Psychiatry Residency Rotations Goals & Objectives

PGY 1 Rotations

Psychiatric Resident on Family Medicine Service

Via Christi Family Practice Residency Goals & Objectives for the Adult Medicine Rotation PGY 1

Via Christi Family Practice Residency Preparation and Policies for the Adult Medicine Rotation PGY 1 Reading List

Adult Inpatient Psychiatry Curriculum

Emergency Medicine

Emergency Psychiatry Curriculum

Internal Medicine – VA Psychiatry Residents Goals and Objectives

Inpatient Psychiatry Rotation

Neurology Goals and Objectives

Resolving Conflicts Mohamed Ramadan, M.D. Wichita, Kan.

Psychiatric Resident on Family Medicine Service
Updated 9/2010

In order to provide the most beneficial education for the visiting Psychiatry resident, and to allow them to have a satisfactory rotation, the following Adult Medicine policy has been crafted for your understanding. These were designed in conjunction with the department of Psychiatry as to their desired educational needs for the adult medicine experience for the psychiatry residents. The overall expectations and requirements by both programs are as follows:
1. The psychiatry resident should arrive each morning at 0600 sharp for check out of the previous night’s admissions and distribution of patients among the team (including the psychiatric resident on the service for the month).

2. The psychiatry residents on the FM service are to see all of their assigned patients each morning. All residents should note that if the census is low, that the upper level residents on the service may round as well on some (or all) of your patients.

3. The psychiatry residents should expect to take calls from the hospital staff and consultants on their patients even after leaving the hospital for the day. Should they need another resident on service to cover for them when they are out of town or unavailable, they can arrange this with one of the senior residents on service.

4. The psychiatry residents should write an order (legibly) identifying themselves as the resident caring for the patient and to direct all calls to them through the paging system when first coming in contact with their assigned patients [“All calls to Dr. [your name]”]. This will allow the nursing staff, the residents on call, the attending physician or any consultants to know whom to contact for any questions or problems on your patient.

5. The psychiatry residents are expected to be at all scheduled meetings for the Adult Medicine Service including checkout (0600), disposition/social work rounds (0900), morning rounds (0915), Teaching rounds and case presentations (1045) unless otherwise excused for other required obligations (these other obligations should be identified at the beginning of the service month so that the supervising residents can account for your absence at those times and make sure that the patients are being covered).

6. You are expected to remain in the hospital and assist with admissions each weekday afternoon (following your required noon conference obligations) until 5 pm. If you have other required meetings or obligations that you must attend, please discuss these with the senior resident on the service as soon as you are aware of the obligations so that your absence will be excused.

7. You are not expected to take call on the Adult Medicine service in the evenings because of your own Psychiatry call, and following a night of psychiatry call, you should round on your patients on the family medicine service that you have been assigned, and work towards leaving the hospital by noon (keeping the 30-hour shift in mind). You should feel comfortable asking the upper level residents on the service to help you with your patients if needed.

8. You should provide a schedule at the beginning of the month from your department stating all of your Psychiatry on-call nights and other responsibilities (i.e. conferences, meetings) so that you are not inadvertently scheduled for Adult Medicine responsibilities.

9. We are aware that the psychiatry residents do not have their own clinics during the month on the Family Medicine service and so other than required meetings and conferences; you will be expected to be around so that you can manage and learn about adult medicine care issues.

10. At the end of the month a detailed evaluation on New Innovations (online) will be submitted concerning your rotations with us. As a result, it is important to be seen and involved with the various attendings on the service (both the FM Faculty and the KIS attendings).

11. We sincerely hope that you enjoy the month and learn the appropriate adult medical care that will benefit you in further training towards a career in Psychiatry.
12. We need your input and discussion in terms of your expertise in behavioral health when dealing with our patients. Please share your knowledge with us. You are a valuable part of our team.

Scott Stringfield, MD

Family Medicine (adult medicine) Service Coordinator

Via Christi Family Medicine Residency Program

Comments or questions – Scott_Stringfield@via-christi.org

Via Christi Family Practice Residency Goals & Objectives for the Adult Medicine Rotation PGY Year 1

Patient Care:

<table>
<thead>
<tr>
<th>Overall Goal</th>
<th>Rotation Specific Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Efficient and complete performance of interviews during the gathering of information from the patient.</td>
<td>History Taking:</td>
</tr>
<tr>
<td></td>
<td>❖ Conducts an interview using appropriate verbal and non-verbal skills to accurately understand the patient’s history of the present illness.</td>
</tr>
<tr>
<td></td>
<td>❖ Learns to prioritize and organize oneself during the workup of patients (time efficiency and organizational skills).</td>
</tr>
<tr>
<td></td>
<td>❖ Able to access various electronic record sources within the system in order to form a complete picture of the patient’s past medical history.</td>
</tr>
<tr>
<td></td>
<td>❖ Satisfactory gathering of all pertinent historical data in the workup of patients.</td>
</tr>
<tr>
<td></td>
<td>❖ Knows how to focus on the pertinent negative and positive parts of the history pertaining to the presenting complaint.</td>
</tr>
<tr>
<td>2. Communication</td>
<td>Communication within the context of patient care:</td>
</tr>
<tr>
<td></td>
<td>❖ Obtain information from other sources when indicated to clarify</td>
</tr>
<tr>
<td>3. <strong>Able to perform complete and efficient physical examinations pertinent to the workup of all patients presenting for care.</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Physical Examination:</strong></td>
<td></td>
</tr>
<tr>
<td>✤ Able to efficiently perform complete and efficient physical examinations relevant to the patient’s presenting complaint.</td>
<td></td>
</tr>
<tr>
<td>✤ Utilizes examination tools for the complete workup of the patient.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. <strong>Assessment and analysis of findings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment:</strong></td>
</tr>
<tr>
<td>✤ Recognizes and appreciates the significance of common and expected abnormal physical findings in the ENT, Cardiac, Pulmonary, Gastrointestinal, Genitourinary, Neurologic, Musculoskeletal, and Dermatologic systems pertinent to the patient’s presenting complaint.</td>
</tr>
<tr>
<td>✤ Able to analyze the history and physical findings and understand the physiological and pathophysiological basis for the condition(s) the patient may have.</td>
</tr>
<tr>
<td>✤ Able to summarize in order of importance the clinical, emotional, social, and psychological conditions pertinent to the patient’s situation.</td>
</tr>
<tr>
<td>✤ Develops appropriate bio-psycho-social hypotheses based on available clinical data that apply to the presenting problem.</td>
</tr>
<tr>
<td>✤ Able to prioritize the various conditions and diseases discovered in order to focus and treat the conditions most relevant to the admission and not exhaust the DRG funding available for the admitting diagnosis.</td>
</tr>
<tr>
<td>✤ Able to recognize and document appropriate diagnoses so that optimal billing and reimbursement can be obtained through the hospital system,</td>
</tr>
</tbody>
</table>
5. Proper communication of clinical data and diagnoses to the patient and family members.

<table>
<thead>
<tr>
<th>Patient Sensitivity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Understands and appreciates the patient’s specific needs, background, societal upbringing, and educational background when communicating findings, diagnoses, therapeutic treatments, and prognosis.</td>
</tr>
<tr>
<td>✓ Considers the patient’s cultural background and language skills when trying to communicate the overall patient condition, as well as the direction of care for that patient.</td>
</tr>
<tr>
<td>✓ Understands and appreciates the clinical application of HIPPA when dealing with outside medical personnel and family members involved in the care of their patients.</td>
</tr>
<tr>
<td>✓ Sensitive to diverse patient population without bias.</td>
</tr>
</tbody>
</table>

6. Implementation of Care

<table>
<thead>
<tr>
<th>Therapeutic Intervention and Plan of Care Issues:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Develops a plan of action that attends to the pertinent medical, psychosocial, family, cultural and socioeconomic issues.</td>
</tr>
<tr>
<td>✓ Develops the ability to synthesize all pertinent information in a manner that results in the best clinical outcomes for the patients under their care.</td>
</tr>
<tr>
<td>✓ Proper utilization of sub-specialty consultants</td>
</tr>
</tbody>
</table>

7. Post-Hospitalization Care

<table>
<thead>
<tr>
<th>Post-Hospitalization Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Arranges for appropriate follow-up of the current problem and attends to the special needs of the patient, family or caregiver.</td>
</tr>
<tr>
<td>✓ Incorporates the principles and practice of health maintenance when appropriate.</td>
</tr>
</tbody>
</table>

8. Character Issues in the application of clinical care

<table>
<thead>
<tr>
<th>Character Development Issues:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Compassionate Care</td>
</tr>
<tr>
<td>✓ Strong Patient Advocate</td>
</tr>
<tr>
<td>✓ Delivers Ethical Care that satisfies the patient’s best need and the institution</td>
</tr>
</tbody>
</table>

9. Procedural skills adequate for complete patient care and applicable to “real world” clinical care after leaving the residency.

<table>
<thead>
<tr>
<th>Procedural Skill Development:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Knows when to consider using a procedure or consultant in order to obtain appropriate data in the workup of the patient.</td>
</tr>
<tr>
<td>✓ Appreciates and considers patient safety when analyzing the best means of performing a diagnostic or therapeutic procedure on a patient.</td>
</tr>
</tbody>
</table>
Utilization of various consultants for the successful application of any procedure on the patient, when appropriate.

Cardiovascular Access Procedures (Central Venous Catheter placement, Percutaneous, Arterial Line placement, and PICC line placement)

Resuscitative Procedures (Defibrillation, Endotracheal Intubation, Pericardial Aspiration, and Cardioversion)

Diagnostic Procedures (Paracentesis, Thoracentesis, Chest Tube Insertion, EGD, and Colonoscopy)

Practice-Based Learning and Improvement:

<table>
<thead>
<tr>
<th>Overall Goal</th>
<th>Rotation Specific Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Resident must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.</td>
<td>Self-Assessment of Clinical Care:</td>
</tr>
<tr>
<td></td>
<td>❖ Locates, appraises and assimilates evidence from scientific studies related to patients’ health problems.</td>
</tr>
<tr>
<td></td>
<td>❖ Utilizes the best evidence in the medical literature in the care and treatment of their patients.</td>
</tr>
<tr>
<td></td>
<td>❖ Remain teachable and responsive to new ideas within the medical literature and from the various consultants involved in the care of their patients.</td>
</tr>
<tr>
<td></td>
<td>❖ Grow and continue to learn clinically throughout the rotation</td>
</tr>
<tr>
<td></td>
<td>❖ Be able to realize the growth in knowledge base and utilization of literature and EBM throughout the course of the rotation so that their knowledge base has grown and continues to grow.</td>
</tr>
<tr>
<td></td>
<td>❖ Realizes the need to teach others within the health care team and strives to do that well.</td>
</tr>
<tr>
<td><strong>Builds on Experiences within Medicine:</strong></td>
<td></td>
</tr>
<tr>
<td>❖ Obtains and uses information from their personal population of patients to improve patient care.</td>
<td></td>
</tr>
<tr>
<td>❖ Continues to expand knowledge base in medicine.</td>
<td></td>
</tr>
<tr>
<td><strong>Information Technology:</strong></td>
<td></td>
</tr>
<tr>
<td>❖ Uses information technology to manage information, access on-line medical information and support own education.</td>
<td></td>
</tr>
<tr>
<td>❖ Can access the various health system sources to utilize and implement the best practices within medicine for their patients.</td>
<td></td>
</tr>
<tr>
<td>Overall Goal</td>
<td>Rotation Specific Objectives</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------</td>
</tr>
</tbody>
</table>
| 1. Demonstrates an awareness of and responsiveness to the larger context and system of health care in order to provide optimal, cost effective care. | Consultations:  
- Arranges for appropriate referrals or consults for patients to optimize care.  
- Communicates with the various consultants involved in the care of their patients so as to provide optimal care of their patients. |
| 2. Timely and cost-effective hospitalization care. | Admission and Discharge Planning:  
- Works effectively with health care managers, social workers, coders, and case-managers to provide optimal, timely, and cost effective care.  
- Has an awareness of discharge planning and ultimate achievable care-management goals from admission to timely discharge.  
- Able to prioritize the various conditions and diseases discovered in order to focus and treat the conditions most relevant to the admission and not exhaust the DRG-funding available for the admitting diagnosis. |
| 3. Aware of the need to advocate for the patient for optimum outcomes in health care, as well as a sensitivity to the overwhelming cost of health care and how they can aid the various health care systems in cost-effective delivery of that health care as well as the conservation of resources. | Patient and Institution Advocacy:  
- Is an advocate for quality patient care and assists patients in dealing with system complexities.  
- Advocates and considers the health system as a whole as they attempt to deliver the best care for their patients.  
- Understands how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources. |

**Medical Knowledge:**

<table>
<thead>
<tr>
<th>Overall Goal</th>
<th>Rotation Specific Objectives</th>
</tr>
</thead>
</table>
| 1. Integration and application of overall level of knowledge of basic and clinical sciences. | Understand and articulate the pathophysiologic etiology for the following medical problems: (list problems pertinent for rotation):  
**Cardiovascular Disease:**  
- Arrhythmias  
- Acute Coronary Syndrome, STEMI, NSTEMI, CAD  
- Heart Failure  
- Valvular heart Disease  
- Pre-operative Cardiac Assessment  
- Post-cardiac Surgical care  
- Hypertension and Hypertensive Emergencies  
- Lipid disorders  
**Gastrointestinal Disease:**  
- Peptic ulcer disease |
- Gastroenteritis
- Irritable bowel disease
- GERD-related disease
- Diverticular disease
- Pancreatitis
- ESLD and Liver Failure
- Jaundice

**Pulmonary Disease:**

- Pneumonia
- COPD
- Pulmonary embolus / DVT
- ARDS
- Respiratory Failure and Ventilator Management
- Asthma

**Rheumatology and Immunology:**

- SLE, RA, OA, and other arthropathies

**Hemtology and Oncology:**

- Anemia
- Blood Component Therapy
- Solid Tumors
- Hematologic Malignancies
- Marrow Failure Issues
- Hemostasis
- Platelet Disorders

**Renal Disease and Electrolytes:**

- Acute and Chronic Renal Failure
- Electrolyte abnormalities
- Fluid Resuscitation
- Hyperosmolar non-ketotic coma
- Workup of hematuria
- Workup of Edema
- Nephrolithiasis

**Cerebrovascular and Neurological Disease:**

- CVA / TIA
- Movement disorders
- Seizure disorders
- Peripheral neuropathy
- Dementia
- Encephalopathy and Delerium

**Infectious Disease:**

- FUO
- HIV
- Sepsis Syndrome
- Infectious Hepatitis
- Pyelonephritis
- Tuberculosis

**Endocrinology and Nutritional Disease:**
<table>
<thead>
<tr>
<th>2. Medical Literature and Clinical Study</th>
<th>Demonstrates an understanding to the diagnostic and therapeutic approaches to the above medical problems.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>❖ With each rotation in Family Medicine prepares for the service care challenges through the reading and understanding of the various above topics</td>
</tr>
<tr>
<td></td>
<td>❖ Completion of the pre-rotation reading assignments by PGY year pertinent to the commonly seen clinical care situations (see reading list).</td>
</tr>
<tr>
<td>3. Approaches learning in a teachable and analytic approach in the acquisition of new information used in the care of patients.</td>
<td>Information Utilization:</td>
</tr>
<tr>
<td></td>
<td>❖ Uses electronic resources to provide justification for management decisions.</td>
</tr>
<tr>
<td></td>
<td>❖ Utilizes current and up-to-date medical information resources to provide the best care for their patients.</td>
</tr>
<tr>
<td></td>
<td>❖ Can develop an evidence-based question and use appropriate search vehicles to find an answer.</td>
</tr>
<tr>
<td></td>
<td>❖ Review class, side effect profile and interactions of all medications prescribed.</td>
</tr>
<tr>
<td>4. Understands complex relations and mechanisms of disease and applies this knowledge to clinical problem solving, clinical decision making and critical thinking.</td>
<td>Application of Clinical Knowledge:</td>
</tr>
<tr>
<td></td>
<td>❖ Understands how to use clinical information to prioritize differential diagnoses.</td>
</tr>
</tbody>
</table>

**Professionalism:**
<table>
<thead>
<tr>
<th>Overall Goal</th>
<th>Rotation Specific Objectives</th>
</tr>
</thead>
</table>
| **1. Demonstrates a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to ethnic differences.** | **Professional Responsibility:**  
- Learning to demonstrate a responsiveness to the needs of patients and society that supersedes self-interest.  
- Learning to leads by example (servant-leadership) in the care of patients  
- Exhibits respect, compassion, integrity and accountability.  
- Learning to engage in activities that will foster personal and professional growth as a physician. |
| **2. Professionalism and Leadership** | **Leadership:**  
- Acts decisively  
- Meets problems head-on and attempts to solve them in a timely and sensitive fashion for the best patient outcomes.  
- Fosters team loyalty (vs. independence)  
- Is punctual (on time for service activities and meetings) |
| **3. Demonstrates a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent and business practices.** | **Ethics:**  
- Demonstrates sensitivity and responsiveness to patient’s wishes, culture, age, gender, disabilities and privacy.  
- Provides ethical care adhering to the Hippocratic principles as well as the guidelines and policies of the health care institution |

*Interpersonal Communication Skills:*

<table>
<thead>
<tr>
<th>Overall Goal</th>
<th>Rotation Specific Objectives</th>
</tr>
</thead>
</table>
| **1. Establishes effective therapeutic relationship with patients and families.** | **Therapeutic Relationship:**  
- Learning to discuss sensitive issues that may impact the management plan.  
- Learning to develop a rapport with the patient and family members that allows for effective and timely communication during the hospital stay. |
| **2. Sensitive to Lifestyle Issues** | **Patient Lifestyle Issues:**  
- Learning to effectively and sensitively obtain a complete social history.  
- Learning to counsel about social habits and lifestyle changes in a |
<table>
<thead>
<tr>
<th>3. Communicating Difficult News and Information</th>
<th>Discussing Difficult Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Learning how to relate bad news or uncertainty in an effective and compassionate manner.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Builds patient relationships through listening, verbal and non-verbal skills</th>
<th>Communication Skills Development and Application:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Conducts an interview in a manner consistent with the values of family medicine using appropriate verbal and non-verbal skills.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Provides education/counseling to patients and families.</th>
<th>Patient Education:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Counsels and educates the patient and family regarding a provisional and working diagnosis in a manner which acknowledges the patient as an equal health care partner.</td>
</tr>
</tbody>
</table>

---

**Via Christi Family Practice Residency Preparation and Policies for the Adult Medicine Rotation PGY 1 Reading List**

**Preparation Reading List:**

<table>
<thead>
<tr>
<th>Up-To-Date Articles to read</th>
<th>Rotation Specific Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gathering the Information</td>
<td>Physical Examination:</td>
</tr>
<tr>
<td></td>
<td>- The detailed neurologic examination in adults</td>
</tr>
<tr>
<td></td>
<td>- History and physical examination in adults with abdominal pain</td>
</tr>
<tr>
<td>Procedural skills adequate for complete patient care and applicable to “real world” clinical care after leaving the residency.</td>
<td>Procedural Skill Development:</td>
</tr>
<tr>
<td></td>
<td>- Cardiovascular Access Procedures (Central Venous Catheter placement, Percutaneous Arterial Line placement, PICC line placement)</td>
</tr>
<tr>
<td></td>
<td>- Placement of central venous catheters</td>
</tr>
<tr>
<td></td>
<td>- Arterial catheterization</td>
</tr>
<tr>
<td></td>
<td>- Resuscitative Procedures (Defibrillation, Transcutaneous Temporary Pacing, Endotracheal Intubation, Pericardial Aspiration, Cardioversion)</td>
</tr>
<tr>
<td></td>
<td>- Basic principles and technique of cardioversion and defibrillation</td>
</tr>
<tr>
<td></td>
<td>- Cardioversion for specific arrhythmias</td>
</tr>
<tr>
<td></td>
<td>- Endotracheal tube management and complications</td>
</tr>
<tr>
<td></td>
<td>- Diagnostic Procedures (Paracentesis, Thoracentesis, Chest Tube Insertion, EGD, Colonoscopy, Bone Marrow Aspiration and Biopsy)</td>
</tr>
<tr>
<td></td>
<td>- Tube thoracostomy</td>
</tr>
<tr>
<td></td>
<td>- Diagnosis and evaluation of patients with ascites</td>
</tr>
</tbody>
</table>
Integration and application of overall level of knowledge of basic and clinical sciences.

Understand and articulates the pathophysiologic etiology for the following medical problems: (list problems pertinent for rotation):

**Cardiovascular Disease:**
- Elevated serum cardiac troponin concentration in the absence of an acute coronary syndrome
- Evaluation and management of asymptomatic left ventricular systolic dysfunction
- Acute therapy of sudden cardiac arrest
- Overview of the management of acute ST elevation myocardial infarction
- Overview of the management of unstable angina and acute non-ST elevation myocardial infarction

**Gastrointestinal Disease:**
- Clinical manifestations and diagnosis of acute pancreatitis
- Treatment of alcoholic liver disease

**Hematology and Oncology:**
- Approach to the adult patient with anemia
- Anemia of chronic disease (anemia of chronic inflammation)

**Rheumatology and Immunology:**
- Overview of the clinical manifestations of systemic lupus erythematosus in adults

**Renal Disease and Electrolytes:**
- Dehydration is not synonymous with hypovolemia
- Clinical manifestations and treatment of hyperkalemia
- Simple and mixed acid-base disorders

**Pulmonary Disease:**
- Mechanical ventilation in acute respiratory failure complicating COPD

**Cerebrovascular and Neurological Disease:**
- Classification of stroke
- Overview of the evaluation of stroke
- Initial assessment and management of acute stroke

**Endocrinology and Nutritional Disease:**
- Clinical features and diagnosis of diabetic ketoacidosis and hyperosmolar hyperglycemic state in adults
- Overview of medical care in adults with diabetes mellitus
- General principles of insulin therapy in diabetes mellitus

**Psychiatric-related Medical Problems:**
### Family Medicine Service Policies:

<table>
<thead>
<tr>
<th>Overall Goal</th>
<th>Rotation Specific Objectives</th>
</tr>
</thead>
</table>
| Compliance with Policies                         | ✤ Arrive each morning at 0600 for check-out  
✤ See his/her patients each morning that are assigned to him/her and on rare occasions when the patient census is low, a senior resident may round behind the primary resident.  
✤ Take calls on all of your patients unless check out to another covering resident on the service.  
➤ This requires placing an order on the chart stating, “Calls to [your name].”  
➤ Place an identifying sticker on the front of every chart stating that you are the resident physician and also the attending physician.  
✤ Attend all morning report, rounds, social work checkout, and teaching sessions.  
✤ Help with admissions each weekday afternoon.  
✤ See the patients during the morning after being on call.  
✤ In light of the 30-hour rule, he/she should leave the hospital by noon the day after his/her call night and should feel comfortable asking an upper level resident for assistance in completing your work. |

---

3. Drug Tx for Obesity Achieves Only Modest Results; BMJ 2007; 335 (December): 1194-1199.
4. PPI Co-Therapy Reduces GI Bleeding Risk in ACS Patients; Am J Gastroenterol 2008; 103 (April): 865-871.
9. Metabolic Syndrome: significant Risk Factor for Ischemic Stroke; Stroke 2008; 39 (January 1); 30-35.
10. Zostavas \textsuperscript{R} Decreases Incidence of Zoster, Vaccination in Immunosuppressed Patients. Special Presentation AjitP. Limaye, MD.
12. Personal Touches are Meaningful to Bereaved Families, Chest 2007; 131 (November): 1245-1247
13. Low Rate of Wafarin in AF, Am Heart J 2007; 154 (November): 893-898
14. Pneumococcal Pneumonia Linked to Acute Cardiac Events, Clin Infect Dis 2007;45 (July); 158-165.
15. Risk of Stroke is High after TIA, Arch Intern Med 2007; 167 (December 10/24); 2417-2422.

**Adult Inpatient Psychiatry Curriculum**

**EDUCATIONAL GOALS:**

Development and display in practice the knowledge, skills and attitudes necessary for the optimal clinical care of patients with mental disorders.

Keeping in mind that each learner begins inpatient psychiatry with their own unique skill set and will progress at different rates, Understanding of **RIME** conceptualization of the learning process:

- **Reporter** collects and reports clinical data but has limited ability to meaningfully prioritize and synthesize the data. This role is assumed by beginning learners.
- **Interpreter** can prioritize and interpret clinical data to formulate diagnostic hypotheses and treatment recommendations.
- **Manager** can see the big picture, apply knowledge, develop accurate diagnostic hypothesis, and initiate appropriate evaluation and treatment plans.
- **Educator**, the highest level in this particular hierarchy and the ultimate goal for all learners, continuously involves self-assessment and personal learning efforts to maintain an up-to-date, in-depth knowledge that is readily applied to patient care and the education of colleagues.

There are six competency domains set out by the Accreditation Council for Graduate Medical Education (ACGME – 2000). Competency in all six areas should be achieved by completion of the residency training program. These domains serve as a guideline for understanding the learning goals in residency training. They include:

1. Patient Care - PC;
2. Medical Knowledge - MK;
3. Practice-base Learning - PBL;
4. Interpersonal and Communication Skills - CS;
5. Professionalism - P; and
The specific learning objectives for the inpatient psychiatry rotations support one or more of the ACGME competency domains.

**LEARNING OBJECTIVES, COMPETENCY DOMAINS, EXPECTATIONS AND EVALUATION**

**Learning Objective**
- Be able to perform a risk assessment of designated patients

**Competency Domain**
- PC, MK, CS, SBP

**Expectations**
- Assess patient’s dangerousness, and need for hospitalization
- Interact with the court system regarding involuntary commitment of mentally ill patients

**Feedback and Evaluation**
- Ongoing and timely feedback based on observation resident’s interaction with the patients
- Ongoing and timely feedback based on resident’s interpretation of data and ability to decide when commitment is necessary
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation

**Learning Objective**
- Be able to perform History and Physical Exam
- Be able to perform Mental Status Exam (MSE)

**Competency Domain**
- PC, MK, CS

**Expectations**
- Interview performed in skillful manner - knowledge of different interviewing techniques
- Physical exam (PE), neurological exam and complete Mental Status Exam (MSE) are competently performed

**Feedback and Evaluation**
- Ongoing and timely feedback based on resident’s ability to perform comprehensive patient interview during morning rounds
- Ongoing and timely feedback of resident’s ability to use different and appropriate interviewing techniques during the patient interview
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation
Learning Objective

• Be able to prioritize, organize and interpret clinical data to formulate a relevant, comprehensive differential diagnosis and plan

Competency Domain

• PC, MK, PBL, CS, P

Expectations

• Formulate diagnostic impression supported by clinical data using a biopsychosocial model and accounting for the patient’s ethnic and cultural background
• Develop a plan for further evaluation (appropriate use of laboratory and psychological testing, and consultation)
• Develop treatment plan including Electro Convulsive Treatment (ECT) during the hospitalization and after discharge from the hospital

Evaluation and Evaluation

• Ongoing and timely feedback based on resident’s ability to create concise, accurate summary of collected data regarding their individual patients
• Ongoing and timely feedback based on resident’s ability to apply analytical thinking to propose plan for the correct evaluation of the patient that will lead to correct diagnosis and treatment, ECT workup included
• Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation

Learning Objective

• Be able to engage designated patients and their families in an empathic manner, discuss and demonstrate a range of interviewing techniques

Competency Domain

• PC, MK, CS, P

Expectations

• Build good rapport with the patient, use of empathy
• Knowledge of different interviewing techniques
• Apply interviewing techniques during interview of the patients/their families

Feedback and Evaluation

• Ongoing and timely feedback based on resident’s ability to recognize patient’s needs and adapt to them during the patient’s interview
• Ongoing and timely feedback based on residents ability to recognize importance to communicate with patient’s families in effective manner during the family meetings and phone conferences
• Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation

Learning Objective
- Recognize the importance of collateral history and be able to obtain and interpret information from multiple sources

**Competency Domain**

- PC, MK, CS

**Expectations**

- Understand importance of collateral information for correct diagnosis
- Become skillful at eliciting and interpreting relevant information from patient’s family, prior care givers and other sources
- Review and summarize previous medical records

**Evaluation**

- Ongoing and timely feedback based on resident’s ability to recognize complex cases, the importance of collateral history, collection and interpretation of collected data.
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation will be based on resident’s performance during the team meeting and review of the written documentation

**Learning Objective**

- Demonstrate ongoing efforts to develop expand and apply in practice a knowledge base in general psychiatry particularly in areas relevant to assigned patients

**Competency Domain**

- PC, MK, PBL

**Expectations**

- Become familiar with diagnostic criteria for common psychiatric diagnosis
- Develop working knowledge of treatment for common psychiatric disorders
- Identify gaps in knowledge base and proactively eliminate them (teaching rounds, lectures, self education)
- Direct personal study to topics relevant to assigned patients
- Regularly seek consultation and feedback from attending physician and senior resident

**Evaluation**

- Ongoing and timely feedback based on resident’s ability to formulate the list of differential diagnosis
- Ongoing and timely feedback based on resident’s ability to propose biological and psychological
- Ongoing and timely feedback based on residents ability to use evidence and methods to investigate, evaluate and improve patient care
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation will be based on resident’s performance during the team meeting and review of the written documentation

**Learning Objective**

- Be able to work effectively as a member of your assigned treatment team and as the physician member of a multidisciplinary treatment team

**Competency Domain**
PC, MK, PBL, CS, P, SBP

Expectations

- Attend team meetings and be prepared to present your patient
- Have a working knowledge of assigned patients including target symptoms, problem list, diagnosis and differential diagnosis, current medication, progress during past 24 hours, plan for next 24 hours
- Work effectively with other members of the treatment team and be appropriately respectful to the attending physician team leader
- Attend Multidisciplinary staff meetings and be prepared to contribute in a concise, meaningful manner
- Work effectively with psychologists, nursing staff, social workers, therapists and other allied healthcare personnel

Evaluation

- Ongoing and timely feedback based on residents ability to collect and interpret collected data, formulate the list of differential diagnosis and propose treatment following biopsychosocial model
- Ongoing and timely feedback based on residents ability to identify target symptoms, follow the change in target symptoms with the treatment and adjust the treatment if needed
- Ongoing and timely feedback based on residents ability to work with other treatment team members demonstrating knowledge of optimal health care delivery
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation will be based on resident’s performance during the team meeting and review of the written documentation as well as feedback from other team members (social workers, nurses...)

Learning Objective

- Be able to skillfully document clinical data in a written format including orders, history, and patient progress; routinely review and be familiar with the sections of a medical inpatient chart.

Competency Domain

- PC, MK, PBL, CS,

Expectations

Be familiar with:

- Physician’s Order Sheet, KU Standing Orders, Detox Orders
- Electronic and handwritten H&P form on newly admitted patients
- Admission status on newly admitted patients (voluntary vs. involuntary)
- Daily progress documentation (electronic or handwritten) should include a review of the prior 24 hours referring to all sections of the patient’s chart on established patients
- Nursing notes yellow pages (Appendix 7)
- Flow sheets – vitals, sleep, food/fluid intake
- MAR (list of all active medications in the hospital)
- Consult notes (Appendix 9) if consult ordered
- Family meeting, outpatient treatment team input, phone calls, etc. – write on green progress note or as addendum on EMR
- Discharge form VC 1635, dictated discharge summary
- Medication reconciliation form (Mirror Image) – created on the discharge date for all patients hospitalized in Via Christi

Evaluation

- Ongoing and timely feedback based on resident’s ability to use appropriate forms of documentation
- Ongoing and timely feedback based on resident’s ability to convey information and data synthesis in oral and written format
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation based on resident’s performance and review of written documentation

**Learning Objective**

- Demonstrate efforts to educate medical students, all treatment team members, patients and their families

**Competency Domain**

- PC, MK, PBL, CS, P, SBP

**Expectations**

- Medical Student Education
- Direct supervision of patient interview
- Review medical student’s documentation
- Encourage direct participation in patient care – conducting interviews, preparing timelines, gathering and summarizing collateral info, working with patients and families
- Educate fellow residents, staff, family members, attendings…

**Evaluation**

- Ongoing and timely feedback based on resident’s ability to engage and educate medical students as observed during their interaction
- Ongoing and timely feedback based on resident’s ability to involve medical student in patient care in meaningful way based on student’s participation case discussion during the team meetings
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation based on resident’s performance

**Learning Objective**

- Be able to discuss and demonstrate behaviors consistent with self-awareness and professionalism

**Competency Domain**

- PBL, P, SBP

**Expectations**

- Recognize need for guidance/supervision when faced with new or complex responsibility
- Develop insight to the impact of one’s behavior on others
- Awareness of appropriate professional boundaries
- Exhibit the qualities of altruism and advocacy including putting the best interests of the patient above self-interest or the interest of others

**Evaluation**

- Ongoing and timely feedback based on resident’s dedication, reliability and integrity
- Ongoing and timely feedback based on resident’s ability to be respectful and sensitive to patient needs
- Ongoing and timely feedback based on resident’s ability to solicit feedback and insight to own deficits with appropriate improvement of these deficits
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation
Recommended Reading


Emergency Medicine

Resident Role & Expectations during Rotation

Residents are expected to be present on time for their scheduled shifts to take over care of those patients whose work-up and management is in progress; as well as start the evaluation and treatment of new individuals who present to the department during their shifts.

Residents are expected to write-up complete and accurate history & physical exams, review old patient records when available, to confirm medication profiles with patients and families, and to assist primary care providers in the care of their patients.

Residents are expected to share the burden of patient load in a fair manner with their cohorts and inform the attending physician on duty of any difficulties that might be arising.

Residents are expected to interact with physicians of different services in a collegial manner and make themselves available to assist in providing the best care for patients and their families.

Goals & Learning Objectives

Goal 1: To develop improved and more streamlined diagnostic approaches, clinical evaluations, and differential diagnoses of disease and correlate history and physical exam findings with disease patterns.

Goal 2: To develop the attitudes, knowledge, and skills for competent care of injured and/or infirm individuals of all ages, socioeconomic statuses, and ethnic backgrounds; including disease prevention, recognition of disease presentation, and promotion of optimal health habits.

Goal 3: To learn basic procedural skills such as wound care, suturing, and splinting based on each individual residents’ skills.

PATIENT CARE & MEDICAL KNOWLEDGE

A. Patient Care:
Objective 1: Demonstrate clinical skills of medical, surgical, and psychiatric history and physical examination;
including competency in developing a comprehensive differential diagnosis of illness.

Objective 2: Demonstrate clinical skill in the diagnosis and management of both acute and chronic illnesses in patients including competency skills in needs assessment for severity of disease, its management, and needs assessment upon discharge to home, inpatient hospitalization, or to a skilled nursing facility.

Objective 3: Demonstrate clinical skill and competency in medical management of patients for safe and appropriate discharge planning, including arranging follow-up care, contacting appropriate follow-up services to coordinate outpatient care, and social services involvement of those patients without defined PCPs or social/family support.

B. Medical Knowledge:
Objective 1: Embrace opportunities to see the entire spectrum of the aging process from pregnancy and its complications, to newborn care and pediatrics (not required but recommended) to adolescent and adult care, geriatrics, and cross specialty health conditions.

Objective 2: Evaluation and treatment of multiple medical and surgical conditions; including appropriate testing and imaging; laboratory and radiographic interpretation, pharmaceutical management, and sub-specialty consultations where indicated.

Objective 3: Describe common presentation of illnesses, and responses to therapy; including the pharmacokinetics and pharmacodynamics of common medical treatments.

Objective 4: Preventive care, including primary and secondary interventions with special emphasis about iatrogenic complications and prevention.

Objective 5: Recognize the legal requirements for psychiatric holds, inter-facility transfers, surgical and procedural consents, and advanced directives and describe the process to patients, families, and/or their legal representatives.

PROFESSIONALISM: INTERPERSONAL & COMMUNICATION SKILLS

A. Professionalism
Objective 1: Demonstrate respectful and compassionate use of medical skills for all individuals. This includes the utility of high-quality care and technology and, in the event of terminal illness, an awareness of the limits of medical intervention and the obligation to provide humane care.

Objective 2: Demonstrate sensitivity and responsiveness to patients’ culture, age, gender, sexual orientation, and/or disabilities.

B. Interpersonal & Communication Skills
Objective 1: Communicate clearly when writing medical orders and when giving verbal orders with attention to language. Avoid abbreviations as per hospital policy.

Objective 2: Communicate clearly, audibly, and with respect when speaking to patients and families with attention to language, and tone. Avoid medical jargon. Utilize hospital interpreter services in all cases where language or cultural factors may influence patient care.

Objective 3: Create a positive relationship with the patient and family to assure optimal medical care, assuring the emotional and cultural needs and expectations of all patients.

Objective 4: Participate and work effectively with others on inter-disciplinary and/or multidisciplinary services to promote optimal patient care.

Objective 5: Work professionally with nursing and ancillary staff to promote optimal patient care. Document and verbalize all orders and obtain an understanding of one’s request from the nursing/ancillary staff. Communicate effectively with primary care providers concerning their patients’ clinical presentations, assessments, conditions, and disposition planning.
Emergency Psychiatry Curriculum

EDUCATIONAL GOALS:

Development and display in practice, the knowledge, skills and attitudes necessary for rapid psychiatric assessment of patient experiencing psychiatric emergency. The residents will be able to:

1. Engage patient and their families/friends in positive and emphatic way
2. Use ASSAULTS assessment (Assess for Safety, Suicide, Aggression, Underlying medical condition, Lethality, Trauma and Substance Use)
3. Collect, prioritize and record the data in meaningful way.
4. Analyze data and formulate appropriate treatment plan, decide if patient requires hospitalization or can be dismissed home with appropriate follow up arrangements.
5. Recognize and treat crisis in early stages.
6. Participate in ongoing research projects.

There are six competency domains set out by the Accreditation Council for Graduate Medical Education (ACGME – 2000). Competency in all six areas should be achieved by completion of the residency training program. These domains serve as a guideline for understanding the learning goals in residency training. They include:

1. **Patient Care (PC)** - Gather data; order diagnostic tests; interpret data; make decisions; perform procedures; manage patient therapies; work with others to provide patient-focused care
2. **Medical Knowledge (MK)** - Fund of knowledge; active use of knowledge to solve medical problems
3. **Practice-Based Learning & Improvement (PBL)** - Analyze practice performance and carry out needed improvements; locate and apply scientific evidence to the care of patients; critically appraise the scientific literature; use the computer to support learning and patient care; facilitate the learning of other health care professionals
4. **Interpersonal & Communication Skills (CS)** - Develop a therapeutic relationship with patients and their families; use verbal and non-verbal skills to communicate effectively with patients and their families; work effectively as a team member or leader
5. **Professionalism (P)** - Demonstrate integrity and honesty; accept responsibility; act in the best interest of the patient; demonstrate sensitivity to patients' ethnicity, age, and disabilities
6. **Systems-Based Practice (SBP)** - Demonstrate awareness of interdependencies in the health care system that affect quality of care; provide cost-effective care; advocate for quality patient care; work with hospital management and interdisciplinary teams to improve patient care

The specific learning objectives for the inpatient psychiatry rotations support one or more of the ACGME competency domains.
LEARNING OBJECTIVES, COMPETENCY DOMAINS, EXPECTATIONS AND EVALUATION

Learning Objective

- Be able to engage the patient and families in emphatic and respectful way, collect meaningful historical data and perform physical exam, including mental status exam (MSE)

Competency Domain

- PC, MK, CS

Expectations

- Build rapport, use empathy
- Interview of the patient performed in skillful manner - knowledge of different interviewing techniques
- Gather information from collateral sources (family, caregivers, outpatient providers or other supportive contacts)
- Perform physical exam (PE), neurological exam and complete mental status exam (MSE)

Performance Assessment

- Ongoing and timely feedback based on resident’s ability to engage the patient as observed or reported by patient or nursing staff.
- Ongoing and timely feedback based on resident’s ability to recognize importance to communicate with patient’s families during the assessment.
- Verbal feedback during individual supervision and written evaluation in the end of inpatient psychiatry rotation

Learning Objective

- Be able to perform a risk assessment of designated patients using ASSAULT model

Competency Domain

- PC, MK, CS, SBP

Expectations

- Assess patient’s safety including access to lethal means, suicidality, aggressiveness, underlying condition responsible in acute mental status changes, lethality of the attempts, traumatic events
- Understanding and use of involuntary)

Performance Assessment

- Ongoing and timely feedback based on observation resident’s interaction with the patients, staff and patient reports
- Ongoing and timely feedback based on the review of the case with supervising attending and review of the documentation
- Verbal feedback during individual supervision and written evaluation in the end of inpatient psychiatry rotation

Learning Objective
• Ability to recognize underlying conditions responsible for psychiatric symptoms and acute mental status changes

**Competency Domain**

• PC, MK, CS, SBP

**Expectations**

• Check vital signs, laboratory values (metabolic and endocrinology abnormalities, medication toxicities, illegal drugs and alcohol intoxication and withdrawal), and radiology results that can cause acute changes of mental status
• Perform physical exam including neurological exam, identify abnormality that can cause mental status changes
• Ability to recognize pharmacologic emergencies, i.e. Neuroleptic Malignant Syndrome, Serotonin Syndrome, acute dystonia, anticholinergic toxicity
• Re-approach Emergency Department physician if further medical workup or stabilization is needed.
• Try to arrange for admission of medically unstable patient to medical floor with help of on call attending physician if needed.

**Performance Assessment**

• Ongoing and timely feedback by supervising physician or physician on call based on case discussion during the phone conversation or during the morning report and chart review.
• Ongoing and timely feedback by supervising physician based on report of the assessment center (AC) nursing staff
• Verbal feedback during individual supervision and written evaluation in the end of inpatient psychiatry rotation

**Learning Objective**

• Safety Assessment

**Competency Domain**

• PK, MK, PBL, CS, SBP

**Expectations**

• Ability to appreciate the biopsychosocial aspects in safety assessment, including intoxications and drug withdrawal
• Knowledge and of risk factors for suicide (SAD PERSONS)
• Knowledge of risk factors for homicide
• Assessment of access to lethal means
• Understanding of Kansas state law in regard to involuntary admission, mandatory reporting of child and elderly abuse, Tarasoff I and Tarasoff II…

**Performance Assessment**

• Ongoing and timely feedback by supervising physician or physician on call based on case discussion during the phone conversation or during the morning report, patient interview and chart review.

**Learning Objective**

• Be able to prioritize, organize and interpret clinical data to formulate a relevant, comprehensive differential diagnosis list
Competency Domain

- PC, MK, PBL, CS, P

Expectations

- Become familiar with diagnostic criteria for common psychiatric diagnosis
- Formulate diagnostic impression supported by clinical data using a biopsychosocial model and accounting for the patient’s ethnic and cultural background
- Identify gaps in knowledge base and proactively eliminate them, direct personal study to topics relevant to assigned patients

Evaluation and Evaluation

- Ongoing and timely feedback based on resident’s ability to create concise, accurate summary of collected data and formulate list of differential diagnosis
- Ongoing and timely feedback based on resident’s ability to apply analytical thinking to propose plan for the correct evaluation of the patient that will lead to correct and safe treatment plan
- Verbal feedback during from physician on call, or supervising physician during individual supervision and written evaluation in the end of inpatient psychiatry rotation

Learning Objective

- Recognize the importance of collateral history and be able to obtain and interpret information from multiple sources

Competency Domain

- PC, MK, CS

Expectations

- Understand importance of collateral information for correct diagnosis
- Become skilful at eliciting and interpreting relevant information from patient’s family, prior care givers and other sources
- Review and summarize previous medical records

Performance Assessment

- Ongoing and timely feedback based on resident’s ability to recognize complex cases, the importance of collateral history, collection and interpretation of collected data.
- Verbal feedback based on resident’s ability to obtain, analyze and interpret obtained information reported to physician on call, during morning reports or during individual supervision.

Learning Objective

- Development of initial treatment plan

Competency Domain

- MC, PK, PBL, SBP

Expectations

- Development of initial treatment plan for hospitalized patients including:
  - having knowledge of vital signs, following up on pending laboratory results including toxic levels of medications requiring therapeutic drug monitoring
- addressing the abnormalities, consideration of consultation
- safe renewal of the home medication,
- starting withdrawal protocols with supportive treatments,
- use of PRN medications to address patient’s agitation and aggression
- recognizing need for hospitalization in the state hospital, giving report to accepting doctor prior to transport, medicating patient prior to transport if necessary

- Development of safe initial treatment plan for patients dismissed from AC when deemed medically and psychiatrically stable. The treatment plan includes:
  - mobilization of support system,
  - follow up in outpatient setting and information about community resources provided,
  - no lethal means available.
  - crisis plan discussion and education with the patient and support system

**Performance Assessment**

- Ongoing and timely feedback based on resident’s ability to propose the treatment plan during the conversation with supervising physician or physician on call
- Verbal feedback during individual supervision and written evaluation in the end of inpatient psychiatry rotation will be based on resident’s performance ability during the team meeting and review of the documentation written by the resident

**Learning Objective**

- Effective and safe management of of agitated and aggressive patient, psychotic patient

**Competency Domain**

- PC, MK, CS

**Expectations**

- Ability to recognize patient’s agitation, and further escalation
- Use of de-escalation techniques, use of medications and restraints, application of knowledge acquired in HOPES training
- Ability to recognize the need for the early abortion of the interview to assure own safety, safety of the staff and the patient
- Effective work with AC Staff in management of agitated and aggressive patient

**Performance Assessment**

- Ongoing and timely feedback by supervising physician or physician on call based on case discussion during the phone conversation or during the morning report
- Ongoing and timely feedback by supervising physician based on report of the assessment center nursing staff
- Verbal feedback during individual supervision and written evaluation in the end of emergency psychiatry rotation

**Learning Objective**

- Effective written and verbal communication with attending physician, colleagues, staff, patient and patient’s family

**Competency Domain**

- PK, CS, P
Expectations

- Document the findings, decision making process and justification of chosen initial treatment plan (History and Physical Exam document, addenda…)
- Report the case to attending physician on call in concise and compelling way when approval for patient’s dismissal from AC or guidance for management of the patient are sought out
- Communicate with emergency department physician if patient’s medical stability is in question
- Attempt to contact patient’s outpatient provider and seek recommendations, follow up appointment if possible
- Sign out the patient to colleague resident in the end of the shift
- Finish the written documentation in timely manner

Performance Assessment

- Ongoing and timely feedback based on residents ability to create accurate and legally sound written document by physician on call or by supervising physician during morning reports.
- Verbal feedback during individual supervision and written evaluation in the end of emergency psychiatry rotation

Learning Objective

- Be able to work effectively as a member of the team

Competency Domain

- PC, MK, PBL, CS, P, SBP

Expectations

- Be on time to AC, find cross coverage and inform supervising physician, physician on call and program director, if unable to come to work
- Be on time to Morning Reports and be prepared to present your patient
- Work effectively with other members of the treatment team and be appropriately respectful to your attending physician

Performance Assessment

- Ongoing and timely feedback based on residents ability to work with other treatment team members demonstrating knowledge of optimal health care delivery
- Verbal feedback during individual supervision and written evaluation in the end of emergency psychiatry rotation will be based on resident’s performance and feedback from nurses and other members of the team.

Learning Objective

- Demonstrate efforts to educate medical students, all treatment team members, patients and their families

Competency Domain

- PC, MK, PBL, CS, P, SBP

Expectations

- Educating medical students and supervising their interaction with patients
- Review and address medical student’s documentation
• Educate fellow residents, medical students, staff, attendings, patients and their families…

Performance Assessment

• Ongoing and timely feedback based on resident’s ability to facilitate medical student education as reported by learners
• Verbal feedback during individual supervision and written evaluation in the end of emergency psychiatry rotation based on resident’s performance

Learning Objective

• Be able to discuss and demonstrate behaviors consistent with self-awareness and professionalism

Competency Domain

• PBL, P, SBP

Expectations

• Recognize need for guidance/supervision when faced with new or complex responsibility
• Develop insight to the impact of one’s behavior on others
• Awareness of appropriate professional boundaries
• Exhibit the qualities of altruism and advocacy including putting the best interests of the patient above self-interest or the interest of others
• Understand sensitivity and awareness to cultural, age, gender, sexual, socioeconomic, religious concerns….
• Demonstrate understanding of ethical values and codes of member of medical profession

Performance Assessment

• Ongoing and timely feedback based on resident’s dedication, reliability and integrity
• Ongoing and timely feedback based on resident’s ability to be respectful and sensitive to patient needs
• Ongoing and timely feedback based on resident’s ability to solicit feedback and insight to own deficits with appropriate improvement of these deficits
• Verbal feedback during individual supervision and written evaluation in the end of inpatient psychiatry rotation

Recommended Reading

Internal Medicine – VA  
Psychiatry Residents Goals and Objectives

Patient Care:
1. Perform thorough history and physical  
2. Synthesize data into a problem list and differential diagnosis  
3. Formulate diagnostic and therapeutic plan with supervision  
4. Demonstrate caring and respectful behavior

Medical College:
1. Demonstrate basic knowledge of pathophysiology and disease processes  
2. Develop basic knowledge base for outpatient clinical care  
3. Facilitate the learning of other learners on the care team  
4. Use technology to enhance patient care and medical education

Practice-Based Learning and Improvement:
1. Develop the ability to self-evaluate educational needs and performance  
2. Incorporate relevant feedback and instruction into clinical activities  
3. Facilitate the learning of other learners on the care team  
4. Use technology to enhance patient care and medical education

Interpersonal and Communication Skills:
1. Develop excellent communication skills  
2. Develop accurate, clear, and complete documentation skills  
3. Learn to present a case accurately and succinctly  
4. Establish an effective therapeutic relationship with patients, families and other health are providers.  
5. Demonstrates effective listening skills

Professionalism:
1. Demonstrate respect and compassion  
2. Display a professional appearance  
3. Demonstrate a commitment to ethical issues  
4. Consider the needs of colleagues  
5. Demonstrate constructive and respectful working relationships with other health care professionals  
6. Consider the needs of patients and families  
7. Fulfill responsibilities  
8. Acknowledge errors and accept criticism

Systems-Based Practice:
1. Develop knowledge of practice and the clinical delivery system  
2. Access appropriate resources
3. Identify error-prone system issues and needed improvements
4. Identify efficiency problems and needed improvement

**Inpatient Psychiatry Rotation**

**INTRODUCTION TO SERVICE**

At the University of Kansas School of Medicine – Wichita, the Department of Psychiatry directs a general adult inpatient psychiatry service, which is located at the Via Christi Behavioral Health Center (VC-BHC). VC-BHC is fairly busy with patients from Sedgwick County, other counties in Kansas and contiguous states. Hence, during the inpatient psychiatry rotations you will be diagnosing and treating patients who have local outpatient providers, but also other patients for whom you will have to provide additional effort in terms of establishing a treatment plan in their communities that are some distance from Wichita.

Inpatient psychiatry is considered by some to be particularly challenging in that patients typically have acute problems, complex situations, and significant symptomatology in order to be admitted to the hospital. Many of these patients already received some first or second level of psychiatric service as an outpatient that was unsuccessful and their diagnosis is often complicated by comorbid conditions such as Substance Use Disorders and Personality Disorders. Although challenging, the inpatient setting is a particularly rich environment for medical education requiring skill at communication, efficient data collection and organization, formulation of differential diagnoses, knowledge of diagnosis and treatments, and sound clinical reasoning.

The standard process in inpatient psychiatry is to:

- **Engage** the patient in an empathic and non-judgmental manner;
- **Evaluate** the patient with skillful examination and review of collateral information;
- **Stabilize** the patient’s condition which warranted hospitalization; and
- **Treat** appropriately as indicated by the assessment using a biopsychosocial model.

Remember, there are no uninteresting “cases”, and every patient was a person before admission to the hospital, continues to be a person regardless of clinical status, and will be a person after dismissal. On inpatient psychiatry we embrace the challenge and opportunity to have a meaningful, positive impact on a person’s life and often the lives of their family as well.

**EDUCATIONAL GOALS AND LEARNING OBJECTIVES**
During your inpatient psychiatry experience, the overall educational goal is to develop and display in practice the knowledge, skills and attitudes necessary for the optimal clinical care of patients with mental disorders.

As you progress through the inpatient rotations and through the residency program your skill set will evolve. Keeping in mind that each learner begins inpatient psychiatry with their own unique skill set and will progress at different rates, the RIME conceptualization of the learning process may be a helpful illustration for your reflection:

- **Reporter** collects and reports clinical data but has limited ability to meaningfully prioritize and synthesize the data. This role is assumed by beginning learners.
- **Interpreter** can prioritize and interpret clinical data to formulate diagnostic hypotheses and treatment recommendations.
- **Manager** can see the big picture, apply knowledge, develop accurate diagnostic hypothesis, and initiate appropriate evaluation and treatment plans.
- **Educator**, the highest level in this particular hierarchy and the ultimate goal for all learners, continuously involves self-assessment and personal learning efforts to maintain an up-to-date, in-depth knowledge that is readily applied to patient care and the education of colleagues.

There are six competency domains set out by the Accreditation Council for Graduate Medical Education (ACGME – 2000). Competency in all six areas should be achieved by completion of the residency training program. These domains serve as a guideline for understanding the learning goals in residency training. They include:

1. **Patient Care (PC)** - Gather data; order diagnostic tests; interpret data; make decisions; perform procedures; manage patient therapies; work with others to provide patient-focused care
2. **Medical Knowledge (MK)** - Fund of knowledge; active use of knowledge to solve medical problems
3. **Practice-Based Learning & Improvement (PBL)** - Analyze practice performance and carry out needed improvements; locate and apply scientific evidence to the care of patients; critically appraise the scientific literature; use the computer to support learning and patient care; facilitate the learning of other health care professionals
4. **Interpersonal & Communication Skills (CS)** - Develop a therapeutic relationship with patients and their families; use verbal and non-verbal skills to communicate effectively with patients and their families; work effectively as a team member or leader
5. **Professionalism (P)** - Demonstrate integrity and honesty; accept responsibility; act in the best interest of the patient; demonstrate sensitivity to patients' ethnicity, age, and disabilities
6. **Systems-Based Practice (SBP)** - Demonstrate awareness of interdependencies in the health care system that affect quality of care; provide cost-effective care; advocate for quality patient care; work with hospital management and interdisciplinary teams to improve patient care

The specific learning objectives for the inpatient psychiatry rotations support one or more of the ACGME competency domains.
<table>
<thead>
<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPECTATIONS</th>
</tr>
</thead>
</table>
| Be able to perform a risk assessment of designated patients PC, MK, CS, SBP | • Assess patient’s **dangerousness**, and need for hospitalization  
• Interact with the **court system** regarding involuntary commitment of mentally ill patients (see Decision Tree – Appendix 26 on Actions with Involuntary Patients) |
| Be able to perform an appropriate History and Physical Exam including a comprehensive Mental Status Exam PC, MK, CS | • **Interview** performed in skillful manner  
• **Physical exam** (PE), neurological exam and complete Mental Status Exam (MSE) are competently performed |
| Be able to engage designated patients and their families in an empathic manner, and discuss and demonstrate a range of interviewing techniques PC, MK, CS, P | • Build good **rapport** with the patient, use of empathy  
• Knowledge of different **interviewing techniques**  
• Apply interviewing techniques during interview of the patients/their families |
| Recognize the importance of collateral history and be able to obtain and interpret information from multiple sources PC, MK, CS | • Understand importance of **collateral information** for correct diagnosis  
• Become skillful at **eliciting and interpreting** relevant information from patient’s family, prior care givers and other sources  
• Review and summarize previous **medical records** |
<table>
<thead>
<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPECTATIONS</th>
</tr>
</thead>
</table>
| Be able to prioritize, organize and interpret clinical data to formulate a relevant, comprehensive differential diagnosis and plan | • Formulate **diagnostic impression** supported by clinical data using a biopsychosocial model and accounting for the patient’s ethnic and cultural background  
• Develop a **plan for further evaluation** (appropriate use of laboratory and psychological testing, and consultation)  
• Develop **treatment plan** including Electro Convulsive Treatment (ECT) during the hospitalization and after discharge from the hospital |
| PC, MK, PBL, CS, P | |
| Be able to work effectively as a member of your assigned treatment team and as the physician member of a multidisciplinary treatment team | • Attend **team meetings** and be prepared to present your patient  
• Have a **working knowledge** of assigned patients including target symptoms, problem list, diagnosis and differential diagnosis, current medication, progress during past 24 hours, plan for next 24 hours  
• Work effectively with other members of the treatment team and be appropriately **respectful to the attending physician** team leader  
• Attend **Multidisciplinary staff meetings** and be prepared to contribute in a concise, meaningful manner  
• Work effectively with psychologists, nursing staff, social workers, therapists and other allied healthcare personnel |
| PC, MK, PBL, CS, P, SBP | |
| Demonstrate ongoing efforts to develop, expand and apply in practice a knowledge base in general psychiatry particularly in areas relevant to assigned patents | • Become familiar with **diagnostic criteria** for common psychiatric diagnosis  
• Develop working **knowledge of treatment** for common psychiatric disorders  
• Direct **personal study** to topics relevant to assigned patients  
• Identify **gaps in knowledge** base and proactively eliminate them (teaching rounds, lectures, self education)  
• Regularly **seek consultation and feedback** from attending physician and senior resident |
<p>| PC, MK, PBL | |</p>
<table>
<thead>
<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be able to skillfully document clinical data in a written format including orders,</td>
<td>Be familiar with Physician’s [Order Sheet](Appendix 11), KU [Standing Orders](Appendix 9), [Detox Orders](Appendix 10)</td>
</tr>
</tbody>
</table>
| history, patient progress; routinely review and be familiar with the sections of a | • **New patients**  
| medical inpatient chart                                                          | 1. INPATIENT HISTORY AND PHYSICAL EXAM on electronic medical record (EMR) or **handwritten H&P form** (Appendix 2) –  
|                                                                                 | 2. Admission status – **voluntary vs. involuntary** (Appendix 18)            |
|                                                                                 | • **Established patient** - daily progress documentation should include a review of the prior 24 hours referring to all sections of the patient’s chart – use INPATIENT PROGRESS NOTE on EMR or handwritten progress note on green sheet (Appendix 6)  
|                                                                                 | • **Family meeting**, outpatient treatment team input, phone calls, etc. – write on green progress note or as addendum on EMR  
|                                                                                 | • **Discharge form VC 1635** (Appendix 3), dictated **discharge summary** (Appendix 4)  
|                                                                                 | • **Medication reconciliation form** (Mirror Image) – created on the discharge date for all patients hospitalized in Via Christi  
|                                                                                 | • **Nursing notes** yellow pages (Appendix 7)  
|                                                                                 | • **Flow sheets** – vitals, sleep, food/fluid intake  
|                                                                                 | • **MAR** (list of all active medications in the hospital)  
|                                                                                 | • **Consult notes** (Appendix 9) if consult ordered  
| (All documentation must dated and timed)                                         |                                                                              |
| PC, MK, PBL, CS,                                                              |                                                                              |
| Demonstrate efforts to educate medical students, all treatment team members,    | • **Medical Students**  
| patient’s and their families                                                    | 1. Direct supervision – patient interview  
|                                                                                 | 2. Review medical student’s documentation  
|                                                                                 | 3. Encourage direct participation in patient care – conducting interviews, preparing timelines, gathering and summarizing collateral info, working with patients and families  
|                                                                                 | • **Fellow residents**  
|                                                                                 | Staff, family members, attendings…  
| PC, MK, PBL, CS, P, SBP                                                        |                                                                              |
| Be able to discuss and demonstrate behaviors consistent with self-awareness and  | • Recognize need for guidance/supervision when faced with new or complex responsibility  
| professionalism                                                               | • Develop insight to the **impact of one’s behavior** on others  
|                                                                                 | • Is cognizant of **appropriate professional boundaries**  
|                                                                                 | • Exhibit the qualities of **altruism and advocacy** including putting the best interests of the patient above self-interest or the interest of others  
| PBL, P, SBP                                                                    |                                                                              |
POLICIES & PROCEDURES

A. CONFIDENTIALITY

All members of the treatment team are compelled to maintain patient confidentiality. This means that we may not discuss the patient’s situation with anyone (including family members) other than the treatment team without the patient’s written consent, which must be documented on the patient’s chart (Appendix 26). The patient must sign a release of information before any information can be given to family members, friends, employers, etc. This policy may not hold in emergency situations. When in doubt seek advisement from attendings.

B. GOOD SHEPHERD CAMPUS (GSC)

1. DAILY ROUTINE - helpful suggestions

<table>
<thead>
<tr>
<th>Morning</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Starting early is recommended</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Get a printed Patients List (by attending’s name) from the nursing station.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Attend the morning report at 7:30 am; participate in the division of new patients. Morning report will be led by PGY-4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Write down the names and locations of the newly assigned patients to your attending service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Round on your established patients, write your progress notes and check if progress note from previous day has been placed properly on the chart</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Attend Team meeting with your attending physician,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. present your patients concisely (Appendix 5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. report change in target symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. present relevant new info (family meeting, collateral info), consultation report, estimated hospital stay, substance abuse evaluation, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Make recommendations for treatment and evaluation including expected discharge date, any required social worker involvement and f/u plan, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Round with your attending on the new and designated patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• New patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Complete the patient’s evaluation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Review relevant documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Write your orders for meds, tests or labs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Afternoon</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• History and Physical needs to be dictated only if the original document is hand written on VC 771. Record dictation # on 1st or last page of hand written H&amp;P document</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discharge patients (Patients are usually discharged in PM) Complete form VC 1635 (Appendix 3) at the time of discharge, dictate DC summary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. ADMISSION

Patients who fulfill admission criteria (Appendix 1) are admitted to VC-BHC general adult or adolescent units or to Senior Behavioral Health Unit (SBHU). Admission procedure and documentation are the same for all types of admission.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Admission Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>VC-BHC Adult</td>
<td>≥18 y/o</td>
</tr>
<tr>
<td></td>
<td><strong>Admission Criteria</strong> (Appendix 1)</td>
</tr>
<tr>
<td></td>
<td>1. Acute cognitive, perceptual or behavioral symptoms/deficits impairing judgment and impulse control requiring clinical attention</td>
</tr>
<tr>
<td></td>
<td>2. Imminent risk to self/others due to mental illness</td>
</tr>
<tr>
<td></td>
<td>3. Current pattern of EtOH consumption that requires medical detoxification</td>
</tr>
<tr>
<td></td>
<td>4. Psychiatric condition significantly interfering with ability to provide care for self</td>
</tr>
<tr>
<td></td>
<td>5. Unable to maintain adequate essentials of daily living</td>
</tr>
<tr>
<td></td>
<td>6. Failure of treatment in less restrictive setting</td>
</tr>
<tr>
<td></td>
<td>7. Patient medically stable</td>
</tr>
<tr>
<td></td>
<td><strong>Exclusion criteria:</strong></td>
</tr>
<tr>
<td></td>
<td>1. Patient who are at high risk for compromising safety on the psychiatric unit</td>
</tr>
<tr>
<td></td>
<td>2. Seeking treatment for substance use other than medical detox</td>
</tr>
<tr>
<td></td>
<td>3. Significant active or unstable general medical conditions (e.g., Open/complex wound/burn care, wound vacs, blood transfusions, dressing changes requiring packing, irrigation, flushing, isolation/draining wounds, continuous IV/IV – ATB/central lines, TPN, ongoing need for bed rest/bathing assistance, need for OT, PT, speech, dialysis, tracheotomy care, acute ortho care, O2 Sat &lt;90%, unstable blood sugars within 8 h of discontinuation of IV Insulin), head injury causing severe cognitive impairment, Mental Retardation with IQ&lt;70</td>
</tr>
<tr>
<td></td>
<td>Write initial orders:</td>
</tr>
</tbody>
</table>
|                       | 1. CBC, CMP, UA, UDS, TSH, BAL, diet, observation level, PRN medications on KU standing orders (Appendix 9, 11). Note: "KU standing order" form is a template that needs to be filled in as appropriate for each patient upon
admission.

2. Therapeutic Drug Monitoring (e.g. total TCA, Lithium, valproic acid, carbamazepine).

3. Continue medications from home or hospital (for transfers) using yellow medication reconciliation sheet. Note: Yellow medication reconciliation sheet is often incomplete or may be inaccurate, but must be completed. When in doubt "DC" any meds listed, sign, date and time. Correct verified meds can then be hand written on the order sheet (Appendix 11). These orders should be dated and timed after yellow sheet entry to avoid confusion.

4. Put patient on detox protocol (Appendix 10) if needed

5. Orders for consultations must first be discussed with an attending unless urgently necessary

| VC-BHC Adolescent | • ≥ 12 y/o and fulfill admission criteria  
| Patients are admitted by | • Admission criteria (Appendix 1) – same as for adults  
| psych attending | • Exclusion criteria – same as for adults  
| or |  
| psych resident |  

SBHU Medicare Unit

Patients are admitted by psych attending or psych resident

- 55 y/o or older with Medicare Disability Insurance
- Admission Criteria (Appendix 1)
  1. Primary psychiatric diagnosis is reason for admission
  2. Medically stable
  3. Approved by unit supervisor

- Exclusion criteria:
  1. Primary psychiatric diagnosis is not the reason for admission
  2. Blood Transfusions required
  3. Mental Retardation IQ<70
  4. Medically unstable for the unit
  5. Not approved by unit supervisor

Transfers to Inpatient Psychiatry:

<table>
<thead>
<tr>
<th>From</th>
<th>Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment Center (AC)</td>
<td>• Admitted by PGY 1-4 residents on call or psychiatry attending physician</td>
</tr>
<tr>
<td></td>
<td>• Communicate to inpatient resident carrying black phone</td>
</tr>
<tr>
<td>Directly from a non-Via Christi</td>
<td>• Admitted by psych attending physician or psych resident if patient is passing through AC, or psych. attending if bypassing AC</td>
</tr>
<tr>
<td>facility</td>
<td>• Communicate to inpatient resident carrying black phone</td>
</tr>
<tr>
<td></td>
<td>• Occurs rarely</td>
</tr>
<tr>
<td>Transferred from medical floor at</td>
<td>• Admitted by psych resident covering Consult and Liaison service with</td>
</tr>
<tr>
<td>Via Christi</td>
<td>attending’s approval or psychiatry attending physician</td>
</tr>
<tr>
<td></td>
<td>• Communicate to inpatient resident carrying black phone</td>
</tr>
</tbody>
</table>
3. **DISCHARGE**

All discharges (planned discharge and discharge against medical advice AMA - Appendix 23, 24, 25) from the inpatient units at VC-BHC and St. Joseph SBHU **must be discussed** with the appropriate supervising faculty attending or the on-call faculty member prior to dismissal (e.g. before the patient leaves the building). In the rare event of AMA discharge the resident and nursing staff should discuss the details directly with the faculty member. Please remember that there is a significant liability risk for AMA discharges and they are relatively rare in inpatient psychiatry.

When dismissing a patient:

| Progress note (Appendix 6) | • Indicates that patient is ready for discharge (summarize objectively the progress/ hospital course of the patient)  
|                           | • Plan will have outpatient follow up plan, discharge medications, social support |
| Review with patient       | • Follow up plan  
|                           | • Crisis interventions (e.g. Comcare Crisis Center contact info) |
| Prescriptions             | • Give medication for up to 30 days (discuss number of days with attending)  
|                           | • Write out the number of dispensed pills (don’t use numerals only, e.g. Disp: #14 (Fourteen)).  
|                           | • Don’t give refills (e.g. Refills: none), the expectation is that patients will receive refills and medication adjustments by the outpatient clinicians identified in the discharge plan. Discuss how to proceed with supervising attending if you get contacted by a patient who is dismissed from GSC requesting additional refills  
|                           | • Controlled medications will require DEA #. You can write “call for” and circle the page operator phone number (pharmacy will page you)  
|                           | • Factor economics into treatment selection. If the patient cannot access medications because of cost, your best efforts at treatment selection are without impact. Select affordable medications (e.g., Walmart & Target $4 list) whenever possible |
| Discharge or Transfer Summary Sheet | • Must be filled out on every patient and has to contain:  
|                                   | 1. Discharge diagnosis  
|                                   | 2. Follow up instructions (further labs…)  
|                                   | 3. Follow up appointments |
### 4. Discharge Summary dictation # if applicable

#### Discharge Order Sheet

- Reconcile medications and complete discharge Med reconciliation form on Mirror Image
- Perform final review of the chart, sign all the verbal orders and other documents
- Write dismissal order:
  1. D/C precautions and D/C home with e.g. mother, to shelter
  2. Give prescriptions
  3. Fax H&P (Appendix 2), VC1635 (Appendix 3), medication reconciliation form, lab and radiology reports, consult notes to outpatient follow up providers
  4. Educate patients re: crisis interventions, give Comcare contact and/or Assessment Center contact info

#### Discharge Summary

Dictate on the day of dismissal if possible, must be dictated within 7 days of dismissal (see DC summary Template (Appendix 4) and record dictation # on VC 1635 (Appendix 3)

### 4. MEETINGS

There are several formal group meetings you will participate in while on inpatient psychiatry.

#### a) MORNING REPORT (Monday – Friday)

<table>
<thead>
<tr>
<th>Morning Report</th>
<th>Be prompt</th>
</tr>
</thead>
<tbody>
<tr>
<td>07:30 - 08:15</td>
<td>Objectives:</td>
</tr>
<tr>
<td>GSC - 2W</td>
<td>1. enhance communication between on-call and inpatient treatment teams (e.g. medical illness requiring early attention, involuntary admission status)</td>
</tr>
<tr>
<td></td>
<td>2. organized, case based, educational experience</td>
</tr>
<tr>
<td></td>
<td>3. maintain cohesion and morale among members of the KU inpatient service teams</td>
</tr>
<tr>
<td></td>
<td>4. optimize evaluation and treatment of patients</td>
</tr>
</tbody>
</table>
b) TEAM MEETING

“Team is a cohesive group of people working together with a purpose, a sense of pride and spirit to achieve both organizational and individual goals.”

The work in GSC is all about team work. The treatment team consists of attending physician, junior and senior residents, and medical students. The treatment team also includes other staff members involved in patient care (social workers, nurses, therapists, etc.). The team meets to discuss new admissions and established patient’s progress. This is an opportunity to demonstrate oral communication of clinical data, reasoning and understanding of assigned patients.

<table>
<thead>
<tr>
<th>Team Meeting</th>
<th>Mo - Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Team meetings typically occur after morning report and will be called to order by the attending.</td>
</tr>
<tr>
<td></td>
<td>• Is led by senior resident or attending psychiatrist and includes junior residents and medical students.</td>
</tr>
<tr>
<td></td>
<td>• Medical students and/or Residents will present a succinct history, tentative assessment and recommendation for further treatment of each of their assigned patients.</td>
</tr>
<tr>
<td></td>
<td>• Patient data will be prioritized, team members will demonstrate clinical reasoning ability as well as critical thinking skills.</td>
</tr>
</tbody>
</table>

PATIENT PRESENTATION EXAMPLES: (Succinct organization is valued but be prepared to provide further information on request)

New Patient:
AJ is 39 y/o female who was found wandering confused in the street and brought to the hospital by WPD. In the ED the patient reported that “I just want to die”. Blood alcohol was 300mg%, other lab pending. She was previously admitted to VC-BHC in 2/04.

Assessment:

1. EtOH Intoxication
2. R/O EtOH Dependence
3. R/O MDD
4. R/O Mood Disorder
5. R/O Psychotic Disorder

Recommendation:

1. EtOH detox protocol
2. Interview patient further, obtain collateral info from family/outpatient clinicians to clarify diagnosis
3. Obtain records from previous hospitalizations (DC summary)

Established Patient:

AJ is 39 y/o female admitted for confusion with a BAL 300mg% and history of depression. From discussion with the patient she reports doing well until receiving divorce papers last week. She minimizes her alcohol use and states she “got drunk” because she was upset about the divorce and has no intentions of suicide. On a prior admission she was diagnosed with Alcohol Dependence and Major Depressive Disorder. Outpatient Psych and CD treatment was arranged. The patient did not follow through with the discharge plan. The patient’s mother was contacted and reports the patient drinks to intoxication daily and she is concerned the patient is “very depressed”.

Patient received 200 mg of Librium in last 24 hour

Assessment:

Alcohol Intox/Dependence/Withdrawal
Adjustment Disorder
MDD by history
R/O MDD

Recommendations:

Review Mood Disorder Criteria with patient
Discuss CD treatment options, explore why she didn’t follow up after last hospitalization
Consider family meeting.
c) MULTIDISCIPLINARY TEAM MEETING

<table>
<thead>
<tr>
<th>Multidisciplinary Staff Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• At GSC, held at least twice a week typically on Tuesdays and Thursdays with other members of the Tx team (RNs, Social Workers, Therapists, Students, Residents, Attending Physician if available)</td>
</tr>
<tr>
<td>• Purpose is to share information from multiple perspectives:</td>
</tr>
<tr>
<td>1. progress of the patient’s hospitalization</td>
</tr>
<tr>
<td>2. new information about the patient,</td>
</tr>
<tr>
<td>3. clarification of diagnosis,</td>
</tr>
<tr>
<td>4. treatment – biological and non-biological treatments</td>
</tr>
<tr>
<td>5. need for family meeting/other interventions</td>
</tr>
<tr>
<td>6. discharge plan - follow up appt for meds, therapy, general medical issues</td>
</tr>
</tbody>
</table>

5. ECT (Electroconvulsive Therapy)

Residents will gain their first exposure to ECT during the inpatient rotations. This experience will include participating in the ECT consultations (suitability of the patient for ECT treatment), pre ECT workup, and assisting during the treatment. An ECT didactic will occur as part of the noon lecture series.

<table>
<thead>
<tr>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ECT treatments are M,W,F at 6:30AM</td>
</tr>
<tr>
<td>• ECT consultations are performed as needed at the direction of the attending</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ECT treatments are at Via Christi - St. Joseph campus in the basement surgery area, go to the surgery reception area and ask to be directed to the correct place for ECT</td>
</tr>
<tr>
<td>• ECT consultations may be at VC-BHC or St. Joseph campus</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>• At the beginning of each month the inpatient residents will devise a rotating schedule so that someone is present at each ECT treatment session</td>
</tr>
<tr>
<td>• ECT consultations will typically be performed by the senior inpatient resident</td>
</tr>
</tbody>
</table>
How

- Participation in ECT treatments will be explained at the treatment sessions
- For ECT consultation the questions are:
  1. Does the patient have a condition for which ECT is indicated?
  2. Is the patient agreeable to ECT and have all their questions been addressed?
  3. Are there any special considerations involving the patient’s general health, medication regimen, etc. that need to be addressed in the decision to perform ECT?
  4. What testing needs to be performed as part of the evaluation for ECT (e.g., CNS and spine imaging, laboratory testing, EKG)?
- In most circumstances that patient will first be seen by the resident who will perform a preliminary consultation and then report to the attending. After discussion the resident and attending will see the patient together to complete the consultation.

Documentation

- Is handwritten on the Via Christi consult form in conjunction with the attending (Appendix 8)

6. VC-BHC EMERGENCIES

a) Resident in house – responds to all the calls from staff

<table>
<thead>
<tr>
<th>Code Blue</th>
<th>RN immediately calls 911</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RN and resident coordinate the care</td>
</tr>
<tr>
<td></td>
<td>Resident in charge of CPR</td>
</tr>
<tr>
<td></td>
<td>AED (automatic external defibrillator)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute Dystonic Reaction</th>
<th>Cogentin 2mg IM (max daily dose 6 mg in 24 hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitor closely</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neuroleptic Malignant Syndrome</th>
<th>Supportive care while waiting for EMS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Call EMS and transfer to Emergency Department (ED) for eval</td>
</tr>
<tr>
<td></td>
<td>Contact ED physician to notify of transfer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergic Reaction</th>
<th>Benadryl 50mg/1ml IM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Epinephrine 0.2 -0.5 mg IM/SQ q 20 min up to 4 hours</td>
</tr>
<tr>
<td></td>
<td>Call EMS if needed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute Bronchospasm</th>
<th>Epinephrine 0.1-0.5 mg IM/SQ q 10-15 min up to 4 hours</th>
</tr>
</thead>
</table>
| **Acute Chest Pain** | • ECG stat  
• O₂ by nasal cannula  
• ASA 325 mg PO x 1  
• Nitroglycerin 0.4 mg SL q 5 min up to 3 doses  
• Call EMS and transfer to Emergency Department (ED) for eval  
• Contact ED physician to notify of transfer |
| **EtOH/Benzodiazepine Withdrawal Seizures** | • Lorazepam 2mg IM, may repeat dose in 10-15 min.  
• Efforts to maintain patent airways and monitor respiration  
• Call EMS if needed, which is more often than not (e.g. fall with possible head injury, uncontrollable seizures, need for further evaluation) |
| **Primary Seizure Disorder** | • Lorazepam 2mg IM, may repeat dose in 10-15 min.  
• Efforts to maintain patent airways and monitor respiration  
• Call EMS and transfer to Emergency Department (ED) for eval  
• Contact ED physician to notify of transfer |
| **Head Trauma** | • Examine patient  
• Call EMS and transfer to ED for eval as needed |
| **Fever** | • Push oral fluids  
• Antipyretics (Tylenol, Ibuprophen available)  
• Reevaluate q 2 hours |
| **Also responsible for** | • Restraint/seclusion orders  
• Face to face assessment  
• Questions about KU patients  
• Orders for unassigned patients in Assessment Center |

**b) Resident not in house:**
<table>
<thead>
<tr>
<th>Emergency</th>
<th>Handled by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Blue</td>
<td>• RN&lt;br&gt;• RN immediately calls 911 for Sedgwick County EMS.</td>
</tr>
<tr>
<td>Non-Code Blue</td>
<td>• RN contacts physician back up:&lt;br&gt;1. Assessment Center (AC) resident&lt;br&gt;2. “2nd call resident (PGY3), if AC resident is too busy,&lt;br&gt;3. On-call attending psychiatrist if residents are unavailable&lt;br&gt;• Resident contacts an on-call attending psychiatrist as needed to work out Tx plan (after discussion w/RN)&lt;br&gt;• If Tx includes sending patient to ED, resident will talk with the ED physician</td>
</tr>
<tr>
<td>Other Emergencies</td>
<td>• As above when Resident in house</td>
</tr>
<tr>
<td>Request for Orders</td>
<td>• AC resident&lt;br&gt;• “2nd call resident (PGY3) if AC resident unavailable</td>
</tr>
<tr>
<td>Restraint &amp; seclusion, face-to-face assessment (Appendix 12, 13)</td>
<td>• Nurse house supervisor or if needed AC or “2nd call resident (PGY3) may be called&lt;br&gt;• must be done within 1 hour of initiation of restraints</td>
</tr>
<tr>
<td>Questions about KU patients</td>
<td>• AC resident&lt;br&gt;• “2nd call resident (PGY3) if AC resident is unavailable</td>
</tr>
</tbody>
</table>

**AC =** Assessment Center = Psychiatric ER attached to SJC ED  
**ED =** St. Joseph Campus Emergency Department  
**GSC =** Good Shepherd Campus  
**OOD =** Officer of the Day. The resident is not scheduled with regular appointments during this time slot  
**KU =** Kansas University  
**RN =** Registered Nurse  
**VCPC =** Via Christi Psychiatric Clinic which is at GSC
C. INPATIENT RESIDENT COVERING ASSESSMENT CENTER (AC)

General Rules:

- Assessing patients in AC is the #1 priority and only emergencies (life threatening emergencies, restraints/seclusion) in VC-BHC take precedence over AC
- When called by AC immediately complete your current obligation, and deal with the AC patient.
- If resident is unable to see every waiting patient within **90 min**, the AC resident will call the "2nd call resident (PGY3) for assistance

<table>
<thead>
<tr>
<th>Resident will assess a Patient in the AC when:</th>
<th>Patient is determined to be unassigned (patient doesn’t have psychiatrist, Prairie View patients, or patients of private psychiatrist who doesn’t have VC privileges)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Patient was medically cleared by ER physician</td>
</tr>
<tr>
<td></td>
<td>• Patient was assessed by AC nurse</td>
</tr>
<tr>
<td></td>
<td>• ER triage T-sheet (Appendix 15), ER Physician T-sheet (14), AC nurse Sorian assessment are available to resident</td>
</tr>
</tbody>
</table>

| Resident will not assess the patient when:     | Patient is “assigned patient”:
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Has psychiatrist, psychiatry nurse practitioner or physician assistant that have VC privileges</td>
</tr>
<tr>
<td></td>
<td>• Is an open Comcare patient (active, referred from Comcare Crisis, not closed to Comcare)</td>
</tr>
<tr>
<td></td>
<td>• Filled psychotropic medication within last 30 days which were prescribed by psychiatrist, psych ARNP/PA</td>
</tr>
<tr>
<td></td>
<td>• Is an established patient in another county Mental Health Center (MHC) and this MHC has contracted with a local psychiatrist who takes care of their patients when hospitalized (e.g. Butler Co, Sumner Co.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prairie View Patient</th>
<th>If patient needs to be admitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. RN will call PV to determine if bed is available</td>
</tr>
<tr>
<td></td>
<td>2. If bed available resident will call PV physician on call, to give report of assessment and basis for hospitalization</td>
</tr>
<tr>
<td></td>
<td>• PV physician accepts the patient, and then patient will be transferred to PV via VC Ground Transport System (not family member).</td>
</tr>
<tr>
<td></td>
<td>• If PV patient is not accepted by PV psychiatrist, resident will admit patient to VC-BHC or Senior Behavioral Health Unit (SBHU)</td>
</tr>
</tbody>
</table>
### Patient log

- Record all patients assessed in AC
- All log columns must be filled out
- Time of assessment must be recorded
- Will be placed into assigned inbox in AC or Resident’s Room in GSC

### 1. AC Coverage

AC is covered by different residents for 24 hours daily

<table>
<thead>
<tr>
<th>When:</th>
<th>Who:</th>
<th>How:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday – Friday</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 am – 2 pm</td>
<td>PGY 3 – Officer of the Day</td>
<td>Tele-video/Phone Assessment</td>
</tr>
<tr>
<td></td>
<td>Supervised by Dr. Khan</td>
<td></td>
</tr>
<tr>
<td>2 pm – 5 pm</td>
<td>VC-BHC resident on call</td>
<td>Tele-video</td>
</tr>
<tr>
<td></td>
<td>supervised by Drs. Burke and Lincoln</td>
<td></td>
</tr>
<tr>
<td>5 pm – 7:30 pm</td>
<td>VC-BHC resident on call</td>
<td>Tele-video/Face Assessment</td>
</tr>
<tr>
<td><em>exception, on Friday the on-call resident for Friday evening starts AC coverage at 5 pm</em></td>
<td>supervised by Attending Physician on Call</td>
<td></td>
</tr>
<tr>
<td>7:30 pm – 7 am</td>
<td>AC resident (or resident on call Friday only)</td>
<td>Face Assessment</td>
</tr>
<tr>
<td></td>
<td>supervised by Attending Physician on Call</td>
<td></td>
</tr>
<tr>
<td><strong>Saturday – Sunday</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:00am – 2pm</td>
<td>Resident on call for AC will call to AC at 7:30 AM and will find out how many patients are waiting for the assessment</td>
<td>Face Assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Dismissals from AC

All dismissals from AC including patients who want to leave Against Medical Advice (AMA – Appendix 23, 24, 25) must be discussed with attending physician on call.

<table>
<thead>
<tr>
<th>Document:</th>
<th>If applicable, use:</th>
</tr>
</thead>
</table>
| All AC dismissals | • Use INPATIENT HISTORY AND PHYSICAL EXAM template on EMR or form VC 771 (Appendix 2) to document H&P  
1. Once documentation is completed a copy of EMR or hand written form should be printed and given to the AC staff  
2. Once printed and given to AC staff, EMR forms are then submitted to the involved faculty attending |
| Physical exam on Tele-video Assessments | • For tele-video assessments - refer to ED physician (Appendix 14) exam on ED T-sheet to complete physical exam (Appendix 2 – page 5 of Form VC771)  
• For face to face assessments – the resident performs physical exam |

Pg. 7 Formulation Box of H&P (Appendix 2 – Form VC771)

Formulate why patient did not need to be admitted, i.e.:

• “Admission was offered as an option but the patient did not want to be hospitalized.”
• “Based on my evaluation, I was able to establish a therapeutic alliance with the patient and he is not a foreseeable risk to commit suicide (or homicide).”

Presence of Inconsistent Risk Factors

(ED T-sheet, BHS nurse documentation) with Resident’s evaluation
- “He denied making any suicidal (or homicidal) statements or threats. His wife refused to confirm her earlier claim that he held a knife to his chest. Staff documented that he made a morbid statement to the police. He was intoxicated during the incident which contributed to his poor judgment.”

Willingness to pursue Tx

- “He has agreed to pursue outpatient treatment.”

Safe/supportive environment upon dismissal:

- “He has support and will stay the night at his parent’s house.” OR “Family agrees with the dismissal treatment plan and supports the patient.”

Alcohol (or drug) use:

- “The patient agreed to remain abstinent from alcohol (or drugs) and expressed insight to the need to abstain.”

| Initial Treatment Plan and Discharge Criteria Box | Follow up appointments (date & time) that have been or will be made by the patient or family (don’t refer pt’s with primary Substance Use Disorder to VCPC) |
| | Write “DC Home with family (or friend)” |
| | Emergency Phone #’s provided |
| | Recommendation: “Remain abstinent from alcohol (or drugs)” |
| | Include any psycho-education provided |
| | Include any handouts provided |
| | “I discussed the case with Dr.…… (name of faculty attending involved) and s/he agreed with the dismissal |

| For Patients Referred to VCPC for Follow-up | Fax following information to VCPC (Fax 858—0596) |
| | H&P - Appendix 2 or printed copy from EMR |
| | Labs |
| | ED T-sheets triage RN (Appendix 15) and physician (Appendix 14) |
| | BHS nurse eval |

3. AC Rotation
(Please refer to section III. B2 for admissions, III. C1 for general rules, III. C2 for schedule, and III. C3 for dismissals).

| AC Rotation | 1 to 2 months long |
| 11.5 hour night shift in AC x 4 days per week (Mo-Thu from 7:30 pm to 7 am) + morning reports/supervision |
• Considered part of Emergency Psychiatry
• Educational Goals and Learning Objectives are outlined in section II.
• Particular emphasis includes:
  1. Assessment of dangerousness and need for hospitalization (see Admission Criteria – Appendix 1)
  2. Knowledge of relevant legal issues (e.g. voluntary versus involuntary admissions and skillful performance of appropriate documentation (see Appendix 17, 18, 19, 20)

| AC Resident’s Responsibility | • Assesses all *unassigned* patients going through AC (children, adolescents, adults, elderly).
  1. Admits patients when indicated – section III. B2 Admission
     • Document H&P using INPATIENT HISTORY &PHYSICAL EXAM template on EMR or VC 771(Appendix 2), physical exam included
     • Write admission orders (e.g. medications, medical tests, level of observation, etc
  2. Dismiss patient from AC (refer to III. C3)
     • All dismissal must be discussed with attending on call, before patient leaves the building, after H&P is filled out and relevant documents are reviewed
     • FU instruction given
     • Support System in place
  3. Come to GSC to present patients at Morning Reports, 7:30 AM promptly
  4. Meet with attending for supervision (will be scheduled on individual basis)
  5. For patients dismissed from AC
     • Handwritten H&P – a copy must be provided directly or faxed to AC
     • EMR H&P – a copy must be sent to/printed at AC before submitting electronic document to faculty.

VC-BHC – Via Christi Behavioral Health Center, SBHU - Senior Behavioral Health Unit

D. CALL

Nursing staff should notify resident on call of any admission during your shift. The first two calls for new residents will be together with PGY2 resident, who will orient and train PGY1 resident during the call. *During these 2 orientation calls, the PGY2 resident should orient you to the following*:

| Call Room | • Phone numbers  
• Forms and where to find them  
• Tele-video, fax machine and computer operations  
• Policy and Procedure Manual |
<table>
<thead>
<tr>
<th>Admissions</th>
<th>• See Admission/VC-BHC part of manual (III B2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergencies</td>
<td>• See VC-BHC Emergencies (Section III B6)</td>
</tr>
</tbody>
</table>
| GSC Staff | • House Supervisor – “Leader” (Tf: 858-0501)  
| | • Nurses (RNs and LPNs)  
| | • Mental Health Technicians  
| | • Social Workers  
| | • Mental Health Protection Worker & Security |
| Back up resident PGY3 | Is called if resident covering AC is unable to see every waiting patient within 90 min. PGY 3 resident will:  
| | 1. Come to AC and help to eval the patients in AC, or  
| | 2. Go to VC-BHC and will help to eval pt’s in AC over tele-video, or  
| | 3. Go to VC-BHC to finish the patient admissions from AC with incomplete H&P and/or admission orders |
| Admission to SBHU | 8 am – 5 pm  
| | All admissions are done/finished by SBHU resident (direct admissions and patients admitted from AC by PGY 1-3)  
| | 5 pm – 10 pm  
| | 2nd call resident (PGY3) all direct admissions and will finish up admissions on pt.’s admitted from AC  
| | 10 pm – 8 am  
| | Direct admissions – orders will by done by 2nd call resident (PGY3), H&P will be done by SBHU resident next day  
| | 7:30pm– 7:00 am  
| | • AC resident (Mo-Thu) for patients going through AC  
| | • PGY 1-2 on call (Fri, Sat, Sun)  
| | • Attending faculty for direct admission |
| Food | • See section III. D 1  
| | • There is food in the fridge in doctor’s lounge |
1. In House Call.

- The residents are to be in the hospital during their on call hours. The only exception is not working Tele-video equipment and resident has to go to AC to perform face to face assessment of the patients.
- While performing in house call the resident is provided meals from the cafeteria, a bedroom and shower facilities.
- The resident is expected to have a **5 minute response** time to any **calls/pages** they receive.
- Leaving the hospital campus is discouraged. If resident must leave the hospital while on call the following protocol will be observed:

  1. The in house resident is to contact 2nd call resident (PGY3) to notify them of their departure and to obtain coverage.
  2. 2nd call resident (PGY3) will have to come into the hospital to cover.
  3. The in house resident will notify the hospital operator that they are leaving the hospital and calls are to be directed to the backup resident.

| Monday – Thursday |  
|-------------------|---
| Day call:         |  
| 8:00 am–7:30 pm  |  
|                   | ● No overnight call in VC-BHC  
|                   | ● Resident is in VC-BHC at all times during day call. Lectures are exception, but must be available for emergencies by pager  
|                   | ● Responsibilities:  
|                   |   1. Complete H&P and admission orders on patients:  
|                   |     ● Transferred from medical floor  
|                   |     ● Admitted from AC  
|                   |     ● Admitted directly from non Via Christi facilities bypassing AC  
|                   |   2. Emergencies in VC-BHC (Section III B6)  
|                   |   3. Face to Face assessments/orders for restrains (Appendix 12, 13) if called by charge nurse or house supervisor  
|                   | ● AC coverage by tele-video 5pm – 7:30 pm  
| Friday            |  
| Day call is:      |  
| 8:00 am–5:00 pm  |  
| Night call:       |  
| 5:00 pm–8:00 am (Sat) |  
|                   | ● Day Call – same as Mo – Thu  
|                   | ● Overnight call  
|                   | ● AC coverage by televideo 5pm Fri – 8am Sat (See section III.C.)  
|                   | ● Responsibilities:  
|                   |   1. Complete H&P and admission orders on patients:  
|                   |     ● Transferred from medical floor  
|                   |     ● Admitted from AC  
|                   |     ● Admitted directly from non Via Christi facilities bypassing AC  
|                   |   2. Emergencies in VC-BHC (Section III B6)  
|                   |   3. Face to Face assessments/orders for restrains (Appendix 12, 13) if called by charge nurse or house supervisor  
|                   | ● Rounds on 50% of the adult and adolescent patients on Saturday |
**morning**

- Post call resident rounds with/checks out to attending the first and leaves GSC - Sat 1pm at the latest. **Don't leave hospital without checking out to attending in person or by phone.**

  Call 2nd call resident (PGY3) if VC-BHC residents gets too busy (unable to see patients in AC within 90 min)

---

<table>
<thead>
<tr>
<th>Saturday – Sunday</th>
<th>• Responsibilities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 am–8:00am next day</td>
<td>1. Transfers from medical floor</td>
</tr>
<tr>
<td>Resident is in GSC at all times during the call</td>
<td>2. Finish admissions from AC</td>
</tr>
<tr>
<td></td>
<td>3. Direct admissions</td>
</tr>
<tr>
<td></td>
<td>4. Emergencies in VC-BHC (Section III.B6)</td>
</tr>
<tr>
<td></td>
<td>5. Face to Face assessments/orders for restraints (Appendix 12, 13)</td>
</tr>
<tr>
<td></td>
<td>6. Rounds on 50% of the patients (adults and adolescents)</td>
</tr>
</tbody>
</table>

- Post call resident rounds with/checks out to attending the first and leaves GSC - Sun 1pm at the latest. **Do not leave hospital without checking out to attending in person or by phone.**

  Call 2nd call resident (PGY3) if VC-BHC resident gets too busy (unable to see patients in AC within 90 min)

---

### 2. Call from home

<table>
<thead>
<tr>
<th>Call from home</th>
<th>• Is to cover AC only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sat - Sun</td>
<td>• Resident will be in AC within 30 – 40 minutes of initial page</td>
</tr>
<tr>
<td>8:00 am – 2:00 pm</td>
<td>• Assesses and admits or discharges all the patients who go through AC during this time frame</td>
</tr>
</tbody>
</table>

- Responsibilities are same as AC resident (see section III C)

**Full Assessment Center (AC) coverage - see AC Coverage of the manual (section III C)**

**Emergencies in Good Shepherd Center (GSC) - see GSC Emergencies (section III B6)**
### E. DOCUMENTATION

The patient’s chart is a legal document. The purpose of written documentation is to communicate data and reasoning. If your hand writing is illegible the documentation is inadequate.

For intake History and Physical and daily Progress Note, residents are to use Electronic Medical Record (EMR) unless other arrangements are made with the attending. These documents need to be submitted daily to the supervising attending physician by noon. On those occasions, when these documents are not completed and submitted by noon, the resident will print the documents after they are finished and put them on the charts in addition of submitting the documents to the supervising attending physician.

Patient relevant information gathered after completion/submission of routine daily documentation (e.g. family meeting, phone calls to outpatient providers, family and friends...) can be documented either handwritten on green paper progress notes or by starting a new EMR encounter. In the case of EMR, documents need to be printed and placed on the chart and then submitted the supervising attending physician.

For clarity of the documentation, a good rule of thumb would be to start each document with the name of the document, such as “History and Physical”, “Progress Note”, “Phone Call”, “Family Meeting”, etc.....

If electronic records cannot be created because of technical problem, use VC 771 for H&P (Appendix 2) and green progress sheets with printed template (VC 128) (Appendix 6) for daily documentation.

<table>
<thead>
<tr>
<th><strong>History and Physical</strong>&lt;br&gt;<em>(Inpatient History and Physical Exam on EMR or Handwritten)</em>&lt;br&gt;H&amp;P/VC Form 771: Appendix 2</th>
<th>• Is created and finished within 24 of admission for all new patients who: 1. Have never been in VC-BHC 2. Were last admitted &gt;30day ago 3. Were transferred from a medical floor and don’t have a dictated Consult Note&lt;br&gt;• Use EMR Inpatient History and Physical (fast track) on EMR and type “History and Physical Exam” as first line of HPI. Use Form VC 771 (Appendix 2) for handwritten H&amp;P in case of technical problem with EMR.&lt;br&gt;• If EMR Inpatient History and Physical Exam (fast track) is created, dictation is not necessary. If Form VC 771 is used, an H&amp;P must be dictated by resident assigned to the patient within 24 hours of admission (record dictation # on 1st or last page of handwritten H&amp;P - VC 771).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Readmission Note</strong>&lt;br&gt;<em>(green Physician’s Progress Note)</em></td>
<td>• If patient is readmitted to VC-BHC within 30 days of last dismissal from VC-BHC&lt;br&gt;• Transferred from medical floor, or SBHU and has H&amp;P dictated&lt;br&gt;• Must contain:&lt;br&gt;  a) relevant changes during the interval between last and current hospitalization,&lt;br&gt;  b) physical exam (HEENT, heart, lungs, abdomen, extremities, neuro exam)</td>
</tr>
</tbody>
</table>
### Appendix 6

<table>
<thead>
<tr>
<th>and vitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>c) MSE,</td>
</tr>
<tr>
<td>d) 5 Axis psych. Dx,</td>
</tr>
<tr>
<td>e) Tx plan (e.g., “evaluate and stabilize”),</td>
</tr>
</tbody>
</table>

- DC summary and H&P from previous hospitalization must be copied from Mirror Image and placed on chart
- Medical record accompanying patient from medical floor must be reviewed
- Copies of the relevant info must by on the chart (e.g., consult note, medical H&P, Tx with mucomyst and # of doses given, relevant test results, follow up instruction for physical problems after DC from VC-BHC, etc.)

### Transfer Note (green Physician’s Progress Note)

- Patient transferred from medical floor, or SBHU and has consult note or H&P dictated
- Must contain:
  - a) relevant changes during the interval between last and current hospitalization,
  - b) physical exam (HEENT, heart, lungs, abdomen, extremities, neuro exam) and vitals
  - c) MSE,
  - d) 5 Axis psych. Dx,
  - e) Tx plan,

- DC summary and H&P from previous hospitalization must be copied from Mirror Image and placed on chart
- Medical record accompanying patient from medical floor must be reviewed
- Copies of the relevant info must by on the chart (e.g., consult note, medical H&P, Tx with mucomyst and # of doses given, relevant tests, follow up instruction for physical problems after DC from VC-BHC, etc.)

### Discharge Documentation

- Form VC 1635 (Appendix 3-Behavioral Health Discharge/ Referral Transfer Summary) must be completed at time of discharge with an order to fax to outpatient provider
- Discharge Summary should be dictated as soon as possible after patient is dismissed from the hospital (see template for DC Summary Appendix 4)
- Will become “delinquent” 7 days after discharge

### Daily Progress Notes

- Use Inpatient Progress Note (fast track) on EMR and write “Daily Progress Note” as first line of HPI
- If hand written progress note is created, it has to include:
  1. Signs and symptoms change
  2. Treatment & side effect
  3. PRN meds use
  4. Testing - vitals, food/fluid intake, #hours of sleep, labs,
| Friday Off Service | Treatment plan of Friday progress note should emphasize  
1. legal status,  
2. weekend plans/recommendations, attention to medical complications  
3. whether patient can be discharged over the weekend. If dismissal of the patient is planned over the weekend, the Rx, paperwork, family meetings, FU appointments must be ready on Friday |
|-------------------|--------------------------------------------------------------------------------------------------|
| Consultation      | Most commonly needed consultations are  
1. Internal Medicine  
2. Psychologist for testing  
Residents are required to discuss need for consultation with attending physician before ordering consultation except in urgent cases |
| Order Sheet (Appendix 11) and KU Standing Orders (Appendix 9) | All orders must be dated, timed and written in legible handwriting  
PRN orders require specific indication, e.g….prn for agitation, insomnia, etc.  
Signature must be readable, or the name must be printed under the signature  
Don’t use forbidden abbreviations (Appendix 27) |
| Release of Information (ROI) VC 2177 | Is a permission given by patient that treatment team can discuss patient’s situation with person named on the ROI  
Not needed for communication with guardian |
| Voluntary Patient | A patient who signs admission consent, and does not oppose admission to VC-BHC |
| Involuntary Patient | A patient who refuses admission to VC-BHC but admission is deemed necessary by clinical team  
Involuntary commitment is initiated with a Application for Emergency Admission and Hold (Appendix 18)  
When a patient is given medication against his/her will, they will assume involuntary status and a court petition will need to be submitted (Appendix 19, 20)  
An involuntary patient may be discharged when the physician indicates that s/he is no longer in need of inpatient treatment and the patient, the patient’s attorney, |
| **Emergency Admission and Hold** (Appendix 18) | • Also called “Application for Emergency Admission and Hold for Observation For Mental Health, Alcohol or Substance Abuse Treatment”  
• Permits holding a patient against his/her will in the hospital for 24 hours if by virtue of mental illness or substance use the patient is believed to represent a danger to self or others  
• Can be filled out by any person who is concerned about the patient’s safety (health care provider, police officer, family member……)  
• The document must be dated and timed and is in effect until 5PM of the next business day after it was signed  
• Within these 24 hours the patient must either become voluntary (signs voluntary admission document) or a formal petition must be filed with the court form (form 2102 or 2202) (Appendix 19, 20) |
| **Mental Health Petition** Appendix 19 | • Can be filled out by Physician, Psychologist or Qualified Mental Health Professional  
• Petitioner certifies that patient is:  
  1. Suffering from Mental Disorder  
  2. Lacks capacity to make an informed decision regarding Tx  
  3. Is likely to cause harm to self, others, or damage to property  
  4. Is not solely diagnosed with Substance Abuse, ASPD, MR, organic personality/mental disorder (see form 2102)  
• Court has 3 working days to schedule hearing (usually at VC-BHC)  
• The hearing will be cancelled if patient signs the waiver offered to him by his attorney on the day before hearing. In this waiver, patient agrees to follow recommendations of Tx team.  
• Unless waiver is signed a hearing will be held (in VC-BHC in AM). The judge will decide whether the patient should be treated involuntarily. |
| **Substance Abuse Petition** Appendix 20 | • Can be filled out by Physician, Psychologist, or State Certified Alcohol and Substance Abuse Counselor  
• Petitioner certifies that patient:  
  1. Lacks self control as to the use of substances  
  2. Is incapacitated as a result of use of substances, with impaired judgment resulting in (see form 2202)  
  3. Is likely to cause harm  
  4. inability to make rational decisions with respect to the need for Tx  
  5. lacking capability to make responsible decisions concerning either the person’s well being or their estate  
• Court has 3 working days to schedule hearing (usually at VC-BHC)  
• The hearing will be cancelled if patient signs the waiver offered to him by his attorney on the day before hearing. In this waiver, patient agrees to follow recommendation of Tx team.  
• Unless waiver is signed a hearing will be held in VC-BHC in AM. The judge will whether the patient should be treated involuntarily. |
| **Statement about patient Lacking the Capacity to Make an Informed Decision concerning** | • Used in voluntary patients who are refusing reasonable treatment efforts and/or receive medication against their will  
• Accompanies petition (mental health or substance abuse) submitted to the court
### Treatment (Appendix 22)

Form 2193a

- Used if patient is already under a court petition and is non compliant with the treatment plan
- Patient can be sent back to the treatment facility (e.g., Psychiatric Hospital, CD Treatment center) against his/her will

### Ex Parte - Notice of Material Noncompliance

Appendix 21

- Request for Discharge from Voluntary Care and Treatment (Known as “72 hour letter of request”)

Appendix 23

Form VC 1572

- Used for voluntary patients only
- Is offered to the patient who wants to be dismissed from the hospital against Tx team recommendation
- Within 72 working hours after letter has been signed by patient – the treatment team must:
  - dismiss the patient from the hospital or
  - file petition with court
- Patients who complete a “72 hour letter of request” may choose on occasion to withdraw the letter and resume “voluntary” treatment status.

### 4. Leave policy

Residents must complete request for vacation, educational, administrative and planned sick leave 4 weeks prior to requested time off.

When absent from work resident must inform:

1. Residency coordinator – Barb (293-2680)
2. Supervising Attending Physician (685-1111)
3. Via Christi page operator (685-1111) with estimated time to return to work.
4. All parties listed above must be notified individually

### Leave Policy

<table>
<thead>
<tr>
<th>Leave</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacation</td>
<td>Can take only <strong>1 week</strong> of vacation <strong>per month</strong> while in Inpatient Psychiatry Rotation</td>
</tr>
<tr>
<td></td>
<td>The <strong>max consecutive time off is 2 weeks.</strong> This can only be approved if the first week occurs at the end of one rotation at the end of the month and the second week occurs at the beginning of the next different rotation the next month.</td>
</tr>
<tr>
<td></td>
<td><strong>End of June</strong> vacation – preference is given to residents leaving program</td>
</tr>
</tbody>
</table>

15 working days/year

Not cumulative
To avoid last minute complications ask chief resident not to be on call during requested time off

Inpatient VC-BHC residents - only 1 resident from those assigned to adult inpatient services may be off at any one time
1. Bring filled out leave request to residency coordinator to check your eligibility for time off (paperwork up to date, other resident is not off at the same time.)
2. Bring leave request approved by coordinator to attending to sign
3. Return signed leave request to program coordinator for final processing

**Education leave**

5 working days/year

Not cumulative

- Can be used for educational activities that are not required by training program
- Educational conferences (program brochure and proof of registration is required)
- Inpatient GSC residents – 5 days of educational leave cannot be taken in series with vacation leave during the same month
- Submit educational leave request to program coordination to initiate processing as for vacation leave (see above)

**Administrative leave**

- Can be used for activities required by program (ACLS, Step 3 – exam days only, Prite…)
- Approved recruitment Activities
- Submit educational leave request to program coordination to initiate processing as for vacation leave (see above)

**Sick leave**

10 days/year

Cumulative up to 30 days

- Planned medical leave:
  1. submit request for leave at least 4 weeks prior to requested time off
- Unplanned medical leave:
  1. Need doctor’s statement if ill more than 3 consecutive days
  2. Need to inform attending physician, program coordinator, Via Christi Operator (if on GSC rotation) individually in AM each day absent
  3. Need to check out your patients to covering resident or attending physician

- Planned or unplanned sick leave is granted for these reasons:
  1. Personal - illness, disability, obstetrical related conditions and recovery, appointments with health care provider
  2. Immediate family member - illness, disability, obstetrical related conditions and recovery, appointments with health care provider
G. Dress Code Via Christi Health

“No shirt, not shoes, no service”

1. **Policy:**
   a. All employees and resident physicians will set an example of neatness and cleanliness in personal appearance during work hours/shifts. Daily grooming and appropriate appearance are essential.
   b. Formal business or business casual attire should be worn. When on-call, hospital scrubs are acceptable attire.

2. **Definitions:**
   a. **Formal business attire:**
      (1) Shirt with collar, tie, jacket, and dress slacks for men.
      (2) Dress, suit or dress slacks and jacket for women.
   b. **Casual business attire:**
      (1) Shirt with collar or turtleneck.
      (2) Casual slacks for men or women (no jeans).
   c. **Grooming:** clean, neat, and pleasing in appearance.
   d. **Excessive:** exceeding what is proper, normal or reasonable.

3. **Responsibility:**
   (1) Residents will be responsible for following the Dress Code and Appearance policy

4. **Procedure:**
   a. The VCRMC, department director, manager, supervisor or KU faculty may request a resident comply immediately with the dress code to continue his/her duties. Time spent away from the facility to meet dress/grooming guidelines will be considered non-paid time.
   b. **Grooming:**
      (1) Hair, beards, and sideburns must be neatly groomed, clean and present a professional appearance.
      (2) Excessive use of cosmetics, fragrances and other accessories is not acceptable.
      (3) Facial jewelry, such as eye, nose, lip or tongue jewelry, is prohibited.
Artificial nails in the clinical and food preparation settings are prohibited as outlined in the VCRMC Infection Control policy.

c. Dress:

(1) Employees not customarily dressed in uniform or specified department attire:

(a) Must present a conservative, businesslike appearance by wearing appropriate clothing for the type of work being performed.

(b) Will not dress in clothing that detracts from the professional image of Via Christi.

(2) Required:

(a) Shoes: defined by department policy in accordance with safety guidelines. Use common sense—shoes should be clean, no sandals or flip flops, sport shoes should be limited to overnight call.

(b) Via Christi or KU ID badge is required and should be worn above the waist so the employee’s name is visibly recognized.

(c) Appropriate undergarments must be worn at all times and should not be visible at anytime.

(3) Inappropriate attire: (examples should not be considered all inclusive)

(a) Stained, wrinkled, tight, frayed, or revealing clothing.

(b) Jeans, other than on “Jean Day”

(c) Shorts

(d) Sweatpants/shorts or wind suits

(e) T-shirt, tank top, tube top, crop top or halter top.

(f) Shirts with inappropriate slogans and/or designs (i.e., only KU and VCRMC logos are acceptable).

(g) Other attire deemed inappropriate by management.

- Special Occasion days, recognized by the Via Christi organization or individual departments, may be observed (i.e., Breast Cancer Awareness Jean Day, Children’s Miracle Network Shirt Day, Christmas

(h) When in doubt about attire, please take the conservative choice to avoid problematic situations

SUMMARY

Above the safety net of your attendings, the inpatient service experience is set up as an opportunity for you to begin practicing what you have learned, learn new things, and hone your skills. The information in this manual may seem
daunting at first pass but we are confident that you will become familiar with and master the guidelines outlined here. Remember when in doubt ask your attendings or senior colleagues.

Things change and this manual will always be a work in progress. As new issues arise they will be addressed in memo format and you should file them in Section VI – Memos. At the end of each year the content of the memos is incorporated into the body of the text. We solicit your input for issues that need to be corrected, clarified, or added/deleted to the manual to make it more helpful for you.

This manual is an effort by the inpatient attendings to provide relevant information and guidelines to help you perform in the inpatient setting at your best and become skillful and accomplished. At times when the work seems arduous, refer to the learning objectives (Section II) and keep in mind that these practice opportunities in a protected setting are meant to help you ultimately become the best you can be, an effective, efficient, erudite psychiatrist who will enhance any professional setting they choose.

Best regard,

JL/MJB

APPENDIX OF FORMS

1) Hospital Admission Criteria
2) History and Physical Handwritten form (VC 771)
3) Discharge/Referral Summary VC 1635
4) Discharge Summary Dictation Template
5) Three minute Presentation
6) a) Physician Progress Note (VC 128)
   b) Physician Progress Note with MSE template (VC 128)
7) Daily Progress Note – Nursing
8) Consult Note (VC 120)
9) Orders – KU standing order template
10) Orders – Detox (VC 391)
11) Orders – Physician (VC 1716)
12) Orders – Restraints (VC 1030)
13) Physician Responsibility in the Use of Restraints/Seclusion
14) ED T-Sheet Psych. Disorder, Suicide Attempt, Overdose – Doctor
15) ED T-Sheet Psych. Disorder, Suicide Attempt, Overdose – Nursing/Triage
Neurology Goals and Objectives

A. **Goal:** The overall goal of the neurology clerkship is to teach the principles and skills underlying the recognition and management of the neurologic diseases a general medical practitioner is most likely to encounter in practice.

B. **Objectives:**
   a. To teach or reinforce the following PROCEDURAL SKILLS:
      i. the ability to obtain a complete and reliable history
      ii. the ability to perform a comprehensive neurologic examination [see Guidelines for a Comprehensive Neurologic Examination below]
         1. Students’ ability to adequately perform a comprehensive neurologic examination will be documented by assessing the bold items in Guidelines below during an observed neurologic examination.
      iii. the ability to perform a brief, screening neurologic examination [see Guidelines for a Screening Neurologic Examination below]
      iv. the ability to examine patients with altered level of consciousness or abnormal mental status [see Guidelines for the Neurologic Examination in Patients with Altered Level of Consciousness below]
      v. the ability to deliver a clear, concise, and thorough oral presentation of a patient’s history and examination
      vi. the ability to prepare a clear, concise, and thorough written presentation of a patient’s history and examination
   b. To teach or reinforce the following ANALYTICAL SKILLS:
      i. the ability to recognize symptoms that may signify neurologic disease (including disturbances of consciousness, cognition, language, vision, hearing, equilibrium, motor function, somatic sensation, and autonomic function)
ii. the ability to distinguish normal from abnormal findings on a neurologic examination
iii. the ability to localize the likely site or sites in the nervous system where a lesion could produce a patient’s symptoms and signs
iv. the ability to formulate a differential diagnosis based on lesion localization, time course, and relevant historical and demographic features
v. an awareness of the use and interpretation of common tests used in diagnosing neurologic disease
vi. an awareness of the principles underlying a systematic approach to the management of common neurologic diseases (including the recognition and management of situations that are potential emergencies)
vii. an awareness of situations in which it is appropriate to request neurologic consultation
viii. the ability to review and interpret the medical literature (including electronic databases) pertinent to specific issues of patient care

**Guidelines for a Comprehensive Neurologic Examination**

By the end of the clerkship, the student will demonstrate the ability to perform the following parts of the neurologic examination.

A. Mental Status
   a. Level of alertness
   b. Language function – Students should assess fluency (listening for fluency of language output) and formally check at least 1 of the following 3 items
      i. Comprehension – Follow a simple command such as “Show me your right thumb”. Be sure to not give any visual cues to the patient.
      ii. Repetition – “Repeat after me: No ifs, ands, or buts.”
      iii. Naming – Point to 2 objects and have the patient name them (Example: pen, watch)
   c. Memory
      i. Short-term
         1. This can be tested in 1 of 2 ways:
            a. Immediate and delayed – Have the patient recite 3 words: apple, table, penny. Then ask the patient to repeat the 3 words later
               -OR-
            b. Answer a couple of orientation questions (place, date, month, etc)
         2. Long-term – Ask the patient a question regarding a generally known historical fact. For example “Who is the president?”
   d. Calculation – Simple arithmetic but not just 2 + 2. Example: “What is 21 minus 7?”
   e. Visuospatial processing – Have the patient draw intersecting pentagons or a clock
   f. Abstract reasoning – Have the patient interpret a proverb. Examples:
      i. If you find a letter with a stamp and address on it lying on the ground, what would you do?
      ii. What does this mean: “A rolling stone gathers no moss.”

B. Cranial Nerves
   a. Smell – Checking each nostril separately, have the patient identify a common smell such as coffee or cinnamon
   b. Vision
      i. Visual fields
      ii. Visual acuity – Using the Snellen eye chart, this should be best corrected, meaning ask the patient to wear their glasses if they use them
      iii. Funduscopic examination
   c. Pupillary light reflex
   d. Eye movements – H-test
e. Facial sensation – Using your fingers or a cotton swab, test the right and left side of the face in all 3 divisions
f. Facial strength – Check muscles of facial expression and muscles of mastication
g. Hearing – Rub your fingers or whisper next to each ear. Do not snap your fingers, just rub them. If they can’t hear the rub, click your fingernails
h. Palatal movement – Observe palatal movement when the patient says “ahh”
i. Speech – Check articulation. Example: Have the patient say “po-ti-ka” which checks labial (lips), lingual (tongue), and palatal (palate) sounds
j. Neck movements against resistance
   i. Head rotation
   ii. Shoulder elevation
k. Tongue movement

C. Motor Function
   a. Pronator Drift – Have the patient hold both arms out straight in front, close their eyes, and observe for drift downward or pronation of either or both arms
   b. Muscle tone in the arms and legs (resistance to passive manipulation)
   c. Bulk – Observe for atrophy, etc.
   d. Strength
      i. Upper extremities: Shoulder abduction, elbow flexion, elbow extension, wrist flexion, wrist extension, finger flexion, finger extension, finger abduction, and thumb abduction
      ii. Lower extremities: Hip flexion, knee flexion, knee extension, ankle dorsiflexion, ankle plantar flexion
   e. Involuntary movements – Observe for any involuntary movements

D. Sensation
   a. Light touch – Use your fingertips or a cotton swab and test each arm and each leg
   b. Pinprick or temperature – Use an unused safety pin and test each arm and each leg
   c. Vibration – Use a 128 Hz tuning fork and test the distal joint in 1 finger on each hand and both great toes. If the patient cannot detect vibratory sense distally, then move proximally
   d. Proprioception – Test joint position sense at the distal joint in 1 finger on each hand and in both great toes. If the patient cannot detect joint movement distally, then move proximally.

E. Reflexes
   a. Deep tendon reflexes
      i. Biceps
      ii. Triceps
      iii. Brachioradialis (supinator)
      iv. Patellar (knee jerk)
      v. Achilles (ankle jerk)
   b. Plantar responses
   c. Frontal release signs

F. Cerebellum
   a. Rapid alternating movements – finger tapping, foot tapping, pronation/supination of the hands
   b. Finger-to-nose
   c. Heel-to-shin

G. Gait/Station
   a. Casual gait – check stride length, arm swing, turns, etc.
   b. On toes – have the patient walk away from you on their toes to assess heel height
   c. On heels – have the patient walk toward you on their heels to assess toe height
   d. Tandem walking – have the patient walk in a straight line with heel touching toes
e. Romberg – have the patient stand with their feet touching together, arms at their sides, and eyes open, then ask them to close their eyes and observe for swaying for a few seconds

**Guidelines for a Screening Neurologic Examination**

All medical students should be able to perform a brief, screening neurologic examination that is sufficient to detect significant neurologic disease even in patients with no neurologic complaints. Although the exact format of such a screening examination may vary, it should contain at least some assessment of mental status, cranial nerves, gait, coordination, strength, reflexes, and sensation. One example of a screening examination is given here.

A. Mental Status
   a. Level of alertness
   b. Appropriateness of responses
   c. Orientation to date and place

B. Cranial Nerves
   a. Visual acuity
   b. Pupillary light reflex
   c. Eye movements
   d. Hearing
   e. Facial strength (smile, eye closure)

C. Motor Function
   a. Pronator drift

D. Sensation
   a. One modality at toes – can be light touch, pain/temperature, or proprioception

E. Reflexes
   a. Deep tendon reflexes (biceps, patellar, Achilles)
   b. Plantar responses

F. Cerebellum
   a. Coordination (fine finger movements, finger-to-nose)

G. Gait
   a. Gait (casual, tandem)

Note: If there is reason to suspect neurologic disease based on the patient’s history or the results of any components of the screening examination, a more complete neurologic examination may be necessary.

**Guidelines for the Neurologic Examination in Patients with Altered Level of Consciousness**
A. Mental Status
   a. Level of arousal
   b. Response to auditory stimuli (including voice)
   c. Response to visual stimuli
   d. Response to noxious stimuli (applied centrally and to each limb individually)

B. Cranial Nerves
   a. Response to visual threat
   b. Pupillary light reflex
   c. Oculocephalic (doll’s eyes) reflex
   d. Vestibulo-ocular (cold caloric) reflex
   e. Corneal reflex
   f. Gag reflex

C. Motor Function
   a. Voluntary movements
   b. Reflex withdrawal
   c. Spontaneous, involuntary movements
   d. Tone (resistance to passive manipulation)

D. Reflexes
   a. Deep tendon reflexes
   b. Plantar responses

E. Sensation (to noxious stimuli)

American with Disabilities Act Statement

- Learning assistance, academic performance enhancement, and psychological services at KUMC are free, confidential, and available by contacting Academic and Student Affairs – Wichita – 316-293-2603.

- Any student in this course who needs an accommodation because of a disability in order to complete the course requirements should contact the instructor or the Equal Opportunity/Disability Specialist (913) 588-7813, TDD 913-588-7963 as soon as possible.
Letter to the Editor

Resolving Conflicts
Mohamed Ramadan, M.D.
Wichita, Kan.

Every year more than 900 new residents enter psychiatry residency programs; about 600 are U.S. graduates from all 50 states, and more than 300 are non-U.S. graduates from all over the world.

These residents work together on a daily basis for four years. For different reasons, they may experience conflicts among each other, and every resident has a way of dealing with such conflicts. However, using several methods of conflict resolution is confusing and time consuming. Thus, I would like to propose to my fellow residents the use of a three-step conflict resolution process that I have found to work very well. I call it the “OCD” guidelines:

First, whenever there is a conflict between two residents, the residents should talk to each Other. If the conflict is not resolved, then they should talk to the Chief resident. If the conflict is still not resolved, talk to the program Director.

Using this approach, my fellow residents and I have found that most conflicts are resolved at step one or two and that the process is time efficient and creates a good working atmosphere.

Reviewing these OCD guidelines with new residents during their program orientation will give them a uniform method to resolve conflicts and spells out the program’s expectations that they will use it.

I think these steps will come naturally to many residents, but clearly describing and reinforcing them are beneficial. Moreover, practicing these guidelines will help the professional growth of the residents and increase the cohesion among them.

PGY 2 Rotations

Division of Child & Adolescent Psychiatry Goals and Objectives Textbook Seminar
Division of Child & Adolescent Psychiatry Inpatient and Consultation and Liaison Rotation
Psychosomatic Medicine
Consultation and Liaison Psychiatry Service
Adult Inpatient Psychiatry Curriculum
Geriatric Psychiatry Service Curriculum – Goals and Objectives
Division of Child & Adolescent Psychiatry Goals and Objectives
Textbook Seminar

Seminar Site:  UKSM-W – Psychiatry Conference Room
1010 N. Kansas
Wichita, KS  67214

Thursdays Noon -1pm

Supervision provided by: Dr. Susan Daily
Dr. Russell Scheffer
Kristin L. Jones, MSN, ARNP, BC

Goals and Objectives

- Knowledge and review of normal growth and development.
  Competencies A. Patient Care
  B. Medical Knowledge.

- Knowledge and review of clinical assessments of children, adolescents, and families
  Competencies A. Patient Care
  B. Medical Knowledge.

- Understand developmentally relevant manifestations of psychopathology
  Competencies A. Patient Care
  B. Medical Knowledge.

- Knowledge of evidence based treatments for children and adolescents
  Competencies A. Patient Care
  B. Medical Knowledge.
  C. Practice – based Learning and Improvement
• Understand and learn how to communicate with the multiple systems involved in child’s life (e.g., parents, school, multidisciplinary team)

Competencies  F. System Based Practice

D. Interpersonal and Communication Skills.

E. Professionalism

Textbooks

by Andres Martin & Fred R. Volkmar (Editors)
www.lewischildpsychiatry.com

Clinical Handbook of Psychotropic Drugs for Children and Adolescents, 2nd Edition
by Kalyna Z. Bezchlibnyk-Butler & Adil S. Virani (Editors)

Lecture series in child and adolescent psychiatry

Part 1: Crash Course (8 weeks)

• Knowledge of policies and procedures for documentation, legal issues, communication and expectations in the Department of Psychiatry and Behavioral Sciences.
• Knowledge of initial assessment and engagement strategies when working with child and adolescent patients and their families.
  o Confidentiality
  o What to look for in a child mental status exam
  o Framework for the initial interview
  o Introduction to child/adolescent assessment tools
• Knowledge and skills for managing crisis situations.
  o Suicidal ideation
  o Abuse/Neglect reporting
  o Violence, legal charges
• Knowledge and review of commonly prescribed pharmacological interventions for children and adolescents.
Part 2: Child Development and Theory (6-8 weeks)

- Developmental milestones
- Freud
- Erickson
- Piaget
- Maslow
- Ainsworth
- Mahler

Part 3: Diagnosis Series (approx. 24 weeks)

Lectures for each topic to include diagnostic criteria, epidemiology, neurobiology, comorbidity, differential diagnosis, assessment tools/scales, medication treatments, psychotherapies, practice parameters.

- Attention and Disruptive Disorders - ADHD, ODD, and Conduct Disorder
- Mood Disorders – Depression and Bipolar
- Suicide in Children and Adolescents
- Anxiety Disorders – Generalized Anxiety, OCD, Tic Disorders
- Neglect, Abuse and Trauma - PTSD, Reactive Attachment, Munchhausen by Proxy.
- Childhood Onset Schizophrenia and other Psychotic Disorders.
- Substance Abuse
- Pervasive Developmental Disorders
- Learning Disorders, Mental Retardation
- Eating Disorders, Sleep Disorders and Elimination Disorders.

Part 4: Special Topics in Child and Adolescent Psychiatry (8-10 weeks)

- Seclusion, restraint and medicating against will for minor patients
- Child and adolescent neurology, traumatic brain injury, prenatal insults or deformities and seizure disorders.
- Divorce, Custody, Adoption
- Introduction to behavioral techniques and parent training interventions
- Psychological testing, neuropsychological testing, and psychoeducational testing
- Forensics
- Working with other professionals
- School services: IEP, 504 plans
- Chronic illness and end of life issues
- Grief
- School refusal
- Impulsivity
- Genetics
- Children of mentally ill parents
- Media influences
- Family dynamics
## Lecture Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Reading</th>
<th>Faculty presenter</th>
<th>Resident presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/2</td>
<td>Intro: documentation, legal issues, clinical expectations</td>
<td></td>
<td>Jones</td>
<td></td>
</tr>
<tr>
<td>7/9</td>
<td>Confidentiality, MSE</td>
<td>Lewis 4.2.1, 4.2.2</td>
<td>Perales</td>
<td></td>
</tr>
<tr>
<td>7/16</td>
<td>Structured interviews, assessment tools</td>
<td>Lewis 4.2.3</td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>7/23</td>
<td>Suicide risk assessment &amp; management</td>
<td>Lewis 5.4.3</td>
<td>Perales</td>
<td></td>
</tr>
<tr>
<td>7/30</td>
<td>Abuse/neglect, violence</td>
<td>Lewis 5.15.1</td>
<td>Perales</td>
<td></td>
</tr>
<tr>
<td>8/6</td>
<td>ADHD &amp; Externalizing Disorders: Stimulants</td>
<td>Handbook 19-38</td>
<td>Scheffer</td>
<td></td>
</tr>
<tr>
<td>8/13</td>
<td>Depression &amp; Anxiety: SSRI’s</td>
<td>Handbook 40-58, 92-102</td>
<td>Scheffer</td>
<td></td>
</tr>
<tr>
<td>8/27</td>
<td>Developmental Milestones</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>9/3</td>
<td>Intro to developmental theory; Freud</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>9/10</td>
<td>Freud; Erickson</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>9/17</td>
<td>Rogers &amp; Maslow</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>9/24</td>
<td>Behaviorism</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>10/1</td>
<td>Piaget</td>
<td>Piaget primer handout</td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>10/8</td>
<td>Temperament</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>10/15</td>
<td>ADHD/ODD/CD</td>
<td>Lewis 5.2.1, 5.2.2, 5.2.3</td>
<td>Jones</td>
<td>Mittal</td>
</tr>
<tr>
<td>10/22</td>
<td>ADHD/ODD/CD</td>
<td></td>
<td>Jones</td>
<td></td>
</tr>
<tr>
<td>10/29</td>
<td>ADHD/ODD/CD</td>
<td></td>
<td>Jones</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Topic</td>
<td>Resource 1</td>
<td>Resource 2</td>
<td>Resource 3</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>11/5</td>
<td>Depression</td>
<td>Lewis 5.4.1</td>
<td>Scheffer</td>
<td>Vijay</td>
</tr>
<tr>
<td>11/12</td>
<td>Depression</td>
<td></td>
<td>Scheffer</td>
<td></td>
</tr>
<tr>
<td>11/19</td>
<td>Bipolar</td>
<td>Lewis 5.4.2</td>
<td>Scheffer</td>
<td>Kereches</td>
</tr>
<tr>
<td>12/3</td>
<td>Bipolar</td>
<td></td>
<td>Scheffer</td>
<td></td>
</tr>
<tr>
<td>12/10</td>
<td>Suicide</td>
<td></td>
<td>Peralas</td>
<td>Bhatti</td>
</tr>
<tr>
<td>12/17</td>
<td>Psychotherapy</td>
<td>Lewis 6.2.1, 6.2.2, 6.2.3</td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>1/7</td>
<td>Anxiety</td>
<td></td>
<td>Jones</td>
<td>Magsalin</td>
</tr>
<tr>
<td>1/14</td>
<td>Anxiety</td>
<td></td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>1/21</td>
<td>Anxiety</td>
<td></td>
<td>Jones</td>
<td></td>
</tr>
<tr>
<td>1/28</td>
<td>Neglect, Abuse and Trauma</td>
<td></td>
<td></td>
<td>Wilkenson</td>
</tr>
<tr>
<td>2/4</td>
<td>Neglect, Abuse and Trauma</td>
<td></td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>2/11</td>
<td>Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/18</td>
<td>Schizophrenia and Psychosis</td>
<td>Lewis 5.3</td>
<td>Scheffer</td>
<td>Eboh</td>
</tr>
<tr>
<td>2/25</td>
<td>Schizophrenia and Psychosis</td>
<td></td>
<td>Scheffer</td>
<td></td>
</tr>
<tr>
<td>3/4</td>
<td>Pervasive Developmental Disorders</td>
<td>Lewis 5.1.1</td>
<td>Daily</td>
<td>Adepoju</td>
</tr>
<tr>
<td>3/11</td>
<td>Pervasive Developmental Disorders</td>
<td></td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>3/18</td>
<td>LD and MR</td>
<td>Lewis 5.1.2, 5.1.3</td>
<td>Klaus</td>
<td>McHale</td>
</tr>
<tr>
<td>3/25</td>
<td>LD and MR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/1</td>
<td>Eating Disorders</td>
<td></td>
<td>Handoo</td>
<td></td>
</tr>
<tr>
<td>4/8</td>
<td>Sleeping and Elimination Disorders</td>
<td></td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>4/15</td>
<td>C&amp;A neurology, TBI</td>
<td></td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>4/22</td>
<td>Divorce, Custody and Adoption</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/29</td>
<td>Seclusion and restraint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/6</td>
<td>Psychological testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/13</td>
<td>Forensics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/20</td>
<td>Chronic illness end of life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Topic</td>
<td>Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------</td>
<td>------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/27</td>
<td>Grief</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/3</td>
<td>Working with other professions</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/10</td>
<td>School services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/17</td>
<td>School refusal/impulsivity</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/24</td>
<td>Behavioral techniques and parent training</td>
<td>Klaus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Expectations and Evaluation

- Residents will attend and actively participate in all lectures
- Lectures will start promptly at noon; residents are welcome to bring lunch
- During part 3 of the lecture series, each resident will give a 15-20 minute presentation on one disorder. Presentations will include DSM criteria (with child specific manifestations as appropriate), a case example, and discussion of differential diagnosis.
- Evaluation may include written exams, PRITE, role plays, and presentations.

Medical Knowledge

- Resident demonstrates knowledge of normal growth and development
- Resident shows knowledge of the psychiatric diagnostic classifications system
- Resident demonstrates knowledge of assessment strategies and tools
- Resident understands biological, psychological, and sociocultural contributions to psychiatric illness
- Resident shows knowledge of appropriate use of psychopharmacological agents
- Resident shows knowledge of appropriate psychotherapeutic and educational interventions

Practice-Based Learning and Improvement

- The resident knows up-to-date practice parameters and treatment guidelines
- The resident demonstrates skill in critical evaluation of treatment options based on emerging scientific literature

Interpersonal and Communication Skills

- The resident gave effective and well-organized presentations as required
- The resident actively engaged in group discussions

Professionalism

- The resident had knowledge of relevant ethical and legal standards
- The resident demonstrated consistent follow through with readings and assignments
- The resident was punctual for lectures
- The resident maintained professional appearance and grooming

Systems-Based Practice

- The resident understands the role of various members of the multidisciplinary team (e.g., schools, social workers, therapists, nursing staff, legal system, etc.)
Division of Child & Adolescent Psychiatry Goals and Objectives
Inpatient and Consultation and Liaison Rotation

Site Locations: Via Christi Good Shepherd Campus

8901 E. Orme
Wichita, KS  67207
316-858-0333

Via Christi St. Francis Campus
929 N. St. Francis
Wichita, KS  67214
316-268-5000

Via Christi St. Joseph Campus
3600 E. Harry
Wichita, KS  67211
316-268-5000

Supervision provided by:  Mercedes Peralas, MD
Susan Daily, MD
Russell Scheffer, MD
Kristin L. Jones, MSN, ARNP, BC

Goals and Objectives

- Knowledge and review of normal growth and development.

  Competencies  A. Patient Care
B. Medical Knowledge.

- Knowledge and review of clinical assessments of children and adolescents versus adult assessments.
  Competencies  A. Patient Care

  B. Medical Knowledge.

- Knowledge and review of resident as educator for children and adolescents and their families.
  Competencies  C. Practice – based Learning and Improvement

  D. Interpersonal and Communication Skills.

  E. Professionalism

- Knowledge and review of coordination of care with multiple disciplines.
  Competencies  F. System Based Practice

  D. Interpersonal and Communication Skills.

  E. Professionalism

- Knowledge, review and implementation of current research and evidence based approaches to patient care.
  Competencies  D. Interpersonal and Communication Skills.

  C. Practice – based Learning and Improvement

- Knowledge, review and implementation of current research and evidence based approaches to patient care.
  Competencies  D. Interpersonal and Communication Skills.

  C. Practice – based Learning and Improvement

- Knowledge, review and implementation of appropriate ethical and/or legal standards and maintaining confidentiality.
  Competencies  E. Professionalism

- Knowledge, review and implementation of cost awareness, resource management and risk-benefit analysis.
  Competencies  F. System Based Practice

Expectations
- Appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies
  A. Patient Care
  B. Medical Knowledge.
  F. System Based Practice
  D. Interpersonal and Communication Skills.
  E. Professionalism

- Documentation consistent with appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies
  F. System Based Practice
  D. Interpersonal and Communication Skills.
  E. Professionalism

- Dependability and evidence of appropriate documentation consistent with appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies
  A. Patient Care
  B. Medical Knowledge.
  F. System Based Practice
  D. Interpersonal and Communication Skills.
  E. Professionalism

- Consideration of legal issues and cultural sensitivities when assessing, documenting and formulating child and adolescent treatment plans.
  Competencies
  D. Interpersonal and Communication Skills.
  E. Professionalism

Resident responsibilities

- Participation in all scheduled inpatient and consultation and liaison responsibilities.
• Participation in providing clinical services for adolescent inpatient and consultation and liaison services including, assessment, treatment formulation, documentation, continued management, coordination of care and referrals.

**Evaluation**

• Residents will be evaluated with consideration being given to the above objectives, expectations, responsibilities and the implementation of these items into treatment.

• Residents will additionally be evaluated using clinical observations by supervising faculty, case presentations and journal presentations.

• PRITE

**Patient Care**

• The resident conducted comprehensive psychiatric interviews with children and families, including developmental history, school functioning, social functioning, and family functioning.
• The resident effectively engaged children and adolescents in the evaluation using language and communication style appropriate for the child’s developmental level.
• The resident performed physical examinations, including detailed neurological examination when indicated.
• The resident made diagnostic formulations commensurate with level of training.
• The resident appropriately assessed for potential dangerous behavior.
• The resident formulated and implemented appropriate treatment plans.
• The resident intervened effectively in emergencies.
• The resident appropriately conducted behavioral therapy when indicated.
• The resident will demonstrate knowledge of the appropriate and legal use of seclusion, restraints and medications given against patient’s will.
• The resident will demonstrate knowledge and appropriate treatment formulation for children and adolescents with substance abuse issues.
• The resident demonstrated knowledge and appropriate interventions for children or adolescents who are dying or dealing with grief issues.
• The resident demonstrated knowledge of policies and procedures for each rotation site.

**Medical Knowledge**

• Resident demonstrates knowledge of normal growth and development.
• Resident shows knowledge of the psychiatric diagnostic classifications system as applied to children and adolescents.
• Resident demonstrates knowledge of assessment considerations and tools for children, adolescents, and families.
• Resident understands biological, psychological, and sociocultural contributions to psychiatric illness in children and adolescents.
• Resident shows knowledge of appropriate use of psychopharmacological agents with children and adolescents.
• Resident shows knowledge of appropriate psychotherapeutic and educational interventions for children and adolescents.

**Practice-Based Learning and Improvement**

• The resident recognized and accepted limitations in his/her own knowledge base and skills.
• The resident demonstrated appropriate skills for obtaining and evaluating up-to-date information from scientific and practice literature and other sources to assist in quality care of patients.
• The resident facilitated the learning of students and other health care professionals.

**Interpersonal and Communication Skills**

• The resident demonstrated effective oral and written communication skills.
• The resident completed proper medical record documentation.
• The resident effectively communicated information about diagnoses and treatment to children and families.
• The resident effectively communicates with schools, referral sources, and other treatment providers as appropriate.

**Professionalism**

• The resident had knowledge of ethical and legal standards in working with children and adolescents and maintained these standards in practice.
• The resident maintained appropriate boundaries with patients and families.
• The resident completed timely medical documentation.
• The resident demonstrated consistent follow through with responsibilities.
• The resident was punctual for meetings and assignments.
• The resident maintained professional appearance and grooming.

**Systems-Based Practice**

• The resident effectively communicates with schools, referral sources, and other treatment providers as appropriate.

**Psychosomatic Medicine**

**Consultation and Liaison Psychiatry Service**

**Location:** Via Christi Health System St. Francis and St. Joseph Medical Centers

**Year of Training:** PGY-2

**Duration:** PGY-2 residents 2 months full time

**Supervising Attending:** Inna D’Empaire, M.D.

Connie Marsh, M.D.
Consultation and Liaison Psychiatry Service supports the mission and vision of the Academy of Psychosomatic Medicine (www.apm.org) by striving to provide excellence in clinical care for patients with comorbid psychiatric and general medical conditions.

General Goals:

1. Expand knowledge of the signs and symptoms, differential diagnosis, course of psychiatric and behavioral conditions commonly encountered in the medical setting.
2. Improve skills on data gathering, case formulation, reasonable treatment intervention and communication in the psychiatric care of the medically ill.
3. Help diagnose, understand and manage a wide variety of conditions and address the needs of the patient and the medical-surgical team.
4. Provide comprehensive clinical care for patients with comorbid psychiatric and general medical conditions in the medical setting.
5. Learn to provide an expert opinion in the diagnosis and treatment of psychopathology in the medically ill by demonstrating appropriate skills for obtaining and evaluating up-to-date information from the literature to assist in the quality care of patients.
6. Understand common differential diagnostic categories of psychiatric conditions in the general hospital:
   a) psychiatric presentations of medical conditions;
   b) psychiatric complications of medical conditions or treatments;
   c) psychological reactions to medical conditions or treatments;
   d) medical presentations of psychiatric conditions;
   e) medical complications of psychiatric conditions or treatments;
   f) comorbid medical or psychiatric conditions.
7. Work collaboratively with physicians and health care teams from various specialties demonstrating awareness and responsiveness to the larger context of the health care system.
8. Learn and apply a variety of psychotherapeutic techniques to the medically ill including crisis intervention, supportive psychotherapy, interpersonal therapy, cognitive-behavioral therapy, pharmacotherapy and other somatic therapies.

Patient Care

Residents must be able to provide psychiatric consultation that is compassionate, appropriate, and effective for the treatment of complex health problems and the promotion of health in patients admitted to the general medical hospital.

Residents are expected to:

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients, their families and the medical staff.
2. Gather essential and accurate information about their patients.
3. Conduct comprehensive psychiatric assessment adequate to formulate and organize DSM-IV multiaxial diagnoses:
   a) obtain medical-psychiatric history;
   b) clarify consultee-stated vs. consultant-assessed reason for referral;
   c) assess for the extent of medical/surgical illness;
   d) assess for the extent of medication/substance abuse;
   e) assess for the adequacy of pain management;
   f) assess for disturbances of cognition;
g) recognize, evaluate and categorize typical signs and symptoms of psychiatric disorders and the patient’s character style and behavior in culturally diverse population;

h) inquire about thoughts of dying;

i) take into consideration and apply relevant ethical principles;

j) perform physical and detailed neurological examination if indicated.

4. Achieve confidence and comfort in interviewing patients in a variety of medical settings.

5. Learn to assess interpersonal and family issues, apply system theory and resolve conflicts.

6. Recognize and manage hospital stressors, place the course of hospitalization and treatment in perspective to individual patient care.

7. Gather data from appropriate sources assess and interpret laboratory and medical information; make informed decisions about diagnostic and therapeutic interventions based on patient information, preferences, up-to-date scientific evidence, and clinical judgment.

8. Appropriately access potential for dangerous behavior requiring intervention, and intervene effectively in emergencies using the range of treatment modalities.


10. Apply a variety of psychotherapeutic techniques (crisis intervention, short-term, supportive, interpersonal, group, family, cognitive-behavioral therapy) to the medically ill in response to the patient’s needs.

11. Make medicolegal determinations: provide, acquire and/or clarify information, support a clinical decision, render an opinion and/or resolve a conflict.

12. Write pertinent, focused and useful consultation note.

13. Provide continuing input as needed, initiate transfers to a psychiatry service, and assist with disposition planning.


**Medical Knowledge**

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences of psychiatric illness in medically/surgically ill patients and apply this knowledge to patient care.

**Residents are expected to:**

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

2. Demonstrate knowledge of psychiatric treatments of patients with complex and comorbid illnesses:
   1) Acute stress reactions
   2) Aggression and impulsivity
   3) AIDS or HIV infection
   4) Alcohol and drug abuse (including withdrawal states)
   5) Anxiety or panic
   6) Assessment of psychiatric history
   7) Burn sequelae
   8) Change of mental status
   9) Child abuse
   10) Coping with illness
   11) Death, dying, and bereavement
   12) Delirium
   13) Dementia
   14) Depression
   15) Determination of capacity and other forensic issues
   16) Eating disorders
   17) Electroconvulsive therapy
   18) Ethical issues
   19) Factitious disorders
20) Family problems
21) Geriatric abuse
22) Malingering
23) Pain
24) Pediatric psychiatric illness
25) Personality disorders
26) Posttraumatic stress disorder
27) Pregnancy-related care
28) Psychiatric care in the ICU
29) Psychiatric manifestations of medical and neurological illness
30) Psychological factors affecting medical illness
31) Psychological and neuropsychiatric testing
32) Psycho-oncology
33) Pharmacology of the medically ill
34) Psychosis
35) Restraints
36) Sexual abuse
37) Sleep disorders
38) Somatoform disorders
39) Suicide in the medical hospital
40) Terminal illness
41) Transplantation issues

3. Advise and guide consultees about the role of the medical disease and appropriate use of psychopharmacological agents in the presenting patient care.
4. Work effectively as a member and leader of the multidisciplinary team to maximize the care of complex medically/surgically ill patients.

Practice-Based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

Residents are expected to develop skills and habits to be able to:

- Identify strengths, deficiencies and limits in one’s knowledge and expertise;
- Set learning and improvement goals
- Demonstrate appropriate skills from obtaining and evaluating up-to-date information from scientific and practice literature to assist in the quality of care
- Facilitate the learning of students and other health care professionals
- Use information technology to optimize learning
- Actively participate and present in weekly clinical Neuroscience case-based presentations and learn to apply scientific evidence to individual patient care

Evaluation:

Case presentation with literature support focused on multidisciplinary patient care approach (resident evaluation form attached).
Systems Based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide care that is of optimal value.

Residents are expected to:

- Coordinate patient care within the Via Christi health care system
- Advocate for quality patient care and assist patients in dealing with complex mental health issues
- Demonstrate an understanding of how various medical practices and delivery systems differ from one another and impact patient care
- Participate in identifying systems errors and in implementing potential systems solutions

Professionalism

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

Residents are expected to demonstrate:

1. Know and maintain applicable ethical, legal standards, professional appearance and grooming, and appropriate boundaries with patients and medical staff.
2. Demonstrate compassion, integrity, and respect for others
3. Demonstrate sensitivity and appreciate ethical issues while caring for patients with diverse psychiatric and medical/surgical conditions
4. Demonstrate accountability to patients needs, other health care providers, and the profession and responsiveness to patient needs that supersedes self-interest
5. Demonstrate consistent follow through with clinical responsibilities and clear, timely and accurate documentation.
6. Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
7. Demonstrate effectiveness and completeness of sign-outs, cross-coverage and on call tasks.

Evaluation:

Timely completion of documentation and follow through with clinical responsibilities (sign out to the 3rd year residents on Fridays, communication with peers while transferring patients to inpatient psychiatric units).

Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and other health care professionals.

Residents are expected to:

- Residents will demonstrate ability to work as a member of a multidisciplinary patient care team
• Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds
• Residents will use effective listening skills, demonstrate empathy and awareness of countertransference, learn to effectively elicit information from and provide information to other health care providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators and consulting physicians
• Demonstrate proficiency in conveying difficult information to the patients and their families
• Advise and guide consultees in managing patients with comorbid psychiatric disorders and complex medical conditions
• Timely and accurately complete medical documentation

360 evaluation provided by the medical staff member

Teaching Methods

1. In the beginning of the rotation each resident has the opportunity to observe the attending perform all the elements of clinical consultation.
2. Teaching at the bedside is enhanced by role modeling.
3. Residents are closely supervised and observed as they complete an entire clinical consultation. Timely feedback is provided as part of the consultation process. Residents are also supervised completing parts of the consultation, including the management of established patients in the hospital.
4. Psychosomatic Medicine Lecture series and group case-based discussions.
5. Weekly multidisciplinary Neuroscience clinical conference focused on clinical care and quality improvement
6. Preparation for multidisciplinary monthly case conferences
7. Teaching at Via Christi Medical Center in different settings, including intensive care units, general medical/surgical units, burn center, trauma unit, epilepsy center

Assessment Method (residents)

1. Weekly case-based assignments
2. Participation in the multidisciplinary Neuroscience clinical conference
3. Participation and presentation at the monthly multidisciplinary case conference
4. Timely completion of documentation
5. Patient satisfaction and feedback
6. PRITE exam
7. Active involvement in patient care

Assessment Method (Program Evaluation)

1. Confidential written feedback by individual residents
2. Resident retreat report

Service Specific Procedures and Responsibilities:

1. Review and print the walk lists for Dr. Inna D’Empaire on a daily basis.
2. The resident on the service will be notified about the new consults by Dr. D’Empaire, KUSM-W Department of Psychiatry or Via-Christi staff.
3. Verify that a written request for a psychiatric consultation is on the order sheet prior to seeing a consult.
4. If it is determined that the pt is active with COMCARE (660-7500) or has a private psychiatrist, notify the staff of such and decline the consult by written order.

5. The process of psychiatric consultation includes the following components:
   a) speak directly with the referring clinician;
   b) review the current record and pertinent past medical records;
   c) review current medications and laboratory tests;
   d) gather collateral information from the medical staff;
   e) interview and examine the patient;
   f) gather collateral information from family after obtaining consent unless an emergency;
   g) formulate a working diagnosis, differential diagnosis, reasonable treatment plan and discuss with the attending physician;
   h) write a brief formulation, including pertinent mental status exam findings, diagnostic impression, and treatment recommendations on the blank consult page;
   i) speak directly with the referring clinician (only after discussion with the attending);
   j) dictate a detailed and thorough consultation report:
      - name of the referring physician;
      - name of the consultant;
      - reason for the consultation;
      - date of the consultation;
      - chief complaint;
      - history of present illness;
      - past psychiatric history;
      - past medical history;
      - allergies;
      - current medications;
      - family history;
      - psychosocial history (including past history of abuse or neglect, education, employment, disability, marital history, legal history, current living arrangements and psychosocial stressors);
      - thorough mental status exam, including MMSE;
      - case formulation;
      - diagnostic impression and differential diagnosis by using multi-axial system and completing all five axes;
      - initial treatment recommendations and follow up plan.
   k) provide periodic follow-up as need dictates.

6. Communicate with the attending physician when changes in orders are recommended.
7. The resident will be expected to maintain an excellent working relationship with the medical support staff.
8. Whenever possible, the resident will be in attendance when the attending interviews the patient to allow for further discussion of the case.
9. Participate in a weekly consultation/liaison reading discussions and Neuroscience clinical case conferences.

Confidentiality:

All members of the treatment team are required to protect patient confidentiality as outlined by HIPPA rules and regulations.

Suggested Reading:

2. Evidence-based journal articles addressing psychiatric comorbidity in the medical setting.
Quality means doing it right when no one is looking ~ Henry Ford

Dear Resident,

I look forward to working with you during your C-L rotation and hope it will be an interesting and fulfilling one.

I am continuously working on improving the flow of the consultation service and would appreciate your feedback.

1) Please plan on starting your day around 7 am at the appropriate hospital (SJC or SFC) based on the consultation need.

2) At the end of each day I will discuss and try to outline the plan for the following business day with you. This plan might change frequently as the day progresses and I would encourage you to always contact me if you have any questions.

3) Since I have to coordinate my C-L service with my administrative duties I would appreciate if you could page me at 8 am every morning with your report. Please page Dr. Don Brada at 2 p.m. since he is covering C-L service in the afternoons.

4) Every Monday morning you should page the 3rd year resident on call for the previous weekend to receive the weekend report for the C-L service and identify the new and follow up patients. The same routine is repeated on Fridays when you sign off for the weekend to the next resident on call.

5) Clinical geriatric psychiatry/consult conference is on Tuesdays at 8:30 am on the Geriatric Unit at SJC.

6) Attached are the objectives for the C-L service, dictation template and helpful references.

Several residents combined their efforts in creating dictation template suggestions. Please review and feel free to modify for your use.

**Multidisciplinary Case Presentation**

3rd Friday of the month

GSH  Room 2009 12-1:30

PGY-1 and PGY-2 residents

Supervising Faculty: Inna D’Empaire, M.D.

**Goals:**

1. Presentation of the challenging and interesting case that would stimulate a collaborative discussion among the medical staff, students, residents and faculty.

2. Improvement of the presentation skills and opportunity to provide constructive feedback.
Competency-specific objectives:

1. **Patient Care**: preparing the presentation will assist the resident in acquiring skills necessary for providing compassionate, appropriate and effective care and assist in decision-making process.

2. **Medical Knowledge**: residents are advised to study the topic of the presentation in depth and present new information useful in guiding patient care.

3. **Interpersonal and Communication Skills**: multidisciplinary approach of the presentation will help the resident focus on effective communication and learn how to maintain professional and therapeutic relationships with health care providers.

4. **System-Based Practice**: discuss opportunities for effective consultation within the health care team.

5. **Practice-Based Learning and Improvement**: researching the literature to support the topics discussed will help resident learn information technology tools to support clinical practice and continue personal education.

6. **Professionalism**: demonstration ongoing commitment to professional development and opportunity to receive faculty, student, staff and peer feedback.

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 20, 2010</td>
<td>Z. Khan</td>
</tr>
<tr>
<td>September 17, 2010</td>
<td>S. Mahal</td>
</tr>
<tr>
<td>October 15, 2010</td>
<td></td>
</tr>
<tr>
<td>November 19, 2010</td>
<td></td>
</tr>
<tr>
<td>December 17, 2010</td>
<td></td>
</tr>
<tr>
<td>January 21, 2011</td>
<td></td>
</tr>
<tr>
<td>February 18, 2011</td>
<td></td>
</tr>
<tr>
<td>March 18, 2011</td>
<td></td>
</tr>
<tr>
<td>April 15, 2011</td>
<td></td>
</tr>
<tr>
<td>May 20, 2011</td>
<td></td>
</tr>
</tbody>
</table>

*Forms*

**APM Practice Guidelines**

**Dictation Template for Psychiatry Consult**
**Adult Inpatient Psychiatry Curriculum**

**EDUCATIONAL GOALS:**

Development and display in practice the knowledge, skills and attitudes necessary for the optimal clinical care of patients with mental disorders.

Keeping in mind that each learner begins inpatient psychiatry with their own unique skill set and will progress at different rates, Understanding of RIME conceptualization of the learning process:

- **Reporter** collects and reports clinical data but has limited ability to meaningfully prioritize and synthesize the data. This role is assumed by beginning learners.
- **Interpreter** can prioritize and interpret clinical data to formulate diagnostic hypotheses and treatment recommendations.
- **Manager** can see the big picture, apply knowledge, develop accurate diagnostic hypothesis, and initiate appropriate evaluation and treatment plans.
- **Educator**, the highest level in this particular hierarchy and the ultimate goal for all learners, continuously involves self-assessment and personal learning efforts to maintain an up-to-date, in-depth knowledge that is readily applied to patient care and the education of colleagues.

There are six competency domains set out by the Accreditation Council for Graduate Medical Education (ACGME – 2000). Competency in all six areas should be achieved by completion of the residency training program. These domains serve as a guideline for understanding the learning goals in residency training. They include:

1. Patient Care - PC;
The specific learning objectives for the inpatient psychiatry rotations support one or more of the ACGME competency domains.

**LEARNING OBJECTIVES, COMPETENCY DOMAINS, EXPECTATIONS AND EVALUATION**

**Learning Objective**
- Be able to perform a risk assessment of designated patients

**Competency Domain**
- PC, MK, CS, SBP

**Expectations**
- Assess patient’s dangerousness, and need for hospitalization
- Interact with the court system regarding involuntary commitment of mentally ill patients

**Feedback and Evaluation**
- Ongoing and timely feedback based on observation resident’s interaction with the patients
- Ongoing and timely feedback based on resident’s interpretation of data and ability to decide when commitment is necessary
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation

**Learning Objective**
- Be able to perform History and Physical Exam
- Be able to perform Mental Status Exam (MSE)

**Competency Domain**
- PC, MK, CS

**Expectations**
- Interview performed in skillful manner - knowledge of different interviewing techniques
- Physical exam (PE), neurological exam and complete Mental Status Exam (MSE) are competently performed

**Feedback and Evaluation**
- Ongoing and timely feedback based on resident’s ability to perform comprehensive patient interview during morning rounds
- Ongoing and timely feedback of resident’s ability to use different and appropriate interviewing techniques during the patient interview
• Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation

Learning Objective

• Be able to prioritize, organize and interpret clinical data to formulate a relevant, comprehensive differential diagnosis and plan

Competency Domain

• PC, MK, PBL, CS, P

Expectations

• Formulate diagnostic impression supported by clinical data using a biopsychosocial model and accounting for the patient’s ethnic and cultural background
• Develop a plan for further evaluation (appropriate use of laboratory and psychological testing, and consultation)
• Develop treatment plan including Electro Convulsive Treatment (ECT) during the hospitalization and after discharge from the hospital

Evaluation and Evaluation

• Ongoing and timely feedback based on resident’s ability to create concise, accurate summary of collected data regarding their individual patients
• Ongoing and timely feedback based on resident’s ability to apply analytical thinking to propose plan for the correct evaluation of the patient that will lead to correct diagnosis and treatment, ECT workup included
• Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation

Learning Objective

• Be able to engage designated patients and their families in an empathic manner, discuss and demonstrate a range of interviewing techniques

Competency Domain

• PC, MK, CS, P

Expectations

• Build good rapport with the patient, use of empathy
• Knowledge of different interviewing techniques
• Apply interviewing techniques during interview of the patients/their families

Feedback and Evaluation

• Ongoing and timely feedback based on resident’s ability to recognize patient’s needs and adapt to them during the patient’s interview
• Ongoing and timely feedback based on residents ability to recognize importance to communicate with patient’s families in effective manner during the family meetings and phone conferences
• Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation
Learning Objective

- Recognize the importance of collateral history and be able to obtain and interpret information from multiple sources

Competency Domain

- PC, MK, CS

Expectations

- Understand importance of collateral information for correct diagnosis
- Become skillful at eliciting and interpreting relevant information from patient’s family, prior caregivers and other sources
- Review and summarize previous medical records

Evaluation

- Ongoing and timely feedback based on resident’s ability to recognize complex cases, the importance of collateral history, collection and interpretation of collected data.
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation will be based on resident’s performance during the team meeting and review of the written documentation

Learning Objective

- Demonstrate ongoing efforts to develop expand and apply in practice a knowledge base in general psychiatry particularly in areas relevant to assigned patients

Competency Domain

- PC, MK, PBL

Expectations

- Become familiar with diagnostic criteria for common psychiatric diagnosis
- Develop working knowledge of treatment for common psychiatric disorders
- Identify gaps in knowledge base and proactively eliminate them (teaching rounds, lectures, self education)
- Direct personal study to topics relevant to assigned patients
- Regularly seek consultation and feedback from attending physician and senior resident

Evaluation

- Ongoing and timely feedback based on resident’s ability to formulate the list of differential diagnosis
- Ongoing and timely feedback based on resident’s ability to propose biological and psychological
- Ongoing and timely feedback based on residents ability to use evidence and methods to investigate, evaluate and improve patient care
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation will be based on resident’s performance during the team meeting and review of the written documentation

Learning Objective
• Be able to work effectively as a member of your assigned treatment team and as the physician member of a multidisciplinary treatment team

Competency Domain

• PC, MK, PBL, CS, P, SBP

Expectations

• Attend team meetings and be prepared to present your patient
• Have a working knowledge of assigned patients including target symptoms, problem list, diagnosis and differential diagnosis, current medication, progress during past 24 hours, plan for next 24 hours
• Work effectively with other members of the treatment team and be appropriately respectful to the attending physician team leader
• Attend Multidisciplinary staff meetings and be prepared to contribute in a concise, meaningful manner
• Work effectively with psychologists, nursing staff, social workers, therapists and other allied healthcare personnel

Evaluation

• Ongoing and timely feedback based on residents ability to collect and interpret collected data, formulate the list of differential diagnosis and propose treatment following biopsychosocial model
• Ongoing and timely feedback based on residents ability to identify target symptoms, follow the change in target symptoms with the treatment and adjust the treatment if needed
• Ongoing and timely feedback based on residents ability to work with other treatment team members demonstrating knowledge of optimal health care delivery
• Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation will be based on resident’s performance during the team meeting and review of the written documentation as well as feedback from other team members (social workers, nurses…)

Learning Objective

• Be able to skillfully document clinical data in a written format including orders, history, and patient progress; routinely review and be familiar with the sections of a medical inpatient chart.

Competency Domain

• PC, MK, PBL, CS,

Expectations

Be familiar with:

• Physician’s Order Sheet, KU Standing Orders, Detox Orders
• Electronic and handwritten H&P form on newly admitted patients
• Admission status on newly admitted patients (voluntary vs. involuntary)
• Daily progress documentation (electronic or handwritten) should include a review of the prior 24 hours referring to all sections of the patient’s chart on established patients
• Nursing notes yellow pages (Appendix 7)
• Flow sheets – vital, sleep, food/fluid intake
• MAR (list of all active medications in the hospital)
• Consult notes (Appendix 9) if consult ordered
• Family meeting, outpatient treatment team input, phone calls, etc. – write on green progress note or as addendum on EMR
• Discharge form VC 1635, dictated discharge summary
• Medication reconciliation form (Mirror Image) – created on the discharge date for all patients hospitalized in Via Christi
Evaluation

- Ongoing and timely feedback based on resident’s ability to use appropriate forms of documentation
- Ongoing and timely feedback based on resident’s ability to convey information and data synthesis in oral and written format
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation based on resident’s performance and review of written documentation

Learning Objective

- Demonstrate efforts to educate medical students, all treatment team members, patients and their families

Competency Domain

- PC, MK, PBL, CS, P, SBP

Expectations

- Medical Student Education
- Direct supervision of patient interview
- Review medical student’s documentation
- Encourage direct participation in patient care – conducting interviews, preparing timelines, gathering and summarizing collateral info, working with patients and families
- Educate fellow residents, staff, family members, attendings…

Evaluation

- Ongoing and timely feedback based on resident’s ability to engage and educate medical students as observed during their interaction
- Ongoing and timely feedback based on resident’s ability to involve medical student in patient care in meaningful way based on student’s participation case discussion during the team meetings
- Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry rotation based on resident’s performance

Learning Objective

- Be able to discuss and demonstrate behaviors consistent with self-awareness and professionalism

Competency Domain

- PBL, P, SBP

Expectations

- Recognize need for guidance/supervision when faced with new or complex responsibility
- Develop insight to the impact of one’s behavior on others
- Awareness of appropriate professional boundaries
- Exhibit the qualities of altruism and advocacy including putting the best interests of the patient above self-interest or the interest of others

Evaluation

- Ongoing and timely feedback based on resident’s dedication, reliability and integrity
- Ongoing and timely feedback based on resident’s ability to be respectful and sensitive to patient needs
• Ongoing and timely feedback based on resident’s ability to solicit feedback and insight to own deficits
  with appropriate improvement of these deficits
• Verbal feedback during weekly supervision and written evaluation in the end of inpatient psychiatry
  rotation

**Recommended Reading**

1. Principles of Inpatient Psychiatry – Fred Ovsiew, Richard I. Munich (2009 by Lippincott Williams and
   Wilkins, a Wolters Kluwer business)
   American Psychiatric Publishing, Inc.)
5. American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders
   Compendium, (May 2006)
7. Essential Psychopharmacology Neuroscientific Basis and Practical Applications – Stephen M. Stahl
8. Psychiatry Rounds: Practical Solutions to Clinical Challenges – Nutan Atre Vaidya, Michael Alan Taylor
   (2004)

**Geriatric Psychiatry Service Curriculum – Goals and Objectives**

**EDUCATIONAL GOALS:**

The development and display in practice the knowledge, skills and attitudes necessary for the optimal clinical care
of geriatric patients with mental disorders.

It is kept in mind that each learner begins inpatient and outpatient psychiatry with their own unique skill set and will
progress at different rates. Education is enhanced by understanding the RIME conceptualization of the learning
process:

• **Reporter** collects and reports clinical data but has limited ability to meaningfully prioritize and
  synthesize the data. This role is assumed by beginning learners.
• **Interpreter** can prioritize and interpret clinical data to formulate diagnostic hypotheses and
  treatment recommendations.
• **Manager** can see the big picture, apply knowledge, develop accurate diagnostic hypothesis, and
  initiate appropriate evaluation and treatment plans.
• **Educator**, the highest level in this particular hierarchy and the ultimate goal for all learners,
  continuously involves self-assessment and personal learning efforts to maintain an up-to-date, in-
  depth knowledge that is readily applied to patient care and the education of colleagues.
There are six competency domains set out by the Accreditation Council for Graduate Medical Education (ACGME – 2000). Competency in all six areas should be achieved by completion of the residency training program. These domains serve as a guideline for understanding the learning goals in residency training. They include:

1. Patient Care - PC;
2. Medical Knowledge - MK;
3. Practice-base Learning - PBL;
4. Interpersonal and Communication Skills - CS;
5. Professionalism - P; and
6. Systems-based Practice - SBP.

The specific learning objectives for the inpatient psychiatry rotations support one or more of the ACGME competency domains.

---

**LEARNING OBJECTIVES, COMPETENCY DOMAINS, EXPECTATIONS AND EVALUATION**

**Learning Objective**
- Competency in performance of a risk assessment of designated patients

**Competency Domain**
- PC, MK, CS, SBP

**Expectations**
- Assess patient’s dangerousness, need for hospitalization, or safety measures
- Interact with the court system regarding involuntary commitment of mentally ill patients
- Interact with family and care providers to arrange a safe living environment

**Feedback and Evaluation**
- Ongoing and timely feedback based on observation of the resident’s interaction with the patients
- Ongoing and timely feedback based on resident’s interpretation of data and ability to decide when commitment is necessary
- Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations

---

**Learning Objective**
• Competency in performance of an History and Physical Exam
• Competency in performance of a Mental Status Exam (MSE)

**Competency Domain**

• PC, MK, CS

**Expectations**

• Interview performed in skillful manner - knowledge of different interviewing techniques
• Physical exam (PE), neurological exam and complete Mental Status Exam (MSE) are competently performed

**Feedback and Evaluation**

• Ongoing and timely feedback based on resident’s ability to perform comprehensive patient interview during morning rounds and on clinical skills exam
• Ongoing and timely feedback of resident’s ability to use different and appropriate interviewing techniques during the patient interview
• Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations

**Learning Objective**

• Competency in prioritizing, organizing and interpreting clinical data to formulate a relevant, comprehensive differential diagnosis and plan

**Competency Domain**

• PC, MK, PBL, CS, P

**Expectations**

• Formulate diagnostic impression supported by clinical data using a biopsychosocial model and accounting for the patient’s ethnic and cultural background
• Develop a plan for further evaluation (appropriate use of laboratory and psychological testing, and consultation)
• Develop treatment plan including Electro Convulsive Treatment (ECT) during the hospitalization and after discharge from the hospital

**Evaluation and Evaluation**

• Ongoing and timely feedback based on resident’s ability to create concise, accurate summary of collected data regarding their individual patients
• Ongoing and timely feedback based on resident’s ability to apply analytical thinking to propose plan for the correct evaluation of the patient that will lead to correct diagnosis and treatment, ECT workup included
• Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations

**Learning Objective**

• Competency in engaging designated patients and their families in an empathic manner, with the ability to discuss and demonstrate a range of interviewing techniques

**Competency Domain**
Expectations

- Build good rapport with the patient, use of empathy
- Knowledge of different interviewing techniques
- Apply interviewing techniques during interview of the patients/their families

Feedback and Evaluation

- Ongoing and timely feedback based on resident’s ability to recognize patient’s needs and adapt to them during the patient’s interview
- Ongoing and timely feedback based on residents ability to recognize importance to communicate with patient’s families in effective manner during the family meetings and phone conferences
- Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback will be based on family meetings and crisis interventions.

Learning Objective

- Recognition of the importance of collateral history and competency in obtaining and interpreting information from multiple sources

Competency Domain

- PC, MK, CS

Expectations

- Understand importance of collateral information for correct diagnosis
- Become skillful at eliciting and interpreting relevant information from patient’s family, prior care givers and other sources
- Review and summarize previous medical records

Evaluation

- Ongoing and timely feedback based on resident’s ability to recognize complex cases, the importance of collateral history, collection and interpretation of collected data.
- Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations, and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback will be based on resident’s performance during the team meeting, teaching rounds, Neuropsychology conferences, family meetings, and review of written documentation

Learning Objective

- Demonstrate ongoing efforts to develop, expand, and apply in practice, a knowledge base of geriatric psychiatry in areas relevant to assigned patients

Competency Domain

- PC, MK, PBL

Expectations

- Become familiar with diagnostic criteria for common psychiatric diagnosis
- Develop working knowledge of treatment for common psychiatric disorders
• Identify gaps in knowledge base and proactively eliminate them (teaching rounds, lectures, self education)
• Direct personal study to topics relevant to assigned patients
• Regularly seek consultation and feedback from attending physician and senior resident
• Become familiar with palliative care, hospice, and end of life issues

Evaluation

• Ongoing and timely feedback based on resident’s ability to formulate the list of differential diagnosis
• Ongoing and timely feedback based on resident’s ability to propose biological and psychological
• Ongoing and timely feedback based on residents ability to use evidence and methods to investigate, evaluate and improve patient care
• Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback will be based on resident’s performance during the team meeting, teaching rounds, Neuropsychology conference, and review of the written documentation

Learning Objective

Competence in working effectively as a member of an assigned treatment team and as physician leader of the multidisciplinary treatment team

Competency Domain

• PC, MK, PBL, CS, P, SBP

Expectations

• Attend team meetings and be prepared to present your patient
• Have a working knowledge of assigned patients including target symptoms, problem list, diagnosis and differential diagnosis, current medication, progress during past 24 hours, plan for next 24 hours
• Work effectively with other members of the treatment team and be appropriately respectful to the attending physician team leader
• Attend Multidisciplinary staff meetings and be prepared to contribute in a concise, meaningful manner
• Work effectively with medical team, psychologists, nursing staff, social workers, therapists and other allied healthcare personnel

Evaluation

• Ongoing and timely feedback based on residents ability to collect and interpret collected data, formulate the list of differential diagnosis and propose treatment following biopsychosocial model
• Ongoing and timely feedback based on residents ability to identify target symptoms, follow the change in target symptoms with the treatment and adjust the treatment if needed
• Ongoing and timely feedback based on residents ability to work with other treatment team members demonstrating knowledge of optimal health care delivery
• Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback will be based on resident’s performance during the team meeting and review of the written documentation as well as feedback from other team members (primary care, neuropsychology, social workers, nursing…)

Learning Objective
Competence in skillful documentation of clinical data in a written format including orders, history, and patient progress; routinely review and be familiar with the sections of a medical inpatient and outpatient chart.

**Competency Domain**

- PC, MK, PBL, CS,

**Expectations**

On inpatient service be familiar with:

- Physician’s Order Sheet, KU Standing Orders, Detox Orders
- Legal documents of power of attorney and/or guardianship
- Court hold and commitment legal documents
- Electronic and handwritten H&P form on newly admitted patients
- Admission status on newly admitted patients (voluntary vs. involuntary)
- Daily progress documentation (electronic or handwritten) should include a review of the prior 24 hours referring to all sections of the patient’s chart on established patients
- Nursing notes yellow pages (Appendix 7)
- Flow sheets – vitals, sleep, food/fluid intake, suicide and safety observations
- MAR (list of all active medications in the hospital)
- Consult notes (Appendix 9) if consult ordered
- Family meeting, outpatient treatment team input, phone calls, etc. – write on green progress note or as addendum on EMR
- Discharge form VC 1635, dictated discharge summary
- Medication reconciliation form (Mirror Image) – created on the discharge date for all patients hospitalized in Via Christi
- DNR and Modified Resuscitation forms
- Discharge Action/Safety Plan

In outpatient clinic be familiar with Electronic Medical Record including

- Legal documents of power of attorney and/or guardianship
- Court hold and commitment legal documents
- Mini Mental State Exam, Montreal Cognitive Assessment, Mini-Cog Clock Drawing Test

**Evaluation**

- Ongoing and timely feedback based on resident’s ability to use appropriate forms of documentation
- Ongoing and timely feedback based on resident’s ability to convey information and data synthesis in oral and written format
- Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback is based on resident performance written documentation.

**Learning Objective**

- Demonstrate efforts to educate medical students, all treatment team members, patients and their families

**Competency Domain**

- PC, MK, PBL, CS, P, SBP
Expectations

- Medical Student Education
- Direct supervision of patient interview
- Review medical student’s documentation
- Encourage direct participation in patient care – conducting interviews, preparing timelines, gathering and summarizing collateral info, working with patients and families
- Educate fellow residents, staff, family members, attendings…

Evaluation

- Ongoing and timely feedback based on resident’s ability to engage and educate medical students as observed during their interaction
- Ongoing and timely feedback based on resident’s ability to involve medical student in patient care in meaningful way based on student’s participation case discussion during the team meetings
- Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback is based on resident performance and medical student feedback.

Learning Objective

- Competence in discussing and demonstrating behaviors consistent with self-awareness and professionalism

Competency Domain

- PBL, P, SBP

Expectations

- Recognize need for guidance/supervision when faced with new or complex responsibility
- Develop insight to the impact of one’s behavior on others
- Awareness of appropriate professional boundaries
- Exhibit the qualities of altruism and advocacy including putting the best interests of the patient above self-interest or the interest of others

Evaluation

- Ongoing and timely feedback based on resident’s dedication, reliability and integrity
- Ongoing and timely feedback based on resident’s ability to be respectful and sensitive to patient needs
- Ongoing and timely feedback based on resident’s ability to solicit feedback and insight to own deficits with appropriate improvement of these deficits
- Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations

Recommended Reading

PGY 3 Rotations

Overview

Learning Objectives

OVERVIEW OF 3RD YEAR ROTATION

DIDACTICS

PSYCHOTHERAPY

COMMUNITY PSYCHIATRY

SUPERVISION

SCHOLARLY ACTIVITY

RESIDENT RESPONSIBILITIES

RESIDENT EVALUATION

RECOMMENDED READING

Minimum requirements for advancement of residents to PGY 3 level of training

Overview

Third year of training is the principal outpatient year for residents in our program where residents become independent practitioners. Residents spend 80% of their time at the Via Christi Psychiatric Outpatient Clinic and 20% at the Community Mental Health Clinic (COMCARE). Throughout the year, residents provide psychiatric care for patients at three different locations:
In 2000, six competency domains set by the Accreditation Council for Graduate Medical Education (ACGME) serve as a guidelines to understand the learning objectives during the residency training. They include:

1. Patient Care - PC
2. Medical Knowledge - MK
3. Practice-base Learning - PBL
4. Interpersonal and Communication Skills - CS
5. Professionalism - P
6. Systems-based Practice - SBP

Overall learning objectives for the outpatient psychiatry rotation supports one or more of the ACGME competencies.

OVER ALL LEARNING OBJECTIVES, EXPECTATIONS, COMPETENCY DOMAINS FEEDBACK & EVALUATION FOR PATIENT CARE IN 3RD YEAR PSYCHIATRY ROTATION AT ALL LOCATIONS:

Learning Objectives

1. Learning Objective: To learn how to perform risk assessment in outpatient setting?

   Expectations: Resident is expected to demonstrate the ability to
   
   - Evaluate patient’s dangerousness and need for hospitalization.
   - Appropriate use of collateral information in these situations.
   - Interact with other providers and court system regarding involuntary commitment if needed.

   Competencies: PC, MK, CS, P

   Feedback & Evaluation:

   - Ongoing & timely feedback almost on a daily basis based on resident’s interaction with their patients
   - Verbal feedback during weekly individual supervision
   - Written evaluation every month for the first quarter and then quarterly throughout the year
   - Evaluation through PRITE scores in Emergency Psychiatry
2. **Learning Objective:** To learn how to diagnose psychiatric disorders in adult & late adolescent outpatients?

*Expectations: Resident is expected to demonstrate the ability to*

- Use appropriate interview techniques
- Use appropriate diagnostic criteria from DSM-IV-TR
- Use different rating scales including SCL-90 & MINI
- Collect and use collateral information
- Asked for Neuro-Psych testing if needed

*Competencies:* PC, MK, P, PBL, SBP

*Feedback & Evaluation:*

- Ongoing & timely feedback almost on a daily basis based on direct supervision of the faculty for all new patients seen by the resident at VCPC and Assessment center
- Verbal feedback during their weekly individual supervision
- Group discussion during team meeting if needed
- Written evaluation every month for the first quarter and then quarterly throughout the year

3. **Learning Objective:** To learn how to manage the ongoing care of outpatients?

*Expectations: Resident is expected to demonstrate the ability to*

- Provide continue outpatient care that is compassionate, appropriate and effective
- Develop an appropriate initial treatment plan
- Educate patient & family about this treatment plan
- Monitor the outcome of the treatment plan
- Communicate with other providers if needed
- Keep an eye on compliance issues
- Revise the treatment plan as indicated by the course of progress of the patient & any current developments

*Competencies:* PC, MK, P, SBP, CS, PBL

*Feedback & Evaluation:*

- Ongoing direct feedback on a daily basis during patient’s evaluations at VCPC and Assessment Center
• Verbal feedback during weekly individual supervision about data gathering, clinical reasoning and overall patient management
• Written evaluation every month for the first quarter and then quarterly throughout the year

4. **Learning Objective:** To learn how to use and manage psychopharmacology in the outpatient psychiatric setting

*Expectations: Resident is expected to demonstrate the ability to*

• Improve knowledge & experience with psychotropic medications
• Acquire knowledge about practice guidelines to treat psychiatric disorders
• Develop a perspective of the difference in the time course of management from the inpatient to the outpatient setting
• Gain experience with sequential trials of pharmacologic agents in cases where the first line agent fails
• Use augmentation strategies in an effective and critical way

*Competencies: MK, SBP, PC, PBL*

*Feedback & Evaluation:*

• Ongoing feedback on a daily basis based on direct faculty observation of resident-patient encounters at VCPC
• Verbal feedback during weekly individual supervision
• Written evaluation every month for the first quarter and then quarterly throughout the year
• Evaluation through PRITE scores in psychopharmacology

5. **Learning Objective:** Learn how to provide psychosocial support in an outpatient setting

*Expectations: Resident is expected to demonstrate the ability to*

• Improve knowledge about available psychosocial resources in the community
• Gain experience with care coordination, including interaction with case managers, home health aids and social workers
• Provide useful information about psychosocial services to patients and their families as part of their treatment plan
• Actively participate in coordinating monthly visits to facilities providing psychosocial services to mentally ill patients e.g., Breakthrough Club
Competencies: PC, P, SBL

Feedback & Evaluation:

- Feedback during those visits as well as during individual supervision if needed
- Written evaluation every month for the first quarter and then quarterly throughout the year

6. Learning Objective: To have experience with focused outpatient assessments for special purposes

Expectations: Resident is expected to demonstrate the ability to

- Provide consultation to primary care practitioner & other providers e.g., Bariatric Surgery
- Provide comprehensive consult report (verbal & written) to the referring physician
- Do disability assessments
- Initiate competency evaluations
- Set appropriate limits when clinically indicated
- Assess the patient’s maximum potential level of functioning

Competencies: PC, MK, P, SBL

Feedback & Evaluation:

- Direct feedback based on observations during the resident-patient encounter
- Verbal feedback during weekly individual supervision
- Written evaluation every month for the first quarter and then quarterly throughout the year
- Evaluation through PRITE scores in C & L Psychiatry

OVERVIEW OF 3RD YEAR ROTATION:
**ORIENTATION DAY:**

Orientation day consists of sharing knowledge about the policies and procedures of the clinic including documentation, dictation, confidentiality, HIPPA regulation, emergency situations, professionalism, communication with staff, goals and objectives of the entire outpatient year and handling of medical records.

**DIDACTICS:**

- **Textbook Seminar** on Tuesday (2-3:30pm) every week.

  *Learning Objective:* Residents usually follow APA textbook of “Essentials of Clinical Psychiatry” or “Kaplan & Sadock’s” under faculty supervision to learn about general psychiatry with particular emphasis on Psychopharmacology

  *Expectations:*
  - Before each seminar, faculty provides articles relevant to the topic to all residents and they are expected to review the topic from the book as well as the articles.
  - Residents are expected to attend all lectures unless on vacation or sick
  - Residents are expected to present topics as well with a power point presentation

  *Competencies:* MK, PBL, SBP, CS

  *Feedback & Evaluation:*
  - Feedback from faculty about the content and presentation of the lecture
  - Evaluation of their knowledge by asking questions during the lecture
  - Evaluation through PRITE scores as well

- **Clinical Skill Assessment** (CSA) twice/month

  *Learning Objective:* Prepares residents for their oral board examination in Psychiatry in terms of timing, setting and grading of the oral interview.

  *Expectations:*
  - Every third year resident is required to be examined twice.
  - Residents are expected to work on interview techniques during patient care
Residents are expected to pass 3 CSA exam before completing their residency
During the interview, residents are expected to gather information, reach a reasonable
diagnosis with comprehensive management plan within 30-35 minutes
After the interview, residents are supposed to present the case

*Competencies:* CS, MK, P, SBP

*Feedback & Evaluation:*

- Extensive feedback right after the interview about interviewing techniques, medical
  knowledge and treatment plan given to the resident
- Written evaluation to the resident regarding the result of CSA exam by the faculty
- Verbal feedback during weekly supervision about the interview

*Team meeting* on first and third Thursday (3-5pm), and second and fourth Thursday (4-5pm). This meeting has been used for:

a. Clinical Skills Assessment Exams
b. Videos for interview techniques
c. Videos for Movement Disorders
d. Presentations on landmark studies in Psychiatry like

- **CATIE** Schizophrenia Clinical Antipsychotic Trials of Intervention Effectiveness)
- **CAMP** Study (Comparison of Antipsychotics for Metabolic Problems)
- **STAR*D** Study (Sequence Treatment Alternatives to Relieve Depression)
- **CO-MED** Study (Combining Medications to Enhance Depression Outcome)
- **CATIE** Alzheimer’s Study
- **TIMA** Study (Texas Implementation of Medications Algorithms)
e. Training for different Psychiatric Rating Scales including

- **HAM-D** (Hamilton Depression Scale)
- **HAM-A** (Hamilton Anxiety Scale)
- **MDRS** (Montgomery Depression Rating Scale)
- **MINI** (Mini International Neuropsychiatric Interview)
- **SCL-90** (Symptom Check List 90)
- **PANSS** (Positive & Negative Symptom Scale for Schizophrenia)
- Movement Disorder Scales

*Expectations:*

- Residents are expected to attend these meetings unless on vacation or sick
Residents are expected to review material about landmark studies like CATIE, provided by the faculty before the team meeting.

Residents are expected to rate different psychiatric scales e.g., PANSS after watching patient video interviews.

**Competencies:** PC, MK, PBL, SBP

**Feedback & Evaluation:**

- Feedback to residents about their rating reliability on different rating scales
- Written evaluation every month for the first quarter and then quarterly throughout the year

**PSYCHOTHERAPY:**

Though the major opportunity to learn and practice psychotherapy is during the third year outpatient rotation, psychotherapeutic knowledge and skill is built throughout the residency according to the following plan:

**PGY2: Introductory Psychotherapy Seminar** introduces residents to the more symptom treating psychotherapies such as supportive, brief (solution-focused and Interpersonal Psychotherapy), and cognitive-behavioral therapies that can be incorporated during inpatient rotations and integrated with their psychopharmacological treatments.

**PGY3: Advanced Psychotherapy Seminar** builds on the introductory skills two sets of more complex psychotherapeutic skills: deeper dynamic interventions according the psychoanalytic model and relational system interventions into marital, parent-child, and family interactions.

**PGY3: Psychotherapy Experience** is a major focus during the outpatient rotation. It gives the residents the chance to apply the psychotherapeutic knowledge learned during the seminars to actual patients in the outpatient clinic. This enables residents to refine their therapeutic skills under the supervision of an experienced psychotherapist.

**PGY3: Psychotherapy Case Conceptualization and Presentation Seminar** provides an opportunity to apply this knowledge to developing an in-depth formulation of the personality and family system dynamics for a psychotherapy case that is being carried by the resident in the outpatient clinic. During the weekly seminar residents will work on developing two formulations: a psychodynamic formulations of the personality dynamics of a case and a therapeutic formulation of the interventions used to treat a case. These will then be
formally presented to all residents and faculty at a monthly meeting. Besides showcasing their conceptualization and therapy skills it gives residents an opportunity for learning to communicate to professional groups.

**PGY4: Continuing Psychotherapy Experience** allows residents to follow selected therapy cases through the fourth year giving them an opportunity for developing their long-term therapy skills.

The specific objectives for each of these areas are as follows:

**PGY2: Introductory Psychotherapy Seminar**

1. **Learning Objective:** *To establish a therapeutic relationship with a patient, assess and formulate a conceptualization of his or her problems, and develop a mutually agreeable treatment plan*

   **Expectations:** Resident is expected to
   
   - Use reflective listening skills to establish an empathic relationship with the client
   - Use knowledge of diagnostic classifications and therapeutic conceptualizations to assess and develop an explanation of the patient’s presenting problems
   - Use motivational interviewing skills to establish a treatment plan that is congruent with the patient’s readiness and abilities

   **Competencies:** PC, MK, CS, P, SBL

   **Feedback & Evaluation:**
   
   - Demonstration of knowledge during the discussion of these topics during the seminar
   - Written assessments of their knowledge over these topics
   - Supervisors formal assessment of these skills as they were demonstrated in interactions with patients on the inpatient rotations

2. **Learning Objective:** *To demonstrate a knowledge of the following psychotherapies: Supportive psychotherapy*

   *Brief psychotherapies (Solution-focused, interpersonal psychotherapy IPT)*

   *Cognitive-behavioral therapy CBT*

   *Dialectical behavioral therapy DBT*
Group Psychotherapies

Expectations: Resident is expected to

- Describe the theoretical basis of the therapy to colleagues
- Assess the indications and contraindications of the therapy for a particular patient
- Explain the therapy to the patient in a way that facilitates the patient’s willingness to participate in the therapy
- Demonstrate the ability to perform the basic techniques associated with the therapy

Competencies: PC, MK, CS, P, SBL

Feedback & Evaluation:

- Demonstration of knowledge during the discussion of these topics during the seminar
- Written assessments of their knowledge over these topics
- Supervisors formal assessment of these skills as they were demonstrated in interactions with patients on the inpatient rotations

PGY3: Advanced Psychotherapy Seminar

1. Learning Objective: To be able to formulate a psychodynamic conceptualization of a patient's deeper personality dynamics and structures according to the psychoanalytic model and then develop an appropriate psychoanalytic treatment plan for this patient.

Expectations: Resident is expected to

- Describe the basic assumptions and approaches of each of the major psychoanalytic models (ego psychology, object relations, self psychology, etc.)
- Explain important psychodynamics concepts such as the unconscious, defense and resistance, transference and countertransference.
- Define the major defense mechanisms and the personality diagnoses with which they are most commonly associated
- Explain the major structural features of a person’s personality (ego, superego, etc.)
- Use these concepts in correctly developing a formulation of the dynamics of a particular patient
- Discuss the appropriateness and limitations of various therapeutic methods to this particular patient
- Know when and how to refer a patient to a more specialized therapist
Competencies:  PC, MK, CS, P, SBL

Feedback & Evaluation:

• Demonstration of knowledge during the discussion of these topics during the seminar
• Formal presentations on selected topics during the seminar
• Feedback from the psychotherapy supervisors on the resident’s ability to apply this knowledge and skill to the resident’s ongoing outpatient cases.
• Formal presentations during the Psychotherapy Case Presentation
• Written quarterly feedback from the psychotherapy supervisor on the psychotherapy rotation evaluation form

2. Learning Objective:  To be able to assess and describe the pertinent systemic dynamics in a couple's relationship, a parent-child relationship, or family relationships and to understand methods of intervening into these relationships to resolve their presenting problems.

Expectations:  Resident is expected to

• Describe the basic principles of family system functioning
• Assess the nature of the problems in a marital or couple’s relationship.
• Intervene into these relational problems using communication, problem solving, and behavioral methods
• Assess for the possibility of abuse in relationships and know how to wisely refer to the appropriate treatment options
• Assess the nature of the problems in a parent-child relationship
• Intervene into parenting problems with the appropriate techniques for developing attachment, facilitating communication, and establishing boundaries and consequences
• Understand the basic concepts and techniques associated with the various methods of family intervention such as strategic, structural, cognitive-behavioral, Bowenian family systems, etc.
• Know when and how to refer a patient to a therapist with more specialized training in these areas

Competencies:  PC, MK, CS, P, SBL

Feedback & Evaluation:

• Demonstration of knowledge during the discussion of these topics during the seminar
• Formal presentations on selected topics during the seminar
• Feedback from the psychotherapy supervisors on the resident’s ability to apply this knowledge and skill to the resident’s ongoing outpatient cases.
• Formal presentations during the Psychotherapy Case Presentation
Written quarterly feedback from the psychotherapy supervisor on the psychotherapy rotation evaluation form

PGY3: Psychotherapy Experience

1. Learning Objective: To be able to select and provide the appropriate psychotherapy in an outpatient setting.

Expectations: Resident is expected to

- Identify appropriate psychotherapy patients
- Select an evidenced-based psychotherapy (supportive, psychodynamic, and cognitive-behavioral)
- Provide brief or long-term psychotherapy as indicated
- Utilize individual, couple, or family format as indicated

Competencies: PC, CS, P, SBL

Feedback & Evaluation:

- The resident will receive verbal feedback during weekly psychotherapy supervision which is provided on an individual basis
- Supervision will initially address such issues as patient and psychotherapy selection but will shift to more complex aspects of theory and technique as the resident acquires increased skill and experience. The resident will receive written feedback by use of the Clinical Rotation Evaluation Form.

PGY3: Psychotherapy Case Conceptualization and Presentation Seminar

1. Learning Objective: To be able to formulate from a psychodynamic perspective and acquire the knowledge and skills needed to conduct psychodynamic psychotherapy.

Expectations: Resident is expected to:

- Attend the weekly six month seminar and complete assigned readings
- Demonstrate understanding of psychodynamic principles by preparing and presenting a psychodynamic case formulation
Competencies: PC, CS, P, SBL

Feedback & Evaluation:

- Residents will receive feedback while in the process of preparing their psychodynamic case presentation and will also receive feedback on the presentation and handout.

2. Learning Objective: To demonstrate the ability to conduct evidence-based psychotherapy.

Expectations: Resident is expected to:

- Attend the weekly six month seminar and complete assigned readings
- Demonstrate rationale for psychotherapy selection and understanding and application of an evidence-based psychotherapy by preparing and presenting a psychotherapy patient

Competencies: PC, CS, P, SBL

Feedback & Evaluation:

- Ongoing feedback is provided during weekly supervision and by the use of the Clinical Rotation Evaluation. Residents will receive feedback while in the process of preparing the psychotherapy presentation and will also receive feedback on the presentation and handout.

COMMUNITY PSYCHIATRY:

- Learning Objective: To learn what kind of psychosocial resources are available in the community

Expectation:

- Residents are required almost every month either during lunch hour or in the team meeting time to visit community psychosocial resources.
- It will facilitate the understanding of the structure the programs offer and requirements of patient’s referrals to those mental health facilities. Facilities included:
- Breakthrough Club
- Mental Health Association
- Heart Spring for Developmental Disorders
- Jail Psychiatric Clinic
- KETCH
- Higher Grounds for Addiction Disorders
- Sleep Disorder Clinic
- Methadone Clinic
- Parallax for Addiction Disorders

**Competencies:** PC, SBP, PBL, CS

**Feedback & Evaluation:**

- Direct feedback from faculty based on resident’s interest and behavior during those tours
- Written evaluation every month for the first quarter and then quarterly throughout the year

**Learning Objective: Community service**

**Expectation:**

- All third year residents are required to go and lead the “Share & Care” meeting session at the local chapter of National Alliance for Mentally Ill (NAMI).
- During this meeting, residents are supposed to answer questions from family members as well as patients about their psychiatric illnesses and treatments. Usually two residents are assigned every month.

**Competencies:** PC, P, MK, CS

**Feedback & Evaluation:**

- Direct feedback from NAMI staff coordinating those meetings to the residents
- Verbal feedback from the faculty

**SUPERVISION:**

**Individual supervision with Dr. Khan.** Residents discussed their difficult cases from the clinic and received feedback from Dr. Khan about their performance in the clinic related to patient care, medical knowledge, clinical skill assessment interviews, and individual evaluations.
• **Individual Supervision** from faculty is also available during Assessment Center coverage everyday where residents discussed their cases they admit or discharge from the Assessment Center.

*Competencies: PC, MK, P, CS, SBP, PBL*

**SCHOLARLY ACTIVITY:**

• Residents are encouraged to participate in at least one scholarly activity during the year under faculty supervision. They can choose to write a case report, review article or their individual research project with a possibility of poster presentation and subsequently the publication.

*Competencies: MK, PC*

**RESIDENT RESPONSIBILITIES:**

• Participation in all didactic activities
• Follow clinic policies and procedures as written in the clinic manual
• Participation in providing clinical services at the clinic, including assessments, treatment formulations, documentation, continued management, coordination of care and appropriate referrals when needed.

**RESIDENT EVALUATION:**

• Residents will be evaluated with consideration being given to the above objectives, expectations, responsibilities and the implementation of these items into treatment.
• Resident will additionally be evaluated using clinical observations by the supervising faculty, case presentations, mock board evaluation and textbook seminar presentation
• Patient’s survey to evaluate resident’s professional qualities at least twice/year
• Annual PRITE exam

**RECOMMENDED READING:**

• Essentials of Clinical Psychiatry by Robert Hales, MD & Stuart Yudofsky, MD. The American Psychiatric Press, Inc. 3rd Edition
Minimum requirements for advancement of residents to PGY 3 level of training:

1. Attendance at required conferences unless on approved leave or excused (must meet 70%)
2. Satisfactory overall evaluation in all categories.
3. Satisfactory achievement of general competencies.
4. No breach in contractual obligations.
5. No instances of unethical or unprofessional behavioral that have not been remediated.
6. Capable of assuming supervisory responsibilities of PGY 3 level of training as determined by the Faculty.
7. Success completion of USMLE Step 3.
8. Approval of program director, faculty and resident faculty committee.

PGY 4 Rotations

Chemical Dependency Goals and Objectives

Division of Child & Adolescent Psychiatry Outpatient Rotation

Division of Child & Adolescent Psychiatry Inpatient and Consultation and Liaison Rotation

Division of Child & Adolescent Psychiatry Camelot Goals and Objectives

Division of Child & Adolescent Psychiatry Textbook Seminar

Child/Adolescent Clinical Research Rotation Goals and Objectives

Geriatric Psychiatry Service Curriculum

PGY-4 Senior Resident Geriatric Inpatient and Outpatient Psychiatry Rotation

Geriatric Psychiatry Outpatient Clinic Goals and Objectives

Neuroimaging Goals and Objectives

Palliative Care Service Goals and Objectives
Goals and Objectives: (core competencies noted in parentheses)

1. Develop clinical competence in diagnostic and therapeutic addiction psychiatry with the following specific objectives:
   a. Develop the ability to perform and record from the biopsychosocial and functional perspectives an accurate and comprehensive psychiatric evaluation of the patient with psychoactive substance related disorders. (PC, IP/C, PBL)
   b. Develop the capacity to arrive at a differential diagnosis of all substance related disorders including abuse, dependence, intoxication, withdrawal, substance-induced mood, anxiety, delirium, and psychotic disorders as well as all other concomitant Axis I and II psychiatric disorders. (MK, PC, PBL)
   c. Develop the capacity to create comprehensive treatment plans from a biopsychosocial and multidisciplinary perspective for patients with psychoactive substance related disorders. (MK, PC, SBP, PBL)
   d. Develop the ability to assess and manage patients with psychoactive substance related disorders in the psych inpatient and patients admitted to medical floors that the resident will see as consults. (PC, PRO, IP/C, MK, SBP)
   e. Become experienced in the use of a variety of psychotherapeutic techniques for treatment of psychoactive substance dependence including motivational interviewing, psychoeducation, relapse prevention, and supportive, cognitive behavioral, psychodynamic, couples, family, and group therapies. (MK, PC, IP/C, SBP, PRO, PBL)
   f. Gain competence in psychopharmacologic treatment of substance use disorders (including use of opioid substitution therapy, opioid antagonist therapy, nicotine replacement therapy, use of disulfiram and naltrexone for relapse prevention, and agents such as clonidine, carbamazepine, valproate, and benzodiazepines used for medically supervised withdrawal), as well as in psychopharmacologic treatment of co-morbid psychiatric disorders. (MK, PC, PBL)

2. Become knowledgeable in addiction psychiatry and the scientific database underlying the discipline via the following specific objectives:
   a. Know the pharmacology and neuropharmacology of all the major substances of dependence including alcohol, opioids, cocaine and other stimulants, cannabis, hallucinogens, benzodiazepines, sedative hypnotics, and nicotine. This includes
knowledge of signs and symptoms of use and dependence, withdrawal, and overdose as well as brain reward systems that subserve addictive processes. (MK)
b. Understand and be able to recognize the social, psychological, medical, and psychiatric problems that frequently occur with psychoactive substance use including problems in family systems, problems of the pregnant substance user, and problems related to HIV infection. (MK, SBP, PC, PBL)
c. Attend at least one AA/NA meeting in the area to become familiar with the 12 step model (MK, SBP, IP/C)

MK=medical knowledge, PC=patient care, PRO=professionalism, PBL=practice based learning, IP/C=interpersonal skill/communication, SBP=systems based practice

Recommended/required reading assignments:
DSM-4-TR section on Substance Related Disorders
Kaplan and Saddock’s Synopsis of Psychiatry section on Substance Related Disorders

**Division of Child & Adolescent Psychiatry Outpatient Rotation**

Rotation Site: UKSM-W

1010 N. Kansas

Wichita, KS  67214

Thursdays 2pm-5pm

Supervision provided by: Russell Scheffer, MD

Kristin L. Jones, MSN, ARNP, BC

**Goals and Objectives**

- Knowledge and review of normal growth and development. Competencies A. Patient Care

  B. Medical Knowledge.

- Knowledge and review of clinical assessments of children and adolescents versus adult assessments. Competencies A. Patient Care

  B. Medical Knowledge.
• Knowledge and review of resident as educator for children and adolescents and their families.
  Competencies C. Practice – based Learning and Improvement
  
  D. Interpersonal and Communication Skills.
  
  E. Professionalism

• Knowledge and review of coordination of care with multiple disciplines.
  Competencies  F. System Based Practice
  
  D. Interpersonal and Communication Skills.
  
  E. Professionalism

• Knowledge, review and implementation of current research and evidence based approaches to patient care.
  Competencies D. Interpersonal and Communication Skills.
  
  C. Practice – based Learning and Improvement

• Knowledge, review and implementation of appropriate ethical and/or legal standards and maintaining confidentiality.
  Competencies E. Professionalism

• Knowledge, review and implementation of cost awareness, resource management and risk-benefit analysis.
  Competencies  F. System Based Practice

Expectations

• Appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies A. Patient Care

  B. Medical Knowledge.

  F. System Based Practice

  D. Interpersonal and Communication Skills.

  E. Professionalism
• Documentation consistent with appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies F. System Based Practice
    D. Interpersonal and Communication Skills.
    E. Professionalism

• Dependability and evidence of appropriate documentation consistent with appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies A. Patient Care
    B. Medical Knowledge.
    F. System Based Practice
    D. Interpersonal and Communication Skills.
    E. Professionalism

• Consideration of legal issues and cultural sensitivities when assessing, documenting and formulating child and adolescent treatment plans.
  Competencies D. Interpersonal and Communication Skills.
    E. Professionalism

Resident responsibilities

• Participation in all scheduled child clinic offerings.

• Participation in providing clinical services in the department’s child clinic, including, assessment, treatment formulation, documentation, continued management, coordination of care and referrals.

Evaluation

• Residents will be evaluated with consideration being given to the above objectives, expectations, responsibilities and the implementation of these items into treatment.
• Residents will additionally be evaluated using clinical observations by supervising faculty, case presentations and journal presentations.

• PRITE

Patient Care

• The resident conducted comprehensive psychiatric interviews with children and families, including developmental history, school functioning, social functioning, and family functioning.
• The resident effectively engaged children and adolescents in the evaluation using language and communication style appropriate for the child’s developmental level.
• The resident performed physical examinations, including detailed neurological examination, when indicated.
• The resident made diagnostic formulations commensurate with level of training.
• The resident appropriately assessed for potential dangerous behavior.
• The resident formulated and implemented appropriate treatment plans.
• The resident intervened effectively in emergencies.
• The resident appropriately conducted behavioral therapy, when indicated.

Medical Knowledge

• Resident demonstrates knowledge of normal growth and development.
• Resident shows knowledge of the psychiatric diagnostic classifications system as applied to children and adolescents.
• Resident demonstrates knowledge of assessment considerations and tools for children, adolescents, and families.
• Resident understands biological, psychological, and sociocultural contributions to psychiatric illness in children and adolescents.
• Resident shows knowledge of appropriate use of psychopharmacological agents with children and adolescents.
• Resident shows knowledge of appropriate psychotherapeutic and educational interventions for children and adolescents.

Practice-Based Learning and Improvement

• The resident recognized and accepted limitations in his/her own knowledge base and skills.
• The resident demonstrated appropriate skills for obtaining and evaluating up-to-date information from scientific and practice literature and other sources to assist in quality care of patients.
• The resident facilitated the learning of students and other health care professionals.

Interpersonal and Communication Skills

• The resident demonstrated effective oral and written communication skills.
• The resident completed proper medical record documentation.
• The resident effectively communicated information about diagnoses and treatment to children and families.
• The resident effectively communicates with schools, referral sources, and other treatment providers as appropriate.
Professionalism

- The resident had knowledge of ethical and legal standards in working with children and adolescents and maintained these standards in practice.
- The resident maintained appropriate boundaries with patients and families.
- The resident completed timely medical documentation.
- The resident demonstrated consistent follow through with responsibilities.
- The resident was punctual for meetings and assignments.
- The resident maintained professional appearance and grooming.

Systems-Based Practice

- The resident effectively communicates with schools, referral sources, and other treatment providers as appropriate.

Division of Child & Adolescent Psychiatry
Inpatient and Consultation and Liaison Rotation

Site Locations: Via Christi Good Shepherd Campus

8901 E. Orme
Wichita, KS  67207
316-858-0333

Via Christi St. Francis Campus

929 N. St. Francis
Wichita, KS  67214
316-268-5000

Via Christi St. Joseph Campus

3600 E. Harry
Wichita, KS  67211
316-268-5000
Goals and Objectives

- Knowledge and review of normal growth and development.
  Competencies A. Patient Care
  B. Medical Knowledge.

- Knowledge and review of clinical assessments of children and adolescents versus adult assessments.
  Competencies A. Patient Care
  B. Medical Knowledge.

- Knowledge and review of resident as educator for children and adolescents and their families.
  Competencies C. Practice – based Learning and Improvement
  D. Interpersonal and Communication Skills.
  E. Professionalism

- Knowledge and review of coordination of care with multiple disciplines.
  Competencies F. System Based Practice
  D. Interpersonal and Communication Skills.
  E. Professionalism

- Knowledge, review and implementation of current research and evidence based approaches to patient care.
  Competencies D. Interpersonal and Communication Skills.
  C. Practice – based Learning and Improvement

- Knowledge, review and implementation of current research and evidence based approaches to patient care.
  Competencies D. Interpersonal and Communication Skills.
  C. Practice – based Learning and Improvement
• Knowledge, review and implementation of appropriate ethical and/or legal standards and maintaining confidentiality.
  Competencies E. Professionalism

• Knowledge, review and implementation of cost awareness, resource management and risk-benefit analysis.
  Competencies F. System Based Practice

**Expectations**

• Appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies A. Patient Care
    B. Medical Knowledge.
    F. System Based Practice
    D. Interpersonal and Communication Skills.
    E. Professionalism

• Documentation consistent with appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies F. System Based Practice
    D. Interpersonal and Communication Skills.
    E. Professionalism

• Dependability and evidence of appropriate documentation consistent with appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies A. Patient Care
    B. Medical Knowledge.
    F. System Based Practice
    D. Interpersonal and Communication Skills.
    E. Professionalism

• Consideration of legal issues and cultural sensitivities when assessing, documenting and formulating child and adolescent treatment plans.
Competencies D. Interpersonal and Communication Skills.

E. Professionalism

**Resident responsibilities**

- Participation in all scheduled inpatient and consultation and liaison responsibilities.

- Participation in providing clinical services for adolescent inpatient and consultation and liaison services including, assessment, treatment formulation, documentation, continued management, coordination of care and referrals.

**Evaluation**

- Residents will be evaluated with consideration being given to the above objectives, expectations, responsibilities and the implementation of these items into treatment.

- Residents will additionally be evaluated using clinical observations by supervising faculty, case presentations and journal presentations.

- PRITE

**Patient Care**

- The resident conducted comprehensive psychiatric interviews with children and families, including developmental history, school functioning, social functioning, and family functioning.
- The resident effectively engaged children and adolescents in the evaluation using language and communication style appropriate for the child’s developmental level.
- The resident performed physical examinations, including detailed neurological examination when indicated.
- The resident made diagnostic formulations commensurate with level of training.
- The resident appropriately assessed for potential dangerous behavior.
- The resident formulated and implemented appropriate treatment plans.
- The resident intervened effectively in emergencies.
- The resident appropriately conducted behavioral therapy when indicated.
- The resident will demonstrate knowledge of the appropriate and legal use of seclusion, restraints and medications given against patient’s will.
- The resident will demonstrate knowledge and appropriate treatment formulation for children and adolescents with substance abuse issues.
- The resident demonstrated knowledge and appropriate interventions for children or adolescents who are dying or dealing with grief issues.
• The resident demonstrated knowledge of policies and procedures for each rotation site.

Medical Knowledge

• Resident demonstrates knowledge of normal growth and development.
• Resident shows knowledge of the psychiatric diagnostic classifications system as applied to children and adolescents.
• Resident demonstrates knowledge of assessment considerations and tools for children, adolescents, and families.
• Resident understands biological, psychological, and sociocultural contributions to psychiatric illness in children and adolescents.
• Resident shows knowledge of appropriate use of psychopharmacological agents with children and adolescents.
• Resident shows knowledge of appropriate psychotherapeutic and educational interventions for children and adolescents.

Practice-Based Learning and Improvement

• The resident recognized and accepted limitations in his/her own knowledge base and skills.
• The resident demonstrated appropriate skills for obtaining and evaluating up-to-date information from scientific and practice literature and other sources to assist in quality care of patients.
• The resident facilitated the learning of students and other health care professionals.

Interpersonal and Communication Skills

• The resident demonstrated effective oral and written communication skills.
• The resident completed proper medical record documentation.
• The resident effectively communicated information about diagnoses and treatment to children and families.
• The resident effectively communicates with schools, referral sources, and other treatment providers as appropriate.

Professionalism

• The resident had knowledge of ethical and legal standards in working with children and adolescents and maintained these standards in practice.
• The resident maintained appropriate boundaries with patients and families.
• The resident completed timely medical documentation.
• The resident demonstrated consistent follow through with responsibilities.
• The resident was punctual for meetings and assignments.
• The resident maintained professional appearance and grooming.

Systems-Based Practice

• The resident effectively communicates with schools, referral sources, and other treatment providers as appropriate.
Division of Child & Adolescent Psychiatry Camelot Goals and Objectives

Supervisor: Russell Scheffer, MD

Goals and Objectives

- Knowledge and review of normal growth and development.
  Competencies A. Patient Care
  B. Medical Knowledge.

- Knowledge and review of clinical assessments of children and adolescents versus adult assessments.
  Competencies A. Patient Care
  B. Medical Knowledge.

- Knowledge and review of resident as educator for children and adolescents and their families.
  Competencies C. Practice – based Learning and Improvement
  D. Interpersonal and Communication Skills.
  E. Professionalism

- Knowledge and review of coordination of care with multiple disciplines.
  Competencies F. System Based Practice
  D. Interpersonal and Communication Skills.
  E. Professionalism

- Knowledge, review and implementation of current research and evidence based approaches to patient care.
  Competencies D. Interpersonal and Communication Skills.
  C. Practice – based Learning and Improvement

- Knowledge, review and implementation of current research and evidence based approaches to patient care.
  Competencies D. Interpersonal and Communication Skills.
  C. Practice – based Learning and Improvement
• Knowledge, review and implementation of appropriate ethical and/or legal standards and maintaining confidentiality.
  Competencies E. Professionalism

• Knowledge, review and implementation of cost awareness, resource management and risk-benefit analysis.
  Competencies F. System Based Practice

Expections

• Appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies A. Patient Care
    B. Medical Knowledge.
    F. System Based Practice
    D. Interpersonal and Communication Skills.
    E. Professionalism

• Documentation consistent with appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies F. System Based Practice
    D. Interpersonal and Communication Skills.
    E. Professionalism

• Dependability and evidence of appropriate documentation consistent with appropriate assessment and formulation of child and adolescent treatment plans.
  Competencies A. Patient Care
    B. Medical Knowledge.
    F. System Based Practice
    D. Interpersonal and Communication Skills.
    E. Professionalism

• Consideration of legal issues and cultural sensitivities when assessing, documenting and formulating child
  and adolescent treatment plans.
  Competencies D. Interpersonal and Communication Skills.
E. Professionalism

Resident responsibilities

- Prompt and consistent attendance at Camelot of Kansas – Riverside Academy.

- Participation in providing clinical services at Camelot of Kansas – Riverside Academy, including assessment, treatment formulation, documentation, coordination of care and referrals.

Evaluation

- Residents will be evaluated with consideration being given to the above objectives, expectations, responsibilities and the implementation of these items into treatment.

- Residents will additionally be evaluated using clinical observations by supervising faculty, case presentations and journal presentations.

- PRITE

Patient Care

- The resident conducted comprehensive psychiatric interviews with children and families, including developmental history, school functioning, social functioning, and family functioning.
- The resident effectively engaged children and adolescents in the evaluation using language and communication style appropriate for the child’s developmental level.
- The resident performed physical examinations, including detailed neurological examination, when indicated.
- The resident made diagnostic formulations commensurate with level of training.
- The resident appropriately assessed for potential dangerous behavior.
- The resident formulated and implemented appropriate treatment plans.
- The resident intervened effectively in emergencies.
- The resident appropriately conducted behavioral therapy, when indicated.
- The resident will demonstrate knowledge of the appropriate and legal use of seclusion, restraints and medications given against patient’s will.
- The resident will demonstrate knowledge and appropriate treatment formulation for children and adolescents with substance abuse issues.
- The resident demonstrated knowledge and appropriate interventions for children or adolescents who are dying or dealing with grief issues.
- The resident demonstrated knowledge of policies and procedures for each rotation site.

**Medical Knowledge**

- Resident demonstrates knowledge of normal growth and development.
- Resident shows knowledge of the psychiatric diagnostic classifications system as applied to children and adolescents.
- Resident demonstrates knowledge of assessment considerations and tools for children, adolescents, and families.
- Resident understands biological, psychological, and sociocultural contributions to psychiatric illness in children and adolescents.
- Resident shows knowledge of appropriate use of psychopharmacological agents with children and adolescents.
- Resident shows knowledge of appropriate psychotherapeutic and educational interventions for children and adolescents.

**Practice-Based Learning and Improvement**

- The resident recognized and accepted limitations in his/her own knowledge base and skills.
- The resident demonstrated appropriate skills for obtaining and evaluating up-to-date information from scientific and practice literature and other sources to assist in quality care of patients.
- The resident facilitated the learning of students and other health care professionals.

**Interpersonal and Communication Skills**

- The resident demonstrated effective oral and written communication skills.
- The resident completed proper medical record documentation.
- The resident effectively communicated information about diagnoses and treatment to children and families.
- The resident effectively communicates with schools, referral sources, and other treatment providers as appropriate.

**Professionalism**

- The resident had knowledge of ethical and legal standards in working with children and adolescents and maintained these standards in practice.
- The resident maintained appropriate boundaries with patients and families.
- The resident completed timely medical documentation.
- The resident demonstrated consistent follow through with responsibilities.
- The resident was punctual for meetings and assignments.
- The resident maintained professional appearance and grooming.

**Systems-Based Practice**

- The resident effectively communicates with schools, referral sources, and other treatment providers as appropriate.
Division of Child & Adolescent Psychiatry Textbook Seminar

Seminar Site:  UKSM-W – Psychiatry Conference Room

1010 N. Kansas
Wichita, KS  67214

Thursdays Noon -1pm

Supervision provided by: Dr. Mercedes Peralas
Dr. Susan Daily
Dr. Russell Scheffer
Kristin L. Jones, MSN, ARNP, BC

Goals and Objectives

- Knowledge and review of normal growth and development.
  Competencies  A. Patient Care
  B. Medical Knowledge.

- Knowledge and review of clinical assessments of children, adolescents, and families
  Competencies  A. Patient Care
  B. Medical Knowledge.

- Understand developmentally relevant manifestations of psychopathology
  Competencies  A. Patient Care
  B. Medical Knowledge.

- Knowledge of evidence based treatments for children and adolescents
  Competencies A. Patient Care
  B. Medical Knowledge.
C. Practice – based Learning and Improvement

- Understand and learn how to communicate with the multiple systems involved in child’s life (e.g., parents, school, multidisciplinary team)

Competencies
F. System Based Practice

D. Interpersonal and Communication Skills.

E. Professionalism

Textbooks

by Andres Martin & Fred R. Volkmar (Editors)
www.lewischildpsychiatry.com

Clinical Handbook of Psychotropic Drugs for Children and Adolescents, 2nd Edition
by Kalyna Z. Bezchlibnyk-Butler & Adil S. Virani (Editors)

Lecture series in child and adolescent psychiatry

Part 1: Crash Course (8 weeks)

- Knowledge of policies and procedures for documentation, legal issues, communication and expectations in the Department of Psychiatry and Behavioral Sciences.
- Knowledge of initial assessment and engagement strategies when working with child and adolescent patients and their families.
  - Confidentiality
  - What to look for in a child mental status exam
  - Framework for the initial interview
Introduction to child/adolescent assessment tools

- Knowledge and skills for managing crisis situations.
  - Suicidal ideation
  - Abuse/Neglect reporting
  - Violence, legal charges

- Knowledge and review of commonly prescribed pharmacological interventions for children and adolescents.

Part 2: Child Development and Theory (6-8 weeks)

- Developmental milestones
- Freud
- Erickson
- Piaget
- Maslow
- Ainsworth
- Mahler

Part 3: Diagnosis Series (approx. 24 weeks)

Lectures for each topic to include diagnostic criteria, epidemiology, neurobiology, comorbidity, differential diagnosis, assessment tools/scales, medication treatments, psychotherapies, practice parameters.

- Attention and Disruptive Disorders - ADHD, ODD, and Conduct Disorder
- Mood Disorders – Depression and Bipolar
- Suicide in Children and Adolescents
- Anxiety Disorders – Generalized Anxiety, OCD, Tic Disorders
- Neglect, Abuse and Trauma - PTSD, Reactive Attachment, Munchhausen by Proxy.
- Childhood Onset Schizophrenia and other Psychotic Disorders.
- Substance Abuse
- Pervasive Developmental Disorders
- Learning Disorders, Mental Retardation
- Eating Disorders, Sleep Disorders and Elimination Disorders.

Part 4: Special Topics in Child and Adolescent Psychiatry (8-10 weeks)

- Seclusion, restraint and medicating against will for minor patients
- Child and adolescent neurology, traumatic brain injury, prenatal insults or deformities and seizure disorders.
- Divorce, Custody, Adoption
- Introduction to behavioral techniques and parent training interventions
- Psychological testing, neuropsychological testing, and psychoeducational testing
- Forensics
- Working with other professionals
- School services: IEP, 504 plans
- Chronic illness and end of life issues
- Grief
- School refusal
- Impulsivity
- Genetics
- Children of mentally ill parents
- Media influences
- Family dynamics

**Lecture Schedule**

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Reading</th>
<th>Faculty presenter</th>
<th>Resident presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/2</td>
<td>Intro: documentation, legal issues, clinical expectations</td>
<td></td>
<td>Jones</td>
<td></td>
</tr>
<tr>
<td>7/9</td>
<td>Confidentiality, MSE</td>
<td>Lewis 4.2.1, 4.2.2</td>
<td>Perales</td>
<td></td>
</tr>
<tr>
<td>7/16</td>
<td>Structured interviews, assessment tools</td>
<td>Lewis 4.2.3</td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>7/23</td>
<td>Suicide risk assessment &amp; management</td>
<td>Lewis 5.4.3</td>
<td>Perales</td>
<td></td>
</tr>
<tr>
<td>7/30</td>
<td>Abuse/neglect, violence</td>
<td>Lewis 5.15.1</td>
<td>Perales</td>
<td></td>
</tr>
<tr>
<td>8/6</td>
<td>ADHD &amp; Externalizing Disorders: Stimulants</td>
<td>Handbook 19-38</td>
<td>Scheffer</td>
<td></td>
</tr>
<tr>
<td>8/13</td>
<td>Depression &amp; Anxiety: SSRI’s</td>
<td>Handbook 40-58, 92-102</td>
<td>Scheffer</td>
<td></td>
</tr>
<tr>
<td>8/27</td>
<td>Developmental Milestones</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>9/3</td>
<td>Intro to developmental theory; Freud</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>9/10</td>
<td>Freud; Erickson</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>9/17</td>
<td>Rogers &amp; Maslow</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>9/24</td>
<td>Behaviorism</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>10/1</td>
<td>Piaget</td>
<td>Piaget primer</td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Topic</td>
<td>References</td>
<td>Authors</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------</td>
<td>-----------------------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>10/8</td>
<td>Temperament</td>
<td></td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>10/15</td>
<td>ADHD/ODD/CD</td>
<td>Lewis 5.2.1, 5.2.2, 5.2.3</td>
<td>Jones, Mittal</td>
<td></td>
</tr>
<tr>
<td>10/22</td>
<td>ADHD/ODD/CD</td>
<td></td>
<td>Jones</td>
<td></td>
</tr>
<tr>
<td>10/29</td>
<td>ADHD/ODD/CD</td>
<td></td>
<td>Jones</td>
<td></td>
</tr>
<tr>
<td>11/5</td>
<td>Depression</td>
<td>Lewis 5.4.1</td>
<td>Scheffer, Vijay</td>
<td></td>
</tr>
<tr>
<td>11/12</td>
<td>Depression</td>
<td></td>
<td>Scheffer</td>
<td></td>
</tr>
<tr>
<td>11/19</td>
<td>Bipolar</td>
<td>Lewis 5.4.2</td>
<td>Scheffer, Kereches</td>
<td></td>
</tr>
<tr>
<td>12/3</td>
<td>Bipolar</td>
<td></td>
<td>Scheffer</td>
<td></td>
</tr>
<tr>
<td>12/10</td>
<td>Suicide</td>
<td></td>
<td>Peralas, Bhatti</td>
<td></td>
</tr>
<tr>
<td>12/17</td>
<td>Psychotherapy</td>
<td>Lewis 6.2.1, 6.2.2, 6.2.3</td>
<td>Klaus</td>
<td></td>
</tr>
<tr>
<td>1/7</td>
<td>Anxiety</td>
<td></td>
<td>Jones, Magsalin</td>
<td></td>
</tr>
<tr>
<td>1/14</td>
<td>Anxiety</td>
<td></td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>1/21</td>
<td>Anxiety</td>
<td></td>
<td>Jones</td>
<td></td>
</tr>
<tr>
<td>1/28</td>
<td>Neglect, Abuse and Trauma</td>
<td></td>
<td>Wilkenson</td>
<td></td>
</tr>
<tr>
<td>2/4</td>
<td>Neglect, Abuse and Trauma</td>
<td></td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>2/11</td>
<td>Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/18</td>
<td>Schizophrenia and Psychosis</td>
<td>Lewis 5.3</td>
<td>Scheffer, Eboh</td>
<td></td>
</tr>
<tr>
<td>2/25</td>
<td>Schizophrenia and Psychosis</td>
<td></td>
<td>Scheffer</td>
<td></td>
</tr>
<tr>
<td>3/4</td>
<td>Pervasive Developmental Disorders</td>
<td>Lewis 5.1.1</td>
<td>Daily, Adepoju</td>
<td></td>
</tr>
<tr>
<td>3/11</td>
<td>Pervasive Developmental Disorders</td>
<td></td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>3/18</td>
<td>LD and MR</td>
<td>Lewis 5.1.2, 5.1.3</td>
<td>Klaus, McHale</td>
<td></td>
</tr>
<tr>
<td>3/25</td>
<td>LD and MR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/1</td>
<td>Eating Disorders</td>
<td></td>
<td>Handoo</td>
<td></td>
</tr>
<tr>
<td>4/8</td>
<td>Sleeping and Elimination Disorders</td>
<td></td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>4/15</td>
<td>C&amp;A neurology, TBI</td>
<td></td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Topic</td>
<td>Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/22</td>
<td>Divorce, Custody and Adoption</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/29</td>
<td>Seclusion and restraint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/6</td>
<td>Psychological testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/13</td>
<td>Forensics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/20</td>
<td>Chronic illness end of life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/27</td>
<td>Grief</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/3</td>
<td>Working with other professions</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/10</td>
<td>School services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/17</td>
<td>School refusal/impulsivity</td>
<td>Daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6/24</td>
<td>Behavioral techniques and parent training</td>
<td>Klaus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Expectations and Evaluation**

- Residents will attend and actively participate in all lectures
- Lectures will start promptly at noon; residents are welcome to bring lunch
- During part 3 of the lecture series, each resident will give a 15-20 minute presentation on one disorder. Presentations will include DSM criteria (with child specific manifestations as appropriate), a case example, and discussion of differential diagnosis.
- Evaluation may include written exams, PRITE, role plays, and presentations.

**Medical Knowledge**

- Resident demonstrates knowledge of normal growth and development
- Resident shows knowledge of the psychiatric diagnostic classifications system
- Resident demonstrates knowledge of assessment strategies and tools
- Resident understands biological, psychological, and sociocultural contributions to psychiatric illness
- Resident shows knowledge of appropriate use of psychopharmacological agents
- Resident shows knowledge of appropriate psychotherapeutic and educational interventions

**Practice-Based Learning and Improvement**

- The resident knows up-to-date practice parameters and treatment guidelines
- The resident demonstrates skill in critical evaluation of treatment options based on emerging scientific literature

**Interpersonal and Communication Skills**
The resident gave effective and well-organized presentations as required
The resident actively engaged in group discussions

Professionalism

- The resident had knowledge of relevant ethical and legal standards
- The resident demonstrated consistent follow through with readings and assignments
- The resident was punctual for lectures
- The resident maintained professional appearance and grooming

Systems-Based Practice

- The resident understands the role of various members of the multidisciplinary team (e.g., schools, social workers, therapists, nursing staff, legal system, etc.)

Child/Adolescent Clinical Research Rotation Goals and Objectives

Supervisor: Nicole Klaus, PhD

1. The resident will learn and understand important scientific elements of research design and conduct.
   - Competencies: A. Medical Knowledge
   - C. Practice-based Learning and Improvement
2. The resident will contribute to research design and implementation with children and adolescents.
   - Competencies: A. Medical Knowledge
   - C. Practice-based Learning and Improvement
3. The resident will develop an appreciation for the practical challenges inherent in clinical research, including balancing scientific and ethical responsibilities, subject recruitment, and obtaining funding.
   - Competencies: C. Practice-based Learning and Improvement
   - E. Professionalism
4. The resident will develop a working understanding of ethical issues, including human subjects protections and Institutional Review Board requirements, in clinical research with children and adolescents.
   - Competency: E. Professionalism
5. The resident will work as part of a multidisciplinary research team.
   - Competency: Interpersonal and Communication Skills
6. The resident will develop skills in data analysis and presentation.
   - Competencies: A. Medical Knowledge
   - C. Practice-based Learning and Improvement
   - D. Interpersonal and Communication skills

Expectations and Evaluation:

1. The resident will complete human subjects training requirements.
2. The resident will participate in various research activities, including but not limited to: literature review, hypothesis generation, selecting appropriate study design and measurement strategies for hypothesis
testing, grant writing, data collection, psychosocial intervention development, data analysis and interpretation, and data presentation.

3. The resident will meet with the supervisor weekly for individual supervision on research projects. The initial meeting will involve reviewing the resident’s interests and preparing individualized goals and objectives for the rotation.

4. The resident will prepare at least one research product suitable for publication or presentation.

5. The resident will be encouraged to submit their research product for the EE Baumhardt award.

Overview of research opportunities:

The resident may participate in two ongoing research studies with children and adolescents (see abstracts below). The resident will be encouraged to identify a specific component of the ongoing research projects to take primary responsibility for from data collection to presentation. With supervisor approval, the resident may develop their own related research project to implement during the rotation.

**Safety Planning with Suicidal Adolescents: The Youth Coping Project**

Safety and crisis response planning is considered by many mental health professionals to be a critical intervention for suicidal youth. While treatment guidelines (American Academy of Child and Adolescent Psychiatry, 2001) recommend the development of safety plans with youth to identify coping skills and emergency contacts to use in the event of future suicidal thoughts, relatively little is known about the most important components of these plans, how they are utilized by adolescents and their families, or their efficacy in preventing or minimizing harmful behavior. As a first step in a program of research to develop and evaluate safety planning interventions for suicidal adolescents, this project will investigate the use and benefit of coping skills and safety plans among adolescents who have been hospitalized for suicidal thoughts or behaviors. Descriptive data about safety plan utilization and the factors that impeded or facilitate such utilization will inform future intervention development. The following specific aims will be addressed:

1) Identify patterns of use and efficacy of coping skills to manage thoughts of self harm among adolescents over the course of 6 weeks post discharge from a psychiatric inpatient unit.

2) Preliminary investigation of individual and family characteristics that may impede or facilitate utilization of the safety plan, including the level of family support, parent-child agreement about the problem, youth psychopathology, and adherence to treatment recommendations.

**Psychoeducational Psychotherapy by Telemedicine for Children with Mood Disorders in Rural Kansas**

Mood disorders (depressive and bipolar disorders) in children age 12 and younger often have a chronic or relapsing course, associated with substantial psychosocial impairment. Despite the significant need for effective psychosocial treatments for children with mood disorders, there is a limited number of randomized controlled efficacy studies, particularly for bipolar disorder (Fristad, Verducci, Walters, & Young, 2009), and evidence-based treatments are not widely available to families, especially those in rural communities. Eight week multi-family psychoeducational psychotherapy (PEP) groups have been associated with significant improvements in mood symptoms compared to treatment as usual over one year follow up (Fristad et al., 2009). Family participation in PEP increased parental knowledge about mood disorders and treatment, which led to accessing higher quality services to improve children’s symptom severity (Mendenhall, et al., 2009).

Telemedicine has the potential to overcome some of the barriers related to accessing specialty care in rural areas. The limited research on telemental health with children has shown feasibility and high client and practitioner acceptance and satisfaction with this mode of treatment (AACAP, 2008). Given the recent findings that participation in PEP was associated with increased parental knowledge, leading to accessing higher quality services and continuing improvements in child mood symptoms one year after completion of the treatment (Fristad, et al., 2009; Mendenhall et al., 2009), the adaptation and systematic evaluation of PEP for delivery by telemedicine has strong potential improve outcomes for children with mood disorders in rural areas.

The current study aims to build on the advances in telemedicine and the latest knowledge about effective interventions for childhood mood disorders by adapting PEP for delivery by telemedicine for families of children in rural areas and conducting feasibility testing of the new intervention. Two important sources of information will guide the adaptation process: advice from an expert panel and results of a community needs assessment. Following
adaptation of PEP, a small feasibility trial of the intervention with families (n =5) will be conducted. We will test four main issues related to the feasibility of implementing the assessment and intervention procedures in a larger efficacy trial (Bowen et al., 2009; Thabane et al., 2010): 1) the recruitment procedures and rate of referrals, 2) duration and completion rate of the assessment battery, 3) family and community provider satisfaction with the intervention, and 4) adherence to the treatment protocol. Quantitative and qualitative data will be gathered to evaluate these questions. Findings from this project will inform the design of a large scale randomized controlled trial to evaluate the telemedicine adaptation of PEP.

Geriatric Psychiatry Service Curriculum

EDUCATIONAL GOALS:

The development and display in practice the knowledge, skills and attitudes necessary for the optimal clinical care of geriatric patients with mental disorders.

It is kept in mind that each learner begins inpatient and outpatient psychiatry with their own unique skill set and will progress at different rates. Education is enhanced by understanding the RIME conceptualization of the learning process:

- **Reporter** collects and reports clinical data but has limited ability to meaningfully prioritize and synthesize the data. This role is assumed by beginning learners.
- **Interpreter** can prioritize and interpret clinical data to formulate diagnostic hypotheses and treatment recommendations.
- **Manager** can see the big picture, apply knowledge, develop accurate diagnostic hypothesis, and initiate appropriate evaluation and treatment plans.
- **Educator**, the highest level in this particular hierarchy and the ultimate goal for all learners, continuously involves self-assessment and personal learning efforts to maintain an up-to-date, in-depth knowledge that is readily applied to patient care and the education of colleagues.

There are six competency domains set out by the Accreditation Council for Graduate Medical Education (ACGME – 2000). **Competency in all six areas should be achieved by completion of the residency training program.** These domains serve as a guideline for understanding the learning goals in residency training. They include:

1. Patient Care - PC;
2. Medical Knowledge - MK;
3. Practice-base Learning - PBL;
4. Interpersonal and Communication Skills - CS;
5. Professionalism - P; and
LEARNING OBJECTIVES, COMPETENCY DOMAINS, EXPECTATIONS AND EVALUATION

Learning Objective

- Competency in performance of a risk assessment of designated patients

Competency Domain

- PC, MK, CS, SBP

Expectations

- Assess patient’s dangerousness, need for hospitalization, or safety measures
- Interact with the court system regarding involuntary commitment of mentally ill patients
- Interact with family and care providers to arrange a safe living environment

Feedback and Evaluation

- Ongoing and timely feedback based on observation of the resident’s interaction with the patients
- Ongoing and timely feedback based on resident’s interpretation of data and ability to decide when commitment is necessary
- Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations

Learning Objective

- Competency in performance of an History and Physical Exam
- Competency in performance of a Mental Status Exam (MSE)

Competency Domain

- PC, MK, CS

Expectations

- Interview performed in skillful manner - knowledge of different interviewing techniques
- Physical exam (PE), neurological exam and complete Mental Status Exam (MSE) are competently performed

Feedback and Evaluation

The specific learning objectives for the inpatient psychiatry rotations support one or more of the ACGME competency domains.
• Ongoing and timely feedback based on resident’s ability to perform comprehensive patient interview during morning rounds and on clinical skills exam
• Ongoing and timely feedback of resident’s ability to use different and appropriate interviewing techniques during the patient interview
• Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations

Learning Objective

• Competency in prioritizing, organizing and interpreting clinical data to formulate a relevant, comprehensive differential diagnosis and plan

Competency Domain

• PC, MK, PBL, CS, P

Expectations

• Formulate diagnostic impression supported by clinical data using a biopsychosocial model and accounting for the patient’s ethnic and cultural background
• Develop a plan for further evaluation (appropriate use of laboratory and psychological testing, and consultation)
• Develop treatment plan including Electro Convulsive Treatment (ECT) during the hospitalization and after discharge from the hospital

Evaluation and Evaluation

• Ongoing and timely feedback based on resident’s ability to create concise, accurate summary of collected data regarding their individual patients
• Ongoing and timely feedback based on resident’s ability to apply analytical thinking to propose plan for the correct evaluation of the patient that will lead to correct diagnosis and treatment, ECT workup included
• Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations

Learning Objective

• Competency in engaging designated patients and their families in an empathic manner, with the ability to discuss and demonstrate a range of interviewing techniques

Competency Domain

• PC, MK, CS, P

Expectations

• Build good rapport with the patient, use of empathy
• Knowledge of different interviewing techniques
• Apply interviewing techniques during interview of the patients/their families

Feedback and Evaluation

• Ongoing and timely feedback based on resident’s ability to recognize patient’s needs and adapt to them during the patient’s interview
• Ongoing and timely feedback based on residents ability to recognize importance to communicate with patient’s families in effective manner during the family meetings and phone conferences
Learning Objective

- Recognition of the importance of collateral history and competency in obtaining and interpreting information from multiple sources

Competency Domain

- PC, MK, CS

Expectations

- Understand importance of collateral information for correct diagnosis
- Become skillful at eliciting and interpreting relevant information from patient’s family, prior care givers and other sources
- Review and summarize previous medical records

Evaluation

- Ongoing and timely feedback based on resident’s ability to recognize complex cases, the importance of collateral history, collection and interpretation of collected data.
- Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations, and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback will be based on resident’s performance during the team meeting, teaching rounds, Neuropsychology conferences, family meetings, and review of written documentation

Learning Objective

- Demonstrate ongoing efforts to develop, expand, and apply in practice, a knowledge base of geriatric psychiatry in areas relevant to assigned patients

Competency Domain

- PC, MK, PBL

Expectations

- Become familiar with diagnostic criteria for common psychiatric diagnosis
- Develop working knowledge of treatment for common psychiatric disorders
- Identify gaps in knowledge base and proactively eliminate them (teaching rounds, lectures, self education)
- Direct personal study to topics relevant to assigned patients
- Regularly seek consultation and feedback from attending physician and senior resident
- Become familiar with palliative care, hospice, and end of life issues

Evaluation

- Ongoing and timely feedback based on resident’s ability to formulate the list of differential diagnosis
- Ongoing and timely feedback based on resident’s ability to propose biological and psychological
- Ongoing and timely feedback based on residents ability to use evidence and methods to investigate, evaluate and improve patient care
- Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback
will be based on resident’s performance during the team meeting, teaching rounds, Neuropsychology conference, and review of the written documentation

**Learning Objective**

Competence in working effectively as a member of an assigned treatment team and as physician leader of the multidisciplinary treatment team

**Competency Domain**

- PC, MK, PBL, CS, P, SBP

**Expectations**

- Attend team meetings and be prepared to present your patient
- Have a working knowledge of assigned patients including target symptoms, problem list, diagnosis and differential diagnosis, current medication, progress during past 24 hours, plan for next 24 hours
- Work effectively with other members of the treatment team and be appropriately respectful to the attending physician team leader
- Attend Multidisciplinary staff meetings and be prepared to contribute in a concise, meaningful manner
- Work effectively with medical team, psychologists, nursing staff, social workers, therapists and other allied healthcare personnel

**Evaluation**

- Ongoing and timely feedback based on residents ability to collect and interpret collected data, formulate the list of differential diagnosis and propose treatment following biopsychosocial model
- Ongoing and timely feedback based on residents ability to identify target symptoms, follow the change in target symptoms with the treatment and adjust the treatment if needed
- Ongoing and timely feedback based on residents ability to work with other treatment team members demonstrating knowledge of optimal health care delivery
- Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback will be based on resident’s performance during the team meeting and review of the written documentation as well as feedback from other team members (primary care, neuropsychology, social workers, nursing…)

**Learning Objective**

Competence in skillful documentation of clinical data in a written format including orders, history, and patient progress; routinely review and be familiar with the sections of a medical inpatient and outpatient chart.

**Competency Domain**

- PC, MK, PBL, CS,

**Expectations**

On inpatient service be familiar with:

- Physician’s Order Sheet, KU Standing Orders, Detox Orders
- Legal documents of power of attorney and/or guardianship
- Court hold and commitment legal documents
• Electronic and handwritten H&P form on newly admitted patients
• Admission status on newly admitted patients (voluntary vs. involuntary)
• Daily progress documentation (electronic or handwritten) should include a review of the prior 24 hours referring to all sections of the patient’s chart on established patients
• Nursing notes yellow pages (Appendix 7)
• Flow sheets – vitals, sleep, food/fluid intake, suicide and safety observations
• MAR (list of all active medications in the hospital)
• Consult notes (Appendix 9) if consult ordered
• Family meeting, outpatient treatment team input, phone calls, etc. – write on green progress note or as addendum on EMR
• Discharge form VC 1635, dictated discharge summary
• Medication reconciliation form (Mirror Image) – created on the discharge date for all patients hospitalized in Via Christi
• DNR and Modified Resuscitation forms
• Discharge Action/Safety Plan

In outpatient clinic be familiar with Electronic Medical Record including

• Legal documents of power of attorney and/or guardianship
• Court hold and commitment legal documents
• Mini Mental State Exam, Montreal Cognitive Assessment, Mini-Cog Clock Drawing Test

Evaluation

• Ongoing and timely feedback based on resident’s ability to use appropriate forms of documentation
• Ongoing and timely feedback based on resident’s ability to convey information and data synthesis in oral and written format
• Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback is based on resident performance written documentation.

Learning Objective

• Demonstrate efforts to educate medical students, all treatment team members, patients and their families

Competency Domain

• PC, MK, PBL, CS, P, SBP

Expectations

• Medical Student Education
• Direct supervision of patient interview
• Review medical student’s documentation
• Encourage direct participation in patient care – conducting interviews, preparing timelines, gathering and summarizing collateral info, working with patients and families
• Educate fellow residents, staff, family members, attendings…

Evaluation

• Ongoing and timely feedback based on resident’s ability to engage and educate medical students as observed during their interaction
• Ongoing and timely feedback based on resident’s ability to involve medical student in patient care in meaningful way based on student’s participation case discussion during the team meetings
• Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations. Feedback is based on resident performance and medical student feedback.

Learning Objective

• Competence in discussing and demonstrating behaviors consistent with self-awareness and professionalism

Competency Domain

• PBL, P, SBP

Expectations

• Recognize need for guidance/supervision when faced with new or complex responsibility
• Develop insight to the impact of one’s behavior on others
• Awareness of appropriate professional boundaries
• Exhibit the qualities of altruism and advocacy including putting the best interests of the patient above self-interest or the interest of others

Evaluation

• Ongoing and timely feedback based on resident’s dedication, reliability and integrity
• Ongoing and timely feedback based on resident’s ability to be respectful and sensitive to patient needs
• Ongoing and timely feedback based on resident’s ability to solicit feedback and insight to own deficits with appropriate improvement of these deficits
• Verbal feedback during weekly supervision, written evaluations in the end of inpatient geriatric psychiatry rotations and tri-yearly evaluations in outpatient geriatric psychiatry rotations

Recommended Reading

PGY-4 Senior Resident Geriatric Inpatient and Outpatient Psychiatry Rotation

The PGY-4 Geriatric Psychiatry Inpatient and Outpatient Rotations are opportunities for senior residents to revisit, refine and consolidate their ability to assess and care for the elderly patients with psychiatric disorders. The PGY-4 residents bring three years of knowledge and experience to these rotations and performance expectations are distinctly higher than for junior residents. The geriatric psychiatry rotations are designed to more closely mimic a multi-faceted private/group practice situation that the majority of senior residents will probably be moving into upon graduation. Although still under the supervision of an attending, the PGY-4 resident will be expected to function more autonomously, independently and efficiently than a junior resident. As such, the senior residents are also expected to manage both inpatient and outpatient care issues and questions while not on location and to learn ways to obtain the information they need to make safe and effective care decisions. The expansion of these experiences will also include greater exposure to community services and working with senior care and long term care facilities as well as greater leadership opportunities and educational/academic opportunities.

Geriatric Psychiatry Inpatient Rotation

**Learning Goals:** The primary learning goal of the PGY-4 Inpatient experience is to demonstrate mastery of the knowledge and skills (i.e., diagnostic, procedural and technical skills) to efficiently and effectively manage the care of hospitalized patients with psychiatric disorders emulating a professional practicing psychiatrist with multiple competing responsibilities. This learning goal requires the ability to engage patients, gather and organize clinical data, interpret the data to develop diagnoses and treatment plans, and communicate this information and supportive reasoning in a concise meaningful manner. Direct patient care is the required means to meet this goal. A secondary learning goal is participate in the education of junior learners and to assist in the general administrative activities associated with the KU inpatient services. A mature initiative to know all patients on the service and to work within the wider system involving the community distinguishes the average senior resident from the exceptional senior resident on the rotation.

**Learning Objectives:**

Clinical
1 – Demonstrate mastery in evaluating assigned patients to develop working diagnostic hypotheses and formulate plans for further evaluation and treatment interventions (PC, MK);

2 – Be able to concisely and accurately communicate clinical findings, reasoning, and management plans to supervising attendings/consultants/colleagues and staff in both written and oral formats, including initial History and Physicals, daily progress notes, and dictated Discharge Summaries (PC, MK, CS);

3 – Be able to formulate meaningful diagnostic and treatment questions, seek out relevant consensus-based supporting information, and apply that knowledge in the timely care of assigned patients (PC, MK, PBL);

4 – Demonstrate a working understanding of health care systems and the timely access of relevant information in the approach to patient assessment, selection of treatment interventions, and development of discharge plans (MK, PBL, SBP);

5—Work effectively in obtaining pertinent history from family and collateral sources and in educating those involved in the patients support system (PC, MK, CS, SBP, P)

6 – Demonstrate insight regarding when to seek supervision and consultation for patient care and timely incorporation of feedback into practice (P).

Educational

1 – Be able to lead the daily Multidisciplinary Team Staffing in a professional, scholarly manner and, as time permits, identify and expand on case-based learning opportunities related to the patients being presented in the weekly Neuropsychiatry Case conferences and twice-weekly meetings with Pharmacy (MK, CS, P);

2 - Be able to advise, assist and refer junior learners on the spectrum from basic knowledge to the clinical skills of engaging patients, collecting clinical data and making diagnostic interpretations and management recommendations (e.g., pointing out omissions, identifying opportunities for improvement, providing references, etc.) (MK, PBL, SBP, P);

3- Demonstrate competence and compassion in educating patients, families of patients, and staff on issues related to diagnosis and treatment, unit milieu needs, DNR and modified resuscitation, court hold and commitment processes, power of attorney and guardianship recommendations, supervision and safety needs, and palliative care/hospice options when appropriate.

Administrative

1 – Demonstrate skillful management of time to perform patient care that is in compliance with the hospital, KU departmental, and third-party payer policies, while addressing any competing, non-inpatient residency-related responsibilities (SBP, P);

2 – Be able to work collaboratively with hospital staff, which includes leading multi-disciplinary staff meetings for assigned patients (CS, SBP, P);
Performance Assessment:

Clinical performance – direct observation by supervising attending, review of documentation, feedback from patients/staff/consultants

Educational performance – direct observation by supervising attending, feedback from junior residents and medical students

Administrative performance – direct observation by supervising attending, feedback from hospital staff

Additional Opportunities:

In addition to the basic course requirements and performance expectations outlined above, the PGY-4 residents on the Senior Resident Inpatient Rotation, depending on their interests, have multiple opportunities to further distinguish themselves by additional clinical, educational or administrative activities. To assure appropriate recognition and coordinate with the established curriculum and schedules of junior residents and medical students, it is advised that these additional activities be discussed with and approved by the supervising attending.

For illustration on a spectrum, additional activities could take the form of preparing formal presentations for various audiences (e.g., junior residents and students, staff, patients), participating in skills training with direct observation of learners, collaborating in medical center policy development or school curriculum development, analyze patient care activities to identify practice improvement opportunities, or taking a leadership role in ECT activities. Visiting nursing homes and assisted living facilities in the community, working more closely with the neuropsychiatry team to learn more about cognitive parameters and testing, and working more closely with speech therapy, physical therapy, and occupational therapy to develop techniques to enhance functionality are additional activities that are highly encouraged. Learning leadership skills by enhancing the education, supervision, coordination, and administration of duties for the junior residents on the rotation is promoted as a demonstration of higher levels of competency.

Geriatric Psychiatry Outpatient Clinic

Learning Goals: The primary learning goal of the PGY-4 Inpatient experience is to demonstrate mastery of the knowledge and skills (i.e., diagnostic, procedural and technical skills) to efficiently and effectively manage the care of elderly outpatients with psychiatric disorders from a variety of living settings patients. This rotation emulates a professional practicing psychiatrist with multiple competing responsibilities. This learning goal requires the ability to engage patients, collateral sources, caregivers, gather and organize clinical data, interpret the data to develop
diagnoses and treatment plans, and communicate this information and supportive reasoning in a concise meaningful manner. Direct patient care is the required means to meet this goal.

Learning Objectives:

Clinical

1 – Demonstrate mastery in evaluating assigned patients to develop working diagnostic hypotheses and formulate plans for further evaluation and treatment interventions (PC, MK);

2 – Be able to concisely and accurately communicate clinical findings, reasoning, and management plans to supervising attendings/consultants/colleagues and staff in both written and oral formats, including initial History and Physicals, daily progress notes, and dictated Discharge Summaries (PC, MK, CS);

3 – Be able to formulate meaningful diagnostic and treatment questions, seek out relevant/consensus-based supporting information, and apply that knowledge in the timely care of assigned patients (PC, MK, PBL);

4 – Demonstrate a working understanding of health care systems and the timely access of relevant information in the approach to patient assessment, selection of treatment interventions, and development of discharge plans (MK, PBL, SBP);

5—Work effectively in obtaining pertinent history from family and collateral sources and in educating those involved in the patients support system (PC, MK, CS, SBP, P);

6 – Demonstrate insight regarding when to seek supervision and consultation for patient care and timely incorporation of feedback into practice (P).

Educational

1 – Be able to lead the education of family members and facility staff in understanding the patients symptom management in relation to their diagnosis and competing co-morbid medical conditions (MK, CS, P);

2 - Be able to educate medical students on the outpatient rotation on the spectrum from basic knowledge to the clinical skills of engaging patients, collecting clinical data and making diagnostic interpretations and management recommendations (e.g., pointing out omissions, identifying opportunities for improvement, providing references, etc.) (MK, PBL, SBP, P);

Administrative

1 – Demonstrate skillful management of time to perform patient care that is in compliance with the KU departmental, and third-party payer policies, while addressing any competing, non- residency-related responsibilities (SBP, P);

2 – Be able to work collaboratively with departmental staff, nursing, and facility staff (CS, SBP, P);
Performance Assessment:

Clinical performance – direct observation by supervising attending, review of documentation, feedback from patients/staff/consultants

Educational performance – direct observation by supervising attending, feedback from junior residents and medical students

Administrative performance – direct observation by supervising attending, feedback from hospital staff

ACGME Competency Domains (Key):

1. **Patient Care (PC)** - Gather data; order diagnostic tests; interpret data; make decisions; perform procedures; manage patient therapies; work with others to provide patient-focused care
2. **Medical Knowledge (MK)** - Fund of knowledge; active use of knowledge to solve medical problems
3. **Practice-Based Learning & Improvement (PBL)** - Analyze practice performance and carry out needed improvements; locate and apply scientific evidence to the care of patients; critically appraise the scientific literature; use the computer to support learning and patient care; facilitate the learning of other health care professionals
4. **Interpersonal & Communication Skills (CS)** - Develop a therapeutic relationship with patients and their families; use verbal and non-verbal skills to communicate effectively with patients and their families; work effectively as a team member or leader
5. **Professionalism (P)** - Demonstrate integrity and honesty; accept responsibility; act in the best interest of the patient; demonstrate sensitivity to patients’ ethnicity, age, and disabilities
6. **Systems-Based Practice (SBP)** - Demonstrate awareness of interdependencies in the health care system that affect quality of care; provide cost-effective care; advocate for quality patient care; work with hospital management and interdisciplinary teams to improve patient care

**Geriatric Psychiatry Outpatient Clinic Goals and Objectives**

**Learning Goals:** The primary learning goal of the PGY-4 Inpatient experience is to demonstrate mastery of the knowledge and skills (i.e., diagnostic, procedural and technical skills) to efficiently and effectively manage the care of elderly outpatients with psychiatric disorders from a variety of living settings patients. This rotation emulates a professional practicing psychiatrist with multiple competing responsibilities. This learning goal requires the ability to engage patients, collateral sources, caregivers, gather and organize clinical data, interpret the data to develop diagnoses and treatment plans, and communicate this information and supportive reasoning in a concise meaningful manner. Direct patient care is the required means to meet this goal.
Learning Objectives:

Clinical

1 – Demonstrate mastery in evaluating assigned patients to develop working diagnostic hypotheses and formulate plans for further evaluation and treatment interventions (PC, MK);

2 – Be able to concisely and accurately communicate clinical findings, reasoning, and management plans to supervising attendings/consultants/colleagues and staff in both written and oral formats, including initial History and Physicals, daily progress notes, and dictated Discharge Summaries (PC, MK, CS);

3 – Be able to formulate meaningful diagnostic and treatment questions, seek out relevant/consensus-based supporting information, and apply that knowledge in the timely care of assigned patients (PC, MK, PBL);

4 – Demonstrate a working understanding of health care systems and the timely access of relevant information in the approach to patient assessment, selection of treatment interventions, and development of discharge plans (MK, PBL, SBP);

5—Work effectively in obtaining pertinent history from family and collateral sources and in educating those involved in the patients support system (PC, MK, CS, SBP, P)

6 – Demonstrate insight regarding when to seek supervision and consultation for patient care and timely incorporation of feedback into practice (P).

Educational

1 – Be able to lead the education of family members and facility staff in understanding the patients symptom management in relation to their diagnosis and competing co-morbid medical conditions (MK, CS, P);

2 - Be able to educate medical students on the outpatient rotation on the spectrum from basic knowledge to the clinical skills of engaging patients, collecting clinical data and making diagnostic interpretations and management recommendations (e.g., pointing out omissions, identifying opportunities for improvement, providing references, etc.) (MK, PBL, SBP, P);

Administrative

1 – Demonstrate skillful management of time to perform patient care that is in compliance with the KU departmental, and third-party payer policies, while addressing any competing, non-residency-related responsibilities (SBP, P);

2 – Be able to work collaboratively with departmental staff, nursing, and facility staff (CS, SBP, P);

Performance Assessment:
Clinical performance – direct observation by supervising attending, review of documentation, feedback from patients/staff/consultants

Educational performance – direct observation by supervising attending, feedback from junior residents and medical students

Administrative performance – direct observation by supervising attending, feedback from hospital staff

**ACGME Competency Domains (Key):**

1. **Patient Care (PC)** - Gather data; order diagnostic tests; interpret data; make decisions; perform procedures; manage patient therapies; work with others to provide patient-focused care
2. **Medical Knowledge (MK)** - Fund of knowledge; active use of knowledge to solve medical problems
3. **Practice-Based Learning & Improvement (PBL)** - Analyze practice performance and carry out needed improvements; locate and apply scientific evidence to the care of patients; critically appraise the scientific literature; use the computer to support learning and patient care; facilitate the learning of other health care professionals
4. **Interpersonal & Communication Skills (CS)** - Develop a therapeutic relationship with patients and their families; use verbal and non-verbal skills to communicate effectively with patients and their families; work effectively as a team member or leader
5. **Professionalism (P)** - Demonstrate integrity and honesty; accept responsibility; act in the best interest of the patient; demonstrate sensitivity to patients' ethnicity, age, and disabilities
6. **Systems-Based Practice (SBP)** - Demonstrate awareness of interdependencies in the health care system that affect quality of care; provide cost-effective care; advocate for quality patient care; work with hospital management and interdisciplinary teams to improve patient care

**Neuroimaging Goals and Objects**

Supervisor: Dr. Reddy

The psychiatry resident will be able to:

- Understand the strengths, weaknesses and limitations of CT vs. MRI in the evaluation of patient’s with central neurologic symptoms and diseases
- Understand the strengths, weaknesses and indications of spine CT, MRI, and myelography in the evaluation of the spine and spinal cord
• Understand the indications for conventional carotid and cerebral angiography, its risks and benefits in comparison with CTA and MRA
• Understand the role of imaging (including MRI vs. CT) in the evaluation of common clinical complaints, including stroke, headache, trauma, mass lesions, back pain, radiculopathy and demyelinating disease
• See how different MR sequences are used to identify different pathophysiological processes.
• Understand the usual appearances of gray matter, white matter, fluid, edema, masses, blood, and fat on common MR sequences (T1, T2, FLAIR, STIR)
• Know some of the uses of contrast in MRI and CT
• Review basic neuroanatomy on head CT and MRI
• Develop a basic but comprehensive standard method to evaluate routine non-contrast head CTs
• Get an overview of common procedures done in neuroradiology, including the use of nerve root blocks for management of back pain and vertebroplasty for compression fractures
• Be able to recognize the appearance of common pathological processes such as stroke, edema, herniation, subdural, epidural and subarachnoid hemorrhage on CT

Palliative Care Service Goals and Objectives

The goal of the Geriatric Psychiatry Residency Program is to produce residents that are specialists in comprehensive psychiatric and neuropsychiatric care of older patients and will obtain added qualifications in the subspecialty of geriatric psychiatry.

The resident will learn skills, knowledge and professionalism necessary to practice highly competent and comprehensive care of older patients with psychiatric and neuropsychiatric illnesses.

Learning Objectives:

Learning objectives while rotating through the Palliative Care Service, the resident is expected to:

1. Assess and manage common end-of-life psychiatric symptoms, including delirium, anxiety and depression.
2. Demonstrate the communication skills necessary for management of patients and families at the end-of-life.
3. Recognize the range of skills and services provided by members of the interdisciplinary team.
4. Understand the key components of the Medicare Hospice Benefit.
5. Develop an appreciation of the contribution art and literature makes to a physician’s growth and development
6. Identify successful and maladaptive responses to terminal illness.
7. Identify ethical and legal issues pertinent to withholding medical information.
8. Identify physical illness and iatrogenic with factors that can alter mental status and behavior.

Rotation Competencies:
**Patient Care**

The resident will:

1. Observe or perform (as determined by supervisor) accurate and complete medical interviews and physical examinations for hospice patients.
2. Obtain and evaluate relevant diagnostic data in the hospice setting.
3. Identify and prioritize the medical problems of hospice patients.
4. Manage patients appropriately based on available evidence, sound judgment, and patient preferences.

**Medical Knowledge**

The resident will:

1. Demonstrate knowledge of the basic and clinical sciences appropriate for his/her educational level.
2. Demonstrate a comprehensive understanding of the common problems related to end-of-life care.
3. Demonstrate the ability to access relevant information related to end-of-life care.

**Practice-Based Learning**

The resident will:

1. Demonstrate the ability to self-evaluate his/her educational needs and performances.
2. Incorporate relevant feedback and instruction into clinical activities of the rotation.
3. Use technology to enhance patient care and further his/her medical education.

**Interpersonal and Communication Skills**

The resident will:

1. Establish an effective therapeutic relationship with patients and families.
2. Demonstrate effective listening skills.
3. Demonstrate effective patient education and counseling skills.
4. Use effective and appropriate nonverbal communications with patients and colleagues.

**Professionalism**

The resident will:

1. Consider the needs of patients and families appropriately.
2. Consider the needs of colleagues (physicians, nurses, other health care professionals, and administrative staff) appropriately.
3. Acknowledge errors
4. Accept criticism.
5. Fulfill responsibilities.
6. Demonstrate ethical behavior.

**Systems-Based Learning**
The resident will:

1. Understand the context of how hospice care is provided within the larger health care system.
2. Refer to specialty care appropriately.
3. Access resources effectively.
4. Use systematic approaches to improve patient care and reduce errors.

**Assessment Tools**

1. Attending feedback (formative)
2. Rotation Evaluation (summative)

**Palliative Care Post-Graduate Year Four Elective Rotation**

The resident will learn skills, obtain knowledge and develop the professionalism necessary to provide competent and comprehensive end-of-life care to patients with co-morbid psychiatric and neuropsychiatric illnesses.

**Learning objectives:**

While rotating through the Palliative Care Service, the resident is expected to:

1. Assess and manage common end-of-life psychiatric symptoms including delirium, anxiety and depression.
2. Demonstrate the communication skills necessary for management of patients and families at the end-of-life.
3. Develop an understanding of how a multidisciplinary team can provide end-of-life care and learn how to coordinate such care.
4. Recognize the range of skills necessary for management of patients and families at the end-of-life.
5. Understand the key components of the Medicare Hospital Benefit.
6. Identify successful and maladaptive responses to terminal illness.
7. Identify ethical and legal issues pertinent to withholding medical information.
8. Identify physical illness and iatrogenic factors that can alter mental status and behavior.

**Rotation Competencies:**

**Patient Care**

The resident will:
1. Observe or perform (as determined by supervisor) accurate and complete medical interviews and physical examinations for hospice patients.
2. Obtain and evaluate relevant diagnostic data in the hospice setting.
3. Identify and prioritize the medical problems of hospice patients.
4. Manage patients appropriately based on available evidence, sound judgment, and patient preferences.

**Medical Knowledge**

The resident will:

1. Demonstrate knowledge of the basic and clinical sciences appropriate for his/her educational level.
2. Demonstrate a comprehensive understanding of the common problems related to end-of-life care.
3. Demonstrate the ability to access relevant information related to end-of-life care.

**Practice-Based Learning**

The resident will:

1. Demonstrate the ability to self-evaluate his/her educational needs and performances.
2. Incorporate relevant feedback and instruction into clinical activities of the rotation.
3. Use technology to enhance patient care and further his/her medical knowledge.

**Interpersonal and Communication Skills**

The resident will:

1. Establish an effective therapeutic relationship with patients and families.
2. Demonstrate effective listening skills.
3. Demonstrate effective patient education and counseling skills.
4. Use effective and appropriate nonverbal communications with patients and colleagues.

**Professionalism**

The resident will:

1. Consider the needs of patients and families appropriately.
2. Consider the needs of colleagues (physicians, nurses, other health care professionals, and administrative staff) appropriately.
3. Acknowledge errors.
4. Accept criticism.
5. Fulfill responsibilities.
6. Demonstrate ethical behavior.

**Systems Based Learning**

The resident will:

1. Understand the context of how hospice care is provided within the larger health care system.
2. Refer to specialty care appropriately.
3. Access resources effectively.
4. Use systematic approaches to improve patient care and reduce errors.
Assessment Tools:

1. Attending feedback (formative).
2. Rotation Evaluation (summative).

Post Traumatic Stress Disorder – Veterans Administration Hospital
Post-Graduate Year Four Elective Rotation

The resident will learn skills, obtain knowledge and develop the professionalism necessary to provide competent and comprehensive care to veterans diagnosed with Posttraumatic Stress Disorder (PTSD) and other co-morbid mental illness.

Learning objectives:

While rotating through the PTSD - VA Specialty Clinic, the resident is expected to:

1. Assess and manage common PTSD symptoms including: persistent re-experiencing of traumatic events, avoidance of associated stimuli to traumatic events and hyper-arousal states.
2. Demonstrate the communication skills necessary to manage patients in individual and group therapy formats.
3. Develop an understanding of how a multidisciplinary team, within the Veterans Administration Hospital, provides care to patients diagnosed with PTSD.
4. Recognize the range of co-morbid psychiatric illness that affect patients diagnosed with PTSD including: other anxiety disorders, mood disorders, substance abuse, anger, and violence.
5. Understand the key components of the Veterans Health Administration.
6. Identify healthy and maladaptive responses to past traumatic events.
7. Identify ethical and legal issues pertinent to Veterans.
8. Identify long term strategies to help patients learn to live and cope with PTSD symptoms.

Rotation Competencies:

Patient Care

The resident will:
1. Observe or perform (as determined by supervisor) accurate and complete psychiatric interviews for Veterans suffering from PTSD.
2. Obtain and evaluate relevant diagnostic criteria for the diagnosis of PTSD (DMS-IV-TR).
3. Identify and prioritize psychiatric symptoms of PTSD.
4. Manage patients appropriately based on available evidence, sound judgment, and patient preferences.

**Medical Knowledge**

The resident will:

1. Demonstrate knowledge of the basic and clinical sciences appropriate for his/her educational level.
2. Demonstrate a comprehensive understanding of the common problems related to PTSD.
3. Demonstrate the ability to access relevant literature/information related to PTSD, including seminal articles/studies.

**Practice-Based Learning**

The resident will:

1. Demonstrate the ability to self-evaluate his/her educational needs and performances.
2. Incorporate relevant feedback and instruction into clinical activities of the rotation.
3. Use technology to enhance patient care and further his/her medical knowledge.

**Interpersonal and Communication Skills**

The resident will:

1. Establish an effective therapeutic relationship with patients in individual and group settings.
2. Demonstrate effective listening skills.
3. Demonstrate effective psycho-educational and counseling skills.
4. Use effective and appropriate nonverbal communications with patients and colleagues.

**Professionalism**

The resident will:

1. Consider the needs of patients appropriately.
2. Consider the needs of colleagues (physicians, psychologists, nurses, other health care professionals, and administrative staff) appropriately.
3. Acknowledge errors.
4. Accept criticism.
5. Fulfill responsibilities.
6. Demonstrate ethical behavior.

**Systems Based Learning**

The resident will:

1. Understand the context of how patient care is provided within the Veterans Administration health care system.
2. Refer to specialty care appropriately.
3. Access resources effectively.
4. Use systematic approaches to improve patient care and reduce errors.

Assessment Tools:
1. Attending feedback (formative).
2. Rotation Evaluation (summative).

Post Traumatic Stress Disorder – Veterans Administration Hospital
Post-Graduate Year Four Elective Rotation Goals and Objectives

The resident will learn skills, obtain knowledge and develop the professionalism necessary to provide competent and comprehensive care to veterans diagnosed patients with Post-Traumatic Stress Disorder (PTSD) and other co-morbid mental illness.

Learning objectives:

While rotating through the PTSD-VA Specialty Clinic, the resident is expected to:

1. Assess and manage common PTSD, symptoms including: persistent re-experiencing of traumatic events, avoidance of associated stimuli to traumatic events and hyper-arousal states.

2. Demonstrate the communication skills necessary to manage patients in individual and group therapy formats.

3. Develop an understanding of how a multidisciplinary team, within the Veterans Administration Hospital, provides care to patients diagnosed with PTSD.

4. Recognize the range of co-morbid psychiatric illness that affect patients diagnosed with PTSD including: other anxiety disorders, mood disorders, substance abuse, anger and violence.

5. Understand the components of the Veterans Health Administration.
6. Identify healthy and maladaptive responses to past traumatic events.

7. Identify ethical and legal issues pertinent to Veterans.

8. Identify long term strategies to help patients learn to live and cope with PTSD symptoms.

Rotations Competencies:

Patient Care:
The resident will:

1. Observe or perform (as determined by supervisor) accurate and complete psychiatric interviews for Veterans suffering from PTSD.
2. Obtain and evaluate relevant diagnostic criteria for the diagnosis of PTSD (DSM-IV-TR).
3. Identify and prioritize psychiatric symptoms of PTSD.
4. Manage patients appropriately based on available evidence, sound judgment, and patient preferences.

Medical Knowledge:
The resident will:

1. Demonstrate knowledge of the basic and clinical sciences appropriate for his/her educational level.
2. Demonstrate a comprehensive understanding of the common problems related to PTSD.
3. Demonstrate the ability to access relevant literature/information related to PTSD, including seminal articles/studies.

Practice-Based Learning
The resident will:

1. Demonstrate the ability to self-evaluate his/her educational needs and performances.
2. Incorporate relevant feedback and instruction into clinical activities of the rotation.
3. Use technology to enhance patient care and further his/her medical knowledge.

Interpersonal and Communication Skills
The resident will:

1. Establish an effective therapeutic relationship with patients in individual and group settings.
1. Demonstrate effective listening skills.
2. Demonstrate effective psycho-educational and counseling skills.
3. Use effective and appropriate nonverbal communications with patients and colleagues.

**Professionalism**

The resident will:

1. Consider the needs of patients appropriately.
2. Consider the needs of colleagues (physicians, psychologists, nurses, other health care professionals, and administrative staff) appropriately.
3. Acknowledge errors.
4. Accept criticism.
5. Fulfill responsibilities.
6. Demonstrate ethical behavior.

**Systems Based Learning**

The resident will:

1. Understand the context of how patient care is provided within the Veterans Administration health care system.
2. Refer to specialty care appropriately.
3. Access resources effectively.
4. Use systematic approaches to improve patient care and reduce errors.

**Assessment Tools:**

1. Attending feedback (formative).
2. Rotation Evaluation (summative).

**PGY-4 Senior Resident Adult Inpatient Psychiatry Rotation**

The PGY-4 Inpatient Rotation is an opportunity for senior residents to revisit, refine and consolidate their ability to assess and care for hospitalized patients with psychiatric disorders. The PGY-4 residents bring three years of knowledge and experience to the senior inpatient rotation and hence performance expectations are distinctly higher than for junior residents. Although still under the supervision of an attending, the PGY-4 resident will function more autonomously, independently and efficiently than a junior resident.

**Learning Goals:** The overall primary learning goal of the PGY-4 Inpatient experience is to demonstrate mastery of the knowledge and skills (i.e., diagnostic, procedural and technical skills) to efficiently and effectively
manage the care of hospitalized patients with psychiatric disorders emulating a professional practicing psychiatrist with multiple competing responsibilities. This learning goal requires the ability to engage patients, gather and organize clinical data, interpret the data to develop diagnoses and treatment plans, and communicate this information and supportive reasoning in a concise meaningful manner. A secondary learning goal is participate in the education of junior learners and to assist in the general administrative activities associated with the KU inpatient services.

Learning Objectives:

Clinical

1. Demonstrate mastery in evaluating assigned patients to develop working diagnostic hypotheses and formulate plans for further evaluation and treatment interventions (PC, MK);

2. Be able to concisely and accurately communicate clinical findings, reasoning, and management plans to supervising attendings/consultants/colleagues and staff in both written and oral formats, including initial History and Physicals, daily progress notes, and dictated Discharge Summaries (PC, MK, CS);

3. Be able to formulate meaningful diagnostic and treatment questions, seek out relevant/consensus-based supporting information, and apply that knowledge in the timely care of assigned patients (PC, MK, PBL);

4. Demonstrate a working understanding of health care systems and the timely access of relevant information in the approach to patient assessment, selection of treatment interventions, and development of discharge plans (MK, PBL, SBP);

5. Demonstrate insight regarding when to seek supervision and consultation for patient care and timely incorporation of feedback into practice (P).

Educational

1. Be able to lead the daily Morning Report in a professional, scholarly manner and as time permits identify and expand on case-based learning opportunities related to the patients being presented (MK, CS, P);

2. Be able to advice, assist and refer junior learners on the spectrum from basic knowledge to the clinical skills of engaging patients, collecting clinical data and making diagnostic interpretations and management recommendations (e.g., pointing out omissions, identifying opportunities for improvement, providing references, etc.) (MK, PBL, SBP, P);


**Administrative**

1. Demonstrate skillful management of time to perform patient care that is in compliance with the hospital, KU departmental, and third-party payer policies, while addressing any competing, non-inpatient residency-related responsibilities (SBP, P);

2. Be able to work collaboratively with hospital staff, which includes leading multi-disciplinary staff meetings for assigned patients (CS, SBP, P);

**Performance Assessment:**

**Clinical performance** – direct observation by supervising attending, review of documentation, feedback from patients/staff/consultants

**Educational performance** – direct observation by supervising attending, feedback from junior residents and medical students

**Administrative performance** – direct observation by supervising attending, feedback from hospital staff

**Additional Opportunities:**

In addition to the basic course requirements and performance expectations outlined above, the PGY-4 residents on the Senior Resident Adult Inpatient Rotation depending on their interests have multiple opportunities to further distinguish themselves by additional clinical, educational or administrative activities. To assure appropriate recognition and coordinate with the established curriculum and schedules of junior residents and medical students, it is advised that these additional activities be discussed with and approved by the supervising attending. For illustration on a spectrum, additional activities could take the form of preparing formal presentations for various audiences (e.g., junior residents and students, staff, patients), participating in skills training with direct observation of learners, collaborating in medical center policy development or school curriculum development, analyze patient care activities to identify practice improvement opportunities, taking a leadership role in ECT activities, etc.
ACGME Competency Domains (Key):

1. **Patient Care (PC)** - Gather data; order diagnostic tests; interpret data; make decisions; perform procedures; manage patient therapies; work with others to provide patient-focused care
2. **Medical Knowledge (MK)** - Fund of knowledge; active use of knowledge to solve medical problems
3. **Practice-Based Learning & Improvement (PBL)** - Analyze practice performance and carry out needed improvements; locate and apply scientific evidence to the care of patients; critically appraise the scientific literature; use the computer to support learning and patient care; facilitate the learning of other health care professionals
4. **Interpersonal & Communication Skills (CS)** - Develop a therapeutic relationship with patients and their families; use verbal and non-verbal skills to communicate effectively with patients and their families; work effectively as a team member or leader
5. **Professionalism (P)** - Demonstrate integrity and honesty; accept responsibility; act in the best interest of the patient; demonstrate sensitivity to patients' ethnicity, age, and disabilities
6. **Systems-Based Practice (SBP)** - Demonstrate awareness of interdependencies in the health care system that affect quality of care; provide cost-effective care; advocate for quality patient care; work with hospital management and interdisciplinary teams to improve patient care

**Neurocognitive Disorders – KUMS-W Neuropsychology Clinic**

**Post-Graduate Year Four Elective Rotation**

The resident will learn skills, obtain knowledge and develop the professionalism necessary to provide competent and comprehensive patient and collateral interviews for patients presenting with neurocognitive disorders. The residents will learn skill, obtain knowledge and develop the professionalism necessary to utilize neuropsychology consultations.

**Learning objectives:**

While rotating through the Neurocognitive Disorder - Neuropsychology Clinic, the resident is expected to:
1. Be a co-interviewer with a faculty neuropsychologist for patient’s presenting with a variety of neurocognitive disorders: These disorders include dementia’s, Traumatic Brain Injuries, and various neurological disorders...
2. Demonstrate the communication skills necessary to interview neuro-cognitively impaired patients and their family members.
3. Develop an understanding of how a neuropsychological evaluation can facilitate diagnosis and treatment decisions.
4. Recognize the range of co-morbid psychiatric illness that may present in patients diagnosed with a neurocognitive disorder including: anxiety disorders, mood disorders, and substance abuse.
5. Recognize that neurocognitive disorders may initially present as psychiatric illness especially depression and anxiety and learn to appropriately include neurocognitive disorders in the process of differential diagnosis.
6. Identify ethical and legal issues that are related to the evaluation and treatment of neuro-cognitively impaired patients.
7. Identify strategies to help patients and families learn to live and cope with cognitive impairment and progressive cognitive decline...

**Rotation Competencies:**

**Patient Care**

The resident will:

1. Observe or perform (as determined by supervisor) accurate and complete interviews for patients presenting with neurocognitive disorders.
2. Obtain and evaluate relevant diagnostic criteria for the diagnosis of various neurocognitive disorders (DMS-IV-TR).
3. Observe or perform (as determined by supervisor) feedback to neuro-cognitively impaired patients and their families.
4. Observe depositions and attorney conferences when available during rotation

**Medical Knowledge**

The resident will:

1. Demonstrate knowledge of the basic and clinical sciences appropriate for his/her educational level.
2. Demonstrate a comprehensive understanding of the common problems related to neurocognitive disorders.
3. Demonstrate the ability to access relevant literature/information related to neurocognitive disorders, including seminal articles/studies.

**Practice-Based Learning**

The resident will:

1. Demonstrate the ability to self-evaluate his/her educational needs and performances.
2. Incorporate relevant feedback and instruction into clinical activities of the rotation.
**Interpersonal and Communication Skills**

The resident will:

1. Establish an effective therapeutic relationship with patients in the neurocognitive diagnostic settings.
2. Demonstrate effective listening skills.
3. Demonstrate effective psycho-educational and counseling skills for use in feedback sessions.
4. Use effective and appropriate nonverbal communications with patients, their families, and professionals.

**Professionalism**

The resident will:

1. Consider the needs of patients appropriately.
2. Consider the needs of colleagues (physicians, psychologists, nurses, other healthcare professionals, and administrative staff) appropriately.
3. Acknowledge errors.
4. Accept criticism.
5. Fulfill responsibilities.
6. Demonstrate ethical behavior.

**Systems Based Learning**

The resident will:

1. Understand the context of how patient care is provided within the neuropsychology clinic.
2. Refer to specialty care appropriately.
3. Access resources effectively.
4. Use systematic approaches to improve patient care and reduce errors.

**Assessment Tools:**

1. Attending feedback (formative).
2. Rotation Evaluation (summative).

**Psychotherapy Goals and Objects**

In the fourth year of training, residents continue to deepen their understanding of the role of psychotherapy in the treatment of their patients by participating in a one-month rotation with a faculty member who provides more intensive psychotherapy in the faculty outpatient clinic. By observing the experienced therapist, the residents have
the opportunity to assess and conceptualize the personality and relational issues of patients and learn how to adapt therapeutic techniques to effectively treat them. In the discussion of each case with the faculty member after the session, the residents' understanding of the patient dynamics and how the therapeutic techniques addressed them are elicited and refined. Residents are encouraged to do more intensive reading about these psychotherapeutic techniques.

In 2000, six competency domains set by the Accreditation Council for Graduate Medical Education (ACGME) serve as a guidelines to understand the learning objectives during the residency training. They include:

1. Patient Care - PC
2. Medical Knowledge - MK
3. Practice-base Learning - PBL
4. Interpersonal and Communication Skills - CS
5. Professionalism - P
6. Systems-based Practice - SBP

Overall learning objectives for the outpatient psychiatry rotation supports one or more of the ACGME competencies.

OBJECTIVES, EXPECTATIONS, COMPETENCY DOMAINS FEEDBACK & EVALUATION FOR 4TH YEAR PSYCHOTHERAPY:

Learning Objectives

1. Learning Objective: To learn how to conceptualize the therapeutic issues for outpatient therapy cases.

   Expectations: Resident is expected to demonstrate the ability to

   • Assess patients’ personality dynamics based on observations made during a therapy session.
   • Assess the relationship and other social and environmental contributions to the patients presenting problems in the therapeutic interview.
   • Communicate an accurate and organized description of the patient’s dynamics and other relationship and social factors to the supervisor after the therapy session.

   Competencies: PC, MK, CS, P

   Feedback & Evaluation:

   • Verbal feedback will be given in the discussion of each case after the psychotherapy session.
In weekly individual supervision sessions, the supervisor will give verbal feedback on the resident’s overall ability to make these conceptualizations of patient dynamics and their therapeutic issues. At the end of the rotation the supervisor will provide written feedback on the resident’s performance in this area.

2. Learning Objective: To learn how to adapt psychotherapeutic treatment plans to more complex patient dynamics?

Expectations: Resident is expected to demonstrate the ability to

- Describe why the therapist used specific interventions in a session based on the dynamics observed by the resident.
- Read the therapeutic literature on more advanced psychotherapy techniques and describe how to apply them to therapy patients
- Describe how the advanced techniques that were studied could be applied to the cases observed in the rotation

Competencies: PC, MK, P, PBL, CS

Feedback & Evaluation:

- Verbal feedback will be given in the discussion of each case after the psychotherapy session.
- Verbal feedback given after the discussion of the resident’s reading in the weekly individual supervision sessions.
- At the end of the rotation the supervisor will provide written feedback on the resident’s performance in this area.

3. Learning Objective: To become more aware of their own transference issues and their strengths and weaknesses in treating psychotherapy patients with different relational styles and problems?

Expectations: Resident is expected to demonstrate the ability to

- Identify their own feelings and reactions in response to their interactions with patients with different personalities and problems.
- Evaluate their strengths and weaknesses in dealing with different types of patients based on their self-knowledge.
- Discuss the implications of this self-knowledge for the type of practice that they see themselves working in after graduation.

Competencies: PC, P, PBL, CS
Feedback & Evaluation:

- Verbal feedback will be given in the discussion of each case after the psychotherapy session.
- In weekly individual supervision sessions, the supervisor will give verbal feedback on the resident’s observations of transference issues and self-knowledge of their relationship strengths and weaknesses.
- At the end of the rotation the supervisor will provide written feedback on the resident’s performance in this area.