Provision of care to chronically mentally ill patients via a wide range of psychopharmacologic, psychotherapeutic, and social rehabilitative interventions
- Indications and contraindications for ECT
- Application of a variety of psychotherapies to the treatment of psychiatric disorders
- Awareness that psychopharmacologic treatment in the elderly as well as minors differs from that used in many adults
- Principles of forensic psychiatry and how those may differ from clinical psychiatry
- Relevance of self-help groups and rehabilitative services in specific patient populations

Additional Skills:

- Initiates and directs the diagnostic assessment and psychiatric evaluation of patients from age 5 to the very elderly
- Evaluates family and/or support systems as part of a comprehensive evaluation
- Develops a preliminary treatment plan for patients from age 5 to the very elderly, including pharmacological, group, family, social, and behavioral interventions
- Recognizes the indications, risks, side effects, expected benefit, and alternatives to a range of psychotropic medications
- Makes admission decisions with only minimal supervision
- Recognizes and is able to treat delirium

- Is able to make recommendations regarding a patient's capacity for medical decision-making
- Prescribes psychotropic medications appropriate for medically ill patients
- Recognizes and is able to plan the interdisciplinary treatment of acute and chronic substance use disorders
- Conducts ECT when indicated, under direct supervision

Additional Attitudes:

- Appreciates the limits of current psychiatric knowledge
- Is receptive to and curious about contemporary neuroscience as well as various psychotherapeutic approaches to patient care

PGY2 General Competencies (Assessed through Milestone Evaluations)

Patient Care:

- Demonstrates the ability to conduct therapeutic interviews
- Performs and documents a comprehensive psychiatric history and examination of patients of varying ages
- Develops and documents an integrated biopsychosocial case formulation
- Demonstrates more skill in conducting individual psychotherapy
- Demonstrates a beginning ability to conduct group and family therapeutic interventions
- Performs and documents emergency psychiatric evaluations of adults

Medical Knowledge:

- Demonstrates knowledge of human growth and development across the life cycle
- Demonstrates knowledge of substances of abuse
- Demonstrates knowledge of forensic psychiatry
- Demonstrates knowledge of behavioral science, learning theory, family systems, and group dynamics

Practice-Based Learning and Improvement:

- Regularly seeks information from the scientific literature and other sources to assist in patient care
- Demonstrates a beginning ability to critically evaluate psychiatric literature
- Evaluates his/her caseload in a systematic manner and is able to describe patient outcomes

Interpersonal and Communication Skills:

- Uses negotiation, when appropriate, to develop an agreed upon treatment plan with patients and families
- Understands and manages, with supervision, his/her own affects and Countertransference

- Obtains, interprets, and evaluates consultations from other medical specialties
- Participates as a full member of a multidisciplinary treatment team

Professionalism:

- Arranges backup coverage with minimal supervision
- Exhibits consistently professional and ethically sound behavior and attitudes in patient and professional interactions
- Insures continuity of care for patients

Systems-Based Practice:

- Has knowledge of diverse systems used in treating adults, adolescents, and children
- Has knowledge of a wider array of community resources
- Demonstrates the ability to interact with managed behavioral health systems, educate patients in their use, and participate in utilization review activities and advocate for quality patient care with minimal guidance

PGY3 Resident

Goals: *By the end of the PG-3 year, the resident will obtain the knowledge, skills, and attitudes to independently provide adult outpatient services, including evaluation, diagnosis, case formulation, and treatment planning by using a full array of modalities including pharmacotherapy and psychotherapy. The resident will demonstrate continued advancement toward attaining the six areas of general competencies and the five psychotherapy competencies.*

Medical Knowledge:

- Psychiatric assessment and differential diagnosis of all psychiatric disorders
- Brain neurotransmitter and receptor systems and their clinical relevance in psychiatry
- Typical dynamics evident in group processes
- Indications for individual, group, and family therapy
- Theories of at least two models of brief psychotherapy
- Theories of cognitive-behavioral therapy
- Indications for treating a patient with brief or long-term psychotherapy
- Theories relevant to psychodynamic psychotherapy
- How to monitor for side effects as well as adherence to psychotropic medications
- Recognition of the challenges involved in integrated and split (sharing with another mental health professional) treatment
- Awareness of the entire spectrum of professional and community resources available to patients

Skills:

- Independently conducts a comprehensive psychiatric evaluation of outpatients

- Integrates data to develop a comprehensive case formulation that includes presentation; predisposing, precipitating, perpetuating, and protective factors; patterns; prognosis; and treatment planning
- Diagnoses and treats a wide spectrum of psychiatric disorders, using a combination of medication and one or more psychological and/or social interventions
- Identifies examples of resistance, transference, countertransference, clarification, confrontation, and interpretation when treating outpatients
- Provides continuous care for a variety of patients with different demographics and diagnoses, who are seen regularly for an extended period of time
- Is able to provide crisis intervention services within the outpatient setting
- Initiates and/or continues psychotherapy with outpatients, including brief and long-term psychotherapy, cognitive-behavioral therapy, combined psychotherapy and psychopharmacology, psychodynamic psychotherapy, and supportive psychotherapy
- Recognizes the impact of drug-drug interactions among psychotropic agents, as well as with other medications and complementary therapeutic agents
- Functions as a leader of a multidisciplinary outpatient treatment team

Attitudes:

Demonstrates growing awareness of personal biases, psychological blind spots, and idiosyncratic limitations

PGY3 General Competencies (Assessed through Milestone Evaluations)

Patient Care:

- Develops and documents a complete case formulation
- Demonstrates the ability to conduct a focused psychiatric evaluation in 30 minutes

Medical Knowledge:

- Demonstrates more sophisticated knowledge of psychosocial therapies
- Demonstrates knowledge of efficient and effective treatment selection
- Demonstrates knowledge of psychiatric administration, including leadership of outpatient interdisciplinary teams, utilization review, quality assurance, and performance improvement

Practice-Based Learning and Improvement:

- Understands the need to be continuously receptive to learning
- Provides information from the scientific literature and other sources to outpatients
- Demonstrates more sophisticated ability to critically appraise psychiatric literature
- Evaluates practice experience in a systematic manner

Interpersonal and Communications Skills:

- Maintains therapeutic relationships with difficult patients
- Independently understands and manages his/her own affects and countertransference

- Able to lead a multidisciplinary outpatient treatment team

Professionalism:

- Independently establishes backup coverage arrangements
- Exhibits professional and ethically sound behavior and attitudes in all but the most difficult patient and professional interactions
- Insures continuity of care for outpatients and when it is appropriate to terminate care, including how to do so administratively
- Demonstrates more sophisticated knowledge of medical ethics

Systems-Based Practice:

- Independently advocates for optimal patient care

PGY 4 Resident

Goals: *At the end of the PG-4 year, the resident will possess the knowledge, skills, and attitudes to have achieved competency in the six general areas of medical practice and in the five psychotherapeutic modalities specified for psychiatry.*

Medical Knowledge:

- Epidemiology of most psychiatric disorders
- The application of ethical principles to commonly encountered clinical and professional dilemmas involving psychiatric practice
- Greater knowledge of psychiatric administration, including leadership of inpatient interdisciplinary teams, utilization review, quality assurance, and performance improvement
- Community resources and services in the public sector for chronic mentally ill patients
- Basic research methodology
- Awareness of how to access tools to assist in entering clinical practice

Skills:

- Competence in teaching medical students and junior residents
- Ability to produce a scholarly paper and give a scientific presentation to a professional audience
- Competence in the diagnosis and treatment of a wide range of psychiatric disorders, including patients with personality disorders
- Emerging competence in an administrative role, including planning and coordinating educational activities, and using delegated authority to lead multidisciplinary treatment teams

Attitudes:

- Awareness that professional education only begins during residency and that he or she is committed to lifelong learning

PGY 4 General Competencies (Assessed through Milestone Evaluations)

Patient Care:

- Develops and documents a complete *DSM* multi-axial differential diagnosis
- Independently admits and transfers patients to various levels of appropriate care
- Demonstrates the ability to independently diagnose and treat a wide spectrum of psychiatric disorders, using a combination of medication and psychological and social interventions
- Demonstrates the ability to conduct a range of psychotherapies using accepted techniques
- Demonstrates the ability to lead multidisciplinary treatment teams in order to efficiently and effectively treat a wide variety of patients in multiple settings

Medical Knowledge:

- Demonstrates comprehensive knowledge of most psychiatric disorders
- Demonstrates advanced knowledge of pharmacotherapy
- Demonstrates knowledge of a broad range of psychosocial therapies
- Demonstrates knowledge of research methodologies
- Demonstrates sophisticated knowledge of community services and resources
- Demonstrates how to acquire the tools to enter clinical practice

Practice-Based Learning and Improvement:

- Understands the importance of seeking additional consultation and supervision after residency
- Is committed to lifelong learning

Interpersonal and Communication Skills:

- Able to address public audiences and provide professional information in a meaningful fashion
- Able to lead multidisciplinary teams and recognize their unique methods of communicating with patients, families, staff members, and each other
- Able to teach a wide variety of health professionals

Professionalism:

- Able to exhibit professional, ethically sound behavior and attitudes in all patient and professional interactions

Systems-Based Practice:

- Able to access multiple services for patients in a wide variety of settings and is committed to seeking new and innovative resources so that patients can be empowered to be full partners in their psychiatric care

XIX. INVOLUNTARY ADMISSIONS UNDER THE MENTAL HEALTH CODE

330.1424 Application for hospitalization; contents; execution; penalty.

Sec. 424.

(1) An application for hospitalization of an individual under section 423 shall contain an assertion that the individual is a person requiring treatment as defined in section 401, the alleged facts that are the basis for the assertion, the names and addresses, if known, of any witnesses to alleged and relevant facts, and if known the name and address of the nearest relative or guardian, or if none, a friend if known, of the individual.

(2) The application may be made by any person 18 years of age or over, shall have been executed not more than 10 days prior to the filing of the application with the hospital, and shall be made under penalty of perjury.

330.1425 Execution of physician's or psychologist's clinical certificate.

Sec. 425.

A physician's or a licensed psychologist's clinical certificate required for hospitalization of an individual under section 423 shall have been executed after personal examination of the individual named in the clinical certificate, and within 72 hours before the time the clinical certificate is filed with the hospital. The clinical certificate may be executed by any physician or licensed psychologist, including a staff member or employee of the hospital with which the application and clinical certificate are filed.

330.1426 Protective custody; receipt of application and physician's or psychologist's clinical certificate by peace officer; transportation.

Sec. 426.

Upon delivery to a peace officer of an application and physician's or licensed psychologist's clinical certificate, the peace officer shall take the individual named in the application into protective custody and transport the individual immediately to the preadmission screening unit or hospital designated by the community mental health services program for hospitalization under section 423. If the individual taken to a preadmission screening unit meets the requirements for hospitalization, then unless the community mental health services program makes other transportation arrangements, the peace officer shall take the individual to a hospital designated by the community mental health services program. Transportation to another hospital due to a transfer is the responsibility of the community mental health services program.

330.1430 Examination; time; certification.

Sec. 430.

If a patient is hospitalized under section 423, the patient shall be examined by a psychiatrist as soon after hospitalization as is practicable, but not later than 24 hours, excluding legal holidays, after hospitalization. The examining psychiatrist shall not be the same physician upon whose clinical certificate the patient was hospitalized. If the psychiatrist does not certify that the patient is a person requiring treatment, the patient shall be released immediately. If the psychiatrist does certify that the patient is a person requiring treatment, the patient's hospitalization may continue pending hearings convened pursuant to sections 451 to 465.

330.1100c Definitions; P to R.

Sec. 100c.

(3) "Person requiring treatment" means an individual who meets the criteria described in section 401.

(4) "Physician" means an individual licensed by the state to engage in the practice of medicine or osteopathic medicine and surgery under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(10) "Psychiatrist" means 1 or more of the following:

(a) A physician who has completed a residency program in psychiatry approved by the accreditation council for graduate medical education or the American osteopathic association, or who has completed 12 months of psychiatric rotation and is enrolled in an approved residency program as described in this subsection.

(b) A psychiatrist employed by or under contract with the department or a community mental health services program on March 28, 1996.

(c) A physician who devotes a substantial portion of his or her time to the practice of psychiatry and is approved by the director.

(11) "Psychologist" means an individual licensed to engage in the practice of psychology under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, who devotes a substantial portion of his or her time to the diagnosis and treatment of individuals with serious mental illness, serious emotional disturbance, or developmental disability.

XX. PROCEDURE FOR INTERACTING WITH PHARMACEUTICAL REPRESENTATIVES

While we welcome interaction with pharmaceutical representatives, we do place some restrictions on activity related to residents.

- Pharmaceutical representatives may not meet with residents in the department without prior approval from the chair and training director.
- Pharmaceutical representatives may make brief presentations during sponsored lunches for residents. Any outside speakers who may accompany representatives will have to be pre-approved by the department chair and residency training director.
- Pharmaceutical representatives will be invited to discuss their current medications with residents at resident lunch (10 – 15 minute presentation).
 - A faculty member will be in attendance.
 - Lunches will be funded by the Department of Psychiatry and representatives will not be permitted to distribute gifts of any kind.
 - They may distribute literature and brochures.
 - After they present they will be excused and the faculty member will lead a discussion regarding the presentation.