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The Morehouse School of Medicine General Psychiatry Residency Program is committed to training excellent psychiatrists with an expertise in community-based health delivery and advocacy, aimed at promoting lifelong health habits that decrease health disparities in poor, rural, racial, and economically disadvantaged populations.

Morehouse School of Medicine seeks to provide students with disabilities equal opportunities and equal access to academic programs, services, and activities. If you have a disability for which you wish to request academic adjustments or accommodations, contact the Office of Disability Services at the beginning of each semester (or as soon as practicable). The Office of Disability Services is located in NCPC, Room 408. You may contact the office at (404) 756-5200 or via e-mail at ODS@msm.edu.
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Program Overview

Introduction
Welcome to the Psychiatry Residency Program at Morehouse School of Medicine (MSM). We are excited to have you as a member of our residency team. Our residency environment will provide you with the clinical case experience, didactic information, and confidence to enter the practice of general psychiatry as a competent, board-eligible physician.

Residency is much different than any previous training you may have experienced. You will learn the skills and didactic information that will enable you to diagnose and treat a diverse patient population with a wide variety of disorders. The skills you learn here will become the foundation of your medical career.

It should be your goal to acquire as much clinical experience in all areas as possible. You should develop a concentrated study program to ensure the steady accumulation of knowledge required to care for your patients.

In the following pages, you will find suggestions for accomplishing your goal of becoming a competent, board-certified psychiatrist. In addition to general program information, this manual provides policies and procedures for the residency. The manual is updated with new information, schedules, and department rosters as they are made available. All goals and objectives are/will be uploaded into your rotation curriculum available online through New Innovations. As always, we welcome your input, constructive criticism, and comments.

Program Mission
Our mission is to train psychiatric residents to provide excellent and quality healthcare to all, especially the underserved. The Psychiatry Residency Program is designed to provide a comprehensive learning experience that prepares psychiatrists to meet the demands of contemporary psychiatric practice. Emphasis is placed on the development of psychiatrists who have acquired their knowledge, skills, and competencies predominantly through community-based learning experiences.

This is a novel approach because our residents gain a significant amount of experience in the community as opposed to traditional residency programs that may focus more on the hospital environment. The program allows residents the opportunity to explore the many facets of psychiatric care in the 21st century.

The city of Atlanta is a multicultural city with a variety of people from different races and ethnicities, and the program benefits from this diversity. Residents benefit from a variety of patient experiences, whether patients are from the inner city, suburbia, foreign countries, or rural areas.

Graduates of the MSM Psychiatry Residency Program, while expected to become excellent clinicians, are equipped to adapt to the rapidly evolving dynamics of healthcare.

Residency Setting
Our program hospital partners include:
- Grady Memorial Hospital (GMH)
- Atlanta VA Medical Center (VA)
- Georgia Regional Hospital (GA REG)
- Laurel Heights Hospital (LHH)
Program Overview

- East Point CBOC (branch of Atlanta VA)
- Families First
- Dekalb Medical

In addition, we have a host of private and public sector partners for our outpatient rotations.

Administrative Structure
The following sections describe the roles and responsibilities of the members of our administration.

Program Director
The program director provides the overall leadership, development, and implementation of the residency program. The program director ensures that the program is compliant with all requirements of the Accreditation Council for Graduate Medical Education (ACGME) for a psychiatry residency training program. The program director is responsible for residents’ progression and matriculation from the program. The program director tracks and reviews all resident evaluations, patient logs, and Duty hours to ensure overall resident and program compliance.

Other responsibilities of the program director include:
- Overseeing all aspects of the residency program and resident education
- Creating and maintaining the affiliation agreements and alliances with the necessary educational and clinical entities, hospitals, clinics, and individual physicians to provide the highest quality training opportunities in the field of psychiatry
- Updating and modifying educational goals and curricula
- Overseeing and approving topics for lectures and instruction as deemed fit by the program and the emerging guidelines of the Residency Review Committee (RRC) and the American Board of Psychiatry and Neurology
- Directly supervising the program manager and the core psychiatry faculty and staff involved with the residency program implementation
- Working closely with the department’s chairperson and other officials at MSM to ensure that the program reflects the mission of the institution as well as of the department
- Overseeing the resident selection and promotion process

Associate Program Director
The associate program director is responsible to:
- Support the training director and program manager with administrative duties within the Psychiatry Residency Program.
- Review program policies.
- Review rotation and didactic goals and objectives.
- Assist with six (6) month resident performance reviews.
- Assist the chief resident in developing the Wednesday Academic Activity Schedule, inclusive of case conferences, journal club, and Grand Rounds.
- Encourage, monitor, and assist residents in identifying and participating in appropriate scholarly activities.
• Attend the Residency Training Committee meetings each month.
• Assist the Psychiatry program with recruitment and active participation in the interview process of applicants for the residency program.

**Chief Resident**
The chief resident supports resident teaching activities such as Grand Rounds, weekly didactics, Journal Club, and Clinical Case Conferences. The chief resident supervises the development and modification of resident schedules, including vacation requests and arranging back-up coverage for unplanned absences. The chief resident attends Residency Training Committee meetings of the department and serves as the resident liaison. A new chief resident is either appointed for each academic year from the graduating class (or PGY-3 class if no graduate is selected). Interested candidates are encouraged to contact the program director as early as possible for consideration.

The chief resident is responsible to:
• Set and maintain the standard of professional conduct for the entire program.
• Support the training director, associate training director, and program manager with administrative duties within the Psychiatry residency program.
• Develop the Wednesday Academic Activity schedule, inclusive of case conferences, journal club, and Grand Rounds.
• Act as liaison between the residency and the program manager, training director, associate training director, and Program Evaluation Committee with regard to policies and procedures within the program.
• Support and enact the policies and procedures of the Psychiatry residency program, the MSM system, and the ACGME to ensure that residents are fulfilling ACGME competencies and ensure continued accreditation as well as the success of the program.
• Attend the Residency Training Committee meeting the third Wednesday bi-monthly and Administrative Supervision biweekly with the training director and/or associate training director.
• Conduct monthly resident meetings to assess resident progress, needs, and concerns.
• Provide an avenue of communication for an educational environment in which interns and residents may raise and resolve issues without fear of intimidation or retaliation.
• Assist with orientation of the interns to ensure continuity of service and care for all Psychiatry patients. Assist residents with transitions to next clinical sites.
• Ensure that the upper level residents are helping in the education of medical students and lower level residents within the Psychiatry Department and rotations of clinical services system.
• Assist the VA chief in completion of the call schedule for Morehouse residents and interns. Provide the training director and program manager with the monthly call schedule every six (6) months.
• Assist the Psychiatry program with recruitment and active participation in the interview process of applicants for the residency program.
• Lead peer selection process of Resident Association (RA) members at large per RA bylaws and deadlines.
• Assist the RA by selecting members at large to represent the program and residents as members to institutional and hospital committees as requested by the Graduate Medical Education Committee.
• Serve as the MSM resident member for GPPA.
• Provide relevant didactic lectures to interns and medical students.
Program Overview

The chief resident is also responsible for the following duties specific to the VA:

- Share responsibility with Emory chief to complete and tend to call schedules and vacation requests for Emory and Morehouse interns, residents, and med students.
- Share responsibility with Emory chief for the orientation of residents and students (computer codes, unit orientation with CPRS note formats, obtaining keys, photo IDs, etc.).
- Set up multisource evaluation meetings for residents twice a year.
- Share responsibility with Emory chief to be available by pager for residents after hours for any on-call clinical issues.
- Track and address vacation and call swaps.
- Mutually serve as back-up for the co-chief during absences.
- Share in teaching duties, which include attending team meetings for MSM interns and teaching for MSM interns separately about clinical information gathering and clinical basics.
- Assist with student orientation.

Program Manager
The program manager manages the daily operational activities of the residency program and interacts with various personnel at affiliated institutions as needed. The program manager ensures that the residents complete all required paperwork, including obtaining evaluations. The program manager also ensures that residents’ master files, evaluations, immunization certificates, visa documents, and United States Medical Licensing Examination (USMLE) scores are kept up to date.

The program manager is responsible for completing and filing all required paperwork and communications from internal and external entities (e.g., MSM Graduate Medical Examination [GME] office, American Board of Psychiatry and Neurology, American Psychiatric Association). The program manager coordinates the resident recruitment activities in conjunction with the program director.

Program Assistant
The program assistant provides administrative support to the program director, associate program director, and the residency program manager. The residency program assistant provides professional and prompt completion of data entry, expense requests, travel support, program documentation, and meeting logistics.
Program Overview

MOREHOUSE
SCHOOL OF MEDICINE
PSYCHIATRY - RESIDENTS 2018-2019

PGY-I Interns
Ashmeer Chima  Ruwaydah Hasan  Kristian Jones  Christopher Villongco

PGY-II Residents
Jeala Barnett  Kendra Michel  Yesha Thakkar  Kamille Williams

PGY-III Residents
Je Ajayi  Sid Shah  Ola Adedapo-Jimoh  Jay Bhimani

PGY-IV Residents
Kevin Simon  Christopher Hoffman  Otega Edukuye  Rashad Smith
General Information

Certifications
Residents are required to be certified in Advanced Cardiac Life Support (ACLS) and Basic Life Support (BLS) throughout their residency. Residents must apply for a National Provider Identifier number (NPI) and use this number for writing prescriptions. As a rising PGY-3 resident, GME will cover the cost to recertify.

Counseling Services
The stress associated with residency programs is well recognized. MSM offers an Employee Assistance Program (EAP) through the insurance carrier United Healthcare. The EAP provides confidential assistance to all MSM employees and their families. Through the EAP, residents and their families can receive confidential, professional help.

To make inquiries regarding assistance, contact MSM’s Human Resources Department.

In the event that a resident is reported as one who appears to be persistently sleepy or fatigued while on duty, the program director and the resident's faculty member advisor will counsel the resident individually to determine if there are some medical, physical, or psychosocial factors affecting his or her performance. Residents may be directed to the Office of Disability Services based on findings if needed.

Disputes with Personnel
In the event of interpersonal conflict that is not mutually and adequately resolved, the dispute should be brought to the attention of the Attending faculty. All parties involved will be assembled to resolve any disagreement. In the event that the dispute cannot be resolved, the matter will be presented to the program director, who will then act as arbitrator.

Leave Information—Vacation, Holiday, Sick Leave, Post Call, and Availability
Residents are expected to perform their duties as resident physicians for a minimum of 11 months each calendar training year. Absences from the training program for vacation, illnesses, or personal business must not exceed a combined total of four (4) weeks per academic year, or extra time will be extended onto the residency.

For successful completion of the program in time for board eligibility in July following graduation, the American Board of Psychiatry and Neurology does not permit more than 30 days leave time per year. Leave time is any time away from the residency training program that is unrelated to educational purposes. Leave time in excess of 30 days is granted at the discretion of the program director. Absences from the residency program in excess of one (1) month within the academic year must be made up before the resident advances to the next level. In addition, time is added to the date of completion of the required 48 months of training.

As a rule, leave must be approved 30 days in advance.

NOTE: You must not make any travel plans before the leave request is approved!

Complete the paper leave form and have ALL supervisors sign it (this includes all the clinical services from which you will be absent) and submit it to the Residency Training Program for the PD's signature. Vacation leave must be submitted in advance. Ms. Burns will enter all vacation and sick time in KRONOS on your behalf.

See Leave Form, under Departmental Forms.
**Vacation**

Each resident is allowed 15 days of vacation. Vacation requests are granted on a first-come, first-serve basis using the official form approved by the program.

Vacation time is scheduled during designated rotations. Any request for leave outside of designated rotations or blocks must be approved by the program director. All requests for exceptions should be in a letter addressed to the program director detailing the request and specific reasons for the deviation from the aforementioned policies. If any changes in the on-call schedule are necessitated by a leave request, it is the resident’s responsibility to secure coverage in advance. The names of the physicians covering the clinic or call hours must appear on the request form.

Submit the leave request in the following sequence:

1. Submit the request to your site supervisor(s) for approval and signature;
2. After you obtain your supervisor(s) signature, submit the leave request to the PM or PA;
3. Then submit the form to the program director or associate program director for approval.

All requests must be made at least 30 days in advance. Requests will be considered in the order in which they are received. **No travel plans should be made until the program director approves the request.**

Vacation days not used will not carry over to the next academic year; they will not be accrued. Vacation leave is not subject to an accumulated “pay out” upon the completion of training or upon a resident’s termination from the program.

**Holidays**

Approved MSM holidays do not apply to your rotation holidays. Check with your particular rotation to determine what days are considered holidays. For example, MSM celebrates Good Friday, but other practices may not. The rotation schedule supersedes any MSM holiday.

**Post Call**

Each resident is responsible to inform the RTP if he or she is post-call on a Wednesday the night before via e-mail to the program manager and the didactics instructor, copying the program assistant.

**Program Duty Hour Logging Requirements**

Duty hour logs are recorded **DAILY** into New Innovations by the residents. Failure to log duty hours for seven (7) or more consecutive days **WILL** result in an administrative call for the resident (**see page 16**).

There are seven (7) types of duty hours that should be entered into New Innovations:

- Shift/rotation—all scheduled activities (including lectures) associated with rotation
- Clinic
- Conference/workshops/lecture—Wednesday didactics, Board review, noon conference, and Grand Rounds only
- Back-up call in—any time a resident is called in for a shift as back-up
- Vacation
- Holiday/day off
Time Management and Administrative Responsibilities

In recent years, ACGME requirements have significantly changed, moving towards resident documentation of competencies and programs’ verification of residents’ competencies. In addition, duty hours have become more restrictive to ease resident fatigue and optimize physical readiness for performing and learning.

Not only are residents and programs obligated to follow these rules, but often credentialing agents request competency-based evaluation of former residents presented before them. Because of this, it is very important that all of the administrative duties, logging of duty hours, patient/procedure logs, and participation in learning opportunities are met and documented by the resident.

The requirements that residents are obligated to complete are listed below, being excused only per the policy outlined in this manual in the corresponding section:

- Duty hours to be logged on a daily basis
- Patient logs to be logged as outlined
- Seventy (70%) attendance to Grand Rounds and Didactics on a quarterly basis*

*Excused absences (e.g., sick, vacation, ER shifts, etc.) will not be counted against the resident.

Be advised that Duty Hours do not include self-study activities.

It is strongly advised that you set aside a minimum of two to three hours per weekday (or ten to fifteen hours per week) to complete these administrative program requirements. The Apple iPad provided by the program can be used to facilitate all of these activities. Like all professionals, it is expected that residents manage their time appropriately. If you are feeling overwhelmed, we suggest setting up a designated time during the week to complete the activities, setting up your Microsoft Outlook calendar to send automated reminders; and meeting with your advisors and fellow residents for suggestions.

Administrative Call

Be advised that each of the listed responsibilities will be reconciled on a quarterly basis. That is, the program director will collect and review the information to ensure that each resident is in compliance, with the exception of Duty Hours, which are monitored weekly.

NOTE: If you are found to be out of compliance (e.g., logs are more than two (2) weeks out of date, less than 70% Grand Rounds/didactic attendance) you will be placed on an administrative shift to complete or review missed materials. Administrative shifts will be completed on Saturday or Sunday at Atlanta VA Medical Center for 12 hour shifts. If the resident completes requirements before 12 hours, the remaining time will then be devoted to reviewing professionalism modules and/or patient care.

Sick Leave

Each resident is allowed a maximum of 15 paid sick days per academic year. This time can be taken for illness, injury, and medical appointments for the resident or for the care of an immediate family member. Sick leave can only be used for sick days and not as extra vacation. If a resident is not ill, it is the program’s expectation that the resident will be there for the patient, as they are counting on YOU.

NOTE: A missed call for sick leave must be made up.
General Information

Other than a missed call, sick days are not required to be made up as long as they do not prevent the resident from receiving a satisfactory evaluation and appropriate exposure to the rotation as determined by the program director and curriculum committee. It is the resident’s responsibility to notify the chief resident by 8 am when he or she is out sick.

It is also the resident’s responsibility to notify his or her attending physician and supervising resident. If three or more sick days are taken during a rotation, or if it appears that sick days are being abused, a physician’s excuse must be provided. Sick leave is not accrued from year to year.

A combination of sick leave and vacation leave may be used to care for oneself or an immediate family member. When these two leave categories are exhausted, any additional leave days are uncompensated (see GME Policy Handbook). You must complete the leave form for all sick days as soon as possible, either when physically better or on the first day back to work.

Leave of Absence (without Pay)
Requests must be submitted in writing to the residency training director for disposition. The request shall identify the reason for the leave and the duration. Requests for a leave of absence without pay are approved only if the residency training director is reasonably sure that the resident’s position is expected to be available when the resident returns. A leave of absence without pay when approved shall not exceed six (6) months in duration. If the absence extends over six (6) months, the resident must re-apply to the residency program.

Other Leave
Other leave types are explained in detail in the MSM Human Resources employment manuals. The resident is advised that in order to fulfill the special requirements of training and of the specialty certification board, it may be necessary for a resident to spend additional time in training to make up for time lost while he or she used vacation, sick leave, the various types of emergency leave, or leave of absence without pay.

Residents are discouraged from taking vacation on timed rotations such as:

- Internal Medicine (PGY-1)
- Neurology Inpatient (PGY-1)
- Child (outpatient and inpatient) (PGY-2 and PGY-3)

NOTE: Administrative leave can be granted at the program director’s discretion and may not exceed 10 days per year (12 months). Keep this in mind when planning for any leave regarding Step III. Residents are advised that some medical boards count administrative/educational leave as time away from training and may require an extension of their training dates. See the Full Resident Leave Policy including Family and Medical Leave, under GME Program Policies.

Library Multi-Media Center
The MSM Multi-Media Center is located in the Medical Education Building on campus. The library’s collection (both electronic and non-electronic) includes access to Psychiatry Online, textbooks, reference books, journals, videos, audiotapes, and color slides. A qualified medical librarian staffs the library full-time. The MSM Multi-Media Center and the Atlanta University Center Woodruff Library are available for residents.
Moonlighting
Moonlighting is defined as any employment for compensation that is unrelated to the MSM Psychiatry Residency Program. Limited outside work for compensation is allowed as long as it does not adversely affect the resident’s home or professional life. This work must not interfere with the resident's regular duties and on-call availability. Residents must not be required to engage in moonlighting and this opportunity is only available to eligible PGY-3 and PGY-4 residents.

At no time should the resident leave a rotation early, begin late, or allow performance to be impaired by fatigue or lack of sleep as a result of a moonlighting experience. Moonlighting is not allowed during a leave of absence. The program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. The director of the program must approve and monitor all moonlighting work. The program director must provide a prospective, written statement of permission to moonlight which must be included in the resident's file. The resident's performance must be monitored for the effect of these activities. Adverse effects may lead to withdrawal of permission to moonlight.

MSM’s malpractice insurance does not cover the resident for moonlighting work.

- The program director must comply with the sponsoring institution’s written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.
- Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours.

A resident who wants to moonlight must discuss and obtain approval for this activity from the program director.

See Moonlighting Policy.

On-Call Hours
When psychiatric residents are admitting new patients or on night shifts, they are expected to remain on the hospital premises until the start of the new shift. If they are on other rotations and are starting on-call at the hospital, they are expected to arrive for the sign-out rounds at the designated sign-out time for that campus and remain there until the end of their shift.

Pagers
The program provides pagers and holders to all residents at no charge. The pagers are alphanumeric and receive three types of messages: text, numeric, and voicemail messages.

- When your pager number is displayed on the pager, you have a voicemail message. Call your pager, press zero, and enter your access code, which is 1234. Press 3 to listen to messages and 2 to delete messages.
- To change your greeting, dial your pager number, press zero, enter your access code (1234), and then press 11 for greeting menu. Press 30 to record, 1 to stop recording, and 40 to playback.

Text messages are sent on the American Messaging Web site www.myairmail.com. You can also send text messages via e-mail by using the e-mail address as [pager number]@myairmail.com. For example, if you want to e-mail to pager number (404) 555-1234, you would enter the e-mail address 4045551234@myairmail.com. Malfunctioning pagers are replaced at no additional charge to the resident. The units are exchanged in the residency office.

NOTE:

- Residents will be charged a $42 fee for lost or stolen pagers.
- You are expected to wear and respond to your pagers at all times while on duty. You are expected to return a page within one (1) hour.
**General Information**

**SPOK On-Call**
Amcom Web utilizes the Amcom Console database to provide web-based access to on-call schedules and to send paging messages to individuals who are on call [http://SPOK-IWEB-PD/Amcom/Amcomweb](http://SPOK-IWEB-PD/Amcom/Amcomweb).

**Communication with Patients**
Residents are expected to utilize methods of contact specified by each clinical site to communicate with patients (i.e. voicemail, pagers, clinical numbers). Residents should not communicate with patients via email. Notify patients who should be contacted in the case of an emergency. For example, you may use the following voicemail message: “In case of an emergency, hang up and call 911 or the Mobile Crisis line at 1-800-715-4225.” Since e-mail addresses are accessible to patients, inform patients that e-mail messages are not the appropriate way to contact a physician in an emergency and that you may not respond immediately.

**Parking**
Parking cards are issued during the Graduate Medical Education Orientation for personal parking at Grady Hospital. Residents must pay a $10 deposit and the first month’s fee of $21. Subsequent months are paid through a payroll deduction. Free parking is available at other work sites (Georgia Regional, Atlanta VA) via a hospital ID badge.

**Problems or Difficulties—What to Do?**
As a resident, you may encounter clinical or personal situations or problems that are difficult to handle. This is usually due to a lack of adequate experience or situations that arise beyond your control. If you have any problems, please ask for help and advice from your resident colleagues, chief residents, Attending physicians, the program manager, or the program director. The program director maintains an open-door policy toward all residents. We are here to assist you with any problem that arises. It is important to notify us so that we can help.

**Professional Organizations**
The MSM Psychiatry Residency Program requires all residents to be members of the APA throughout their time of residency. Membership includes a yearly subscription to *The American Journal of Psychiatric News*. Our program has joined the ranks of an exclusive organization within the APA: The 100% Club. Our program has been part of the 100% Club Gold Level for more than five consecutive years. Residents benefits for being part of this club include: SET for Success (featuring more than 60 free courses on the APA Learning Center), a special practice resource gift, priority access to new learning formats on the APA Learning Center and priority access to moderator positions at the Annual Meeting and IPS: The Mental Health Services Conference which includes reimbursement for meeting registration!

**Resident Faculty Advisor Responsibilities**
Psychiatry residents are assigned to a faculty advisor throughout their four years of training. The advisor’s role is to be the resident’s mentor in issues of professional training and career planning, as well as to assist in the resident’s ongoing training and evaluation process.

The faculty advisor undertakes the following primary responsibilities:

- Set up a schedule for regular meetings with the resident for the academic year, focusing on plans for self-assessment, and monitoring progress; provide residents with advice to help them study for the psychiatric boards and prepare for in-service exams and quizzes starting early in their PGY-1 year and follow-up on these plans over time. The minimum frequency of meetings is once per month.
- Discuss resident’s performance on the PRITE exam. For those residents who fall below the national mean, the resident and faculty advisor will develop a remediation plan to correct the identified areas of
weakness. The plan will be closely monitored to assist the resident in attaining scores at or above the national mean.

- Guide the resident to an appropriate mentor for his or her research project. The goal is for each resident to develop a research interest and become involved in an independent research study under the guidance of a mentor. The mentor also assists the resident in becoming part of any ongoing projects by the end of the PGY-1.
- Review copies of all the advisee’s evaluations from different rotations and give additional recommendations and constructive criticism. All evaluation forms are available to the Faculty Advisor in New Innovations.
- Provide additional focus on career guidance to residents in the PGY-2 through PGY-4 years. After exploring their interests and future plans, it may be necessary to direct residents to other faculty members who may provide additional guidance in the resident’s field of interest.

**USMLE Policy**
Residents must pass USMLE Step 3 by their 20th month of residency. Residents must present the official results of their USMLE Step 3 examination to the residency program director before the last working day of the resident’s 20th month which, in a normal appointment cycle, is February. Residents who have not passed Step 3 by the end of the 20th month will not receive a reappointment letter to a residency program at the regular time. Residents who pass USMLE Step 3 between the 21st and 24th month, may receive a reappointment letter to a residency program at the time of receipt of the results, if this is the sole reason for not receiving an appointment letter.

See GME USMLE Step 3 Requirement Policy under GME Program Policies.

**When to Call for Help**
For clinical help, seek your supervising resident or chief resident first. If the situation is not resolved or if no supervising resident is available, call your Attending physician.

If personal problems arise, you may discuss them with the program director and/or you may contact Human Resources and ask for the Employee Assistance Program (EAP). We maintain an open-door policy for any problems.

**Work Hours**
Unless otherwise specified by the clinical supervisor, the work day generally begins at 8 a.m. and continues until the end of the clinical work day for the rotation. Ending times may vary from rotation to rotation, but in general, ending time is usually between the hours of 5 p.m. and 6 p.m.

**Email**
All residents are expected to check their MSM e-mail daily. The program is instructed to send all communications through MSM e-mail; your personal e-mail address is not to be used.

**Compliance Hotline**
Morehouse School of Medicine is committed to maintaining an environment where open, honest communication is the expectation. You will have access to a phone and the internet-based reporting system that is administrated and managed by a third party, NAVEX EthicsPoint, Inc. This comprehensive reporting tool will assist us in working together to proactively address compliance concerns and potential violations of regulations and policies. Any information you provide to NAVEX EthicsPoint will remain confidential. Reports can be made through the easy to use NAVEX EthicsPoint 24-hour website: [www.msm.ethicspoint.com](http://www.msm.ethicspoint.com) or by
Program Goals

Overall Residency Program Goals
The MSM Psychiatry Residency Program develops psychiatrists who are proficient in the details of medical management as well as sensitive and responsive to the special circumstances that often prevail in medically and psychiatrically underserved and disadvantaged communities.

PGY-1 Residents
This is a transitional year during which residents rotate in neurology, inpatient medicine, and family medicine. Rotations also include inpatient and geriatric psychiatry training at the Atlanta Veterans Health Care Systems. Residents are introduced to patient safety and quality improvement curriculums and ACGME core competency expectations.

PGY-2 Residents
This year provides training and experience in outpatient community psychiatry. Experiences in child and adolescent psychiatry, addiction psychiatry, psychosocial rehabilitation, and community outreach services are included. Residents participate in patient safety and quality improvement activities/projects and begin work within the different psychotherapy competencies.

PGY-3 Residents
In this year, residents complete an emergency psychiatry rotation, consultation-liaison rotation, forensic rotation, adult inpatient rotation with the severe and persistently mentally ill at the state hospital, inpatient child and adolescent rotation, and a substance abuse-trauma recovery rotation. Residents will continue care for long-term supervised psychotherapy cases and patient safety/quality improvement projects.

PGY-4 Residents
Residents in their fourth year of training will complete a psychotherapy rotation at the Atlanta VA/CBOC, VA/COE, and VA Center for Cognitive Excellence. Residents will customize the remainder of their training with elective clinical experiences.

Competencies
The Accreditation Council for Graduate Medical Education (ACGME) has developed formal guidelines for competencies, both general and specialty-specific, as well as acceptable methods for evaluating these in-training programs across the United States. A list of the critical information can be obtained from the ACGME Web site (http://www.ACGME.org). These competencies should serve as a guide for the skills that you should strive to develop as you progress in your subspecialty education.
ACGME Competencies

Patient Care and Procedural Skills
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Residents must demonstrate competence in the evaluation and treatment of patients of different ages and genders from diverse backgrounds, and from a variety of ethnic, racial, sociocultural, and economic backgrounds. Residents must also demonstrate competence in:

- Forging a therapeutic alliance with patients and their families of all ages and genders, from diverse backgrounds, and from a variety of ethnic, racial, sociocultural, and economic backgrounds;
- Formulating a clinical diagnosis for patients by conducting patient interviews;
- Eliciting a clear and accurate history;
- Performing a physical, neurological, and mental status examination, including use of appropriate diagnostic studies;
- Completing a systematic recording of findings in a medical record;
- Formulating an understanding of a patient’s biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment;
- Developing a differential diagnosis and treatment plan for patients with psychiatric disorders;
- Managing and treating patients using pharmacological regimens, including concurrent use of medications and psychotherapy;
- Managing and treating patients using both brief and long-term supportive, psychodynamic, and cognitive-behavioral psychotherapies;
- Providing psychiatric consultation in a variety of medical and surgical settings;
- Managing and treating chronically-mentally ill patients with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;
- Providing psychiatric care to patients receiving treatment from non-medical therapists and coordinating such treatment; and
- Recognizing and appropriately responding to family violence (e.g., child, partner, and elder physical, emotional, and sexual abuse, and neglect) and its effect on both victims and perpetrators.

NOTE: Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

Medical Knowledge
Residents must demonstrate knowledge about established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents must demonstrate competence in their knowledge of:

- Major theoretical approaches to understanding the patient-doctor relationship;
- Biological, genetic, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle;
- Fundamental principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, family, sociocultural, and iatrogenic factors that affect the prevention, incidence, prevalence, and long-term course and treatment of psychiatric disorders and conditions;
• Diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, including neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, neurocognitive disorders, seizure disorders, stroke, intractable pain, and other related disorders;
• Reliability and validity of the generally-accepted diagnostic techniques, including physical examination of the patient, laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing;
• Indications for and uses of electroconvulsive and neuromodulation therapies;
• History of psychiatry and its relationship to the evolution of medicine;
• Legal aspects of psychiatric practice;
• Aspects of American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values, and preferences, and power; and
• Medical conditions that can affect evaluation and care of 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 life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:
• Identify strengths, deficiencies, and limits in one’s knowledge and expertise;
• Set learning and improvement goals;
• Identify and perform appropriate learning activities;
• Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
• Incorporate formative evaluation feedback into daily practice;
• Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;
• Use information technology to optimize learning; and
• Participate in the education of patients, families, students, residents and other health professionals.

Interpersonal and Communication Skills
Residents must demonstrate interpersonal and communication skills that result in effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:
• Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
• Communicate effectively with physicians, other health professionals, and health-related agencies;
• Work effectively as a member or leader of a healthcare team or other professional group;
• Act in a consultative role to other physicians and health professionals; and
• Maintain comprehensive, timely, and legible medical records, if applicable.
• Residents must learn to communicate with patients and families to partner with them to assess their care goals, including when appropriate, end-of-life goals.
Competencies

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

- Compassion, integrity, and respect for others;
- Responsiveness to patient needs that supersedes self-interest;
- Respect for patient privacy and autonomy;
- Accountability to patients, society, and the profession;
- Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; and
- High standards of ethical behavior which include respect for patient privacy and autonomy, ability to maintain appropriate professional boundaries, and understanding the nuances specific to psychiatric practice.

- Ability to recognize and develop a plan for one’s own personal and professional well-being
- Appropriately disclosing and addressing conflict or duality of interest

Systems-Based Practice
Residents must demonstrate an awareness and responsiveness to the larger context and system of healthcare as well as the ability to call effectively on other resources in the system to provide optimal healthcare. Residents are expected to:

- Work effectively in various healthcare delivery settings and systems relevant to their clinical specialty;
- Coordinate patient care within the healthcare system relevant to their clinical specialty;
- Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- Advocate for quality patient care and optimal patient care systems;
- Work in inter-professional teams to enhance patient safety and improve the quality of patient care;
- Participate in identifying system errors and implementing potential systems solutions;
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling healthcare cost, ensuring quality, and allocating resources;
- Practice cost-effective healthcare and resource allocation that is aligned with high quality of care, including an understanding of the financing and regulation of psychiatric practice, as well as information about the structure of public and private organizations that influence mental healthcare;
- Assist patients in dealing with system complexities and disparities in mental healthcare resources; and
- Advocate for the promotion of mental health and the prevention of mental disorders.

- Must demonstrate competence in understanding health care finances and its impact on individual patients’ health decisions
- Must learn to advocate for patients within the health care system to achieve the patient’s and family’s care goals, including, when appropriate, end-of-life goals.

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

Program directors have the responsibility of ensuring that residents’ progress on all 22 psychiatry subcompetencies (as identified in the top row of each milestone table) is documented every six months through the Clinical Competency Committee (CCC) review process. The CCC’s decisions should be guided by information gathered through formal and informal assessments of residents during the prior six-month period. The ACGME does not expect formal, written evaluations of all milestones (each numbered item within a subcompetency table) every six months. For example, formal evaluations, documented observed encounters in inpatient and outpatient settings, and multisource evaluation should focus on those subcompetencies and milestones that are central to the resident’s development during that time period.

Progress through the Milestones will vary from resident to resident, depending on a variety of factors, including prior experience, education, and capacity to learn. Residents learn and demonstrate some skills in episodic or concentrated time periods (e.g., formal presentations, participation in quality improvement project, child/adolescent rotation scheduling, etc.). Milestones relevant to these activities can be evaluated at those times. The ACGME does not expect that resident progress will be linear in all areas or that programs organize their curricula to correspond year by year to the Psychiatry Milestones. All milestone threads (as indicated by the letter in each milestone reference number, the “A” in PC1, 1.1/A) should be formally evaluated and discussed by the CCC on at least two occasions during a resident’s educational program.

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

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

Selection of a level for a subcompetency implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels (see the diagram on page vi). A general interpretation of levels for psychiatry is below:

- **Has not Achieved Level 1**: The resident does not demonstrate the milestones expected of an incoming resident.
- **Level 1**: The resident demonstrates milestones expected of an incoming resident.
- **Level 2**: The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.
- **Level 3**: The resident continues to advance and demonstrate additional milestones; the resident demonstrates the majority of milestones targeted for residency in this sub-competency.
*Level 4 is designed as the graduation target and does not represent a graduation requirement. Making decisions about readiness for graduation is the purview of the residency program director (see the FAQ, “Can a resident graduate if he or she does not reach every milestone?” in the Frequently Asked Questions document posted on the Next Accreditation System section of the ACGME website for further discussion of this issue). Study of milestone performance data will be required before the ACGME and its partners will be able to determine whether Level 4 milestones and milestones in lower levels are in the appropriate level within the developmental framework, and whether milestone data are of sufficient quality to be used for high stakes decisions.*

*See appendix for all 22 Psychiatry Milestones in specific detail*
Scheduled Rotations

Each clinical rotation involves specific time scheduling and administrative requirements. The residency program office must be able to locate all residents during scheduled working hours. Should a resident fail to report to the scheduled rotation site during scheduled work hours without prior notification to the supervisor for approval, disciplinary measures will be taken that might include documentation of poor professional conduct in his or her permanent file or dismissal from the program, if necessary.

If a resident fails a rotation, he or she is placed on remediation. Failed remediation and other failures may result in disciplinary action, including the dismissal from the program.

Resident assignments for each post-graduate year are described in the following sections.

PGY-1
- Internal Medicine—Ward/Grady Memorial Hospital (two (2) months)
- Family Medicine—Outpatient/Grady East Point Clinic (two (2) months), Dr. Bell-Carter
- Neurology—Grady Memorial Hospital/Emory (one (1) month)
- Neurology—Dekalb Medical (one month), Dr. Weissman *Residents are required to take a Sunrise Clinical Manager (SCM) training class prior to rotation to obtain clearance to hospital. Residents must designate their 1st, 2nd and 3rd choice from the dates that are offered.
- Psychiatry—Inpatient/Atlanta VA Medical Center (six (6) months), Dr. Troy Kapral (site supervisor)
- ECT Observership experience/Atlanta VA Medical Center, Dr. Troy Kapral

PGY-2
- Community Psychiatry—Outpatient/Grady Behavioral Health/Park Place (twelve (12) months), Drs. Cosby, Bharmal, Kalarithara, Chandora and Howard
- Psychosocial Rehab (PSR)—GBH/PP, Dr. Bharmal
- Assertive Community Treatment (ACT), Dr. Vickerson
- Psych OB—Grady Memorial Hospital, Dr. Herbert
- Child Psychiatry—Chris 180, Dr. Vinson
- Momentum/Intake Clinic—GBH/PP, Dr. Kasiah
- Clozaril Clinic—GBH/PP, Dr. Cotes

PGY-3
- Emergency Psychiatry—Grady Memorial Hospital (two (2) months), Dr. White
- Consultation Liaison—Grady Memorial Hospital (three (3) months), Drs. Gaston and Schwartz
- Adult Inpatient Psychiatry Admissions and East Unit—Georgia Regional Hospital (two months), Dr. Mendoza and Dr. Famakinwa
- Adult Forensic Psychiatry—Georgia Regional Hospital (one month), Dr. Gartrell
- Substance Abuse Treatment Program (SATP)—Atlanta VA Medical Center, Dr. Shongo (six (6) weeks)
- Trauma Recovery Program (TRP)—Atlanta VA Medical Center, Dr. Kurlyandchik (six (6) weeks)
Scheduled Rotations

- Child Psychiatry—Laurel Heights Hospital (one (1) month), Dr. Sewell *Residents must complete an LHH onboarding packet at least one month prior to rotation. They also require a fingerprint based criminal record check.

PGY-4
- East Point CBOC, Drs. Roohi Abubaker and Kristine McDaniel
- Grady Psychiatry Electives
- Other Electives (see below)

Electives are customized based on resident interest and preferences. Depending on the days of availability, electives may be combined to give a complete schedule.

1. Veritas Collaborative (Eating Disorder Center)
   - Contact: Anna Butters Tanner, MD, FAAP, FSAHM, CEDS
   4190 Gatewood Lane
   Peachtree Corners, GA 30097
   Phone: (770) 871-3730
   Anna.tanner@veritascollaborative.com

2. Geriatric Psychiatry/ECT (Wesley Woods)
   Goals and Objectives: Develop skills in caring for the geriatric patient – including interview technique, education and guidance for patients and their families, and treatment plan decision making and formulation, expand medical knowledge of common geriatric mental health disorders, including late life depression, anxiety disorders, and cognitive syndromes
   Contact: William McDonald, MD and Adriana Hermida, MD
   Email(s): ahermid@emory.edu and wmcdona@emory.edu

3. Community Psychiatry
   Goals and Objectives: Provide an opportunity for residents to evaluate and manage chronic mentally ill individuals with or without substance use disorders, strengthen knowledge of community resources, social services and case management services. Residents will also have the opportunity to teach third and fourth year students.

   a. Momentum Clinic (Park Place)
      Clinical Supervisor/contact: William Hudson, MD
      whudson@msm.edu
      Schedule: M – F 9:00 AM – 5 PM (except Wednesdays)

   b. Suboxone Clinic, Contact Aalok Chandora, MD
      achandora@msm.edu

   c. Clozaril Clinic –
      Contact: Robert Cotes, MD
      Robert.o.cotes@emory.edu
      404-616-4752 office
d. **Grady IDP**
Dr. Nicole Cotton (contact)  
ncotton@msm.edu  
404-756-5716 (office)

4. **Addiction Psychiatry**
   a. **Anchor** - 5454 Yorktowne Drive, Atlanta, GA 30349  
   Contact Dr. Bharmal

5. **Psychotherapy**
   a. Family Medicine Comprehensive Clinic, 1513 E. Cleveland @ Buggyworks  
   **Marietta Collins, PhD (contact)**  
   404-756-1218  
   mcollins@msm.edu

6. **Faculty Development**
   Goals and Objectives: Residents will complete a series of professional development classes, each culminating in a project that demonstrates successful completion of a topic. Modules include teaching, grant writing, health services research, writing for medical literature, curriculum development, and career development.  
   Contact:  **Shanae Lee**  
   404-756-8907 (office)  
   shalee@msm.edu

7. **Child and Adolescent Psychiatry**
   a. **Devereux**
      1291 Stanley Road, NW  Kennesaw, GA 30152  
      **Contact: Yolonda Graham, MD**  
      ygraham@devereux.org  
      678-303-5208 (work)  
   Goals and Objectives: Through performance of admission evaluations and development of treatment plans, residents will strengthen areas of medical knowledge, patient care, and systems based practices. Residents also attend a bi-weekly meeting of therapists where family therapy interventions are discussed and participate in family sessions assisting in the advance of interpersonal and communication skills.  
   b. **Lakeview Behavioral Health**  
      990 Hammond Drive, Suite 525  
      Atlanta, GA 30328  
      **Contact: Byron Evans, MD**  
      psychiatric.consultants@yahoo.com  
      404-234-0981 (work phone)
8. Forensic Psychiatry
   a. Funmilayo Rachal, MD (contact)
      Atlanta Psychiatric Consultation Center
      www.psychiatrist-midtownatlanta.com
      1718 Peachtree Street, NW Suite 265
      Atlanta, GA 30309
      404-254-3508
   b. DJJ/Dr. Vinson
   c. GRH with Dr. Tiffany Gartrell

9. Transgender Clinic @ Grady – Dr. Sarah Herbert (contact)
   Currently meeting 2\textsuperscript{nd} and 4\textsuperscript{th} Mondays of each month, approx. 8am-1pm
   Meet 1x/month as a committee on 3\textsuperscript{rd} Tuesday/month 6-730pm @ Grady

10. Treatment Resistant Depression Clinic, - Dr. Todd Antin (contact)
    Pact Atlanta, LLC, 465 Winn Way, #221 Decatur 30030
    (404) 292-3810 ext 205
    drantin@pactatl.com

11. Telepsych –
    Bakari Vickerson, MD (contact)
    Dr. Kasiah is also doing Forensic telepsych with DJJ with Macon (Wednesday mornings only)
Educational Requirements

Didactics
All conferences are mandatory for residents to attend. Residents are expected to attend a minimum of 70% of mandatory conferences. As special circumstances occur, trainees must notify the program director or associate director prior to the conference in order to be excused from a particular conference for personal reasons.

All group educational conferences will take place on Wednesdays (unless otherwise noted) on the first floor Psychiatry Board Room at the Buggyworks Building, 100-A.

Interns will attend all Wednesday didactic sessions and are excused from their rotation duties during that time. Exceptions include the following reasons:

- Post-call or post-shift
- Sickness
- Vacation

It is still necessary to inform and/or remind the Chief Resident(s) and the Residency Training Program administration when you are going to be absent on a Wednesday or during a scheduled educational activity (as a result of one of the excused absences listed above).

Residents are required to sign in when they arrive. An attendance report is prepared for the program director who provides feedback to residents during the required semi-annual resident reviews. Faculty is encouraged, but not required to attend the Wednesday conferences.

For missed conferences, residents should review the lecture handouts. See colleagues, chief resident, or presenter for handouts.

A Year in the Life of a Residency Program

July—July 1st—beginning of the academic year in all GME programs

August
- GME Career and Business Development Forum

September—September 1st—Mid-Rotation 360 VA meeting

October:
- PRITE Exam
- Fall Residency Retreat
- Interview Season Pep Rally

November—Interview season begins *Residents sign up for mixers (night before interview day) and as Tour Guides for Interview Day Tour (as schedule permits)

December:
- Semi-annual reviews and Milestones narratives
Patient Logs—Guidelines and Requirements

- Department holiday party
- Flu vaccinations
- IHI modules

January—Interview season ends

February—NRMP rank order list

March:
- NRMP Match Day
- 2nd Mid Rotation 360 VA meeting
- Spring residency retreat

April:
- Annual Dewitt C. Alfred Jr., MD Behavioral Health Symposium
- Annual PPD and immunizations begin
- GME Continuing resident orientation (Session 1)

May:
- End of the year evaluations (semi-annual)
- APA annual meeting
- GME Continuing resident orientation (Session 2)
- Mr. William Booth and Dr. James Zaidan Resident Research Day
- GME Chief Resident Academy
- Enter scholarly activity in New Innovations and update CV for program administration
- Recertification of ACLS/BLS (for rising PGY-3 residents only)

June:
- GME Joint Graduation ceremony
- Resident Compact Ceremony
- Program Graduation Luncheon
- IHI/IPM Modules due for continuing residents
- Department orientation for new interns
- Exit Interviews for graduates

Patient Logs—Guidelines and Requirements

Residents are expected to complete a log of their patients in New Innovations. From your home page, go to LOGGER then choose LOG PROCEDURE. From there, everything should be self-explanatory. Update patient log entries no less than once per week.
The patient logs are to be reviewed by the site supervisor for accuracy and by the supervisor and resident to verify that the patient is getting a broad patient exposure in terms of patient demographic and diagnoses. The logs will also be reviewed by the associate program director and program director no less frequently than quarterly to verify completion and broadness of exposure, and to identify deficiencies in experiences.
Patient Safety/Quality Improvement

Patient Safety is the delivery of healthcare in a manner that employs safety methods and minimizes the incidence and impact of adverse events while maximizing recovery from such events.

Quality Improvement is a formal approach to assess the degree to which services provided by healthcare professionals for individuals and populations increases the likelihood of the desired outcome and are consistent with evidence-based standards of care and the systematic effort to improve performance.

The goal of this curriculum is to educate psychiatry residents at Morehouse School of Medicine on the principles and practices of patient safety and quality improvement.

In terms of objectives, by the end of this curriculum, learners will be able to:

- Discuss the historical background of Patient Safety/Quality Improvement.
- Define terminology pertaining to PS/QI (including near miss and adverse events).
- Define PS/QI problems specific to psychiatry.
- Demonstrate a high-quality hand-off by the end of the intern year.
- Formulate a Quality Improvement project or participate in a project that is already in progress.
- Demonstrate behaviors associated with effective teamwork and interpersonal and communication skills.

Curriculum

Core Content

1. Knowledge
   a. History
   b. Terminology
   c. Root cause analysis
   d. Error reporting
   e. Safety culture inclusive of documentation of medication reconciliation, completion of suicide risk assessments, and use of seclusion and restraints

2. Skills
   a. Root cause analysis
   b. Formulate QI question
   c. QI project
   d. Identify types of medical errors
   e. Proper handoff
   f. Effective teamwork, interpersonal skills and communication

3. Attitude
   Appreciation of Patient Safety and Quality Improvement
Strategies

- Psychiatry orientation in June
- GME orientation
- Quarterly didactics
- Psychiatry Grand Rounds and Case Conferences
- QI projects
- Direct observation of hand-offs
- Weekly supervision with psychotherapy supervisor

PGY-1
During the six (6) month VA experience, residents will complete Patient Safety modules from the Institute for Healthcare Improvement online program and observe senior resident handoffs to inpatient treatment team during 7:30 morning report.

PGY-2
Residents will prepare one case conference per year that incorporates patient safety and quality improvement issues. Residents should complete QI modules from the Institute for Healthcare Improvement online program.

PGY-3 and PGY-4
Residents will prepare one case conference per year that incorporates Patient Safety and Quality Improvement issues. Residents will design a QI project with the assistance of a mentor (faculty) or will participate in an already established QI project at Grady, GRH/A, VA and/or the Center of Excellence (COE) at the Atlanta VA. Residents should complete QI modules from the Institute for Healthcare Improvement online program.

Learner Assessment

- Direct clinical observation and clinical skills verifications during years PGY-1 through PGY-4
- Complete Cognitive Exam (PRITE)
- Undergo 360 degree evaluations of teamwork, interpersonal, and communication skills
- Present QI project prior to leaving program

Program Evaluation

- Resident feedback on faculty and clinical experience
- Faculty evaluation on educational resources

*See GME Program Policy entitled “Resident Learning and the Working Environment Policy.”

Grady Sub-Committees available for resident membership:

Infection Control Committee
Pharmacy and Therapeutic Committee
Advanced Practice Provider Subcommittee
Cancer Committee
CPR Committee
Credentials Committee
Health Information Management Committee
Patient Safety/Quality Improvement

Laboratory and Blood Usage Committee
MEC Quality
Medical Ethics Committee
Medical Staff Committee
Medication Safety Subcommittee
Patient Safety/Medical Errors Reduction Committee Radiation Control Council Research Oversight Committee Sepsis Committee Special Committees??
Surgical Operation and Performance Improvement Committee Utilization Review Committee Well-Being Committee
Perinatal Quality Subcommittee
Guidelines for Journal Club and Clinical Case Conference Presentations

The following guidelines are to be followed for all journal club and clinical case conference presentations.

Journal Club

Journal Club Article
The resident facilitator must contact the faculty facilitator 6-8 weeks in advance. The article for the journal club can be selected by the resident, faculty, or by the combined effort of both. The article must be approved by the faculty facilitator. The article must be e-mailed to all residents and Michele Baskett at least two (2) weeks in advance.

NOTE: All residents are expected to review the article and complete the critical review form in advance of the journal club date.

Journal Club Facilitation Guide
The journal club facilitation guide must be prepared in advance and reviewed and approved by the faculty facilitator at least two (2) weeks in advance. The resident facilitator must complete a critical review form and discuss with the faculty facilitator in advance of the journal club date. The format for the facilitation guide can be a PowerPoint presentation or a written discussion guide. Residents can consult with the course director for examples.

Journal Club Pre and Post-Tests
Resident facilitators are responsible for preparing a pre- and a post-test. Both tests must be collected by the resident facilitator, scored, and given to Michele Baskett at the end of the activity.

NOTE: It is the resident’s responsibility to ensure that copies are available for other residents at the time of presentation. If you want Ms. Baskett to assist you with these copies, submit the documents two weeks in advance of the journal club date.

Clinical Case Conference

Clinical Case Conference Format
An example of the Clinical Case Conference format is posted on the board in the residents’ lounge. It is the responsibility of the presenting resident to review this example and follow its format. The write-up and presentation must include a Bio-Psycho-Social formulation.

Clinical Case
The clinical case is selected by the presenting resident. This case should be a psychiatric case of an interesting case or patient which the resident had interviewed and/or followed during his or her rotations. If the resident has not yet rotated through psychiatry, an exception can be made allowing the clinical case to be from neurology, internal medicine, or family medicine.

Clinical Case Conference Discussant:
The presenting resident must contact the discussant four (4) weeks in advance. The Clinical Case Conference write-up must be e-mailed to the discussant two (2) weeks in advance for review.

NOTE: It is the resident’s responsibility to ensure that copies are available for other residents at the time of presentation.
**Guidelines for Journal Club and Clinical Case Conference Presentations**

**Format for Presenting an Article for Critical Appraisal**
Use the following outline to format articles which will be subject to critical appraisal:

- **Background**—Why do the study?
- **Objective**
- **Study Design**
  - Type of design
  - Selection of subjects
  - Measurement of important variables— independent variable, dependent variables, potential confounders
  - Potential biases and how investigators ensured limiting these biases
    - Selection bias—generalizability
      - Ensure that the right subjects are selected.
      - Ensure that comparison groups are similar except for the intervention.
      - Ensure that one comparison group is no more likely to be exposed than the other.
    - Measurement bias
      - Reliability of the measurement tools
      - Validity of the measurement tools
    - Confounding—avoid other competing risk factors or interventions causing the outcomes of interest.
  - Analysis
    - Consideration for avoiding a type I or type II error
    - Power of the study to avoid a type II error

- **Results**
  - What are the main results?
  - Are the results valid or could failure to account for potential biases lead to the results?
  - Did the results support the study hypotheses/and or objectives?

- **Discussion**
  - Applicability of findings to your practice
  - Will findings change the way you practice?

**Guide for Presenting Case Review of the Month**
The monthly case review serves multiple purposes:

**Quality Improvement Program**
Case review is part of our department’s formal Quality Improvement program.

Cases may be about biomedical issues (diagnosis, treatment), or about delivery of care (communication, how well we identify and meet patients’ needs). It provides opportunities for faculty and residents to collaborate in investigation, planning, and presenting.
Guidelines for Journal Club and Clinical Case Conference Presentations

Conference
The conference should stimulate thought and discussion among those present and hopefully result in concrete suggestions for future practice. Sessions should be planned with questions for the audience, and sufficient time for discussion.

Goals
Effective case reviews should:
• Facilitate learning from our clinical and hospital practice;
• Improve our delivery of care; and/or
• Avoid similar occurrences in the future.

Objectives
At the end of each conference, participants will be able to:
• Describe the undesirable/desirable outcomes.
• Analyze the case presented for potentially avoidable negative influences and/or opportunities for potentially beneficial interventions.
• Discuss cost and liability issues relative to the alternatives described.
• Suggest systems which might be implemented to ensure that any identified problems in care delivery do not recur.
• Demonstrate appropriate means of communication with peers, consultants, and patients about problems or possible errors in care.
• Discuss appropriate diagnostic and/or therapeutic approaches for the problem in question, according to the literature.

The content of the monthly case review is confidential. The meeting is intended for review of the quality of healthcare and education of clinical providers in the context of peer review. Use of patient names or other identifiers is prohibited.

Issues for Discussion
Each presentation should address both medical and systems issues in the case, such as:
• Medical care
  o Diagnostic approaches/alternatives
  o Therapeutic approaches/alternatives
  o Liability risks
  o Cost
• Systems issues
  o Communication among providers and services
  o Collaboration with consultants
  o Continuity of care/involvement of primary provider
  o Information systems and support structures
  o Follow-up arrangements

Process
• Conferences are scheduled as part of the Wednesday didactics calendar.
• Choose the case for discussion with your faculty discussant
• Send your slides via e-mail to the faculty of record at least one (1) week in advance for approval
Guidelines for Journal Club and Clinical Case Conference Presentations

Presentation Pointers

- Prepare slides well in advance—remember they must be reviewed by faculty of record before your presentation.
- Develop no more than 10 slides of didactics on the disease topic.
- Identify patient by initials only.
- Don’t identify providers by name.
- Plan for discussion and interaction; plan open-ended questions to ask your audience.
- Ensure that your planned content is appropriate for the amount of time.
- Prepare for the presentation.
- Take advantage of your faculty’s assistance early on in the development process.
- Arrive early to be sure everything is set up as you need it to be.
- Keep discussion positive and practical.
- Encourage suggestions for specific clinical improvements.

NOTE: After your session, if you have any specific suggestions for clinical practice/operations, be sure to convey them to the program director or associate program director.
WHAT TO LEARN AND HOW TO TEACH IT
WHAT TO READ AND HOW TO READ IT:
(JOURNAL CLUB THE FUN WAY)

Prepared by Glenda Wrenn, MD, MSHP

Adapted from a presentation by Michele T. Pato, MD

Objectives-Why does this skill really matter?

1) How to find the ANSWER to the question/hypothesis you have.

2) How to scan an article quickly to decide if it is worth reading (ie: Will it answer your question/hypothesis? (the rule of 5)

3) How to apply the findings in an article so you can use it. Is it generalizable to your practice?
Research Literacy and Scholarly Activity

Research literacy is the ability to critically appraise and understand the relevant research literature, and to apply research findings to clinical practice.

Scholarly Activity = EBM

“In a broader sense, Evidence Based Medicine’s goal is to regulate the way in which physicians gather, analyze, and use clinical information in their treatment of patients”

Fauman MA, Psychiatric Times Feb 2002
“Teaching Scholarly Activity in Residency Training”

IoM in 2003 addresses 3 overarching issues important for the Future of Psychiatric Training.
1. The importance of having better and more data regarding the research workforce and society’s need for psychiatrist-researchers.
2. The need for more outcome data in ongoing and novel patient-oriented research training efforts.
3. The need for a national effort to promote, implement, and monitor the training of psychiatrist-researchers

Resident Facilitator’s Role

- Select a suitable article in consultation with faculty facilitator and course director (if needed)
- Conduct independent critical appraisal
- Design the group facilitation guide (team based learning format or active discussion preferred to lecture)
- Engage with faculty facilitator in advance to discuss the article
Faculty Facilitator’s Role

- Approve the article and assist with selection (if needed)
- Conduct independent critical appraisal
- Guide the resident facilitator in advance of the session to review their critical appraisal form and discuss the article
- Remind yourself that this activity aims to foster residents as teachers

The real goals

- The most valuable aspect of journal club comes from engaging the group in discussion. So
  1. How do you get people to read before they come?
  2. How do you get them to think when they are there?
  3. How do you get them to say what they are thinking?
What sabotages journal clubs:

- Lack of knowledge about the article topic
- Feeling too intimidated to provide a critique.
- Little knowledge of statistics
- Lost in the details of a study with a resultant loss in the utility of discussion
- Not find the article “interesting” or “clinically relevant”
- And thus not read it

◆ This is the biggest problem to get over because if they read it you can engage them by asking PROVOCATIVE questions

Step 1: Pick a good article
How Can Technology Help You Avoid Information Overload?

- PubMed adds over 500,000 new citations to its database every year -- that's over 1300 articles every single day
- So when search for articles to read to answer your questions use: the 3A's of Searching
  1) Ask - Asking well-focused questions that includes the PICOT: Patient, Intervention, Comparison, Outcomes, study designs based on Type of question
  2) Acquire - Knowing the advantages of EBM resources, which identify relevant and valid studies
  3) Appraise - Understanding the study methodology and being able to review the study for possible sources of limitations/bias

Making your search more efficient: EBM-PubMed

1) Focusing the question;
2) Check Details to see how PubMed translated your terms;
3) Making sure that the search terms include appropriate Medical Subject Headings (MeSH);
4) Combining terms appropriately – AND makes all terms appear in the same article; OR makes at least one of the terms appear in the same article; and
5) Filtering, the topic at the end for: study design, language and age groups, if appropriate.
5 steps to decide: Should I read on!

1. **Read the title**
   - Does it intrigue you or grab your attention?

2. **Look at the authors**
   - Do those authoring the manuscript have appropriate expertise

3. **Look at the references**
   - Are they comprehensive and not biased to author's views

4. **Read the abstract or the first & last paragraph**
   - Does it have the information you are looking for?

5. **Look at the pictures**
   - looking at the tables, graphs, and figures do they make sense?

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Step 2: Prepare by conducting your own critical appraisal
Critical Appraisal

1. Does the INTRO tell me **WHY** they are doing it?
2. Does the METHODS tell me **WHAT** they are doing in enough detail for GENERALIZABILITY & REPRODUCABILITY
3. Do I **understand** the RESULTS?
4. ARE their DISCUSSIONS/CONCLUSIONS clear?  
   And **Do I AGREE** or DISAGREE? Why?
5. **Will it change my Practice**?-Should this be the FIRST question?
Psychiatry Residency Program-Level Policies and Procedures 2018-19

The psychiatry residency follows and complies with all policies, procedures, and processes of Morehouse School of Medicine MSM Human Resources and Graduate Medical Education.

All residents are responsible for reviewing and adhering to policies, procedures, and processes of MSM and affiliate training sites.

The Graduate Medical Education policy manual can be found in New Innovations.
Resident Concern, Complaint, and Due Process Policy

I. PURPOSE:

1.1. The Psychiatry Residency Program follows all MSM and GME policies for resident due process, concerns, and complaints available in the GME policy manual on the New Innovations website.

1.2. Refer to the online version of the MSM GME Policy Manual for detailed information regarding the Adverse Academic Decisions and Due Process Policy.

II. RESIDENT CONCERN AND COMPLAINT PROCESS:

To ensure that residents are able to raise concerns and complaints, and to provide feedback without intimidation or retaliation, and in the confidential manner as appropriate, the following options and resources are available and communicated to residents and faculty annually.

2.1. Step One

Discuss the concern or complaint with your chief resident, clinical service director, program manager, associate program director and/or program director as appropriate.

2.2. Step Two

If the concern or complaint involves the program director and/or cannot be addressed in Step One, residents have the option of discussing issues with the department chair, Dr. Gail Mattox (gmattox@msm.edu or (404) 756-1440) or chief of service of a specific hospital as appropriate.

2.3. Step Three

If you are not able to resolve your concern or complaint within your program, the following resources are available:

2.3.1. For issues involving program concerns, training matters, or work environment, residents can contact the Graduate Medical Education Director, Tammy Samuels (tsamuels@msm.edu or (404) 752-1011).

2.3.2. For problems involving interpersonal issues, the Resident Association president or president elect may be a comfortable option to discuss confidential informal issues apart and separate from the Psychiatry Department.

2.3.3. Residents can provide anonymous feedback/concerns/complaints to any department at MSM by completing the online form—GME Feedback (http://fs10.formsite.com/bbanks/form33/index.html). Comments are anonymous and cannot be traced back to individuals.

2.3.4. Personal follow-up regarding how feedback/concerns/complaints have been addressed by departments and/or GME will be provided only if residents elect to include their name and contact information in the comments field.
2.3.5. MSM Compliance Hotline, 1 (888) 756-1364 is an anonymous and confidential mechanism for reporting unethical, noncompliant, and/or illegal activity. Call the Compliance Hotline to report any concern that could threaten or create a loss to the MSM community including:

- Harassment—sexual, racial, disability, religious, retaliation
- Environment Health and Safety—biological, laboratory, radiation, laser, occupational, chemical and waste management safety issues
- Other—misuse of resources, time, or property assets; accounting, audit and internal control matters; falsification of records; theft, bribes, and kickbacks
Clinical Experience and Education Policy

I. PURPOSE:

1.1. Programs must design an effective program structure that is configured to provide residents with educational and clinical opportunities, as well as reasonable opportunities for rest and personal activities. Clinical experience and education are defined as all clinical and academic activities related to the program, including inpatient and outpatient patient care assignments, administrative duties, call, and scheduled activities such as conferences and moonlighting.

1.2. Clinical experience and education do not include reading and study time.

1.3. Residents must adhere to all duty hour restrictions and requirements as outlined below:

1.3.1. Clinical experience and education must be limited to no more than 80 hours/week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home and all moonlighting.

1.3.2. Residents must have one (1) day in seven (7) free from all educational and clinical responsibilities, averaged over a four (4) week period.

1.3.3. Residents should have eight (8) hours off between scheduled clinical work and education periods.

1.3.4. In-house call must occur no more frequently than every fourth night for psychiatry rotations (no more frequently than every third night for medicine rotations), averaged over a four (4) week period.

1.3.5. Continuous on-site duty must not exceed 24 consecutive hours for interns and residents. Residents may remain on duty for up to four (4) additional hours to maintain continuity of medical care as needed. Up to four (4) additional hours may be used for activities related to patient safety (e.g., transitions). Residents must have 14 hours free of clinical work and education after 24 hours of in-house call.

1.3.6. No new patients may be accepted after 24 hours of continuous duty.

1.3.7. Moonlighting is permitted for PGY-3 and PGY-4 residents in good standing, with an independent medical license and proper malpractice coverage. Residents who want to moonlight must obtain written permission from the program director. See Moonlighting Policy for additional details. Moonlighting must not interfere with the ability of the resident to achieve the goals/objectives of the educational program nor interfere with duty hours. Internal moonlighting is considered part of the duty hour limitations.
1.3.8. Residents must log clinical experience and education into New Innovations daily. Failure to log for four (4) days out of seven (7) will result in an e-mail notification of non-compliance to the program director and manager. Logging guidelines include the following requirements:

1.3.8.1. Logging should be consistent with no gaps (for example, for lunch or travel).
1.3.8.2. Conferences should be logged consistently as other duties with no gaps in between.
1.3.8.3. Use the duty type “Call” to log in-house calls.
1.3.8.4. For back-up call assignments, if the resident has to go into the hospital, use the duty type “Back Up-Called In.” Back-up residents do NOT log if they do not go into the hospital.
1.3.8.5. If your 24-hour shift is extended duty to post call transitions of patient care or mandatory conferences, do NOT log the hours that extend beyond the 24 hour period as either duty types “Post Call” or “Conferences.” This is considered a violation.
1.3.8.6. Log appropriate duty types for moonlighting, vacation, holiday/day off, or sick days.
1.3.8.7. Each resident must enter written justification or cause in the event of a violation. Justifications apply to violations of 24+ or short break rule. Causes apply to any violation.
1.3.8.8. Make sure to submit to the program director.

II. PROTOCOL FOR EPISODES WHEN RESIDENTS REMAIN ON DUTY BEYOND SCHEDULED HOURS:

2.1. There may be circumstances where residents choose to stay to care for their patients or return to the hospital with fewer than eight (8) hours free of clinical experience and education. This must occur within the context of the 80 hour and the one (1) day off in seven requirements.

2.2. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must:

2.2.1. Appropriately hand over the care of all other patients to the team responsible for their continuing care.

2.2.2. Document the reasons in New Innovations for remaining to care for the patient in question.

2.3. The program director reviews each submission of additional service and tracks both individual resident and program-wide episodes of additional duty.
Appendix A

2.4. Failure to comply

2.4.1. In all cases, the program director should be informed of the occurrence and nature of the situation in which the respite rule might have been an issue regarding duty hour standards compliance.

2.4.2. All clinical experience and education violations are monitored and recorded in New Innovations. Violations are automatically reported to the program director, chair, and manager electronically.

2.4.3. Repeated instances of non-compliance will be regarded as failure to adhere to accepted standards of professionalism.

2.5. New Innovations notifies the program director of clinical experience and education violations automatically. The residents are then asked to submit a justification for the violation into New Innovations. The program director notes if the justification is acceptable. The program director, chief resident(s), and resident meet to review the cause for the violation. The program director and chief resident then work with the resident(s) and service administrator to resolve future duty hour violations.
Evaluation and Promotion Policy

I. PURPOSE:

1.1. Psychiatry residents are evaluated throughout their four (4) years of training.

1.2. The purpose of the evaluation process is to determine the value of the residency education process. The following sections outline the components of the evaluation system.

II. RESIDENT EVALUATION AND PROMOTION:

2.1. Resident evaluations are performed monthly and reflect achievement of the six (6) core competencies of Patient Care, Medical Knowledge, Interpersonal Skills, Practice-Based Learning, Professionalism, and Systems-Based Practice.

2.2. Evaluations concerning performance and progression in the residency program will be provided to the resident throughout the duration of the program. Evaluations will measure performance based on milestone assessments.

2.3. Residents will be provided with a mid-point evaluation for each rotation in an effort to identify deficiencies early. This requirement serves to provide the resident with an opportunity to cure the deficiency noted.

2.4. Residents will be provided with a final, global evaluation for each rotation and didactic experience within two (2) weeks of completion of the assignment. These evaluations must be immediately available for review by the resident. Resident notification of completed evaluations should be set up in New Innovations by requiring that residents sign off electronically on the evaluation.

2.5. There must be an opportunity to review evaluations with supervisors and to attach a written response, preferably in the form of reflection and planning for improvement.

2.6. Additionally, multisource methods and evaluators will be used to provide an overall assessment of the resident's competence and professionalism. Methods and evaluators include:

- Faculty evaluations of rotation and didactic performance
- Direct resident evaluations
- 360 evaluations/narrative evaluations by faculty and non-faculty evaluators (the RTP requests one 360 per clinical rotation)
- Peer evaluations
Appendix A

- Patient feedback
- Resident self-assessment (completed quarterly)
- Clinical skills verifications
- PRITE and psychotherapy examinations

Reference the MSM GME policy handbook in New Innovations.

2.7. Additionally, each resident will maintain and submit a portfolio of assessment tools to document the core competencies and all academic activity during residency that is maintained in New Innovations.

2.8. Residents and supervisors access evaluations in New Innovations. Evaluations of both the residents and Attendings will be compiled. An electronic copy will be sent to the resident, and a hard copy will be placed in each resident’s file.

2.9. A Clinical Competency Committee will be appointed by the program director. This committee will meet quarterly to review all evaluative information regarding each resident and make recommendations to the program director regarding resident progress, promotion, remediation, and dismissal.

2.10. Semi-Annual Evaluation—At least twice in each post graduate year, the associate program director or program director will provide each resident with a performance evaluation summary incorporating input from the Clinical Competency Committee and ACGME Milestone summaries.

2.11. Summative Evaluations—The program director will provide a summative evaluation for each resident upon completion of the program. This evaluation will verify that the resident has demonstrated sufficient competence to enter practice without direct supervision and will become part of the resident’s permanent record maintained by the program and will be accessible for review by the resident in accordance with institutional policy.

III. RESIDENT PROGRESSION:

3.1. Resident promotion is determined by recommendation from the CCC.

3.2. Promotion/progress is determined based on:

- Clinical performance (i.e., evaluations)
- PRITE performance
- Annual Psychotherapy Exam
- Participation in any mandatory program requirements
- CCC recommendations

3.3. Academic support and counseling is available to residents and should be sought on an individual, as-needed basis.

3.4. Resident promotion for all PGY levels is based on the following criteria:

3.4.1. The resident must pass a complete clinical skills assessment (direct observation by faculty).

3.4.2. The resident must receive an overall “Satisfactory” evaluation in all of his or her required rotations.

3.4.3. The resident must not have any professionalism or ethical issues that preclude him or her from being moved to the next level of residency in the opinion of the Clinical Competency Committee.
3.4.4. The resident must be continually eligible to practice medicine on a limited license in Georgia.

3.4.5. The resident must complete the GME returning resident orientation.

3.4.6. The resident must be compliant with all MSM Psychiatry Residency Program policies including, but not limited to being up to date with his or her duty hour and patient logs.

3.5. Additional criteria for promotion from PGY-2 to PGY-3 include that the resident must pass USMLE Step 3 by the 24th month of residency.

3.6. The following resident graduation criteria apply to all PGY-4 residents and PGY-3 residents transferring into a Child and Adolescent Fellowship Program:

3.6.1. The resident must fulfill all promotion criteria stated above.

3.6.2. The resident must have completed an approved scholarly activity.

3.6.3. The resident must have completed three (3) Clinical Skills Verifications with Board-certified psychiatrists.

3.6.4. The resident must complete GME, HR, and MSM Psychiatry exit procedures.

3.6.5. The resident must demonstrate a satisfactory performance in all six ACGME competencies.

3.6.6. For graduating residents, the program director must determine that the resident has had sufficient training to practice medicine independently as evidenced by meeting the goals above, completion of training criteria on program-specific criteria set forth by the ACGME-RRC, and a final summative assessment.

3.7. Final decisions on promotion to the next level of residency are made by the Clinical Competency Committee, Program Evaluation Committee, and the program director.

IV. FACULTY EVALUATION:

4.1. Faculty evaluations are performed annually by department chairs in accordance with the faculty bylaws.

4.2. Annually, the program director will evaluate faculty performance as it relates to the educational program. This evaluation will include a review of the faculty's participation in educational activities, professionalism (including, but not limited to, evaluation completion in a timely manner), and scholarly activities. This information will be provided to the chair for inclusion in the faculty's evaluation.

4.3. Residents will be given the opportunity at least annually to submit a confidential written evaluation of faculty. In order to maintain confidentiality of faculty performance evaluations, the program director will provide a generalized resident summary to avoid identifying specific resident feedback.
Appendix A

4.4. The program director will maintain continuous and ongoing monitoring of faculty performance via automated alerts regarding low evaluation scores on end-of-rotation evaluations by residents, regular surveillance of evaluations, and regular verbal communication with residents regarding their experiences. The program director will notify the Psychiatry Department chair of resident feedback for review and discussion during the annual faculty evaluation.

V. PROGRAM EVALUATION:

5.1. The program is monitored in accordance with ACGME Psychiatry and MSM Graduate Medical Education standards.

5.2. Faculty and residents are provided the opportunity to confidentially review the program, program director, and associate program director at least annually.

5.3. The program director appoints a Program Evaluation Committee (PEC) to oversee the educational activities of the program, curriculum, resident/faculty performance and development, and program quality via the Annual Program Evaluation.

5.4. The program director and the PEC will submit a written Annual Program Evaluation report to the GME office to document initiatives to improve program performance and delineate how these initiatives will be monitored.

5.5. The Office of Graduate Medical Education and the GMEC are tasked with ensuring MSM programs’ compliance with ACGME accreditation and training standards and to provide oversight of programs’ annual program evaluation processes per Institutional, Common, and Specialty Specific program requirements.

5.6. The Document Review Meeting is the first phase of the MSM GMEC APR process. In this meeting, the program manager/assistant and GME Director/Manager review program compliance with administrative functions such as required content and items of resident training files; completion of required set up, data, and information in the New Innovations system; program letters of agreement, program policy manual, etc. The effectiveness and quality of the program’s overall administrative work and monitoring of duty hours and evaluation completion are also assessed.

5.7. The APR Meeting is the second phase of the MSM GMEC APR process.

5.7.1. In this meeting, the GMEC review team, comprised of the GME DIO and director, and PD and PM of another program, meet with the leadership of the program being reviewed.

5.7.2. These participants assess APE efforts through a detailed review and discussion of the programs’ scorecards and APE reports from the last three (3) years.

5.7.3. The primary focus of the review is on identified data trends, areas of improvement, best practices, action plans to address issues, future goals, needed resources, and results of the document review meeting.

5.7.4. Interviews with residents and faculty also occur for Special Review programs and/or programs identified by the DIO.
Fatigue Management and Mitigation Policy

I. PURPOSE:

This policy is designed to increase faculty and resident awareness and recognition of the signs of fatigue and sleep deprivation, the negative effects of sleep deprivation and fatigue on their ability to provide safe and effective patient care, and to identify strategies to minimize the effects of fatigue.

II. DEFINITION:

2.1. Fatigue is defined as a feeling of weariness, tiredness, or lack of energy than can impair a physician's judgment, attention, and reaction time.

2.2. Signs and symptoms of fatigue include, but are not limited to: moodiness, depression, irritability, apathy, impoverished speech, flattened affect, impaired memory and confusion, difficulty focusing on tasks, sedentary nodding off during conferences or while driving, and repeatedly checking work. These harmful effects can lead to medical errors and compromise patient safety.

III. POLICY ON PROGRAM RESPONSIBILITIES:

3.1. Programs must educate all faculty members and residents to recognize true signs of fatigue, sleep deprivation, alertness management, and the fatigue mitigation process. Residents and faculty will be educated on the hazards of sleep deprivation and fatigue in the workplace and in their personal lives through the following means:

3.1.1. Annual GME and Departmental Orientations
3.1.2. Departmental Patient Safety Didactics
3.1.3. Completion of Professionalism and Patient Safety modules (at least annually)
3.1.4. Faculty presentations during the Annual Program Review
3.1.5. Faculty meetings

3.2. A presentation on Sleep Deprivation and Fatigue Management should be available for residents in the Drop Box for review at any time and for the faculty on the department's SharePoint.

3.3. Residents will be provided with sound didactic and clinical education planned and balanced with concerns for patient safety and resident wellbeing.

3.3.1. The program will ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations.

3.3.2. Didactic and clinical education must have priority in the allotment of the resident's time and energy.
Appendix A

3.4. Faculty will assess if residents are sleep-deprived and then make appropriate recommendations to the resident to correct this problem. Faculty will encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

3.5. Faculty members are to assist in enforcing the limitations of the role of a resident under the duty hour mandates.

3.6. Morehouse School of Medicine must ensure adequate sleep facilities and safe transportation for residents who may be too fatigued to return safely home.

3.7. Sleep facilities must be safe, quiet, and private and must be available and accessible for residents to support education and safe patient care.

IV. POLICY ON RESIDENT RESPONSIBILITIES:

4.1. The resident is expected to:

4.1.1. Adopt habits that will provide him or her with adequate sleep in order to perform the daily activities required by the program.

4.1.2. Adhere strictly to Duty Hour limitations.

4.1.3. Discuss time and stress management with his or her faculty advisors at least monthly.

4.2. In the event that the resident is at the end of a work period and is too sleepy to drive home, he or she is encouraged to use another form of transportation or nap in the onsite call room prior to leaving the training site. Residents should provide receipts to the program administration for reimbursement if alternate transportation is needed.

4.2.1. The resident should contact the chief resident, program director, or associate program director for assistance if neither of the aforementioned options is feasible.

4.2.2. MSM provides access to appropriate and confidential counseling and medical and psychological support services. Residents are encouraged to utilize EAP or their own physician and the Office of Disability Services when indicated.
Moonlighting Policy

I. PURPOSE:

1.1. The General Psychiatry Residency Training Program at Morehouse School of Medicine recognizes that because residency education is a full-time endeavor, the institution and the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve goals and objectives of the educational program, and must not interfere with the resident’s fitness for work nor compromise patient safety.

1.2. Professional and patient care activities that are external to the educational program are called moonlighting.

1.3. Moonlighting activities, whether internal or external, must not interfere with sufficient time for rest and restoration to promote the residents’ educational experience and safe patient care.

1.4. In addition, Morehouse School of Medicine abides by the ACGME institutional requirements which set policies for moonlighting. The following policy will define the parameters that are to be used in monitoring and approving moonlighting activities.

II. POLICY:

2.1. Only PGY-3 and PGY-4 residents in good standing with the program are eligible to moonlight. PGY-3 residents are required to meet the mean PRITE score and/or complete Psych ER/Consultation Liaison prior to moonlighting experience. In line with ACGME policy, PGY-1 residents are not permitted to moonlight.

2.2. Residents are not required to engage in moonlighting.

2.3. Residents must obtain PD approval before engaging in moonlighting activities.

2.4. The trainee and the program director must sign a statement acknowledging that this policy is understood. The statement will be maintained in the resident’s file. Non-compliance with the signed policy may result in disciplinary action including probation, termination of contract, or dismissal.

2.5. Moonlighting requests must be documented in writing submitted to the training director, detailing specifically the moonlighting responsibilities, the time requirements involved, and the supervisor(s) for the trainee who will be moonlighting. The training director must provide approval for the specific moonlighting job by signing off in writing.

2.6. The resident’s performance will be monitored for the affect these activities have upon performance. Adverse effects may lead to withdrawal of permission to moonlight.

2.7. Any internal external moonlighting (within any of the major participating institutions) must be considered as part of the 80-hour work week.

2.8. Morehouse School of Medicine will not provide liability coverage to residents while on professional activities (moonlighting) outside of the training program.
Professionalism Policy

I. PURPOSE:
Programs must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

II. POLICY ON RESIDENT RESPONSIBILITIES:
2.1. Residents are expected to demonstrate respect, compassion, and integrity towards all individuals.

2.2. Residents should demonstrate sensitivity and responsiveness to the patient’s culture, age, gender, race, linguistics, religion, sexual orientation, and disabilities.

2.3. Residents must also:
   2.3.1. Protect and respect the legal and ethical rights of patients.
   2.3.2. Respect individual patient concerns and perceptions.
   2.3.3. Maintain a work environment that is free of harassment of any sort.
   2.3.4. Refrain from discussing patient information in public areas, including in elevators and cafeterias, over the phone, through e-mail, and on social media.
   2.3.5. Respect colleagues by maintaining effective communication.

2.4. Residents are also expected to demonstrate a responsiveness to the needs of patients and society that supersedes self-interest. Residents must also:
   2.4.1. Ensure that proper hand-off procedures are followed.
   2.4.2. Ensure continuity of care when a patient is discharged from a hospital by documenting who will provide that care and informing the patient of how the caregiver can be reached.
   2.4.3. Respond promptly to phone messages, pages, e-mail, and all other correspondence.
   2.4.4. Ensure their fitness for work, including time management of clinical assignments as well as recognition of impairment from illness, fatigue, and substance abuse in themselves and members of the healthcare team.
   2.4.5. Provide reliable coverage when not available.
2.5. Residents are also expected to demonstrate accountability to patients, society, and the profession. Residents must also:

2.5.1. Introduce him- or herself to the patient and the patient’s family members and explain their individual roles in the patient’s care.

2.5.2. Wear name tags that clearly identify names and roles.

2.5.3. Maintain legible and up-to-date medical records, including completion of records within the approved hospital guidelines.

2.5.4. Complete all hospital, GME, and program educational and administrative assignments by the given deadline. This includes but is not limited to:

2.5.4.1. Timely completion of evaluations and program documentation

2.5.4.2. Timely logging of Duty Hours and patient logs

2.5.4.3. Arriving promptly for educational, administrative, and service/patient care activities

2.5.4.4. Meeting with psychotherapy supervisors (weekly) and advisors (monthly).

2.5.5. Maintain and promote physician-patient boundaries.

2.5.6. Adhere to the policy that states that while on duty it is strictly prohibited to use alcoholic beverages, engage in illegal use of drugs, abuse pharmaceuticals that impair judgment, or report for duty under the influence of any agent that may impair judgment.

2.5.7. Encourage team-based care.

2.6. Residents are also expected to demonstrate a commitment to ethical principles pertaining to the provision of withholding of clinical care, confidentiality of patient information, and informed consent. Residents must also:

2.6.1. Respect patients’ autonomy and the right of a patient and a family to be involved in care decisions.

2.6.2. Ensure patient and family understanding and informed consent for use of neuroleptic agents.

2.6.3. Always obtain informed consent for use of prescribed medications.

2.7. Residents are also expected to demonstrate a commitment to excellence and ongoing professional development. Residents must also:

2.7.1. Respect the systems in place to improve quality and safety of patient care.

2.7.2. Demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events.

2.7.3. Improve systems and quality of care through critical self-examination of care patterns.

2.7.4. Adhere to ABPN and APA codes of professionalism.

2.7.5. Strive for personal growth and improvement through attention to constructive criticism and awareness of opportunities for improvement. Residents should be open to feedback.
Appendix A

2.7.6. Demonstrate a commitment to lifelong learning and monitoring of their patient care performance indicators.

2.7.7. Demonstrate accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.

III. POLICY ON PROGRAM RESPONSIBILITIES:

3.1. The program must accomplish learning objectives through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events, without excessive reliance on residents to fulfill non-physician obligations.

3.2. Faculty must provide a culture of professionalism that supports patient safety and personal responsibility.

3.3. Faculty should demonstrate responsiveness to patient needs that supersedes self-interest. This includes recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.

3.4. Faculty must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff.

3.5. Morehouse School of Medicine in partnership with the program director must provide a culture of professionalism that supports patient safety and personal responsibility.

3.6. Morehouse School of Medicine in partnership with the Psychiatry Residency program must education residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.

3.7. Morehouse School of Medicine must ensure that its residency programs provide a professional, respectful and civil environment that is free from unprofessional behavior, including mistreatment, abuse and/or coercion of residents, other learners, faculty members, and staff members.

3.8. Morehouse School of Medicine in partnership with its residency program must have a process for education of residents and faculty members regarding unprofessional behavior, and confidential process for reporting, investigating, monitoring, and addressing such concerns.

IV. DRESS CODE:

4.1. In order to maintain proper identification, unaltered ID badges must be visible at all times. If using a lanyard, it should be the break-away variety.

4.2. White coats are worn while in the hospital and at the discretion of the clinical service.

4.3. Scrubs are acceptable on call only and should not be worn outside of the hospital.

4.4. Clothing must reflect a professional image:

4.4.1. Dress or casual pants and shirts must be free of insignia bearing a political, controversial, inflammatory, or provocative message. Ties are optional, unless required by the Attending physician.

4.4.2. Skirts and/or dresses must be knee level or below.

4.4.3. Tops should cover back, shoulders, and midriff.

4.4.4. Necklines should be modest (no cleavage).
4.4.5. Shoes should be clean and in good repair. No open toed shoes may be worn. Shoes must have fully enclosed heels or be secured with a strap heel for safety. Clean tennis shoes are acceptable when on call.

4.5. Personal Hygiene:

4.5.1. Hair must be kept clean and well groomed.

4.5.2. Avoid extreme hair color or style.

4.5.3. Facial hair must be neat, clean, and well-trimmed.

4.5.4. Fingernails must be kept clean and at an appropriate length.

4.5.5. Avoid overpowering perfume, cologne, creams, or lotions.

4.6. The following clothing items are unacceptable: flip-flops or sandals, jeans, suggestive, revealing, or tight-fitting clothing; mini-skirts
Appendix A

V. SOCIAL MEDIA:

5.1. Social media includes but is not limited to social networking sites, wikis, blogs, content communities, and virtual communities.

5.2. Utilize best judgment when posting; residents are responsible for anything they post to social media sites either professionally or personally:

5.2.1. Be respectful.
5.2.2. Remember your audience.
5.2.3. Ensure your account’s security.
5.2.4. Do not post confidential information about MSM, students, faculty, staff, patients, or alumni.
5.2.5. Do not post information that is proprietary to an entity other than yourself.
5.2.6. Be aware of copyright and intellectual property rights of others and the university. Refer to MSM policies for additional information.

5.3. Do not imply MSM endorsement.

5.4. MSM’s logo, word mark, iconography, or other imagery shall not be used on personal social media nor shall the MSM name be used to promote a product, cause, or political party/candidate.

See MSM, Department of Psychiatry Social Media Policy for further details.
Resident Eligibility and Selection Policy

I. **RESIDENT ELIGIBILITY:**

1.1. Applicants must meet one or more of the qualifications set forth by the MSM Graduate Medical Education Office in order to be eligible for appointment to the MSM, Psychiatry and Behavioral Health Department.

1.2. These qualifications include but are not limited to:

   1.2.1. Graduates of medical schools in the United States accredited by either the LCME or the AOA; graduates of Canadian medical schools approved by the LMCC

   1.2.2. Graduates of medical schools outside of the United States and Canada with a current and valid ECFMG certificate

1.3. All applicants must be either a United States citizen, lawful permanent resident, refugee, asylee, or possess the appropriate documentation to allow the resident to legally train at MSM.

II. **RESIDENT SCREENING AND SELECTION:**

2.1. All Psychiatry PGY-1 positions shall be made available for application through the NRMP. All PGY-1 applicants must apply through ERAS.

2.2. Available positions are dependent on the current number of positions authorized by the ACGME and upon space available.

2.3. Applicants from the United States or Canadian-accredited medical schools must supply an original copy of a letter of recommendation or verification from the dean of the medical school for submission with their ERAS application.

2.4. Applicants from an LCME or AOA accredited United States medical school must provide proof of graduation or pending “on-time” graduation. This verification, via transcripts, diplomas, or statements within or separate from the dean’s letter, should be submitted with the ERAS application.

2.5. Applicants shall provide official proof of passing both USMLE Step 1 and USMLE Step 2 CK and CS before they are eligible to begin the Psychiatry Residency Program.

   2.5.1. The Department of Psychiatry requires that applicants successfully complete Step 1 and Step 2 CK within two (2) attempts and Step 2 CS on the first attempt.*

   2.5.2. Applicants cannot begin the Residency Program without passing Step 2 CS.

   2.5.3. These expectations must be met by the time of submission of the Rank Order List by the program director to the NRMP.

2.6. The Psychiatry Residency Program also requires that applicants submit three letters of recommendation from within the last 18 months; at least one (1) of these letters should be from a psychiatrist.

2.7. Applicants will be screened and evaluated based on their academic record, leadership, and evidence of community service.
Appendix A

2.8. The Psychiatry Residency Program will consider transfer residents for vacant positions.

2.8.1. The State of Georgia and MSM consider any time spent in a residency program as time that must be declared by the applicant when applying for a temporary Resident Postgraduate Training Permit.

2.8.2. A letter of explanation/verification is required from the applicant and the past residency program director.

2.8.3. Before accepting a transfer resident, the program director of MSM, Department of Psychiatry, must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation from the current/previous program director.

2.9. Personal interviews of applicants shall be conducted by at least two (2) faculty members assigned to the program.

2.9.1. The interviews will be documented for the residency program files and be retained for the period determined by MSM management policies.

2.9.2. These interviews also become a permanent part of a selected applicant’s file.

2.9.3. If telephone interviews are performed, the same standards and documentation criteria are used to record the interview.

2.10. A faculty consensus is formed on the selections for entry into the NRMP Rank Order Listing or for departmental selection for those positions not placed in the match (PGY-2 and above). Final disposition for applicant selection and ranking is done by the program director, associate program director, and chair.

*The number of attempts for completion of USMLE Steps 1 and 2 (CK and CS) is at the discretion of the program director and Program Evaluation Committee. Exceptions may be made with evidence of outstanding performance and/or service in other areas.
Social Media Policy

I. PURPOSE:

1.1. Online social media allow faculty, staff, and residents to engage in professional and personal conversations. These guidelines apply to residents participating in the Morehouse School of Medicine (MSM) Psychiatry Residency Program (MSMPRP) who identify themselves with MSM and/or use their MSM e-mail address in social media platforms such as professional society blogs, LinkedIn, Facebook, etc. for deliberate professional engagement or casual conversation.

1.2. These guidelines apply to private and password-protected social media platforms as well as to open social platforms.

II. SCOPE:

2.1. In general, Morehouse School of Medicine Psychiatry Residency Program (MSMPRP) views Internet social networking sites positively. This includes Facebook, MySpace, Twitter, YouTube, and LinkedIn, as well as personal websites, podcasts, wikis, and blogs (individually and collectively considered “social media”) among others.

2.2. MSMPRP respects the right of residents to use them as media of self-expression. However, social media can also be abused by individuals who enter information on it or by those who access and read it with a result that MSM Psychiatry RTP or its affiliates could be viewed negatively or be subject to other adverse consequences.

2.3. The term “affiliate” means any entity or person that works directly with the MSMPRP or MSM to supervise residents or deliver services and goods to the program.

III. POLICY:

The following guidelines apply to any MSM Psychiatry resident who engages in the use of social media:

3.1. Residents must be respectful in all social media communications. Residents should not use obscenities, profanity, or vulgar language, nor may they engage in threatening behavior online or make defamatory statements.

3.2. Residents should only use their work e-mail for work-related forums (e.g., following a professional organization, like MSM, on Facebook). Otherwise, residents are strongly recommended to use personal e-mail for personal communication.

3.3. “Friending” is a way to establish online communication with others on social media sites. It is highly recommended that you do not allow patients (former or current) to be added to your personal friend list.

3.3.1. This may compromise patient privacy and confidentiality as well as overstep appropriate physician-patient boundaries.

3.3.2. It is always acceptable to refuse inappropriate “friend” requests (University of Maryland).
Appendix A

3.4. Residents may not comment through social media in any manner that conveys an impression that he or she is acting as a representative or spokesperson for MSMPRP, MSM, or any of its affiliates. The social media policy applies to personal activity and/or professional activity that is not part of official MSMPRP communication, and where the affiliate identifies him- or herself as an MSMPRP resident, either through a bio, comments, or by using an MSM e-mail address.

3.5. The following disclaimer should be added whenever you identify yourself as part of MSM while not officially acting on behalf of the medical center:

*The views and opinions expressed here are not necessarily those of Morehouse School of Medicine nor its affiliates, and they may not be used for advertising or product endorsement purposes.*

3.6. If you list Morehouse School of Medicine as your employer on your Facebook info tab, you must add the disclaimer on the tab as well.

3.7. If you do not identify yourself as being affiliated in any way with MSMPRP, MSM, nor any of its affiliates, the policy does not apply.

3.8. Residents must not use social media to disparage the MSM faculty, program, other residents, or other affiliates of MSMPRP, or its parent institution, Morehouse School of Medicine.

3.9. Residents must follow the same MSM guidelines in regard to:

3.9.1. Compliance (HIPAA and the protection of patient information)

3.9.2. Conflict of Interest Policy

3.10. Residents must follow general civil behavior guidelines with respect to:

3.10.1. Copyrights

3.10.2. Disclosures

3.10.3. Refraining from revealing proprietary financial or intellectual property

3.10.4. Refraining from revealing information about patient care or similar sensitive or private content (Vanderbilt)

3.11. Residents must not use social media to harass, threaten, or intimidate others. Behaviors that are prohibited include, but are not limited to:

3.11.1. Comments that are derogatory regarding race, sex, religion, color, age, disability, or any other protected status

3.11.2. Any sexually suggestive, humiliating, or demeaning comments

3.11.3. Threats or bullying comments (such as threats to stalk, haze, or physically injure others)

3.12. Residents must not use social media to discuss engaging in conduct that is prohibited by MSMPRP and MSM policies, including but not limited to:

3.12.1. The improper or illegal use of drugs or alcohol

3.12.2. Any harassing, discriminatory, or retaliatory behavior that might violate MSMPRP and MSM policies against harassment and discrimination

3.13. Residents must not post pictures or videos of faculty, program staff, other residents, patients, or any affiliates on a website or other social media venue without first obtaining written permission from the person or entity whose picture or video is being used.
3.14. Residents should be aware that pictures, videos, and comments posted on social media sites are often available for viewing by third parties and could be considered detrimental to MSMPRP, MSM, or our affiliates. Therefore, in addition to the other requirements of this policy, residents must review their privacy settings on the various social media sites they use, and make any adjustment to those settings or edit the content of those sites in order to be in full compliance with this policy.

3.15. Residents must comply with any applicable federal or state trademark, copyright, trade secret, or other intellectual property laws.

3.16. The use of MSMPRP and MSM name, logo, or any copyrighted material of our organization is not allowed without prior written permission of MSM.
Supervision and Accountability Policy

I. PURPOSE:

The purpose of this policy is to define the process for resident supervision, including progressive responsibilities of residents for patient care and faculty responsibility for supervising resident patient care. Supervision in the setting of GME provides safe and effective care to patients, ensures each resident's development of the skills, knowledge, and attitudes required to enter unsupervised practice of medicine, and establishes a foundation of continued professional growth.

II. PROCESS:

2.1. Faculty physicians assigned as full-time, part-time, or adjunct MSM faculty by the MSM Department of Psychiatry Executive Committee supervise all patient care.

2.2. Each patient must have an identifiable and appropriately credentialed privileged Attending physician who is responsible and accountable for their care.

   2.2.1. This information must be available to patients, residents, faculty, and other members of the healthcare team.

   2.2.2. Residents and faculty must inform each patient of his or her respective roles in that patient’s care when providing direct patient care.

2.3. Specific responsibilities for patient care are included in the written description of each service/rotation by program year. This information is available in the program handbook at any time.

2.4. For daily clinical activities, faculty and/or senior resident(s) are on site and available for direct observation or indirect supervision with a direct supervisor immediately available as required for PGY-1 residents.

   2.4.1. As the resident’s competency and skill set advances, faculty and/or chief residents continue to be on site; however indirect observation is allowed.

   2.4.2. For PGY-2 residents and above, a faculty member and/or chief resident provides direct and/or indirect supervision based on the resident’s competency.

2.5. For call activities, a senior resident is on site for supervision and a faculty physician is available to supervise the entire team.

2.6. A rapid, reliable system for communication with the supervisory faculty is available.

2.7. On-call responsibilities, assignments, and supervision are documented through the call schedule.

2.8. Faculty supervision assignments must be of sufficient duration to adequately assess resident competency and delegate the appropriate level of patient care authority and responsibility.
III. **LEVELS OF SUPERVISION:**

For many aspects of patient care, the supervising physician may be a more advanced resident. Other positions can be adequately supervised by the immediate availability of faculty/senior residents on site or via telephone. To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

3.1. **Direct Supervision**—The supervising physician is physically present with the resident and patient.

3.2. **Indirect Supervision with Direct Supervision Immediately Available**—The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide

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

3.4. **Oversight**—The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

IV. **PATIENT LOGS:**

4.1. Residents are to keep a daily log of all patient encounters.

4.2. These logs are subject to oversight supervision by the supervising Attending, associate program director, and/or program director periodically to ensure a variety of cases, treatment options, and appropriateness of care.

4.3. Faculty observation of clinical assessment with case presentation is an important form of supervision. Faculty and residents are encouraged to provide a minimum of one (1) supervisory session per rotation of an entire patient interaction. Direct supervision in this manner allows for specific feedback and can be used for Clinical Skills Verifications.

V. **FACULTY INVOLVEMENT:**

5.1. Each resident must know the limits of his or her scope of authority and the circumstances under which the resident is permitted to act with conditional independence.

5.2. Residents MUST communicate with the appropriate supervising faculty in the following circumstances/events:

5.2.1. Hospital admissions

5.2.2. Civil commitments

5.2.3. Family wishes to speak to the Attending physician

5.2.4. Significant change in the clinical status of a patient

5.2.5. Any uncertainty regarding diagnosis and/or management

5.2.6. Any patient safety concern/issue

5.2.7. AMA discharge

5.2.8. Medical errors
Appendix A

VI. INPATIENT SETTING:

6.1. Regarding faculty supervision, in the inpatient setting, residents receive direct supervision by an Attending physician caring for a specific patient or by the physician on service or on call through the 24/7 coverage schedule.

6.2. The following guidelines refer to resident graduated responsibility for patient care:

6.2.1. Depending on the patient’s complexity, inpatients are initially evaluated by the more junior resident.

6.2.2. This resident may then present the patient history and plan to the chief resident, senior resident, or faculty physician who will evaluate the patient and review the note before significant plans are enacted.

6.2.3. Residents are to contact the supervising Attending and present their plan whenever significant changes in patient status occur, or before initiating new medication, or admitting or discharging patients.

VII. EMERGENCY SETTING:

7.1. Regarding faculty supervision in the emergency department, residents may receive direct supervision or indirect supervision with direct supervision immediately available by the Crisis Intervention Service Attending caring for a specific patient or by the physician on call through the 24/7 coverage schedule.

7.2. Regarding resident graduated responsibility for patient care, patients are initially evaluated by the resident physician and the patient history, safety, and ability to care for self-assessment, and plan are presented to the Attending physician.

VIII. CONTINUITY SETTING:

8.1. The following guidelines refer to faculty supervision:

8.1.1. A supervising Attending is assigned to the resident clinics every session.

8.1.2. The Attending is available for direct supervision and indirect supervision with direct supervision immediately or non-urgently available.

8.1.3. Each Attending documents his or her level of involvement on each case through the electronic medical record.

8.2. The following guidelines refer to a resident’s graduated responsibility for patient care:

8.2.1. Residents have individualized assignments for patient care in the continuity clinic, with each resident assigned for a minimum of 1.5 to 2 days per week.

8.2.2. Patients are initially evaluated by the resident physician.

8.2.3. The case is then presented to the faculty Attending and depending on complexity, the Attending will assess the patient and guide the resident in developing a care plan and follow up.
IX. PSYCHOTHERAPY SUPERVISION:

9.1. Each resident is expected to meet with his or her supervisor once a week for indirect clinical supervision.

9.2. The sessions should include but are not limited to the following topics:

   9.2.1. Patient selection
   9.2.2. Key elements in setting the foundation for psychotherapy
   9.2.3. Case formulation and treatment planning
   9.2.4. Review of process notes
   9.2.5. Identification of relevant transference, countertransference, and boundary concerns
   9.2.6. Identification of key elements and processes of the individualized psychotherapy plan
Appendix A

Position Description for Resident Physicians

General Principles of the Training Program for Residents in Psychiatry at Morehouse School of Medicine:

1. The house staff physician meets the qualifications for resident eligibility outlined in the Essentials of Accredited Residencies in Graduate Medical Education in the AMA Graduate Medical Education Directory.

2. Because the position of house staff physician involves a combination of supervised, progressively more complex, and independent patient evaluation and management functions and formal educational activities, the competence of the house staff physician is evaluated on a formal semi-annual basis as required by the Residency Review Committee (RRC). The program maintains a confidential record of the evaluation.

3. The position of house staff physician entails provision of care commensurate with the house staff physician’s level of training and competence, under the general supervision of appropriately privileged Attending teaching staff. This includes:
   • Participation in safe, effective, and compassionate patient care;
   • Developing an understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education and of how to apply cost-containment measures in the provision of patient care;
   • Participation in the educational activities of the training program and, as appropriate, assumption of responsibility for teaching and supervising other residents and students;
   • Participation in institutional orientation and education programs and other activities involving the clinical staff;
   • Participation in institutional committees and councils to which the house staff physician is appointed or invited; performance of these duties in accordance with the established practices, procedures, and policies of the institution, and those of its programs, clinical departments, and other institutions to which the house staff physician is assigned, including, among others, state licensure requirements for physicians in training, where these exist;
   • Following the rules and guidelines as directed by the MSM Psychiatry Department resident protocol.
Position Descriptions for Resident-Level Specific Physicians

PGY-1 on Ward
- Writes admission orders
- Examines every assigned patient (daily exam)
- Performs the main write-up on every admitted patient
- Schedules tests; reviews lab data
- Reports to resident at work rounds
- Reports to Attending at Attending rounds (if no student)
- Supervises student on writing orders, collecting labs, physical exam
- Writes/supervises daily progress note
- Performs procedures under supervision of resident or Attending until proficient
- Outpatient or subspecialty consult service
- Takes history, examines patient, writes basic note
- Reports to Attending
- Ensures that all work is directly checked by Attending
- Writes prescriptions, lab, and imaging orders
- Reviews results with Attending
- Communicates with referring physicians and other consultants

PGY-2/PGY-3 on Ward
- Supervises PGY-1 and students
- Organizes and directs ward team
- Primary contact with Attending unless designated to PGY-1
- Fills in when PGY-1 is not adequate
- Direct teaching and supervision of students
- Reviews all student work-ups
- Instructs students in physical and patient management
- Directs students to information resources
- Provides outpatient/subspecialty consult service
- Takes history, examines patient, writes note
- Reports to Attending
- Writes prescriptions, lab, and imaging orders
- Reviews results with Attending
- Communicates with referring physicians and other consultants
Appendix A

Psychiatry PGY-1 on Internal Medicine/Neurology/Family Medicine

- Writes admission orders
- Examines every assigned patient (daily exam)
- Performs main write-up on every admitted patient
- Schedules tests; reviews lab data
- Reports to resident at work rounds
- Reports to Attending at Attending rounds (if no student)
- Supervises student on writing orders, collecting labs, physical exam
- Writes/supervises daily progress note
- Performs procedures under supervision of resident or Attending until proficient
- Provides outpatient neurology consult service
- Takes history, examines patient, writes basic note
- Reports to Attending
- Ensures that all work is directly checked by Attending
- Writes prescriptions, lab, and imaging orders
- Reviews results with Attending
- Communicates with referring physicians and other consultants

PGY-1 on Psychiatry Service at Atlanta VA

- Examines assigned patients (history, physical, and psychiatric evaluation)
- Reviews admission orders with Attending physician
- Participates in team treatment planning and progress meetings
- Participates in patient conferences
- Follows patients for medication management and psychotherapy under supervision
- Participates in family conferences
- Presents patients in case conferences and grand rounds

PGY-2 Outpatient Psychiatry at Grady

- Performs psychiatric evaluations of patients including substance abuse history and mental status examination
- Plans and performs psychotherapy and psychopharmacologic treatments under supervision
- Participates in case conferences
- Participates in group and family therapy
- Participates in clinical out-patient research
- Participates in evaluation treatment and management of patients on the following services:
  - Community outreach
  - Child psychiatry
  - Psychosocial rehabilitation
Position Descriptions for Resident-Level Specific Physicians

PGY-3 on In-Patient Psychiatry at GA Regional Hospital

- Evaluates acute psychiatric patients for in-patient treatment including psychiatric evaluation, substance abuse history, and mental status examination
- Plans and performs psychotherapy and psychopharmacologic treatments under supervision
- Participates in case conferences
- Participates in group and family therapy
- Participates in clinical out-patient research
- Evaluates acute/emergency psychiatric patients on:
  - Emergency psychiatry service and
  - Psychiatric consultation service (2 months) at Grady Memorial Hospital
- Psychiatric consultation service—Grady
- Substance abuse services—Grady
- Forensic psychiatric services—GA Regional

PGY-4

Performs psychiatric evaluations, treatment, management, and coordination of care under appropriate supervision for patients in the following treatment settings:

- Outpatient psychiatry—East Point VA CBOC, VA Women’s Center, VA Cognitive Center
- Participate in PS/QI activities and VA Cognitive Center.
Transfer of Care and Patient Sign-Out Policy

I. **RATIONALE:**
As modern medicine moves more towards a team approach to patient care and as we turn our focus towards patient safety, quality, and continuity of care, patient hand-off/transition of care communication has become increasingly important. Programs must design clinical assignments to optimize transitions in patient care (including their safety, frequency and structure), to ensure effective hand-over processes to facilitate continuity of care, and to ensure residents are competent in communicating with team members in the handover process.

II. **DEFINITIONS:**

2.1. **Transition of Care**—A transfer is a real time, active process of conveying the responsibility for the care of a patient from one entity to another. It may involve the discharge from one entity and the admission to another along with the patient’s medical and/or psychiatric records.

2.2. “Sign-out” is the term used to refer to the verbal and written patient hand-off communication that takes place between the outgoing and on-coming teams at the change of shift and in transferring care to another service.

2.2.1. This may be done via a verbal and/or written sign-out.

2.2.2. The sign-out/hand off is a way to provide information to facilitate continuity of care.

2.2.3. The sign out will be conducted in conjunction with, but not limited to, changes in call status, when contacting another physician when there is a change in the patient’s condition, and transferring a patient from one care setting to another.

III. **POLICY:**

3.1. A standardized approach to handovers/transfers at Morehouse School of Medicine Hospital sites provides an opportunity to ask and respond to questions.

3.2. **Morehouse School of Medicine must ensure and monitor effective, structured patient hand-over processes to facilitate continuity of care and patient safety at participating sites**

3.3. Providers involved in the sign-out/hand-off process include, but are not limited to, physicians, nurses, therapists, technicians, and transporters.

3.4. Key elements of patient information are included in the handover/transfer process as determined by the service or team of caregivers. Patient information related to current condition and present treatment patient information will include at a minimum:

- Patient name, location, age/date of birth
- MR #
- Diagnosis
- Allergies, medical history, and psychiatric history
Transfer of Care and Patient Sign-Out Policy

- Important current labs and vitals; pending tests and studies which require follow-up
- Level and commitment status
- Medications
- Potential seclusion/restraint issues
- What to watch for or monitor during the next interval of care
- Important items planned between now and discharge

3.5. Handover/transfer communication may include verbal face-to-face or telephone reports accompanied by a written handoff; written reports or handover/transfer should be documented using the templates developed at the unit or departmental level.

3.5.1. Telephone hand-offs occur when transferring a patient on a civil commitment from the outpatient setting to the emergency receiving facility; however, a written hand-off must accompany the patient to the facility via staff and/or security.

3.5.2. Otherwise, telephone hand-offs are not acceptable.

3.5.3. Any time written communication is used in a handover/transfer, the name and contact number of the caregiver handing off or transferring care will be included to facilitate the asking of questions.

IV. PROCEDURE:

4.1. Caregivers will identify a quiet area, such as the resident workroom, to give report that is conducive to transferring information with limited interruptions.

4.2. Caregivers will have at hand any supporting documentation or tools, such as paper instructions, used to convey information and immediate access to the patient record.

4.3. All communication and transfers of information will be provided in a manner consistent with protecting patient confidentiality.

4.4. Caregivers will afford each other the opportunity to ask or answer questions and read or repeat back information as needed. If the contact is not made directly (face-to-face or by telephone), the caregiver must provide documentation of name and contact information (extension, pager, or e-mail address) to provide opportunity for follow-up call or inquiry.

4.5. The patient will be informed by the departing resident or Attending of any transfer of responsibility even if temporary or brief.

4.6. A resident physician must not leave the hospital until a hand-off has occurred.

4.7. Verbal Sign-out—This is the verbal status update of all patients admitted during the shift or being transferred to an emergency-receiving facility. This sign-out includes all new admission, pertinent labs, and new developments that occurred during a shift. See the hand-off policy for the VA Health Care System below.

4.8. Written Sign-out—This is the written patient hand-off communication used to keep record of patients admitted or cared for during the residents call.

4.8.1. These written communications are updated throughout the shift as patients are admitted, have status changes, or are discharged.

4.8.2. Customarily, the written communication is printed for review during the verbal sign-out for visual re-enforcement and so that additional notes can be made.
Appendix A

4.9. Additional Procedures:

4.9.1. SBAR can be used to deliver or receive the information:
   - **Situation**: What is the problem?
   - **Background**: Pertinent information to the problem at hand
   - **Assessment**: Clinical staff’s assessment
   - **Recommendation**: What do you want done and/or think needs to be done?

4.9.2. Anticipate information needed for a hand off
   - **Admission demographics**: e.g., patient name, age, admission diagnosis, allergies
   - **Now**: Current condition (stable vs. unstable), pertinent labs, current meds, and updated diagnosis and assessment
   - **Tasks to be done overnight**: Include time for receiver’s questions and clarifications on the patients
   - **Contingency planning**: Given the current condition and status of the patient, what important events can occur overnight and what can be done for the same (e.g., what has or has not worked in the past; difficult family or psychosocial situations; level/commitment status; complications)
   - **Interruptions**: Was the hand-off free from interruptions (e.g., noise, distractions, lack of dedicated space or time)

4.10. Clinical sites must maintain schedules of Attending physicians and residents currently responsible for care, and must ensure continuity of care in the event that a resident may be unable to perform his or her patient care responsibilities due to excessive fatigue, illness, or family emergency.

V. ATLANTA VA MEDICAL CENTER—GUIDE TO SHIFT HAND-OFF:

5.1. Shift hand-off ensures safe ongoing patient care.

5.2. The importance of shift hand-off is to communicate essential knowledge to oncoming providers so that errors are eliminated and relevant information is communicated in an efficient manner.

5.3. The ultimate goal of shift hand-off is to prevent mistakes and potential errors that may be avoided.

5.4. At the VAMC there are two major hand-off periods: AM and PM.

5.4.1. Morning (AM) hand-off: weekdays

5.4.1.1. At the VAMC, the first hand-off occurs at the administrative meeting during the week. The point of this meeting is to account for the patients that were seen overnight.

5.4.1.2. This helps staff understand the disposition for all of the patients that were evaluated, arrange any follow up that is appropriate, and to highlight any systems issues. Additionally, if there are patient care concerns for the next shift, these should be communicated to the oncoming teams.

5.4.1.3. At this meeting, the resident will communicate information on all patients that were seen in the ED Annex or as a consult (either in the ED or on med/surgical floors).

5.4.1.4. Next, the resident will communicate any major medical or psychiatric issues that happened in the ED Annex or on the inpatient unit (e.g., patient placed in restraints, patient transferred to medicine for shock).
5.4.1.5. Finally, any issues that need follow up during the day should be communicated to one of the physicians starting the day shift (chief of service, chief resident, or one of the inpatient residents). An example would be, “I ordered a head CT for Mr. X due to a fall, but the result is not back yet. Serial cardiac enzymes are pending.”

5.4.2. Evening (PM) hand-off: weekdays

5.4.2.1. The evening hand-off begins at the beginning of the shift for the oncoming POD (16:00).

5.4.2.2. At the VAMC, all patients on a level 4 need sign-out; and any patient who is on a lower level, but has new issues that are significant, also needs sign-out.

5.5. The key information to sign-out on the patients includes:

5.5.1. Reason for admission

5.5.2. Concerns for any monitoring above Q15 minute checks

5.5.3. Any risky or concerning behaviors

5.5.4. Medication initiations or changes that could cause problems

5.5.5. Restricted medications—are there medications the patient should not receive?

5.5.6. F/U labs, imaging that may be important overnight

5.5.7. Any medical conditions that may likely become unstable overnight

5.6. For patients on lower level, an example of a sign-out would be “Patient X had an episode of syncope yesterday. BP has been stable. If episode returns, will need to contact MOD and check orthostatic.”

5.7. Admissions—if there is an admission to your team (transfer patient from another service or outside hospital) that has not arrived on your shift, sign the patient out to the POD since they will have to do the admission. If you have any paperwork, be sure to pass that on to the POD.

5.8. As a backup, information on all patients on the inpatient unit will be entered into the shift hand-off tool in the medical record and updated on a daily basis to reflect clinical changes. This will be available to the POD overnight should issues arise.

VI. WEEKENDS:

6.1. On the weekend, there is one major sign-out period at 08:00 AM. This should occur with the Attending physician, the outgoing POD, the incoming POD, a nursing representative, and sometimes a moonlighting physician.

6.2. The resident beginning the Saturday shift should print out the census for 4PSY. This census should be passed along on Sunday at hand-off and again at the administrative meeting to the chief resident.

6.3. During the sign-out, all relevant issues will be communicated by both verbal and written (shift hand-off tool) means to the oncoming physicians. Any pending testing or evaluations must also be communicated at this time, similar to the hand-off during the week.
Well-Being Policy

I. PURPOSE:

According to ACGME, in the current healthcare environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is a vital component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training.

II. POLICY:

2.1. The residency program and faculty must ensure that efforts are provided to enhance the meaning that each resident finds in the experience of being a physician, including:

2.1.1. Protecting time with patients
2.1.2. Minimizing non-physician obligations
2.1.3. Providing administrative support
2.1.4. Promoting progressive autonomy and flexibility
2.1.5. Enhancing professional relationships

2.2. Clinical supervisors, chief residents, and program administrators must provide the following elements that contribute to workplace well-being:

2.2.1. Attention to scheduling, work intensity, and work compression that impacts resident well-being
2.2.2. Evaluation of workplace safety data
2.2.3. Provisions for the safety of residents and faculty members

2.3. Morehouse School of Medicine must oversee that the program fulfills its responsibility to address well-being of residents and faculty members, consistent with the Common and Psychiatry Program Requirements, addressing areas of non-compliance in a timely manner.

2.4. Morehouse School of Medicine in partnership with the Psychiatry Residency Program must educate faculty members and residents identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. This responsibility includes educating residents and faculty members in how to recognize those symptoms in themselves, and how to seek appropriate care.

2.5. Morehouse School of Medicine in partnership with the Psychiatry Residency Program must:

2.5.1. encourage residents and faculty members to alert the Program Director, DIO, or other designated personnel or programs when they are concerned that another resident or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence;

2.5.2. provide access to appropriate tools for self-screening; and
2.5.3. provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

2.6. Morehouse School of Medicine must ensure a healthy and safe clinical and educational environment that provides for:

2.6.1. Access to food during clinical and educational assignments; and

2.6.2. Safety and security measures for residents appropriate to the participating site

III. RESPONSIBILITIES:

3.1. The residency program must:

3.1.1. Ensure that policies and programs encourage optimal resident and faculty member well-being.

3.1.2. Provide residents the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.
Appendix A

3.1.3. Ensure that attention is paid to resident and faculty member burnout, depression, and substance abuse.

3.1.3.1. The program must educate faculty members and residents in the identification of the symptoms of burnout, depression, and substance abuse, including the means to assist those who experience these conditions.

3.1.3.2. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care.

3.1.4. Encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.

3.1.5. Provide access to appropriate tools for self-screening.

3.1.6. Provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

3.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. In the event that a resident may be unable to perform his or her patient care responsibilities, the resident should contact his or her clinical supervisor, chief resident, advisor and program director for guidance in transitioning patient care and obtaining self-care. Residents should use the Office of Disability Services as appropriate.
Appendix A
*Insert pages 8-43 from Psychiatry Milestones T: drive ACGME folder