In 1973, the American Psychiatric Association (APA) published the first edition of *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*. Subsequently, revisions were published as the APA Board of Trustees and the APA Assembly approved additional annotations. In July of 1980, the American Medical Association (AMA) approved a new version of the *Principles of Medical Ethics* (the first revision since 1957), and the APA Ethics Committee incorporated many of its annotations into the new *Principles*, which resulted in the 1981 edition and subsequent revisions. This version includes changes to the *Principles* approved by the AMA in 2001.

The committee included Herbert Klemmer, M.D., Chairperson, Miltiades Zaphiropoulos, M.D., Ewald Busse, M.D., John R. Saunders, M.D., and Robert McDevitt, M.D. J. Brand Brickman, M.D., William P. Camp, M.D., and Robert A. Moore, M.D., served as consultants to the APA Ethics Committee.

Chapter 7, Section 1 of the Bylaws of the American Psychiatric Association (May 2003 edition) states, “All members of the Association shall be bound by the ethical code of the medical profession, specifically defined in the *Principles of Medical Ethics* of the American Medical Association and in the Association’s *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*.” In interpreting the Bylaws, it is the opinion of the APA Board of Trustees that inactive status in no way removes a physician member from responsibility to abide by the *Principles of Medical Ethics*.

Foreword

All physicians should practice in accordance with the medical code of ethics set forth in the *Principles of Medical Ethics* of the American Medical Association. An up-to-date expression and elaboration of these statements is found in the Opinions and Reports of the Council on Ethical and Judicial Affairs of the American Medical Association. Psychiatrists are strongly advised to be familiar with these documents.

However, these general guidelines have sometimes been difficult to interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even though the basic principles are the same. The annotations are not designed as absolutes and will be revised from time to time so as to be applicable to current practices and problems.
Principles of Medical Ethics American Medical Association

Preamble
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Section 1
A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

Section 2
A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

Section 3
A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

Section 4
A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

Section 5
A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

Section 6
A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

Section 7
A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

Section 8
A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

Section 9
A physician shall support access to medical care for all people.

Principles With Annotations
Following are each of the AMA Principles of Medical Ethics printed separately along with annotations especially applicable to psychiatry.

Preamble
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Section 1
A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.

1. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor–patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the
essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with
the psychiatrist.
2. A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of
any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.
3. In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his
or her work to peer review and to the ultimate authority of the medical staff executive body and the hospital
administration and its governing body. In case of dispute, the ethical psychiatrist has the following steps available:
a. Seek appeal from the medical staff decision to a joint conference committee, including members of the medical
staff executive committee and the executive committee of the governing board. At this appeal, the ethical
psychiatrist could request that outside opinions be considered.
b. Appeal to the governing body itself.
c. Appeal to state agencies regulating licensure of hospitals if, in the particular state, they concern themselves with
matters of professional competency and quality of care.
d. Attempt to educate colleagues through development of research projects and data and presentations at
professional meetings and in professional journals.
e. Seek redress in local courts, perhaps through an enjoining injunction against the governing body.
f. Public education as carried out by an ethical psychiatrist would not utilize appeals based solely upon emotion,
but would be presented in a professional way and without any potential exploitation of patients through
testimonials.
4. A psychiatrist should not be a participant in a legally authorized execution.

Section 2
A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to
report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.
1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all
the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model
his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the
treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and
psychiatrist, while weakening the objectivity necessary for control. Additionally, the inherent inequality in the
doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient
is unethical. 5
2. The psychiatrist should diligently guard against exploiting information furnished by the patient and should not
use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in
any way not directly relevant to the treatment goals.
3. A psychiatrist who regularly practices outside his or her area of professional competence should be considered
unethical. Determination of professional competence should be made by peer review boards or other appropriate
bodies.
4. Special consideration should be given to those psychiatrists who, because of mental illness, jeopardize the
welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another
psychiatrist to intercede in such situations.
5. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between
the patient and the physician. The provisions of the contractual arrangement, which are binding on the physician
as well as on the patient, should be explicitly established.
6. It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of
the specific contractual agreement with the patient. Charging for a missed appointment or for one not canceled 24
hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make
such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration
for the patient and his or her circumstances.
7. An arrangement in which a psychiatrist provides supervision or administration to other physicians or nonmedical
persons for a percentage of their fees or gross income is not acceptable; this would constitute fee splitting. In a
team of practitioners, or a multidisciplinary team, it is ethical for the psychiatrist to receive income for administration, research, education, or consultation. This should be based on a mutually agreed-upon and set fee or salary, open to renegotiation when a change in the time demand occurs. (See also Section 5, Annotations 2, 3, and 4.)

Section 3
A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

1. It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his or her patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.

2. Where not specifically prohibited by local laws governing medical practice, the practice of acupuncture by a psychiatrist is not unethical per se. The psychiatrist should have professional competence in the use of acupuncture. Or, if he or she is supervising the use of acupuncture by nonmedical individuals, he or she should provide proper medical supervision. (See also Section 5, Annotations 3 and 4.)

Section 4
A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he or she must be circumspect in the information that he or she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business or-organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the students’ explicit permission.

3. Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

4. The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his or her duty of confidentiality.

5. Ethically, the psychiatrist may disclose only that information which is relevant to a given situation. He or she should avoid offering speculation as fact. Sensitive information such as an individual’s sexual orientation or fantasy material is usually unnecessary.
6. Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.

7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time, the psychiatrist must assure the minor proper confidentiality.

8. When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient.”

9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients, he or she may comply or he/she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.

10. With regard for the person’s dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering if the confidentiality of the presentation is understood and accepted by the audience.

11. It is ethical to present a patient or former patient to a public gathering or to the news media only if the patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion.

12. When involved in funded research, the ethical psychiatrist will advise human subjects of the funding source, retain his or her freedom to reveal data and results, and follow all appropriate and current guidelines relative to human subject protection.

13. Ethical considerations in medical practice preclude the psychiatric evaluation of any person charged with criminal acts prior to access to, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical treatment.

14. Sexual involvement between a faculty member or supervisor and a trainee or student, in those situations in which an abuse of power can occur, often takes advantage of inequalities in the working relationship and may be unethical because:

- Any treatment of a patient being supervised may be deleteriously affected.
- It may damage the trust relationship between teacher and student.
- Teachers are important professional role models for their trainees and affect their trainees’ future professional behavior.

Section 5
A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

1. Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.

2. In the practice of his or her specialty, the psychiatrist consults, associates, collaborates, or integrates his or her work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, and the like. Furthermore, the nature of modern psychiatric practice extends his or her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he or she is dealing is a recognized member of his or her own discipline and is
competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he or she refers patients. Whenever he or she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her.

3. When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he or she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if the psychiatrist allows himself/herself to be used as a figurehead.

4. In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.

5. The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve, he or she may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

Section 6
A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

1. Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his or her patient should take precedence over all other considerations. Professional courtesy may lead to poor psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.

2. An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist’s opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment.

Section 7
A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

1. Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he/she speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid cloaking their public statements with the authority of the profession (e.g., “Psychiatrists know that”).

2. Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.

3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement.

4. The psychiatrist may permit his or her certification to be used for the involuntary treatment of any person only following his or her personal examination of that person. To do so, he or she must find that the person, because of
mental illness, cannot form a judgment as to what is in his/her own best interests and that, without such treatment, substantial impairment is likely to occur to the person or others.

5. Psychiatrists shall not participate in torture.

Section 8
A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

Section 9
A physician shall support access to medical care for all people.

Notice of his/her right to Appeal the decision within 30 days of receipt of the letter. The Complainant shall not be notified until all appeals or the time for all appeals has expired.

c. If the decision is to expel the member, the DBEC shall not provide Notice until the APA Board of Trustees has approved the expulsion pursuant to Part V.B.4. Once approved by the Board, the DBEC shall provide written Notice to the Complainant and Accused Member, with a copy to APA, that Expulsion has been approved by the Board of Trustees and that the decision is final.

PART VII: APPEALS.
A. Appeal Panel
1. All appeals shall be considered and decided by a panel of three (3) members of the APA Ethics Committee who have not been involved in a review of the case pursuant to Part VI.
2. The Chair of the APA Ethics Committee may appoint a replacement if there are not three members of the Committee who have not been involved in the case who are able to serve.

B. Grounds for Appeal
All appeals shall be based on one (1) or more of the following grounds:
1. That there have been significant procedural irregularities or deficiencies in the case;
2. That The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry has been improperly applied;
3. That the findings of or sanction imposed by the DB are not supported by substantial evidence;
4. That substantial new evidence has called into question the findings and conclusions of the district branch.

C. Accused Member’s Request For Appeal
1. The Accused Member’s request for an appeal must be received within 30 days of the date the Accused Member is notified of the district branch decision. Upon receipt of the Accused Member’s request for an appeal, the APA Ethics Committee shall request and the DB shall provide to the APA Ethics Committee a copy of the DB file, including the recording of the hearing. The APA Ethics Committee shall make a copy the DB file available to the Accused Member upon request and compliance with any conditions set by the APA Ethics Committee.
2. In appeals heard by an APA Ethics Committee appeals panel, the panel will review and decide the appeal solely on the basis of the DB’s documentary record of its actions and decision and any written appeal statements filed by the Accused Member and the district branch. The Accused Member’s statement will be provided to the DB, which may file a written response. Any DB response will be forwarded to the Accused Member, who will have the opportunity to respond in writing prior to the Ethics Committee’s consideration of the appeal. Filing deadlines and other procedures governing the appeal shall be established by the APA Ethics Committee.

D. Decision by APA Ethics Committee Appeal Panel
1. After reviewing all documents, the APA Ethics Committee appeals panel may take any of the following actions:
   a. Affirm the decision, including the sanction imposed by the district branch;
   b. Affirm the decision, but alter the sanction imposed by the district branch;
   c. Reverse the decision of the district branch and terminate the case; or
   d. Remand the case to the district branch with specific instructions as to what further information or action is necessary. Remands will be employed only in rare cases, such as when new information has been presented on appeal or when there is an indication that important information is available and has not been considered. After the district branch or panel has completed remand proceedings, the case shall be handled in accordance with procedures in Part VI and VII.
2. After the APA Ethics Committee appeals panel reaches a decision, if the decision is anything other than to expel a member or remand, the Chair of the APA Ethics Committee shall provide Notice to the DB of the decision. The DB shall then provide Notice to the Accused Member and the Complainant of the decision and that it is final.

3. If the decision is to expel the member, the decision would be forwarded to the APA Board of Trustees as outlined in Part V.B.4.

Guidelines for Ethical Practice in Organized Settings

At its meeting of September 13–14, 1997, the APA Ethics Committee voted to make the “Guidelines for Ethical Practice in Organized Settings,” as approved by the Board and the Assembly, an addendum to The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, to be preceded by introductory historical comments and cross-referenced to the appropriate annotations, as follows:

This addendum to The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry was approved by the Board of Trustees in March 1997 and by the Assembly in May 1997. This addendum contains specific guidelines regarding ethical psychiatric practice in organized settings and is intended to clarify existing ethical standards contained in Sections 1–9.

Addendum

Psychiatrists have a long and valued tradition of being essential participants in organizations that deliver health care. Such organizations can enhance medical effectiveness and protect the standards and values of the psychiatric profession by fostering competent, compassionate medical care in a setting in which informed consent and confidentiality are rigorously preserved, conditions essential for the successful treatment of mental illness. However, some organizations may place the psychiatrist in a position where the clinical needs of the patient, the demands of the community and larger society, and even the professional role of the psychiatrist are in conflict with the interests of the organization.

The psychiatrist must consider the consequences of such role conflicts with respect to patients in his/her care, and strive to resolve these conflicts in a manner that is likely to be of greatest benefit to the patient. Whether during treatment or a review process, a psychiatrist shall respect the autonomy, privacy, and dignity of the patient and his/her family.

These guidelines are intended to clarify existing standards. They are intended to promote the interests of the patient and should not be construed to interfere with the ability of a psychiatrist to practice in an organized setting. The Principles and Annotations noted in this communication conform to the statement in the preamble to the Principles of Medical Ethics. These are not laws but standards of conduct, which define the essentials of honorable behavior for the physician.

1. Appropriateness of Treatment and Treatment Options
   a. A psychiatrist shall not withhold information that the patient needs or reasonably could use to make informed treatment decisions, including options for treatment not provided by the psychiatrist. [Section 1, Annotation 1 (APA); Section 2, Annotation 4 (APA)]
   b. A psychiatrist’s treatment plan shall be based upon clinical, scientific, or generally accepted standards of treatment. This applies to the treating and the reviewing psychiatrist. [Section 1, Annotation 1 (APA); Section 2 (APA); Section 4 (APA)]
   c. A psychiatrist shall strive to provide beneficial treatment that shall not be limited to minimum criteria of medical necessity. [Section 1, Annotation 1 (APA)]

2. Financial Arrangements
   When a psychiatrist is aware of financial incentives or penalties that limit the provision of appropriate treatment for that patient, the psychiatrist shall inform the patient and/or designated guardian. [Section 1, Annotation 1 (APA); Section 2 (APA)]

3. Review Process
   A psychiatrist shall not conduct reviews or participate in reviews in a manner likely to demean the dignity of the patient by asking for highly personal material not necessary for the conduct of the review. A reviewing psychiatrist
shall strive as hard for a patient he or she reviews as for one he or she treats to prevent the disclosure of sensitive patient material to anyone other than for clear, clinical necessity. [Section 1, Annotations 1 and 2 (APA); Section 4, Annotations 1, 2, 4, and 5 (APA)]
Handoffs
**Handoffs**

Transfers of patient care from one physician to another, a process known as “handoffs,” are ubiquitous in healthcare. The frequency of handoffs has increased with the restriction of resident duty hours by the Accreditation Council on Graduate Medical Education (ACGME) in 2003 followed by additional restrictions scheduled for July, 2011. Handoffs are vulnerable to communication failures, which can lead to medical errors and harm to patients. The Joint Commission (JC) has found that two out of three sentinel events have communication errors as a contributing cause and that over half of these errors involve handoff failures. Communication failures during handoffs are characterized by omissions of important medical information and/or failure-prone communication processes. The failure-prone communication processes include unstructured written and verbal communication, non-face-to-face sign-out, poorly communicated rationale for the clinical plan, inadequate training of clinicians in handoffs communication, occurrence of handoffs in settings that are neither quiet, private, nor free of interruptions, and the lack of infrastructure to support handoffs such as protected time (overlapping shifts) or a structured electronic written template linked to the EMR.

**Purpose of Handoff**

The responsibility of patient care transferred from one physician to another is considered a handoff, and the information transferred to manage this discontinuity is referred to as the sign-out. The purpose of any handoff is to establish a shared mental model about a patient in order to avoid unwarranted changes in goals, decisions, priorities, or plans.

**Regulatory Response**

The potential for harm during these transitions has led to regulatory and policy initiatives. The Institute of Medicine recommended and the ACGME began requiring, as of July, 2011, enhanced training for residents regarding handoffs. Similarly, the JC has mandated a standardized approach to handoff communications.

### 2011 ACGME Common Program Requirements: Handoffs

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<th>Requirement</th>
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<td>Programs must design clinical assignments to minimize the number of transitions in patient care.</td>
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<td>Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes that facilitate both continuity of care and patient safety.</td>
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<td>Programs must ensure that residents are competent in communicating with team members in the hand-over process.</td>
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<td>The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient’s care.</td>
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### Joint Commission: National Patient Safety Goal, Handoffs

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<td>Implement a standardized approach to “handoff” communications including an opportunity to ask and respond to questions</td>
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<tr>
<td>Expectations:</td>
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<td>Interactive communications: opportunity for questions</td>
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<td>Minimum content: Up-to-date information</td>
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<tr>
<td>Interruptions are limited</td>
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<td>Process for verification: “read-back”</td>
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Thus, we have tightened and systematized our UCSD Handoff procedures and have re-instituted morning and sign-out rounds at the VA and UCSD. These procedures are a work in progress. We welcome your input as we continue to monitor and strengthen this important component of patient care and residency training. Below are our current handoff procedures for the VA, UCSD Hospital and Outpatient Service.

**Sign Outs and Handoffs at the VA – 2S/ADTP/PEC Residents**

**Treating Resident to On-call Resident**

1. Residents should use the Shift Handoff Tool in CPRS under “Tools”, making sure to update the yellow areas at least once per week and the “To Do” area nightly. There should be a brief one-liner about the patient, a multiaxial diagnosis, and a “To Do” list filled out daily. Meds, allergies, code status and patient identifiers including name and location are auto-populated on this form.

2. If you leave before 5 pm you need to be available by pager and designate someone who knows your patients who you could call to assist with issues that may arise on the unit (ie your fellow resident on your team, your senior resident, etc) — it is not OK for the PEC resident to be getting called about your patients at any time under any circumstances. The covering resident would need to be able to respond within 5 minutes to an urgent matter on the unit regarding your patient. Between 5 and 6:30 pm you may sign out directly to the PEC resident or the ‘on-call’ resident if they are available. After 6:30, sign out directly to the on call resident.

3. Sign out in person either to the person you would call from your team should an issue arise or to the PEC resident (if you leave prior to 6:30 pm). If you sign out after 6:30 pm you will need to contact the overnight resident directly and sign out face to face. Sometimes you will need to wait until the PEC resident or overnight resident is done with what they are doing to sign out. It is not OK to interrupt them if they are in with a patient so that you may sign out.

4. Residents must sign out anything that the resident must follow up on that evening, and any concerns or other issues that the overnight person should be made aware of (ie what to use as prn in case of agitation or pain, allergies or adverse reactions to medications)

5. The PEC resident must sign out any patients in the ED to the incoming overnight resident and patients who had been ‘signed-out’ to them by other residents.

**On-Call Resident to Treating Resident**

6. In the morning, all treating residents, including the PEC resident must receive sign-out information from the overnight resident. It is expected that when 2S and ADTP residents arrive in the morning, that they find the overnight on call resident (ideally before 8 am or at sign-in rounds at 8 am) or to receive their updates on their patients. Residents should arrive at the VA by 8am. Receiving ‘sign-out’ information from the overnight resident is mandatory.
7. The overnight resident is tasked with both leaving a note in CPRS and making a notation on the paper sign out if there is an issue with a patient.

8. The overnight resident will need to sign out any patients left in the ED to the PEC resident.

9. To facilitate this process, there will be morning ‘sign in’ teaching rounds to review the previous night’s activities and ensure that all ‘sign out’ information is conveyed and all questions answered and discussed. The ‘on-call’ and PEC residents are always expected to attend; other VA-based residents are encouraged to attend. The senior resident or Attending Psychiatrist leaders are:
   - Monday – Yang
   - Tuesday – Lanouette
   - Wednesday – Porras
   - Thursday – Porras
   - Friday – Iglewicz

Off-Service Hand Offs

10. At the end of a rotation residents must write off service notes which should include:
   a) a complete progress note from that day
   b) the entire clinical course from that hospital stay including all medication trials,
   c) the clinical rationale for the patient’s current treatment
   d) any adverse events or medical issues
   e) the expected future clinical course during that hospital stay so that the oncoming resident will have a general idea where to proceed with the patient
   f) an account of all legal proceedings that have taken place
   g) a summary of collateral information received by the team.

This should be submitted on the Friday before leaving service. Anything that does not belong in the official chart but that needs to be communicated regarding a particular patient should be done so prior to the new resident taking over.

Sign Outs and Handoffs at UCSD Hospital

Morning Hand-Off

8 am – Attended by the on-call intern/resident, NBMU interns, NBMU chief, C/L resident, C/L attending and medical students.

Handing off resident provides written sign out detailing information on patients on the C/L service and in the Emergency Department. Details of sign out documentation below. Signing off resident also updates EMR as appropriate including EPIC, WebCharts and iShare.

The handing off resident also provides oral report of the following:

- Emergency Department – presents patients still in the ED. Also presents any pertinent learning cases that were discharged overnight. Presents any administrative problems.
Consults: presents new consults on hospitalized patients seen overnight.

NBMU: presents issues arising on the psychiatric unit—include medical and administrative issues.

Telephone calls: presents any calls from outside patients to the on-call pager.

Admissions: are NOT presented until rounds unless there is something that requires emergent attention like a serious medical issue or a hold.

**Evening Hand Off**

5-6PM on weeknights. Attended by Night Float/overnight resident, a rotating NBMU intern, medical student, C/L resident.

The C/L resident provides updated written sign-out. See details below. The NBMU interns provide written sign out of admitted patients. Signing off residents also updates EMR as appropriate including EPIC, Web Charts and iShare.

The C/L resident who is handing off care also provides oral report of the following:

- Emergency Department: presents patients still in the ED and awaiting disposition
- Consults: Presents any pending/new consults. Also provides information about issues that may come up overnight/over the weekend

The NBMU intern will provide an oral report of the following:

- NBMU: presents any ongoing issues with admitted patients. Also pending lab or examinations to follow up on. Proposed medication changes in response to possible lab results.

**NBMU Sign Out Documentation:**

Information should include:

Name, MRN, DOB, Date of Admission, Brief ID statement, Multi-axial diagnoses, target symptoms, All Medications (medical and PRN included), Allergies, Legal Status, pending issues (labs results, expiring holds, proposed medication changes, contraindications for medications); brief, relevant hospital course (focusing on any medication changes/trials or IM’s); History of Assault/Elopement.

**C/L Sign Out List:**

- You must record the following information on the C/L list:
  - Patient Name
  - MRN
  - Requesting attending’s name
  - Requesting resident’s name and pager number
Patient’s insurance
Bed/Floor
ID statement
Relevant Medications
Consult question
Legal Status
To Do list (issues/follow up overnight or over the weekend, especially legal holds)

Education:

- Incoming interns are educated on the written, verbal and electronic hand off system during first week of residency.
- During first week of residency crash course, new interns have opportunity to observe hand offs. During the first month of residency, interns will also have the opportunity to perform hand offs under supervision of the Chief Resident.
- Attending teaching hand offs are done Monday, Wednesday and Friday morning at 8am. Interns receive real-time feedback/supervision regarding clinical work and hand-off communication.

Sign Outs and Handoffs at the Outpatient Service

Parting is all we know of heaven
And all we need of hell—Emily Dickinson

The following are a few paragraphs of collective wisdom and guidance that will hopefully facilitate a good transition for you and your patients as you prepare to leave the Outpatient Service. Articles on transfer and termination will also be distributed that we have found helpful.

You have made a significant impact on your patients’ lives and will become a part of their collective memory of obtaining help from mental health professionals. We trust that their memory of you will be one that provides encouragement and hope in their daily lives. The therapeutic experience with you will also instill a desire to continue treatment with a new clinician or to return when needed. Although the patient’s feelings at the end of the relationship are determined largely by how the relationship has been experienced over time, the last few months of treatment tend to act as a screened memory for the whole relationship.
As you are also ending a significant and pivotal experience in your professional life it is important that you take time to reflect on your own feelings about leaving. These feelings will probably include a mixture of relief, pride, sadness, regret, disappointment, anxiety and excitement about the future. Your experience here and in your training program and your personal history with separation and loss will, of course, influence your own reactions. Also, consider your modus operandi when ending relationships or leaving prior places and former colleagues and friends. Awareness of your own responses will enable you to be available and open to your patients’ experience.

The anticipation of separation and loss often generates anxiety as it threatens our basic sense of safety and security maintained through attachment to significant others. Anxiety may be expressed directly but more often is expressed through actions. Patients may protest and cling, deny, appear unconcerned or become sad, anxious and disorganized. Some will escalate substance abuse, suicidal behaviors or start missing appointments. Our goal is to minimize the fear and anxiety surrounding the transition through assurance of continued services in the Outpatient Service (i.e. institutional transference or continued secure attachment), transfer to other services in the community or through their memory of the relationship with us and what they have gained. Remember that when loss and separation occur we retain the memory of “the way things were” in a relationship; the way we were treated and how the other person made us feel. The memory of being cared for serves as an anchor during the transition.

General Guidelines

If you have not yet done so, at the beginning of the next session, remind your patients that you are leaving and give them the approximate number of sessions that are left and the exact week you are leaving. Inform them of any intervening vacations. Observe their immediate reactions and those at subsequent sessions to determine their particular style of handling separation and loss.

The last few meetings should generally be conducted like all previous sessions. It is not a time for new techniques, new medications, new issues, confrontation or confessions. It is a time to consolidate the best aspects of the relationship, review what has been gained and establish future goals. A major objective during this period is to strengthen the patient’s self-esteem, convey a sense of work well done and instill hope in the future. Another important goal is to reinforce their feeling of security and trust that help, when needed, is available.

How you discuss termination and transfer depends upon your patients’ unique needs and capacities. Consider the form of attachment (secure, insecure dismissing, insecure anxious preoccupied or disorganized) that each patient exhibits in the context of their current psychiatric status, past history of loss, personality style and psychosocial support system. These factors will provide important information as to how your patient will handle your leaving. As some of our patients have been through the transfer process many times, each person will experience unique and common elements. Take time to review last year’s notes when appropriate to determine any patterns and ask your patient what his/her experience was.

As you discuss the transition acknowledge when appropriate that the training rotation, not the patient’s needs, is forcing this termination. Follow your patient’s non-verbal and verbal behavior as to what level of support they need from you.

While it is important to provide an opportunity for your patient to express and discuss his thoughts and feelings regarding the end of the therapeutic relationship with you, many patients have a limited capacity to do so. They may experience our exploration of feelings as pressure to “feel” or to “react” to our leaving. This can be interpreted as a demand to take care of the clinician and make the clinician feel
good. A sense of inadequacy and guilt may be generated if the patient feels they are not ending according to the “book.” Others may experience anger at perceived pressure to meet our needs.

**Schizophrenia/Schizoaffective Disorder and Psychosis NOS**

A highly structured predictable transition is our goal for patients with these disorders. Change and the anticipatory anxiety it generates is extremely stressful and disorganizing for this patient group. They have minimal capacity to process feelings. Be concrete as you discuss this transition in order to reduce anxiety. Tell them when you are leaving, where you are going in generic terms, and who will be taking your place. If the patient misses an appointment call them to follow-up.

During the last meetings explicitly state what progress you feel they have made on whatever level it has been, e.g., stayed on medications, stayed out of the hospital or known when they needed a hospital admission, attended group regularly, developed a friendship, attended AA, kept their appointments. Be straightforward and matter of fact about the change and don’t press for “feelings” if they are not forthcoming. Reassurance that care will remain stable even though you leave is essential to preventing relapse and disorganization. Reinforce the continuity of attachment to the institution.

If there is any sign of a relapse reach out and provide additional support or arrange for hospitalization or a START program. Common signs of decompensation are medication noncompliance, increase in symptoms, and missed sessions. Remember that these individuals may not appear to be very attached to you but are highly dependent and will react through an increase in symptoms and decrease in functioning.

**Personality Factors**

The majority of our Gifford patients with mood and anxiety disorders have co-morbid personality disorders and, of course, all have unique personality styles. Under the stress of change and loss our patients will respond with an exaggeration and amplification of their particular personality traits (as do we). The more disordered the personality structure the more extreme the maladaptive response may be depending upon their current psychiatric status, psychosocial stressors and support system.

Remember that rigidity and impaired self-reflection are the key features of personality disorder. Under stress these features are amplified.

Those with Cluster A disorders and traits may appear unaffected but become increasingly disorganized, paranoid, eccentric, withdrawn and detached. Those with Cluster B disorders and traits are likely to become more disorganized behaviorally, more narcissistic, grandiose, demanding, labile and dramatic. Those with Cluster C disorders and traits may exhibit greater anxiety and become more avoidant or clinging, fearful, obsessional and compulsive. Those with severe personality disorders will often express a mixture of traits from each cluster. Their response set may become increasingly rigid and/or highly disorganized.

Respond with empathy to the underlying feelings e.g. fear, anxiety, hurt, anger rather than to the manifest behaviors or distorted cognitions. Work in supervision to understand the particular meaning and challenge to your patient of this transition. It is especially important to maintain steady involvement, provide kind and consistent structure and prevent premature termination.

**Borderline Personality Disorder**

This patient group is particularly vulnerable to loss of significant others. They require a highly predictable transition with a clear idea of whom they will be seeing and when their next appointment
will be. Expect an emotional storm and vacillation between dismissing you and demanding more from you. You may also anticipate increased behavioral manifestations of anxiety i.e., suicidal threat, cutting or whatever the patient characteristically does when overwhelmed with affect. Stay steady, calm, concerned and open. Provide a consistent structured appointment schedule. Help the patient to articulate what your leaving means to the extent possible. It may be useful to discuss for the patient in simple psychoeducational terms what termination may mean based upon your understanding of their relationship history.

Provide protection and containment through increased visits or phone contacts or a START stay if dangerous behaviors escalate. Patients with BPD need steady structured involvement during the transition so it is important to guard against getting provoked into being angry, withholding or punishing and pushing the patient away. Get additional supervision as needed to manage your reactions and maintain the alliance through to the last visit.

A WORD OF CAUTION: This transition places our patients at higher risk for suicide or psychotic episode especially with newer unstable, poorly engaged patients. Please take special care to respond to crises and be alert to disorganization and demoralization. Patients with co-morbid anxiety and personality disorders with impulsivity and/or substance abuse are at highest risk as are those who have limited social supports. Please consult. The more responsive and engaged we are with the patient the lower the risk. The goal is to build a prosthetic support structure around them to facilitate a safe transition.

Contact after Termination?

In general we inform our patients that our trainees are not available to contact after the end of the year. Discuss any questions regarding this in supervision.

Transfer or Terminate

For those patients seen in individual therapy we will work towards termination, transfer to community self-help and support services or for those patients still in acute need or high risk (MORS Score 5 or under) transfer to incoming interns and residents. Those patients with continued higher vulnerability will be transferred to group or reduced sessions with incoming interns. Patients who have a MORS score of 6 but require continued medication management should be considered for a transfer to a Family Health Center. Caseloads should be reviewed carefully in supervision to determine the most appropriate discharge plan given the patient’s needs and the resources available.

Medication Management

Our patients rely heavily on their physician-patient relationship even though appointments may be brief and less frequent. The supportive, regulating and containing function of the relationship is very sustaining to them. Consequently, transfer of patients from one physician to the next is just as anxiety provoking as the transfer from intern to intern. All of the principles that apply to transfer and termination for psychotherapy patients apply to the “meds-only” relationship.

Groups

In general the same principles apply to patients participating in our groups as for individual therapy and medication management. Discuss with your group members how they would like to handle the last group meeting. It may be helpful to organize a potluck
and facilitate a positive social experience. Rituals help but it depends on the nature and length of the group. We also ask that you review the Client Plan and determine future treatment goals beyond group. This can include other community programs, self-help groups and medications alone. Consult with your supervisor as to whether to refer a patient for continued group treatment in July. The same groups will be available during the next training rotation.

**Administrative Issues**

Review your caseload with your primary supervisor to determine the disposition of each patient. Plan to terminate all patients who appear to have left treatment. Send letters or call those you are concerned about to clarify this issue. A form letter is available online.

You and your supervisor will prioritize urgency of next appointment, frequency of visits and identify special needs (wheelchair access, language, gender preference). In general, interns and students will transfer to incoming interns and students.

Please coordinate with the intern/resident who is also providing services to your client as to who will complete the **Discharge Summary**. Please update the **Client Plan** for group, individual and medication management in Anasazi for continuing clients. Also on the HOMS website please update the MORS score and complete the Client and Clinician **Recovery Markers Questionnaire**.

**Parting Thoughts**

Enjoy the good work that you and your patients have done together and all you have learned. Remember that we usually remember how people made us feel not what they said. We carry the heart of the relationship within us as we move through life. Your work with your patients will help sustain them over the years and serve as a foundation for all of your future professional work.

...Nothing matters in the end but the quality of affection that has carved its trace in the mind....

Ezra Pound Canto LXXVI

Poet and patient at St. Elizabeth's Hospital, Washington, DC 1945-1957
**Overview of San Diego County**

The County of San Diego was one of the original 27 counties created by the California State Legislature in 1950. The County covers 4,225 square miles making it larger than Delaware, Rhode Island, and Washington, DC combined. Due to unique geographic characteristics, the county remains relatively isolated as a major metropolitan area. The geographic isolation is a result of the Mexican border to the south, Pacific Ocean to the west, two major mountain ranges to the east and northeast, and a 20-mile barrier between San Diego and Orange Counties created by Camp Pendleton Marine Corps Base.
The Community Mental Health System in San Diego County is governed by State laws and regulations. Of primary importance are the provisions of the Bronzan McCorquodale Act of 1991 and the Lanterman Petris Short Act of 1968, which are summarized below:

**Bronzan McCorquodale Act = “Realignment”**

1. Counties are designated as the local unit of government to administer the mental health service system.
2. Every county develops an annual performance contract with the State, based on client outcome measurements.
3. Sales tax and vehicle license tax fees are allocated to each county by formula based on need and available resources. Monies are placed in a Local Mental Health Trust Fund for county use. The county must “match” realignment dollars with a fixed dollar amount based on 1989.90 match levels. San Diego County’s match for Fiscal Year 1994.95 is $4,701,332.
4. The target populations to be served under this Act are: seriously emotionally disturbed children and adults; adults and older adults with a serious mental disorder; adults or older adults who require, or are at risk of requiring, acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention; and persons who need brief treatment as a result of a natural disaster or severe local emergency.
5. Counties provide the following treatment options “to the extent that resources are available”: pre-crisis and crisis services; comprehensive evaluation and assessment; individual service plans; medication education and management; case management; 24-hour treatment services; vocational rehabilitation; residential services; and services for homeless persons.
6. A 40 member California Mental Health Planning Council advises the Governor, Legislature and the Director of the State Department of Mental Health in the provision of mental health services statewide. A 15 member local Mental Health Board advises the Local Mental Health Director of the County.

**The Lanterman Petris Short Act**

1. Mentally disordered persons, developmentally disabled persons, individuals who are inefvriated or impaired by chronic alcoholism, and users of narcotics and dangerous drugs may be serviced under this Act.
2. Individuals who are gravely disabled or a danger to themselves or to others, but who are unable or unwilling to voluntarily accept public or private help, may be involuntarily detained for treatment in county designated facilities. Involuntary treatment must be in accordance with specified time limits and procedures.
3. Every person retains the right to judicial review any time he/she is held involuntarily.
4. Certain legal and civil rights are guaranteed to all patients. These rights are prominently posted in both English and Spanish in each facility and are brought to the attention of the patient when he enters the facility.

5. A conservatorship procedure is specified for patients who are “gravely disabled” as a result of a mental disorder.

San Diego County has decentralized all services to make them more readily available to consumers. As part of this process the county was divided into five regions: North Coastal, North Inland, East, Central and South.

Services within each region include outpatient treatment, day services, aftercare follow-up, residential programs. The only centralized services are the countywide hotline and psychiatric hospitalization. Outpatient services are based on a sliding scale formula determined by the State and is referred to as the Uniform Method of Determining Ability to Pay (UMDAP).

Alcohol and Drug Services (619.692.5727)

A referral service for drug and alcohol abusers are also decentralized within each region. Services include crisis, detoxification, residential and outpatient program. Individuals with primarily drug or alcohol problems should be referred to one of these programs before a referral is made to a mental health program. The County Alcohol and Drug Services reports directly to the local Director, Department of Health Services.

Developmental Disabilities (619.576.2938 or 576.2996)

Services for individuals with developmental disabilities include diagnostic evaluations, counseling, referral and placement. Offices are located throughout the County. This program is non-profit and State funded. The San Diego Regional Center for the Developmentally Disabled is the service provider.

Department of Social Services (619.557.0422)

The San Diego County Department of Social Services administers income maintenance programs which include Aid to Families with Dependent Children (AFDC), General Relief (GR), Medi Cal, and the Food Stamps program. In addition, the Department provides a range of social services which include: adoption, foster home licensing, children’s protective services, employment, home management, housing and transportation, protective services for adults, money management, child care and in-home supportive services.
To apply for income maintenance, General Relief or Medi-Cal individuals must go to the office in their zip code area and go through an eligibility screening.

**Supplemental Security Income (SSI) (1.800.772.1213)**

Individuals who are aged, blind, physically or emotionally disabled and in financial need may be eligible for SSI. This program is administered through the Social Security Administration, The Federal Department of Health and Welfare. Individuals eligible for this program are also eligible for services from the department of Social Services and Medi-Cal assistance. To apply, individuals must call 1.800.772.1213. All applicants must go through an evaluation and screening process (6-18 months).

**County Medical Services (CMS) (619.492.4444)**

Individuals who are not Medi-Cal eligible and do not have sufficient income to afford private medical insurance are eligible for county funded medical care. They can receive care only at contract hospitals/agencies of the county. Eligibility is determined through an application and screening process. CMS is administered through the Department Health Services, Community Health Services.

**Office of AIDS Coordination (619.515.6699)**

Coordinates and provides services to persons with HIV infection and AIDS through a countywide network of contract providers.
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**UCSD Outpatient Psychiatric Services Resource List**

Access Line 1 (800) 479-3339

- **Capstone**: 693.4123
- **Case Management**: 602.8215
- **CS Gen Info**: 800.772.1213
- **SCS Gen Info**: 467.0146
- **Employment Services**: 276.4021
- **Semi-Supervised Living**: 233.776
- **Outpatient (CNIHC)**: 576.583

**Legal Issues**

- **Inpatient (CABS)**: 529.370
- **GCRI Legal Aid Soc.**: 262.586
- **Scop. Used J's**: 560.036

**Forensic Eval Unit**

- **UC-CSO Forensic**: 531.0042
- **UC-CSO Medical Rec.**: 543.6026
- **Project Enable (ESD)**: 263.6155
- **VA Hepatitis**: 543.6026

**Radiology, UCSD**

- **Ct: Adult**: 291.0611
- **Psychology**: 291.0611

**MOSAIC HOUSE**

- **Moses**: 279.4110

**UCSD MedCare**

- **UCSD MedCare**: 279.4110
- **UCSD MedCare**: 279.4110

**CMHC**

- **CMHC**: 602.3200

**UCSD MD Molli**

- **Catholic Health Sys**: 271.2828
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**Low-Fee Counseling**

UCSD Psychiatric Associates – 140 Arbor Drive
Fee: $30.00
Ph: 619.407.6610

Alpha of San Diego (9-5 daily) Youth & Family Services
North Park Community Center – 4069 30th Street
Fee: $15 & up; English & Spanish Counseling/Parenting/Anger Management
Ph: 619.285.9990

Catholic Charities – 349 Cedar Street
Sliding Fee Scale
Ph: 619.231.2828

Community Center – 43rd & University
Food disbursement, 1st day of month, 92105 zip code only
The Center (Lesbian & Gay) AKA: Center for Social Services
3916 Normal Street
Fees: $0 & up Counseling/Drug & Alcohol; AID support (holistic); AIDS prevention
Ph: 619.692.2077

Center for Community Solutions (formerly Center for Women’s Studies & Services)
2467 E Street (Golden Hill)
Fees: $5 & up—0.1% income (special arrangements can be made)
Ph: 619.233.8984

Family Service Association – 7645 Family Circle (Linda Vista)
Especially for couples & families; parenting, ACA)
Fees: $22-100; $15 for some classes
Ph: 619.279.0400

Jewish Family Services – 3715 6th Ave.
Sliding Fee Scale
Ph: 619.291.0473

SDSU Student Counseling – 6363 Alvarado Court
(limited therapy available) Fees: $10-80
Ph: 619.594.5134

Union of Pan Asian Communities of SD County – 1031 25th Street
(Services & Counseling for Asian immigrants) Fees: County contract – no fees
Ph: 619.232.6454

YMCA – 5505 Friars Road
has other branch) Fees: $15-80
Ph: 619.293.3165

California School of Professional Psychology – 6315 Ferris Square, Ste. 180
Provides individual, marital, family, and group psychotherapy on either a short- or long-term basis. Also provides crisis intervention, play therapy, grief counseling, & biofeedback. Variable fee, sliding scale: from $30–100, depending on income and family size. Intake $30. Services also offered at “Bayside Settlement House” facilities in City Heights and Linda Vista were fees vary from $1-$30 and there is no charge for intakes.
Ph: 619.457.1464

Episcopal Community Services – 3585 5th Ave.
Offers individual, couple, family, & group counseling, post-traumatic stress therapy, and court-ordered domestic violence programs for men.
Fees: sliding scale; from $5-70.
Ph: 619.688.2440

YWCA Battered Women’s Services – 2550 Garnet Avenue
Provides individual, couple, & group counseling to families experiencing domestic violence. Peer support groups are offered for victims. A domestic violence treatment program is available for perpetrators.
Fees: Sliding. Donations are requested for support groups.

EMERGENCY HOUSING, CLOTHING & FOOD REFERRAL LIST

DOWNTOWN AREAS
Catholic Charities, Rachel’s Women’s Center—759 8th Ave.
7-day shelter, food, clothing for women. Shower/laundry facilities, lunch; call for times and intake information.
Ph: 619.696.0873

YWCA Downtown Center (WOMEN ONLY) – 1012 C Street
Passages supportive living program. Includes shelter, food, case management & support services for clients advancing toward independent living (1 year).
Ph: 619.239.0355

God’s Extended Hand – 469 16th Street
Tue: 1 meal at 5pm (be there at 3:30). Wed–Fri: 2 meals at 9am, 3:30pm & 5pm. Thu: Clothing
Ph: 619.234.3251

St. Vincent de Paul – 1550 Market Street (Thrift Shop)
must be sponsored by social agency. Honor clothing voucher by Catholic & Episcopal services
Ph: 619.687.1070

City Rescue Mission (MEN ONLY) – 1150 J Street
3pm daily bed assignment; need an ID or referral; limited 5-day stay every 30 days
Ph: 619.234.2109

Big Sisters (WOMEN ONLY) – 115 Redwood Street
$10 a month, must have income source (i.e., SSI). 31 beds with 3 or 4 to a room. New facility on Upas and 4th – 14 beds.
Ph: 619.297.1172
CRASH Inc. – 2410 E Street

drug related only. 6-8 week waiting list
Ph: 619.233.8054, 619.239.9691

Episcopal Community Services – 1129 Broadway

referral for housing canned food, M-F 8-11:30am, (only eligible once every 6 months) must have picture ID and rent receipt legal aid services, (M-Th) 9-11am
Ph: 619.239.6061

Neighborhood House Association Mountain View Multi-Service Center – 841 S. 41st Street

interview for referrals 9-11:30amd, 1-3:30pm landlord/tenant issues, also tries to locate apartments
Ph: 619.263.7761

Metropolitan Good Neighbor Center – 906 N. 47th Street

(9:30-2:30) eligible once every 6 months only for emergency supplies 2-3 days supply of food furniture available see picture ID and address
Ph: 619.294.0368

Presbyterian Crisis Center – 2459 Market Street

eligible once a year for emergency supplies picture ID & rent receipt if possible. Food and clothing. Once a month if homeless, 1-3 times a month if not
Ph: 619.232.7753

Community Christian Services – 1675 Garnet Ave.

10-4 M-Th; 10-3 Fri
Ph: 619.274.2271
Salvation Army Emergency Lodge – 726 E Street

maximum 7 nights, social worker determines length of stay if patient has case worker here. 2 weeks -3 months stay possible. no single males. Ph: 619.239.6221

OCEANSIDE AREA

North County Community Services – 605 San Diego Street

housing referrals, employment assistance

Ph: 760.757.7011

Lifeline North County – 200 Jefferson, Vista

Phone for appointment

Ph: 76.726.4900

Women’s Resource Center – 1963 Apple Street

San Luis Rey, CA 92068

Serving persons for sexual abuse or assault

Ph: 760.757.3500

SOUTH BAY

Salvation Army – 648 Third Ave., Chula Vista

Ph: 619.422.8825, 619.422.9295

MAAC – 1671 Albany, Chula Vista, 663 E. San Ysidro Blvd., San Ysidro

Clothing during holidays, rental assistance

Ph: 619.422.9236, 619.428.1139
Casa Familiar - 119 W. Hall San Ysidro
Shelter, forms for aid, emergency food is seasonal, not always available
Ph:  619.428.1115

EL CAJON
East County Emergency Shelter - 290 S. Magnolia, El Cajon
call first
Ph:  619.447.2428

Crisis House - 125 W. Main
9am M, T, Th F; 1pm Wed  emergency food, domestic violence program, case management, FEMA, Opt Program-Grossmont College ID Verification of income  Ph: 619.444.1194

UCSD MEDICAL CENTER
OUTLINE OF GOALS FOR RESIDENT CURRICULUM

I. In-Patient Psychiatry
   A. Skills Required
   B. Evaluations
      1. Interview History
      2. Complete & Brief Presentation
      3. DSM-IV Formulation
      4. Multidisciplinary Team
      5. Supervision: To be able to accept
      6. Written Supervisor Evaluation
      7. Understanding Principles of
      8. Understanding pathology of
      9. Basic psychopharmacology of
   10. Oral Board Exams at end of rotation
   11. Mental Status Exam
   12. Attending Rounds
   13. Reviewed during ongoing rounds and supervision
   14. Feedback from Team Coordination, treatment planning
   15. I-5 above
   16. Therapists, Family and other collateral information sources
   17. I-5 plus selected reading Supportive psychotherapy
   18. I-5 plus selected reading schizophrenia, depression, bipolar and severe personality disorders
   19. I-5 plus selected reading antipsychotics, antidepressants, mood stabilizers.

PSYCHIATRIC EMERGENCY/CONSULTATION - LIAISON SERVICE

I. Description of Service
   Residents of the Department of Psychiatry assigned to take call at University Hospital provide psychiatric evaluation, admission to the psychiatric ward, crisis intervention and referral services to the patients requesting such services and when patients are referred by housestaff in the Emergency Room and Medical or Surgical wards.
II. Policies and Expectations

A. On Call

Residents are required to be in the hospital at all times and to respond immediately to requests for a psychiatric consult from the Emergency Room or Medical and Surgical wards. Rounds should be held between incoming and outgoing residents to exchange the beeper and to discuss any problems. The beeper should be checked periodically to make sure it is operating properly.

Weekdays: Daytime on call begins at 8:00 am and ends at 5:00 pm during the week. Psychiatric consults requested after 7:30 am are the responsibility of the daytime resident. Those requested after 4:30 pm are the responsibility of the nighttime resident. Nighttime on call begins at 5:00 pm and ends at 8:00 am. Any problems that arise during the day should be directed to the C/L attending and in their absence the senior resident. During the evening the faculty backup must be called on every discharge and may be called for each patient there are any questions on.

Weekends and Holidays: On call begins at 8:00 am and ends at 8:00 am the next day. Any problems should be discussed with the faculty backup or senior resident. Any new consults that occurred on your shift should be specifically signed out to the on-call resident and Attending coverage for the weekend. Pending labs should also be passed along to the next resident.

NBMU Admissions: The on call resident is responsible for checking the results of labs tests ordered on admitted patients or by the primary team (if labs were drawn on the weekend). The resident is also responsible for ordering appropriate follow-up studies for any abnormalities found. If labs are not back when you leave it is your responsibility to tell the incoming resident that labs/x-rays, etc. must be checked. We have excellent medical and surgical consultation services at University Hospital and these should be utilized without hesitation for both care and delivery and learning purposes.

Non NBMU Admissions: Patients who do not have funding for admission to NBMU must be referred to Community Mental Health (CMH) or a crisis house, unless there is an IRB approved study in progress on the inpatient unit an the patient is appropriate for the study.

When NBMU is full, patients who have funding can be referred to any private hospital in the area.

B. Charting

The following outline is to be followed for charting in the Emergency Department/Consult Service:

1. Chief complaint, age, sex, marital status, occupation, referral source.

2. Precipitating stress, i.e., why patient came to the Emergency Room at this point in time and the current events that led to the Emergency Room visit.

3. Current living situation and social support system.


5. Current/past medications (name and dosage).
6. Drug and ETOH abuse.


8. Disposition. Include rationale for disposition, patient's attitude towards disposition and patient's emotional state at the end of the interview.

In general, the write-up should give the reader and adequate understanding of why the patient came to the Emergency Department, what your impressions were and how you arrived at the disposition. This should be done concisely. This record is a legal document and is also used as a teaching tool.

Residents should record each Emergency Department patient contact in the Psychiatry ER Register. Patients requiring outpatient follow-up may be referred to UBH for indigent or Medic Cal patients. Medicare patients can be referred to any # of psychiatrists in the community.

UCSD PSYCHIATRIC OUTPATIENT SERVICES

I. PROGRAMS:

A. UCSD OUTPATIENT PSYCHIATRIC SERVICES

Description of Service

The UCSD Outpatient Psychiatric Services Clinic (Central Office), located at 140 Arbor Drive, San Diego, is an outpatient psychiatric clinic administered by the Department of Psychiatry and funded through a contract with the County of San Diego. It was established by the Department in 1970 to provide an outpatient training site for residents, medical students, social work and psychology interns. Its services include evaluation, crisis intervention, individual, couple, family, a wide variety of group therapies, and psychopharmacologic treatment. The clinic serves individuals 18 years of age and over who live in the Central Region of San Diego and who do not have the financial means to afford private care.

B. UCSD PSYCHIATRIC ASSOCIATES

Description of Service

The UCSD Psychiatric Associates is an outpatient mental health program directed and operated by the Department of Psychiatry of the UCSD School of Medicine. Treatment modalities featured in the program include both short and long-term individual therapy, couples counseling, marital and family therapy, crisis intervention, a full range of group therapies, psychopharmacologic treatment, psychological testing, and special programs directed towards working with mood and depressive disorders, anxiety and panic disorders, bereavement counseling, diagnosis and treatment of sleep disorders, behavioral therapy for eating disorders, sexual dysfunctions, substance and alcohol abuse and control of habit disturbance.

The UCSD Psychiatric Associates is designed to provide high quality care at moderate rates. People who are unable to afford full fees in the private sector or are reluctant to seek assistance from public funded clinics will find the UCSD Psychiatric Associates program to be an attractive and appropriate alternative.
G. RESEARCH

Description of Service

The UCSD program has several ongoing clinical research studies available for the residents' participation. Projects that will be available for resident participation include a treatment protocol for patients with schizophrenia or schizoaffective disorders, a study of a new form of psychotherapy for patients with major depression and dysthymia, a study assessing attrition and compliance during the termination process and ongoing studies on grief and bereavement. Residents are encouraged to participate in one of these research projects or doing their own during their outpatient experience.

II. PGY-3 YEAR ROTATION

A. Policies and Expectations

The PGY-3 residents will spend a year at the clinic learning outpatient psychiatric work. Approximately half of their time will be spent in direct patient care and the other half in supervision sessions, seminars, and teaching conferences. Residents will be encouraged to develop a varied caseload which will provide them with experience utilizing a range of treatment strategies. Responsibilities will include:

1. Two intakes per week throughout the year.
2. Up to 24 patient hours per week. This will include individual, group and medication work.
3. Medical coverage for "team" evaluation clinic.
4. Medical consultative responsibilities for non-physician staff and trainees.
5. Attendance at weekly staff meetings, case conferences, and seminars.
6. Regular medical charting.
7. Adherence to the policies and procedures of the clinic.
8. Teaching fourth year medical students.

"THE VILLAGE"

St. Vincent de Paul Village is a world-renowned program of comprehensive services to the homeless community. The Village Medical Clinic serves those persons residing in the Village as the first priority, the homeless on the street as the next priority, and the local poor-but-housed (uninsured) as the next priority. Homeless persons entering the recovery program of St. Vincent de Paul Village can live there for up to two years, and continuity of care is the norm with the
Village population, the homeless, and the local community clinic population. With an estimated 75% or more of the homeless community suffering from substance abuse, mental illness, or both, it seems particularly appropriate that the residents in the combined Family Medicine-Psychiatry program have this exceptional clinic as their Family Practice Center. This will place primary care physicians who will be uniquely trained to address the comprehensive needs of the homeless in a setting that addresses itself to the most medically under-served members of our community.

St. Vincent de Paul Village Medical Clinic was founded in 1987 to provide free health care to uninsured, homeless persons. The Village Medical Clinic is located in one of the most medically under-served areas of California, and this licensed community clinic provides medical and dental care to the otherwise under-served in our community. The clinic is owned by St. Vincent de Paul Village, a non-profit, community-based organization, governed by the board of community directors. There is a president of the board, the Reverend Monsignor Joseph Carroll, and two vice-presidents. The St. Vincent de Paul Center was originally operated by the Catholic Diocese of San Diego, but incorporated as a federally recognized 501©(3) as St. Vincent de Paul Village in January, 1992. The corporation’s financial stability is based on strong capitalization and government contracts, corporate giving and community donations. St. Vincent de Paul Village is the lead agency in the San Diego “consortium of care” for the homeless, and receives support from government programs and grants, the United Way, and individual and corporate philanthropy to support these efforts. Additional financial support comes from the thrift stores located throughout the county.

The patient population served by the clinic starts with the residents of St. Vincent de Paul Village: “The Village” is comprised of several adjacent residential centers where people may live for up to two years, including:

- **The Joan Kroc Center** – housing more than 320 families and women with children
- **(approximately 120 children 12 years of age live in the JKC at any given time)**
- **The Paul Mirable Center** – housing 282 single men and 68 single women
- **The Bishop Maher Center** – housing 150 single men
- **The Josue AIDS Centers** – housing 26 individuals with AIDS
- **The Toussaint Teen Center** – housing 30 homeless and/or runaway teens

The Village provides a full spectrum of services to residents of the Village, including literacy and adult education (including completion of GEC), chemical dependency treatment, the “Challenge for Change” program, which addresses specific causes of homelessness for the person, job preparation and training for specific careers (the local community has on-site classes), School from Kindergarten through Grade 12 is provided on-site by San Diego City Schools, and day-care service is provided for mothers seeking employment. The clinic, staffed by the UCSD Combined...
Family Service – Psychiatry Residency Program – provides comprehensive family medical care, and psychiatric care to the very high risk population. In addition to serving the 865+ residents of the Village and the more than 1,200 people who come to the Village for day services and meals, the clinic next serves the thousands of individuals persistently homeless in San Diego, and then the additional thousands who live in the geographic area served by the community clinic – the “housed but poor.” St. Vincent de Paul Village Medical Clinic, which also provides laboratory services and pharmaceuticals, with all care free of charge to the patient, is not simply a quixotic “free clinic” affiliated with a soup kitchen. It is part of a world renowned, comprehensive system of services to the homeless which has an outstanding record of ending homelessness for those individuals who complete the program.

THE PATIENT POPULATION SERVED BY ST. VINCENT DE PAUL VILLAGE MEDICAL CLINIC: The 865+ residents of the Village are the first priority, and the housed-but-poor who live in the geographic area of the clinic are next priority. Because all care, laboratory and x-ray services and medications provided at the clinic are free of charge to patients, there is a long line of people seeking care each day. Currently, patients are screened by social workers, and referred to other agencies if they have any financial means of care elsewhere. It is anticipated that once the UCSD Family Medicine – Psychiatry Residents are fully present at the Village Medical Clinic, many more of those otherwise “underserved” patients in our community will have access to medical and psychiatric care.

SOME FAMILY AND SOCIAL CHARACTERISTICS OF THE PATIENT POPULATION SERVED BY THE VILLAGE MEDICAL CLINIC:
(Age, sex, race, education, employment, socio-economic status)

100% are below the poverty level
47% are female and 53% are male
16% are children and adolescents
84% are adults
13% were over age 65 (This group will be increased when there are physicians (ours) available to see them)

The ethnic breakdown is as follows:

- African American 19%
- Asian <1%
- Hispanic 58%
Patients have not been asked their education level in the Medical Clinic in the past, but the homeless population portrays the entire spectrum, from partial grade school education to those with Ph.D.s, with the majority of people having completed at least some high school.

CAPS—(Child and Adolescent Psychiatry Service)

PGY-II Child Psychiatry Rotation

PGY-2 residents have a two-month rotation at this JCAHO accredited facility. Currently, PGY-3 residents evaluate children and adolescents weekly for six months at CAPS during their outpatient year. This rotation for PGY-3 will be phased out by July 1998. PGY-4 residents in the child program spend the equivalent of eight months on this rotation. UCSD Child and Adolescent Services (CAPS) is a 28-bed inpatient service that was transferred under contract to UCSD from the County of San Diego. The hospital includes an adolescent inpatient service with children ages 14-17, and a combined child-adolescent inpatient service where the age range is 2-14.

A. INDIVIDUAL TREATMENT

Assignment

Each resident will be assigned 4 cases to provide a complete psychiatric evaluation, treatment and overall management. Treatment will include working with other members of staff assigned to the cases such as the family therapist, the primary nurse, team psychologist and the school personnel. Daily progress notes required in the chart.

Supervision

1. Participation in the interdisciplinary treatment team meeting under direct supervision of Dr. Nasra Haroun and/or the Child Psychiatry resident (PGY-4).

2. Weekly supervision by Gloria Giraldi, RN, Ph.D. for individual and play therapy.

B. FAMILY TREATMENT/ PRIMARY CLINICIAN

Assignment
Each resident will be assigned 1 to 2 families for which resident will provide family assessment and treatment as well as work on discharge planning and associated liaison with other agencies, making follow-up plans, completing patient satisfaction forms and tracking patient satisfaction.

Supervision

Once a week, group supervision by Allison Conn-Caffaro, MFCC. Please see Primary Clinician Guidelines for Charting in your orientation package.

C. GROUP THERAPY

Assignment

Each resident will be assigned a weekly group with either another resident or a psychology intern. Groups may include social skill training or process groups.

Supervision

Weekly supervision by the post-doctoral psychology fellows and monthly supervision by Sandra Brown, Ph.D.

D. OTHER SPECIALIZED TREATMENTS

Cognitive behavioral therapy, visual imagery, etc. If a resident feels that the above treatments may be indicated, they may request extra supervision from staff who have special expertise.

E. OUTPATIENT

Once a week, the residents will accompany the child psychiatry resident and observe outpatient evaluation and medication management at Children’s Hospital Outpatient Psychiatry Clinic.

F. DIDACTICS

Residents rotating through Child Psychiatry will be required to attend the Child Psychiatry Crash Course in July and August (see PGY-2 didactic schedule). All PGY-2s will be required to attend the “Introduction to Child and Adolescent Psychiatry” series in September and October at the VA Hospital.

Residents will also attend the bimonthly Case Conferences at UCSD CAPS on Wednesdays from 8:30 am to 10:30 am. All PGY-2s will also attend Grand Rounds on Friday mornings in room #113 at Children’s Hospital. Residents will also participate in many of the didactic courses offered at Children’s Hospital on Tuesday mornings.
VAMC

VA MEDICAL CENTER

VAMC FACULTY AND ROLES

VA Chief of Service ......................................................... Maria Tiamson-Kassab (Acting)

Site Director ................................................................. Sanjai Rao

Director 2 South

Team I ................................................................. David Lehman

Team II ................................................................. Sanjai Rao

Team III ................................................................. David Printz

Director Primary Care ...................................................... Kristin Cadenhead

Director ADTP ............................................................... Shannon Robinson

Medical Director ADTP ...................................................... Steve Groban

Director PEC/ Emergency Services ...................................... Maria Tiamson-Kassab

STEP (Special Eval and Treatment Unit) .................................. John Kelsoe

Director Consult/Liaison VA ............................................... Kristina Beizai and Sanjai Rao
2—SOUTH INPATIENT UNIT

Description Of Service

2 South has 37 beds, acute care inpatient beds, and a psychiatric primary care clinic. The 3 inpatient units are comprised of one Psychiatric Intensive Care Unit—PICU (B POD), one step-down unit (C POD) and one Geriatric/Neurobehavioral unit (A POD).

Each inpatient team may have patients on any of the three units. All admissions are rotated among the junior (PGY I and II) residents. Although mostly male, the patient population is representative of the diagnostic spectrum and severity of psychopathology seen in general hospital inpatient services. The staff on 2 South consists of faculty (attending) psychiatrists, senior (PGY IV) residents, junior residents, nurses and nursing assistants, social workers, occupational therapists, recreational therapists, pharmacists, and administrative staff. Students from various disciplines also frequently spend time in clinical training on 2 South.

Resident Education And Supervision

Along with the provision of excellent patient care, training shares the highest priority of 2 South activities. Students of various disciplines make valuable contributions to patient care while learning clinical psychiatry. Each discipline is responsible for the caliber of education and supervision of its students. Psychiatric residents are involved in the educational program at two levels—junior (PGY I and II) and senior (PGY IV). The general principle of medical education, which guides the program's activities, is that the physician is a perpetual student and teacher. Each patient and staff member, then, is viewed as someone from whom to learn as well as teach.

The focus of education for the junior residents is the assumption of primary responsibility for the total care of the patients assigned to them. The senior resident on the team provides most direct day-to-day supervision for this. Faculty psychiatrists provide formal input during scheduled patient-oriented conferences, rounds, supervision (formal & informal). The VA faculty also provides much teaching by informal contacts and availability in emergency situations. Junior residents serve as teachers and role models for UCSD medical students during their clinical clerkship on 2 South.

The educational goal for the senior residents is to prepare them to handle the supervisory role as well as develop administrative skills in managing the multidisciplinary team. Direct supervision is provided by the faculty attendings. Senior residents are directly responsible for supervising the day-to-day work of the junior residents on their team and share responsibility for medical student supervision with both the junior residents and the attending psychiatrists.

Policies And Procedures

The policies for 2 South include all the policies for the Psychiatry Service in general. The following is a brief resume of policies of particular importance to 2 South. Any questions regarding the more specific details of these policies should be referred to the attending physician or the official Psychiatry Service Policy Manual. In the event of any clinical or administrative emergency/problems, junior residents should attempt to contact a senior resident or attending (in that order). If unable to contact them, the Medical Director (or his/her designee) on 2 South should be consulted.
Work Day

1. The regular workday begins with sign-in rounds on Tuesday and Fridays at 8:00 a.m. On weekends and holidays, this is handled directly between the residents covering call. Residents should check with nurses on each pod after sign-in rounds regarding important patient care issues prior to attending classes. Assessing any patients in seclusion is the highest priority in the morning following sign-in.

2. The ability to contact junior residents for patient care issues during the day is essential. Residents leaving the hospital for any reason during the workday must arrange appropriate coverage, notify their senior resident, and inform the unit of who will be covering and for how long.

3. Residents sign out any pertinent clinical issues regarding their inpatients to the on-call resident. Although the on-call duties begin each weekday at 3:30, this is not meant to signify the end of the workday when there is more work to be done.

On-Call

1. During nights, weekends, and holidays, the on-call resident is responsible for providing psychiatric coverage for the medical center, including the Urgent Care Center, medical/surgical, and psychiatric services. Weekday call is from 4:00 p.m. to 8:00 a.m. Patients arriving for emergency assessment after 4:00 p.m. are the responsibility of the on-call resident. Weekend and holiday coverage is from 8:00 a.m. to 8:00 a.m. On weekends and holidays, the resident coming on-call must meet with the resident going off-call to discuss any problems.

2. On-call residents must check in with the charge nurse and make brief rounds on the psychiatric service during their shifts. Weekend and holiday on-call residents must write notes on patients in seclusion. Seclusion policy is complex, and each resident should feel competent in understanding the California State directives.

3. Faculty on backup call expect to be called in the event the on-call resident feels consultation is needed regardless of the time. On occasion, the faculty member may come into the hospital to supervise. Liberal use of consultation with the backup is recommended during the first month in particular. Unplanned discharges from the locked unit or D/C of patients on a hold require documentation of attending approval. All unplanned discharges should be cleared by an attending.

4. Residents may trade on-call dates to suit their needs. The resident originally scheduled to be on-call is responsible for notifying the Urgent Care Center, the VAMC & UCSD operators, the Chief Residents, the Residency Training Office, and the unit staff of the details of the switch. It helps to personally update the on-call rosters on the unit.

Admission Rotation

1. Patients are admitted to junior residents/interns in rotation. Residents generally determine their preferences for admitting order at the start of the year. Patients transferred from other VAMC services count
as admissions. Residents will ordinarily admit to themselves when on call, taking into consideration the team area of expertise and ward milieu.

2. Each resident should expect to treat between 6 and 12 patients at any one time. Should those limits be exceeded, senior residents and attending staff may take steps to correct the unbalanced caseload.

3. When a resident takes scheduled leave or sick leave, his or her patients will be covered in cooperation by the remaining first or second year resident and senior resident on the team.

4. Patients readmitted within 10 days after discharge will be assigned to their former team.

Admission Process

1. Decisions to admit are made by the Psychiatric Emergency Clinic during the day and the on-call resident during off-hours. The Psychiatric Consultation Liaison Service arranges transfers from other SDVAMC services.

2. All admissions, including those that are prearranged, must be discussed with the 181 nurse before going to the ward so that eligibility can be confirmed and the necessary forms and nameplate required by the ward staff can be prepared. All patients and facilities with which arrangements for admission are being made should be informed of this procedure.

3. The 181 or ward clerk has been requested to notify the resident on-call of the arrival of all prearranged admissions as a courtesy. Since the admission has already been accepted by our psychiatrist, these patients must be admitted and receive the same work-up as a regular admission (see below). A nurse will document resident notification.

4. The Psychiatric Intensive Care and step down unit (PICU - B and C Pods) are for direct admissions or transfers of patients requiring such a setting, i.e. disruptive, suicidal, and acutely psychotic patients. A Pod is the neurobehavioral unit for the cognitively impaired veteran. Direct admission should not be made to the last remaining seclusion room as this should be reserved for in-house use. The nurse coordinator in consultation with the admitting physician will determine the appropriate admitting unit for each patient.

5. Staff must accompany all admissions to the unit. A patient brought to the unit by the resident should not be left unattended. Patients admitted between 4 p.m. and 8 a.m. should be gowned in the UCC prior to arriving on 2 South. Between 4 p.m. and 8 a.m., the admitting resident and 2 South nurse both accompany the patient to the unit from UCC for safety reasons.

6. When suitable beds are unavailable for admissions, transfers to other hospitals may be necessary. See Section H for procedures.

Admission Workups

Work-ups on all patients must be completed by junior residents/interns. Medical students may work up the patient, but the PE must be completed by the resident/intern. Admission work-ups must be co-signed by an attending. All H&P’s are computerized and must be signed by the resident/intern and co-signed by the attending within 24 hours.
1. Complete admission evaluations must be recorded on the appropriate forms in the computer before the resident goes off duty. This includes full history (including past and current history of violent or suicidal behavior), mental status examination, physical examination, and the initial problem list and treatment plan.

2. Multidisciplinary treatment plans should be initiated by the admitting R.N. and M.D.

3. Patients transferred from another SDVAMC service must have a transfer acceptance note written by the assigned or on-call junior resident. They also require a complete admission evaluation as in #1 above.

4. The following laboratory tests should be ordered: Chemistries, TFT, CBC, urinalysis and urine Toxicology. All patients over 40 years of age or where there is a clinical indication should have an EKG. A chest x-ray should be ordered at least yearly or if there is a clinical indication including suspicion of TB exposure (e.g., a homeless individual). Other procedures such as EEG or MRI, skin testing for TB and mycoses, HIV tests, RPR, psychological testing and CT scan should be ordered when there is a specific question to be answered.

5. Special care must be taken with all patients when handling blood products and body fluids. All fluids should be treated as if infected with the HIV virus. Infection control precautions include strict regard for using gloves and avoiding body fluids. Although the VA is a federal medical facility, we do follow California law, which currently states that patients may not be tested for AIDS without their consent. Also, patients must be given pre-test and post-test counseling by a physician or a trained staff member when undergoing HIV testing. Physicians may not disclose test results to outpatient facilities without written consent. As in all confidential matters, we must be extremely careful about where and with whom we discuss these matters.

**Administration Of Electroconvulsive Therapy (ECT)**

1. The administration of ECT will be the responsibility of that patient’s treatment team. ECT is normally given in the morning on Mondays, Wednesdays, and Fridays.

2. A member of the attending staff provides supervision of ECT.

3. The medical student(s) assigned to the resident administering ECT on a given day should also attend and participate.

4. The treating physicians make decisions regarding frequency and number of ECTs.

5. Prior to initiating ECT, consultation with two attending physicians must be documented in the chart.

6. A complete procedure note for each ECT treatment must be documented. Include attending name, medication, ECT information, and complications.

7. The patient must be given the consent form and information no less than 24 hours prior to the first ECT.

8. A complete packet of information regarding ECT is available on 2 South.

**Physician-Orders**
Physician Orders are done via CPRS. Policy regarding computer charting and order will be distributed and training will be provided. Ongoing CPRS training is readily available. Help is immediately available at ext. 4767.

Progress Notes—entered on CPRS

Progress notes should refer directly to the patient’s treatment plan and should detail the rationale for any changes. Medical student progress notes may not be substituted for resident notes and a physician must countersign them, adding a note of agreement.

1. Routine progress notes must be written each regular workday. A staffing note should be written for each admission, reflecting discussions or plans made in the context of clinical rounds.

2. Patients must be seen within one hour after initial seclusion and restraint order. Patients who are in seclusion must be seen at least every four hours—Saturdays, Sundays and holidays included. The on-call resident during those days will write a progress note documenting the visit. Orders may indicate seclusion and restraint not to exceed four hours.

3. A note should be written documenting any unusual occurrences or special meetings (e.g., family meeting, initiation of seclusion, “code greens”). In addition, a note should be written if the patient is presented at Grand Rounds or to a consultant.

4. Attending supervision should be documented and referred to in progress notes (i.e., “patient interviewed by attending” or “issue discussed with attending”).

Seclusion And Restraint

1. Seclusion with or without the use of restraints requires a physician’s order. Each incident of seclusion and/or restraint requires a physician to provide a face-to-face assessment of the patient within 1 hour after being placed in seclusion or restraints. Seclusion with or without the use of restraints requires a physician’s order. The only exception is emergency seclusion by nursing personnel, which must be reviewed by the responsible physician. Orders for seclusion and/or restraints may be written for only up to 4 hours at a time and must state the specific behavioral reason (e.g., danger to others).

Transfers

1. Transfers of patients between 2 South units require physician’s orders. Transfer to a less restrictive unit requires documentation in the Progress Notes or physician’s orders of agreement by an attending, faculty back-up or senior resident physician. Consultation with the nursing staff is also essential before ordering a transfer. Patients on the PICU are to be assessed daily for readiness for transfer. Transfers should be ordered and accomplished as early in the day as possible.

2. Patients are not normally transferred off the PICU during nights, weekends, or holidays, unless readiness is previously indicated by the treatment team. Attending approval must be documented for transfer to less acute setting. Patients who may become ready for transfer off the PICU during these times should be identified on the census board in the PICU and an appropriate note made in their Progress Notes. This will assist in locating possible beds on the PICU during off-hours.

Discharge Process
1. The junior resident must enter the discharge summary before a patient leaves the hospital. Delinquent charts will result in suspension of clinical privileges and mandating annual leave until delinquencies are corrected. Medical students are not authorized to sign discharge summaries in the computer.

2. A transfer note written by the junior resident must accompany any patient transferred to a non-psychiatric SDVAMC service. In addition, if the patient has been hospitalized for one week or longer on 2 South, a transfer summary must be entered in the progress notes.

3. Planning for discharge begins on admission and continues throughout the hospital stay. Tentative discharge dates are placed on each patient’s treatment plan.

4. All discharges must have approval from the attending physician.

5. Staff, patients and the patient’s family is well informed of each impending discharge.

6. Patients should not be discharged without having been seen and interviewed by an attending physician or senior resident. Staff’s attending notes are required by the VA on all patients.

7. All discharge paperwork (including summary) on patients admitted and discharged before being seen by the assigned junior resident (e.g. on weekends and/or holidays) is the responsibility of the resident who discharges the patient.

8. The discharge order sheet and hospital summary must be completed before the patient can be discharged. Discharge orders and medication scripts should be completed the day prior to discharge if possible. Appointments for outpatient follow-up should also be made prior to the day of discharge and discussed with the patient. Discharges should be completed before 11:00 am.

Conferences/Treatment Team Rounds

1. Certain patient-oriented conferences are considered essential for the junior resident’s educational and patient care goals. Punctual, regular attendance is required in order to make optimal use of the faculty and senior resident time available for these educational activities. Only clinical emergencies, administration of ECT, and court appearances may take precedence over attendance at these conferences.

2. Sign-in rounds are held each regular workday morning from 8:00 a.m. to 8:30 a.m. At this conference the resident who was on call for the previous shift reports on patients seen in the ER, in emergency consultation, and in emergency situations on the psychiatric services. All admission to the unit during off-hours must have the signature of the sign-in attending on the history and physical form.

3. Sign-out rounds are held each regular workday afternoon at 5:00 p.m. The resident coming on call for the night receives information regarding potential and/or actual patient problems from the other 2 South residents. Particular attention is paid to patients in the PICU and seclusion.

4. At staffing conferences, newly admitted patients are presented to the team attending and/or senior resident for formal diagnostic formulation and treatment planning. Medical students are encouraged to take responsibility for case presentations. Patients will be staffed as soon as possible and must be presented to an attending by the next working day.
5. Team meetings are held regularly to discuss the clinical courses of the patients and the progress of their treatment plans. Treatment plans are discussed among the multidisciplinary team members—each patient’s plan must be updated regularly (see form for timetable).

Consultations

1. The SDVAMC offers a complete range of medical/surgical specialty services, which are available for consultation. A liberal approach to consultation requests should be followed, since their educational aspects (for consultee and consultant) are as important as assuring patients the best clinical care. A direct call to the consultant by the junior resident may yield quicker attention to the request as well as minimizing misunderstandings regarding the nature of the request. Consults require a computer order.

2. Most special psychiatric services available to the patients require consultation requests (e.g., psychological testing, occupational therapy, recreational therapy, most special patient groups). These can be obtained by writing an order for the service and detailing the purpose of the request.

Pgy 2 Outpatient Experience

In order to provide exposure to the breadth of psychiatric and medical problems facing outpatients in psychiatry, all residents are required to participate in one of two outpatient longitudinal experiences. The Mental Health Primary Care clinic and the 2 West Special Evaluation and Treatment Unit (STEP) are clinics in which the residents will spend one afternoon per week.

Leave

1. The Chief Resident(s) and Residency Training Office coordinates junior resident vacation schedules. Departmental Guidelines regarding vacation time and scheduling are contained elsewhere in this manual and should be referred to for signatures. The Medical Director coordinates senior resident and attending vacations.

2. Junior residents taking vacation or special leave (meetings, emergencies, and illness) must arrange for coverage of their patients. Ordinarily, the senior resident and the remaining junior resident on that team will share the duties of coverage. Normally, only one junior resident may be on leave at a time, for no more than two weeks at a time. Normally, annual leave should be taken in at least one-week blocks.

3. Senior residents must arrange for vacation and/or special leave coverage with the team attending.

Research

Various research projects will be occurring at the SDVAMC throughout the year. Occasionally, designated research patients may be admitted to 2 South. Where feasible, residents are encouraged to participate in those projects in which they have an interest.

Legal Proceedings/Court Appearances

1. Legal proceedings related to involuntary detention of patients are important aspects of current psychiatric practice. Residents are expected to participate actively in legal proceedings affecting their patients.
2. Hearings are required for all patients being detained involuntarily beyond 72 hours in order to determine if probable cause exists to justify the prolonged detention and emergency treatment. These hearings are presided over by a court appointed hearing officer and are held at the Medical Center within four days of filing the 14-day certification. While not formal court proceedings, these hearings have the same influence over our ability to involuntarily treat patients. Consequently, residents must be prepared to discuss the cases with and present their evidence to the hearing officer.

3. Appearances in court are required for a variety of proceedings, most often for conservatorship hearings and trials. In order to maximize the learning experience and minimize confusion with court appearance, residents must call the Counselor in the Mental Health Office (565-3500) to discuss the case prior to the court date. A senior resident will accompany the junior resident to court for the first 2-3 court experiences and in any further hearings as requested by the junior resident. It is the responsibility of the junior resident to notify the senior resident of the upcoming hearing.

4. Patients accused of committing a crime will be subject to legal action. Alleged crimes must be reported immediately to the VA Police. They are responsible for contacting officers of the appropriate law enforcement agency. Patients charged with offenses requiring incarceration will be released to the VA Police for disposition to the appropriate law enforcement officers as soon as possible.

COMPUTER ISSUES

Each resident, during his or her orientation week, will be instructed on how to use the computer system. The CPRS (Computerized Patient Record System) is the integrated hospital information system. The IRMS (Information Resource Management Service) is the service that implements and maintains the CPRS system. Both services publish booklets that serve to orient the new resident and can be used as reference guides. In particular, the IRMS employee orientation booklet lists emergency numbers, service numbers, VAMC paging and UCSD paging systems, telecommunications, and data systems. Ongoing computer education and problem solving is available.

CONSULTATION-LIAISON

ADTP WARD

(Alcohol, Drug Treatment Program)

Supervision

Dr. Steve Groban
Dr. Shannon Robinson

Team A & B: Tuesdays 10:00, Fridays 10:00

In discharge summaries – at end of summary include Steve Groban or Marc Schuckit, depending on whom the case was presented on Wednesday staffing.
Meetings

Team Rounds – Monday to Friday 8:00 a.m. – 9:00 a.m.

ADTP Staffing – Wednesday 1:30 – 2:30 p.m., 2 North, Room 2455

Group Therapy – Monday, Tuesday, Thursday 11:00 a.m. – 12:00 p.m.; Friday 10:40 – 11:40 a.m.

Staff Meeting – Wednesday 1:00 – 1:30 p.m., 2 North, Room 2455

In-service – Wed. 2:30 – 3:30 p.m., 2 North, Room 2455 every other week

Work-ups

H&P (on Progress Paper)

1. The PGY-2 resident should complete the primary admission work-up on a Standard admission form. The write-up needs to be completed on the day of admission.

2. Medical student write-ups may also be added to the chart and should be on progress note paper.

3. When a PGY-2 resident is on vacation, the primary admission work-up may be done by the senior resident, the PGY-2 resident on the other team, or by the medical student if co-signed by the senior resident.

4. The Alcohol Research Center has interview to be conducted on the day of admission also. Let them know when you will be through with the patient.

Problem List

Include current diagnosis (medical and psychiatric) and any allergies patient may have (or NKDA). This must be documented on all patients.

Progress Note
1. You are responsible for 2/wk (Mon./Thurs.) on all patients. The first Progress note after a patient’s admission needs to reflect a careful review of all laboratory data, with any abnormal values documented, along with any planned follow-up.

2. Each primary contact must have one detailed note per week.

**Treatment Plan & Diagnostic Summary**

The treatment team formulates an individualized treatment plan on each patient. All documentation concerning the treatment plan, and the completion of a Diagnostic Summary are the responsibility of the staff member who serves as primary contact for that patient. Residents and medical students are not responsible for completing the Diagnostic Summary or the Treatment Plan. Complete guidelines for formulation of Treatment Plan and Diagnostic Summary are available in a black loose-leaf binder on the patient chart cart. These should be reviewed carefully.

**Medical Problems**

Note: The physician must verify that all patients are free of any signs of TB or other serious infectious process by virtue of a CXR obtained within 3 months prior to admission. No patient (ASMRO included) will be admitted without a CXR being reviewed by the radiologist.

- You are the primary Doctor for your contacts.
- You will also follow up all medical problems on the team.
- Nurses and other staff will discuss all problems in team, or contact you directly.
- Orders. *All orders must be dated, timed, and signed with 4-digit ID number.

**New Admissions**

- Routine orders – see enclosure
- Admission orders need to be written by 3:00 p.m. the day of admission.

**Consults, Special Tests.** All appropriate forms need to be filled out.
Routine ongoing orders will be written during Team Rounds.

1. **Self Meds** — In addition to being included in the standard admission orders, all routine meds are also recorded on a separate order sheet as “Self Meds to Begin _______” (Date of the Monday following admission). Each such medicine is written for seven days. At the end of the list of self meds, “Refill X 3” should be added, so that patients will receive a continuous supply for their 4-week stay.

2. **Discharge Meds** — Write for 30-day supply with No Refills.
   e. Laboratory Data

Review and initial all results. Please circle all abnormal values. Be sure your notes reflect knowledge and plans of any problems. Please review all results with the patients to educate them as to the damage they have done secondary to their alcohol and/or drug dependence.

**New Problems**

Add to problem list.

**Optional films about Alcoholism**

A. Each approximately 20—30 minutes in length.
B. Arrange to see by contacting Bob Janke, R.N., 2 North, Ext. 3665
C. Titles:
   1. Physical Aspects of Alcoholism, Parts I and II
   2. Group Therapy
   3. Self-Image
   4. AA and Alcoholism
   5. Thinking About Drinking
   6. Establishing Goals
7. Utilizing the Treatment Plan
8. Alcoholic Families
9. Antabuse
10. Alcoholism and the Family, Dr. Martin
11. Drugs of Abuse

Contacts (Primary patients assigned)
A. Residents should have 4 primary contacts. Please establish these
B. Contacts early in the notation.
C. Minimum contact time is three 30-minute sessions or two 45-minute
D. Sessions per week. Sessions should be at regular designated times (i.e. Mr. "S" Monday, 9-9:45 and
   Thursday, 1-1:45).
E. Please SOAP outline your program notes.

Discharge
A. Discharge summaries should be dictated at least 5 working days before the discharge date. This
   expedites recovery home placement.
B. At the end of each discharge summary, after your own name and title, dictate "Fred Berger, M.D.,
   Attending Physician."
C. Complete parts 7012 of the "Referral for Continuity of Patient Care" form at least 5 working days
   before discharge.

Routine Orders
Admit to 3 WA or B.
Diagnosis: Alcohol Dependence, continuous
Condition
Allergies
Vital Signs

Diet

LOR: Off with others for 24 Hours. Then off alone. Day passes at team discretion

LABS: Chem 20, GGT, Folic Acid, B12, Mg, CBC with diff, U/A & RPR (EKG and Thyroid studies as needed). To be drawn in a.m. Write this in ALL admissions including transfers. (If these were obtained prior to admission – do not repeat them unless clinically indicated).

MEDS: Thiamin 100 mg po qam

Folate 1 mg po qam

Stress Tabs 1 po qam

Tylenol 650 mg po q4h for pain prn

MOM 30 cc po qo for constipation prn

Mylanta II 15 cc po q4h prn indigestion

Note

A. Transfers

All routine orders needed to be rewritten. Lab work done this admission need not be reordered.

B. Scripts for self med: write on a separate order sheet: Self-Meds

To start (Date of next Monday)

- Drug name, dose per cap/tab etc.

- Sig: (how to be given – e.g., tid, qhs, etc.)

- For how many days. For any med the patient will take for the entire stay (e.g., thiamin, stress tabs), the med is written for 7 days. “Refill x 3” can be added at the end to cover all of the self meds, so that a patient gets 4 weeks total.

Role Responsibility – Primary Contact

The basic responsibility of a Primary Contact is to establish a therapeutic alliance with the patient and be a liaison between the team and the patient. All patients will have Primary Contacts who will be members of the multidisciplinary treatment team.
The therapeutic program created by the team is carried out by the Primary Contact. Responsibility for the completion of the Treatment Plan and the Diagnostic Summary rests with the Primary Contact.

The Primary Contact is responsible for coordinating the patient’s care with other disciplines and seeing that the individual is followed by other care providers or health facilities after discharge, when appropriate. The Primary Contact is responsible for evaluating the patient’s care and is accountable for that care provided to the patient and his significant others. The Primary Contact is responsible for providing support during the transitional phase of returning to the community.

Responsibility of the Primary Contact Person:

A. Informs the patient he is the Primary Contact and explains to him what this means in terms of their relationship.

B. Conducts an interview of the patient as soon after admission as possible.

C. Initiates a plan of care with the patient and the team. This should be started on admission and will be revised and kept current throughout hospitalization. The patient will be as actively involved as possible in defining specific problems and approaches.

D. Weekly progress notes summarizing patient’s treatment and his participating in program are to be written by the Primary Contact.

E. Assesses and plans for 24 hour total care, actively incorporating the involvement of other team members.

F. Communicates with the family and/or concerned others throughout the hospitalization for purposes of information gathering, emotional support, health teaching, and discharge planning.

G. Records progress notes for any pertinent behavior changes or observations. Clearly indicates the ongoing plan in the progress notes.

H. Regularly attends Health Team Rounds. Reviews the care plan with the team to keep them informed regarding his interactions and planning with the patient, to incorporate their perceptions and feedback and to keep others relevant and current.

I. Communicates with others who care for the patient such as physical therapist, dietician, social worker, etc.

J. Initiates appropriate referrals and actively involves the patient in the discharge planning. Provides necessary support during the patient’s return to the community.

K. Write summaries on the progress notes at time of transfer and/or discharge.
Team Responsibility

A. The team has the responsibility to be aware of the contact-patient relationship and to support that relationship.

B. The team will provide assistance, as indicated, in identifying the patient’s problems, establishing goals.

C. At times the entire team may share the role of Contact Person.

Mental Health Intensive Care Management (MHICM)

MHICM is a program developed in 2003 to address the seriously mentally ill veterans. This intensive multidisciplinary team approach to ambulatory management and treatment of patients in, and coordinated with the community and its services, is clearly distinguished from usual case management by: engagement in community settings of highly dysfunctional patients traditionally managed in hospitals; an unusually high staff to patient ratio; multiple visits per week if needed; interventions primarily in the community rather than in office settings; and fixed team responsibilities, around the clock, for total patient care over a prolonged period.

PSYCHIATRY PRIMARY CARE CLINIC (PPCC)

Description

Access to primary care has been shown to be a key to good health care. Many patients with mental illness have difficulty accessing traditional primary care providers i.e. internists, family physicians, etc. Those who are able to access primary care clinics often receive ineffective care due to their physical health problems. Thus, provision of primary care to mental health patients by their psychiatrists may be the most effective way to provide a majority of health care services.

In the residents’ psychiatry primary care clinic, residents will be providing primary care and mental health services to patients with (in most cases) mild to moderate physical health problems and a range of severity of mental illness. Primary care services include providing for a majority of patients’ common health problems, such as hypertension, diabetes, hyperlipidemia, asthma/ COPD, etc. as well as referral to, and coordination of care, among other specialists when necessary. All primary care activities will be done with supervision and precepting by and attending, on-site internists with corresponding arrangements for mental health activities. A dedicated primary care in mental health lecture series, textbooks, journals, CD-ROM series, diagnostic and treatment algorithms, and videotape series will be provided to support the ongoing primary care activities.
All PG-2 residents participate in the PPC clinic and have the opportunity to maintain their clinic during PG-3 & PG-4 years if they choose.

The goal of this program is not to develop “free standing” primary care providers, but to enhance residents’ skills in these areas so they can interact more effectively with PCP’s as part of a patient’s “treatment team”. And, in those cases where a patient is unable/unwilling to access a PCP, the residents will be able to provide reasonable quality, basic primary care services while accessing information from consultants, etc.

This clinic will provide psychiatry residents with the opportunity to maintain and enhance the medical skills acquired during medical school and internship and will provide the training to make participating residents unique among the nation’s psychiatrist. In the process, mentally ill patients will receive the services they badly need.

INTRODUCTION

The Psychiatric Emergency Clinic (PEC) is one division of the US Department of Veterans Affairs Medical Center, San Diego, Outpatient Psychiatry Service. The functions of the Psychiatric Emergency Clinic are described below in detail. The Outpatient Psychiatry Service provides 14 subspecialty programs (described below). The three largest programs are geographically located on 2North with the PEC and are the Mood Disorders Clinic, the Cognitive Disorders Clinic and the Alcohol and Drug Treatment Program. The PEC is a service that averages 300 visits per month.

PSYCHIATRIC EMERGENCY CLINIC SCOPE OF SERVICES

A. Team - The Psychiatric Emergency Clinic (PEC) team consists of a faculty psychiatrist, the PEC Coordinator (a clinical nurse specialist or a licensed clinical social worker), and a second-year (PGY 11) resident who rotates on a monthly basis. The second-year resident is full-time to the program. Clinical supervision to the second-year resident is provided by the faculty psychiatrist and assigned clinical faculty supervisors for PEC. Clinical nurse specialists and staff nurses provide 40 hours per week coverage during usual day hours, and function as the PEC Clinical Coordinator. Clinical back-up is provided by part-time staff psychiatrists during most clinic hours.

B. Educational functions - Each morning except Thursdays, Sign In & PEC rounds begin at 8:00 am in Room 2366 C. Cases are presented from evaluations done the prior day to the Chief of PEC. Transfers, administrative problems, and community liaison issues are reviewed, as indicated. Faculty clinical supervisors assigned to work with the resident provide direction, discussion, and didactic material centered on the physician-patient interaction. Supervisors may see PEC patients with the resident and provide “live” supervision. In addition, the Chief is available at any time for informal supervision. Fourth-year medical students, Medicine residents, and Neurology residents rotate through the PEC on an elective basis.
C. Service functions – The Psychiatric Emergency Clinic provides emergency evaluation, assessment, triage, referral, and treatment of outpatients. Consultation for inpatients is handled by the consult service and those calls can be referred to Main Psychiatry at x3576. The Psychiatric Emergency Clinic also assists in transferring patients from other hospitals to the VA psychiatric wards, and handles telephone calls from the community.

Emergency evaluation is the primary responsibility of the PEC staff. The patient will check in at the clerk’s window, indicating he/she has no appointment. Patient’s will be screened by the PEC Coordinator and assigned an acuity level: emergent, urgent, today/routine or next available appointment. A report will be written on each patient seen in PEC. This report normally includes basic identifying data, chief complaint, history of present illness, past medical and psychiatric history, family history, medications, mental status exam, differential diagnosis and assessment, and finally disposition.

PHYSICIAN ASSIGNMENT TO PEC

A. Tour of Duty – Each second-year resident will rotate to the PEC for a period of one month. During this time, the designated tour of duty is from 8:00 a.m. to 5:00 p.m., Monday through Friday. The on-call schedule is in effect from 5:00 p.m. through 8:00 a.m., Monday through Friday, and from 8:00 a.m. through 8:00 a.m. the next day on weekends and holidays. The PEC resident is expected to complete the disposition of the patients who checked in before 4:00 P.M. Patients presenting to the Triage Nurse in the Admissions Area at 4:00 p.m. or later will be instructed to go to the Emergency Room and will be evaluated by the resident who is on call for psychiatry.

B. Medical Coverage – The PEC residents are expected to remain inside the hospital at all times during their tour of duty. In general, she/he should remain in the PEC area, particularly if there are patients awaiting evaluation. Whenever it is necessary to leave the PEC area, please inform the PEC clinical coordinator and the clinic clerk that you are leaving.

If the PEC resident must leave the hospital, he/she first must notify the faculty supervisor and the PEC Coordinator. Annual leave during the PEC rotation must be cleared through the Director of PEC and is strongly discouraged. The PEC resident must designate a physician substitute and ensure that this person is physically present and carrying the PEC beeper.

The PEC Director and the staff psychiatrists are available as needed for consultation with the second-year resident on issues of assessment, management and disposition. When none of these are available, the Chief Resident for Psychiatry at the VA should be paged for supervision.

C. Physician Back-Up Coverage – If additional coverage is required, the Director of PEC should be notified.
PATIENT ASSESSMENT, PLANNING AND PROVIDING CARE

A. Eligibility: Any veteran presenting to PEC, irrespective of eligibility status, is entitled to a one-time emergency evaluation. However, the veteran should first be processed through the first floor eligibility division because further ongoing treatment is determined by their eligibility status. Clinical staff are not responsible for determining eligibility. Member Services is. All honorably discharged veterans are eligible for treatment in Outpatient Psychiatry Service subspecialty programs, including the Mood and Cognitive Disorders Clinics. Eligibility requirements include not exceeding a maximal income limit for non-service-connected (NSC) veterans. Normally, Member Services staff makes the eligibility determinations before the patient is evaluated. If there is any concern about eligibility requirements, consult with the PEC Clinical Coordinator. Veterans who are service-connected for psychiatric reasons are our highest priority. The clinic staff determines the level/intensity of care. Category C patients may be billed a co-payment fee and should have signed that agreement during their eligibility review.

B. How Patients Reach PEC - The most common ways of reaching PEC are by telephoning or walking in. At times, consultation requests originate from the Emergency Room, Alcohol Treatment Program, one of the outpatient psychiatry subspecialty programs, or from the Primary Care clinics.

1. Telephone Calls: tend to originate from one of the following sources: veterans, family or friends of veterans; community agencies, especially Board and Care operators and conservators; other VA agencies such as the Mission Valley Outpatient Center or the Vietnam Veteran Outreach Center, or from other hospitals or community clinics. The clerk is able to inform the caller of the clinic hours and of the procedure to follow when walking in, but must refer other matters to the clinical coordinator. A central Southern California VA telephone advice system may also refer a patient to PEC.

2. Walk-in Patients: The clerk checks in the patients after looking in the computer to determine that eligibility has been handled and records the patients name and time of check in on the PEC log. The clerk is not expected to obtain clinical/personal data from the patient. However, the clerk is expected to report unusual observations about the patient or data the clerk received from another source, to the PEC coordinator. The PEC coordinator, as noted above, will screen and triage the patient for acuity level and initial disposition, i.e. psychiatrist, pharmacist.

3. Consultation Requests: Between 8:00 a.m. and 4:00 p.m. all requests, including emergencies from the inpatient services, are referred to the Consultation-Liaison Service (ext. 3576). The Psychiatry OD handles all emergencies after 4:00 p.m. and signs them out to the consultation service the next morning. Requests from outpatient areas are triaged, and emergencies seen by PEC, others referred to appropriate clinic.
4. Transfers from other hospitals are processed by the second-year PEC resident and the PEC clinical coordinator as well as the 181 2 South nurse. This is described in greater detail in a following section.

C. Patient Assessment

The clinical coordinator, medical students, social work and psychology interns, subinterns, Medicine and Neurology residents, outpatient clinic staff, staff psychiatrists, and the PEC residents conduct evaluations. It is important to ensure that a complete evaluation was conducted and that appropriate diagnoses and treatment plans are made.

A complete evaluation includes chief complaint, history of the presenting problem, past psychiatric and medical history, family history, substance use/abuse history, current medications, and a mental status exam. At times much of the past history has been previously documented elsewhere in the chart and simply has to be cross-referenced. At times stable patients being followed in medication clinics simply need refills and new appointments. Some patients can present with so much psychopathology that admission to a secured and intensive treatment environment is indicated despite a very limited evaluation. Very often it is appropriate to check with family members or friends in order to obtain a complete assessment. A Comprehensive Suicide Risk Assessment (CSRA) is completed for all patients or is referenced if there is no change to the most recent CSRA. A suicide behavior report and a suicide safety plan is also completed when necessary.

D. Dispositions from PEC—The more common dispositions are admission, crisis intervention, crisis house placement, outpatient intakes, or referral to other sources of psychiatric care such as the Alcohol and Drug Treatment Program and the Vet Centers. Patients are often referred to various community agencies for welfare, food, emergency lodging, or job placement services. Patients with medical or neurological problems are referred back to the Emergency Room. More detailed discussions follow. Medication Clinic patients needing refills are handled as follows.

E. Medication Refills—Refills of medication that have lapsed for whatever reason are to be strongly discouraged as this is frequently non-therapeutic for a patient who is being followed on a regular basis (using PEC for missed appointments). Unless otherwise medically indicated, do not substitute drugs or otherwise alter a patient’s pharmacotherapy. Our policy is to leave only the exact number of tablets until the patient’s next scheduled medication appointment. Continued manipulation of the PEC area should be brought to the attention of the clinical coordinator or the patient’s therapist in the outpatient Clinic, so that appropriate intervention can take place. Either the PEC Coordinator or the clinic clerk will assist in scheduling patients for medication follow up.
A. General Guidelines

All Category A veterans, service connected or not, are potentially eligible for admission. Any patient who presents evidence that they are dangerous to themselves or others in the immediate future as a result of a mental disorder can be admitted to the hospital involuntarily. Similarly, they can be admitted involuntarily if they are gravely disabled as defined by state law.

Those patients who demonstrate psychotic decompensation of either an acute or chronic nature, who qualify for the diagnosis (DSM-IV criteria) of either Brief Reactive Psychosis, Psychotic Disorder NOS, Schizophreniform Disorder, Schizophrenia, Mood Disorders, or Selected Organic Mental Disorders (see E,2) are eligible for admission to the psychiatry service.

Frequently, patients require admission despite the fact that they cannot be diagnosed as having one of the above conditions. This occurs when there are realistic threats to the life of the patients or others. Such patients often have diagnoses of drug or alcohol intoxication or abuse or one of the associated disorders. Equally often, these patients have personality disorders, particularly borderline or anti-social, as defined in DSM-IV. On Axis I, the appropriate diagnosis is often one of the Adjustment Disorders.

The following examples are likely candidates for admission:

1. An alcohol or drug dependent patient in withdrawal who has no system of supports and who is functioning at a regressed level.
2. An intoxicated patient who is suicidal, homicidal, or very aggressive. This hospital does not have a holding area and patients should not be kept waiting in the ER for several hours.
3. A suicidal patient who has previously made serious suicide attempts or been assaultive.
4. A homicidal patient who has intentions to hurt someone else. (see appendix for mandatory reporting).

These guidelines are general, and decisions for admission must be made on an individual basis. Part of the process of deciding to admit a patient includes making an assessment of the level of care that this patient requires. In this hospital, the following Levels of Care are available and must be specified on admission orders:

B. Involuntary Admissions and Holds and Patient Rights

1. This hospital is a designated evaluation and treatment facility for San Diego County and the State of California. Any patient who is suspected to be dangerous to himself, dangerous to others, or gravely disabled may be brought to the Veterans Hospital by the police to be evaluated by the psychiatrist.
on duty for involuntary hospitalization. These patients are admitted to the B-pod, or are transferred to other locked facilities when the VA has no beds available (or no seclusion rooms should that be the necessary level of care). The procedures for transferring patients are described elsewhere.

2. The second-year PEC resident may see patients who need to be placed on an involuntary hold according to the LPS act. This may be done either in PEC or on 2 South. If the second-year PEC resident initiates the hold, then she/he is responsible for informing the patient of his rights, and for filling out the advisement form.

3. Frequently, the psychiatry resident on duty is asked by family members to send ambulances or provide similar intervention to bring involuntary patients to the hospital for evaluation. This is, of course, both illegal and unethical, and those calls should be referred to the local law enforcement agency that can make those “home visits.” The San Diego Counselors in Mental Health, 565-3500, can sometimes be of more help than the police. Police calls go through our VAMC police at ext. 3647.

4. The psychiatry resident on duty is authorized under law to accept patients “on hold” from other evaluation facilities, for ongoing treatment in this hospital. This transfer should be consistent with the wishes of the patient to be transferred to this facility, cleared by MAS and the 2-South charge nurse.

5. On the occasion that our beds are full to maximum capacity, we are authorized to transfer involuntary as well as voluntary patients to other VA hospitals, once the staff psychiatrist at that facility accepts the patient. The Transfer Coordinator and the PEC Coordinator will coordinate the transfer.

6. Involuntary patients may not be transferred to private psychiatric hospitals under a 72-hour hold, unless the accepting psychiatrist is there to meet the patient and re-sign a hold.

C. Voluntary Admissions

The residents and staff psychiatrists have admitting privileges to 2 South, but not to the Alcohol and Drug Treatment Program. When a patient is admitted to 2 South, decisions must be made regarding the level of care required. Admission orders must specify the Pod to which the patient is to be admitted. See 2-South policy.

D. Admission Policies for Patients with Dementia and other Chronic Organic Brain Syndromes

Psychiatry, Neurology, and Medicine all share responsibility for this group of patients. The following guidelines have been agreed upon by the three services for the admission of these patients:
1. Neurology accepts those patients who need hospitalization and who have not undergone diagnostic evaluation to determine the etiology of the illness.

2. Psychiatry accepts those patients who present because of serious dangerousness to self or others provided that a diagnostic work-up has been previously done and that the behavioral disturbance is not due to delirium. For example, behavioral disturbance secondary to diabetes or medications, or other reversible conditions in which underlying organic factors cause the mental dysfunction would not fit the psychiatric criteria.

3. Patients with chronic OBS whose disposition fails within six months of their discharge are to be readmitted to the last service that discharged them. Patients with OBS who also have medical problems requiring specialized care are to be admitted to medicine.

4. Patients with chronic OBS who are not in the above categories are to be admitted among the three services on a rotating basis. However, when a service has an 80% occupancy rate, that service will drop out of the rotation, still receiving credit for admissions. Nursing Service administers the rotation in the Admissions Area.

E. Admission for Detoxification, Overdoses or Delirium

Please see 2 South Policy Manual for most current policy

a. In accord with stated policy of the Ambulatory Care Committee, we do not admit intoxicated patients for alcohol detoxification only. Referral of such patients to a detoxification center is most appropriate. Again, however, medical emergency situations will be assessed and disposition dependent on patient safety/medical care need. The following guidelines are proposed as standard procedure between the psychiatric emergency clinic and the medical admissions area for rational triage of alcoholic patients who need admission.

The patient who shows:

   a. Altered mental statuses without change in vital signs admit to psychiatry.
   b. Altered mental status with elevated temperature >101.5°F, increased pulse, diaphoresis, admit to medicine.
   c. Alcohol paranoid state, admit to psychiatry.
   d. Alcohol hallucinosis, admit to psychiatry.

   c. Overdoses

   • All overdoses must be evaluated and found to have a clear sensorium before admission to psychiatry. Direct observation unit admission if there are any concerns regarding the timing or nature of overdose.
An overdose patient with a potential for delayed sequelae, i.e., tetracycline, tricyclics, thioridazine, glutethimide, should be admitted to medicine.

An overdose patient with a clear medical status (sensorium) and stable vital signs can be evaluated for admission to psychiatry.

If a patient’s major symptomatology is behavioral and perceptual, i.e., illusions, hallucinations, and agitation with stable vital signs and no acute medical problem, he/she should be admitted to psychiatry. If the drug ingested is known and no latent sequelae of its ingestion are suspected.

If a patient presents mainly with an altered sensorium with fluctuating levels of consciousness, this case should be considered a medical/neurological problem until proven otherwise.

Patients requiring intravenous therapy, oxygen, or foley catheters, cannot be admitted to psychiatry by hospital policy.

Delineation of Admitting Privileges

If a patient requires transfer, the nurses in PEC will arrange adequate supervision.

See 2 South Policy Manual

Admission Procedure

Once it has been determined that a patient will be admitted, the second-year PEC Resident should notify the PEC Coordinator, and the admission nurse on 2 South, who heads the team receiving the admission. Contacts should be given adequate information so that they can prepare for the admission. Delayed admission orders should be written. Whenever possible, cooperative patients should have a CXR done prior to admission if indicated or if none has been done for 1 year.

TRANSFER POLICIES AND GUIDELINES

A. Transferring Patients from PEC to other Hospitals—Whenever our service cannot provide the needed level of care (please see IV Above), the patient may be transferred to another VAMC or a community facility. Available VISN 22 VA beds must be sought first. Community hospitalization at VA expense is only a last resort. This decision is made at the attending level in concurrence with the Chief of Psychiatry, and facilitated by MAS. A history, PE and labs should be ascertained prior to transfer.
For patients awaiting transfer to another hospital the following guidelines apply. CPRS and notify the ED physicians. The patient must be escorted to the Emergency Room by the staff nurse/PEC Coordinator. The patient is then placed in the assigned room that is free of any objects that may cause harm to the patient. The patient must be searched, usually by the VA police, and any incendiaries or sharp items removed prior to the time when the patient is left unattended. The door will be kept closed and visual checks will be carried out every 15 minutes by the Triage Nurse. If the Admission/Nursing Triage staff is unable to carry out these orders for any reason, the Nursing Supervisor or Nurse on duty should be paged, either by the psychiatrist or the nurses. The supervisor then makes alternate arrangements for coverage. The psychiatry resident on duty must make a determination and document in the patient record whether the patient is an elopement risk or danger to self or others. If the patient is suicidal, considered an elopement risk or on a hold, the patient must be on 1:1 observation.

The VA police will be requested to assist in securing, guarding or intervening with assaultive and aggressive patients in the Triage Area until transfer is accomplished. The psychiatrist should notify security, if not already present.

**Decision Making/Problem Solving**

It is expected that the Psychiatric OD, the Triage nursing staff, the on-duty Nursing Supervisor and the VAMC Police will continue to work together on the assessment, plan and implementation of patient care during transfers.

**8. Transferring Patients from Other Hospitals to this VAMC**

Acceptance of a patient for transfer is accomplished through Member Services for eligibility review, then through the 2 South charge nurse for level of transfer priority and the role of the resident is to ensure medical stability of the patient and appropriateness for admission. When need for admission is in question the patient may be accepted for “evaluation” in PEC or UCC. Appropriate disposition can then be made. If transfer may result in admission the open 2 South bed should be held until final disposition is made.

Refer to the following Flow Charts for the steps in the Transfer in and Transfer out Process:

**TRANSFERRING VETERANS TO COMMUNITY HOSPITALS:**

The PEC resident makes the decision to admit.

If no beds are available on 2S, the PEC resident places a consult to the Transfer Coordinator for External Services, Inpatient transfer. The transfer coordinator then searches for available VA VISN 22 beds. Community hospitalization at VA expense is only a last resort and must have concurrence at the Deputy Chief of Staff level. The consult template includes the veteran’s name, PEC admitting dr., diagnosis, hold status, relevant MSE (e.g., cooperative, agitated).
transfer coordinator calls community hospitals and gets the intake person on the line and informs the PEC resident or the resident on call if they need to call the accepting facility’s psychiatrist to discuss the clinical data. The transfer coordinator calls the resident back with final decision of accepting hospital.

**ACCEPTING TRANSFERS FROM COMMUNITY HOSPITALS:**

The transfer Coordinator is contacted by the referring hospitals and every morning during the workweek discusses bed availability with the 3S Charge nurse. If a bed is available, the transfer coordinator contacts the hospital and requests for clinical information. The transfer coordinator then gets the approval of the accepting attending psychiatrist. Once the patient is accepted, the Transfer Coordinator arranges for the patient to transfer and informs the 3S Charge nurse. The patient is brought by ambulance directly to 3S where the resident who will be accepting the patient is then paged and admission orders and evaluations are done by the accepting resident.

**Continuum Of Care**

1. **Mental Health Outpatient Programs-Hospital Based** – PTSD, Mood Disorders and Cognitive Disorders Clinics operate on 2 North between 8:00 a.m. and 4:30 p.m. Monday through Friday. Some clinics are open until 8 p.m. on Wednesday evenings. Eligibility criteria for various services have been described previously in Section III A of the manual. (See the appendix for a description of the Ambulatory Care Programs offered in Psychiatry).

This Medical Center does not offer services for the following categories of request:

a. No forensic related evaluations (court ordered treatment is available under special circumstances)

b. Child molestation (refer to Child Protective Services) and/or sex offenders (refer to County Mental Health or private practitioners).

2. **Intake (Initial Patient Assessment) Appointments** for the STEP, PTSD, Mood Disorders or Cognitive Disorders Clinics are given to persons who are entitled to ongoing care in outpatient psychiatry, according to the eligibility criteria listed in Section III A. Patients with affective spectrum illness, including bipolar disorder, are appropriate for the Mood Disorders Clinic. Patients with psychotic spectrum disorders, including schizoaffective illness and drug-induced psychosis are appropriate for the Cognitive Disorders Clinic. Patients with PTSD are appropriate for the PTSD clinics. Elective consultation requests from outpatient clinics are also given Intake Appointments, and dispositions are made from that point according to eligibility and clinical needs.
3. Same Day Access clinic:

From intake, the following dispositions may occur singly or in combinations: admission, interim (crisis) clinic, medication clinic, group psychotherapy, individual psychotherapy, marital/family therapy, no further treatment, referral to community resources, or to the Alcohol and Drug Treatment Program.

- **Individual Psychotherapy** – the primary treatment modality offered in the outpatient 2N clinics is group psychotherapy. Occasionally, individual therapy may be available through interns and trainees, under clinical supervision. It is not always possible to provide this service to everyone who requests it. During the intake appointment, the appropriateness of this treatment modality is carefully assessed.

- **Group Psychotherapy** – This is one of the more common treatment modalities offered in the 2N outpatient clinics. Among the groups typically offered at any given time are the following: depressed patient groups, including cognitive-behavioral treatment, schizophrenic groups, borderline personality groups, medical problems group, assertiveness training group, stress reduction, anxiety management and relaxation group, and grief groups. Other therapy groups may be developed as evolving needs are defined.

- **VA Homeless Veteran’s Outreach Program** – The Homeless Veteran’s Outreach Program is available to individuals who have been honorably discharged from the armed forces and who have an emotional illness. The Program offers mental and physical health assessment and treatment, problem-solving assistance, and follow-up and short and long-term rehabilitation programs. Assistance is also available on an individual basis for job counseling and referral, application for veteran benefits, identification, referral to substance abuse programs, and other assistance programs, and other needs with which the Program may help. To refer a patient into the program, contact The Homeless Outreach nurse in La Jolla at x3044. See the Homeless Handout in the appendix. Copies of this handout can be given to patients to facilitate contacting the homeless team. The Homeless Outreach Program is not an immediate placement option. Consider a crisis house if appropriate or an emergency shelter.

- **Marital and Family Therapy** – these services are offered through the Family Mental Health Program, a component of the outpatient psychiatry programs. With an orientation based upon Social Learning Theory, the FMHP offers a diversified range of services focusing on the treatment of couples and families. Referrals are made directly to the Coordinator of the Program.
Medication Clinics - are conducted by staff psychiatrists and are usually thirty-minute follow up visits. When stable, patients are seen once every three months. Some patients are seen more frequently when clinically indicated and their conditions warrants intensive management. (See the MD Standards of Care with Treatment Algorithms in the appendix).

Pharmacy education: The clinical pharmacists are usually available daily to see patients seen in other medication clinics for education regarding their medications, possible side effects and possible drug interactions. In addition to providing this service to patients enrolled in outpatient medication clinics, the pharmacists carry their own caseload of stable patients.

Same Day Access Clinic: This is a walk-in clinic that operates from 8:00 am to 4 pm at the La Jolla medical center. The clinic offers complete mental health evaluations to veterans who have never received mental health services at any VA, including VA San Diego Healthcare System and veterans who have not received mental health services in VA SDHS in the past two years. When the intake is performed by a non-MD, the patient is sometimes referred to PEC for medication management.

Community Based Outpatient Clinics: There are four outpatient clinics and one contract clinic serving the veterans in the catchment areas of the San Diego VAHS:

- Mission Valley VA OPC MHC at 2022 Camino del Rio North, San Diego,
  - Telephone is (619) 220-4092.
- Chula Vista
- Oceanside
- Escondido
- El Centro

Out-Patient Psychiatric Treatment in the Community

Patients in need of on-going psychiatric care but ineligible for VA care should be referred to the community. See available low cost and no cost options in the Directions resource manual in the PEC coordinator office. County Mental Health Services are available for indigent patients throughout the county.

Outpatient County Mental Health Clinics (CMH)

1. Central San Diego 1250 Morana Blvd, San Diego, CA 92087-8750
2. East County 833 Broadway El Cajon, CA 441-6550
3. North Coastal 1701 Mission Avenue Oceanside, CA 967-4475
4. North County Inland 125 West Mission, # 1 03 Escondido, CA 741-4461
5. Southeast 3177 Ocean View Blvd. San Diego, CA 505-4400

INFO-LINE (Computer data bank of social welfare resources)
Telephone 631-4729 can provide additional information for psychosocial assistance.

D. Crisis House Referrals: Veterans sent from PEC to a crisis house are eligible to have the VA cover this expense. The Transfer Coordinator must have the information in advance of placement for this financial coverage. The patient must sign a release of information. The crisis house, address, telephone number and staff member accepting the patient must be in the progress note referring the patient. The PEC Coordinator or ED social worker will prepare the packet of documents for the Crisis House and will fax the packet to the crisis house after the resident has signed them. Patients can be given a maximum of a 14 day supply of medications. A list of available crisis houses is in the appendix.

EMERGENCY MANAGEMENT OF DANGEROUS OR DISRUPTIVE BEHAVIORS:

Please refer to the 2 South Policy Manual

Code Yellow Or Code Green

In the hospital, persons whose behavior strikes the staff as dangerous and/or disruptive may become the object of either a Code Green or a Code Yellow, the names given to emergency procedures designed to contain aggressive behaviors as quickly as possible. The emergency code system is designed to enable the staff to control the situation as safely as possible for all parties involved and any bystanders. Both emergency procedures are initiated by dialing and telling the operator that a Code Green or Yellow exists and at what location. Dialing ext. 3333 accesses both codes.

Code Yellow is a call requesting immediate VA police intervention to manage disruptive and/or dangerous behavior. Such calls may be made from any area of the Medical Center regarding anyone displaying such behavior. Behavior involving weapons or physical assault automatically becomes a “Code Yellow” situation.

When the VA Police are primarily managing a situation, the ranking officer present is in charge. In Code Green actions, the officer may assume leadership if he/she feels the situation is beyond the control capability of the Code Green Team which then converts the code to a Code Yellow. The VA Police may request backup assistance from the
Code Green Team or from other outside law enforcement agencies (UCSD Police, San Diego Police, California Highway Patrol). The VA Police handles all situations involving weapons or physical assault.

Code Green is a call requesting immediate Code Green Team intervention to manage disruptive and/or dangerous behavior displayed by psychiatric inpatients or by individuals whom a psychiatrist has determined will be admitted to a psychiatric inpatient service.

The Code Green Team consists of clinical staff who have been cleared by in-service education to participate in Code Green actions and who are carrying Code Green pagers at the time a Code Green is called. Code Green duties may also be delegated by the Code Green leader to other staff members attending a Code Green situation who have had proper in-service education. A minimum of five persons are designated on a 24 hour basis to be carrying Code Green pagers as follows:

1. Department of Psychiatry R.N. Code Green Leader
2. Psychiatric Resident
3. 2 Inpatient Staff Nurses or Nursing Assistants
4. VA Police Officer

Disability Determinations

Disability forms are frequently brought by the patient to PEC for completion and signature. PEC staff do not complete disability forms. In general patients should be advised to have their primary provider complete the forms. If the patient is not enrolled in an outpatient mental health program and there is a clinical need, he should be scheduled for an appointment.

Forensic Evaluations

Forensic evaluations are not provided as a service in PEC or in the outpatient psychiatry programs. Patient requiring a forensic evaluation should be referred to County Mental Health.

A CURRENT AND COMPLETE VA POLICY GUIDE CAN BE OBTAINED THROUGH VISTA
ACGME Program Requirements for Graduate Medical Education in Psychiatry

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

Int.A. Definition of the Specialty

Psychiatry is a medical specialty focused on the prevention, diagnosis, and treatment of mental, addictive, and emotional disorders. An approved residency program in psychiatry is designed to ensure that its graduates are able to render effective professional care to psychiatric patients. The graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders, together with other common medical and neurological disorders that relate to the practice of psychiatry. Graduates must have a keen awareness of their own strengths and limitations, and recognize the necessity for continuing their own professional development.

Int.B. Duration and Scope of Education

Int.B.1. Admission Requirements

Physicians may enter psychiatry programs at either the first-year or second-year postgraduate level. Physicians entering at the second-year postgraduate level must document successful completion of a clinical year of education in an ACGME-accredited specialty requiring comprehensive and continuous patient care, such as a program in internal medicine, family medicine, pediatrics, or transitional year program. For physicians entering at the PG-2 level after completion of such a program, the PG-1 year may be credited toward the 48-month requirement.

Int.B.2. Length of the Program

Int.B.2.a) Residency education in psychiatry requires 48 months, of which twelve months may be completed in an ACGME-accredited child and adolescent psychiatry program. Although residency is best completed on a full-time basis, part-time training at no less than half-time is permissible to accommodate residents with personal commitments (e.g., child care).

Int.B.2.b) A program may petition the residency review committee to alter the length of education beyond these minimum requirements by presenting a clear educational rationale consistent with the program requirements. The program director must obtain the approval of the sponsoring institution and the Review Committee prior to implementation and at each subsequent review of the program.

Int.B.2.c) Prior to entry into the program, each resident must be notified in writing of the required length of education for which the program is accredited. The required length of education for a particular resident may not be changed during his or her program without mutual

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agreement, unless there is a break in education or the resident requires remedial education.

Int.8.2.d) Programs should meet all of the Program Requirements of Residency Education in Psychiatry. Under rare and unusual circumstances, one- or two-year programs may be approved, even though they do not meet the above requirements for psychiatry. Such one- or two-year programs will be approved only if they provide some highly specialized educational and/or research program. These programs may provide an alternative specialized year or two of training, but do not provide complete residency education in psychiatry. The traditional program time and the specialized program must ensure that residents will complete the didactic and clinical requirements outlined in the program requirements.

Int.8.2.e) Electives should enrich the educational experience of residents in conformity to their needs, interest, and/or future professional plans. Electives must have written goals and objectives, and must be well constructed, purposeful, and lead to effective learning experiences. The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor.

Int.8.2.e).(1) The Review Committee encourages programs to identify residents who may be interested in academic psychiatry by introducing subspecialty education and research electives early in the residency program. This will provide an opportunity for education in general psychiatry, and exposure to a psychiatry fellowship (e.g., geriatric psychiatry) through electives.

Int.8.2.e).(2) All such electives must demonstrate compliance with the requirements in general psychiatry, and be submitted to the committee prior to implementation for review and approval. Submissions must also outline the educational curriculum necessary to meet the requirements of general psychiatry and how elective education will be structured to prepare the resident for subspecialty education. Prior to entry into the program, residents must be informed in writing that all general psychiatry requirements must be met prior to graduation.

Int.8.3) First Year of Education

Int.8.3.a) The program director of the psychiatry residency program must monitor performance and maintain personal contact with residents during the first postgraduate year while they are on services other than psychiatry. A first postgraduate year in psychiatry should include:

Int.8.3.a) a minimum of four months in a primary care clinical setting that provides comprehensive and continuous patient care in specialties such as internal medicine, family medicine, and/or pediatrics. Neurology rotations may not be used to fulfill this four-month requirement. One month of this requirement may be fulfilled by either an emergency medicine or intensive care rotation, provided the experience is predominantly with medical evaluation and treatment and not surgical procedures, and

I. Institutions

I.A. Sponsoring Institution
One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

I.B.1.c) specify the duration and content of the educational experience; and,

I.B.1.d) state the policies and procedures that will govern resident education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

The number and distribution of participating sites must not preclude satisfactory participation by residents in teaching and didactic exercises. Geographic proximity of participating sites will be one factor in evaluating program cohesion, continuity, and peer interaction.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

II.A.2.a) In general, the minimum term of appointment must be at least the duration of the program plus one year.

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;
II.A.3.b) current certification in the specialty by the American Board of Psychiatry and Neurology, or specialty qualifications that are acceptable to the Review Committee; and,

II.A.3.c) current medical licensure and appropriate medical staff appointment.

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

II.A.4.b) approve a local director at each participating site who is accountable for resident education;

II.A.4.c) approve the selection of program faculty as appropriate;

II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

II.A.4.e) monitor resident supervision at all participating sites;

II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

II.A.4.j.(1) distribute these policies and procedures to the residents and faculty;

II.A.4.j.(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

II.A.4.j.(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue, and;

II.A.4.j.(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

II.A.4.k) monitor the need for and ensure the provision of back-up support systems when patient care responsibilities are unusually difficult or prolonged;

II.A.4.l) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

II.A.4.n) obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting to the ACGME information or requests for the following:

II.A.4.n).(1) all applications for ACGME accreditation of new programs; II.A.4.n).(2) changes in resident complement;
II.A.4.n).(3) major changes in program structure or length of training;
II.A.4.n).(4) progress reports requested by the Review Committee;
II.A.4.n).(5) responses to all proposed adverse actions;
II.A.4.n).(6) requests for increases or any change to resident duty hours;
II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs;
II.A.4.n).(8) requests for appeal of an adverse action;
II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and,
II.A.4.n).(10) proposals to ACGME for approval of innovative educational approaches.

II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

II.A.4.o).(1) program citations, and/or
II.A.4.o).(2) requests for changes in the program that would have significant impact, including financial, on the program or institution.

II.A.4.p) make resident appointments and assignments in accordance with institutional and departmental policies and procedures.

II.A.4.q) supervise residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff.

II.A.4.r) regularly evaluate residents’ knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.

II.A.4.s) monitor residents’ stress, including physical or emotional conditions which inhibit performance or learning, as well as drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Educational situations that consistently produce undesirable stress on residents must be evaluated and modified.
II.A.4.t) dedicate no less than 50% (at least 20 hours per week) of his or her professional effort to the psychiatry educational program and receive institutional support for this time. This effort must be devoted to administrative and educational activities of the psychiatry educational program.

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location. The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities, and to demonstrate a strong interest in the education of residents; and

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Psychiatry and Neurology, or possess qualifications acceptable to the Review Committee.

II.B.2.a) A physician faculty member may be appointed to the School of Medicine as a voluntary faculty member.

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b.(1) peer-reviewed funding;

II.B.5.b.(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

II.B.5.b.(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

II.B.5.b.(4) participation in national committees or educational organizations.

II.B.5.c) Faculty should encourage and support residents in scholarly activities.

II.B.6. The faculty must participate regularly and systematically in the educational program, and must be readily available for consultation whenever a resident is faced with a major therapeutic or diagnostic problem.
II.B.7. The faculty should actively participate in the planning, organization, and presentation of conferences as well as in clinical teaching and supervision.

II.B.8. A member of the teaching staff in each participating site must be designated to assume responsibility for the day-to-day activities of the program at that site, with overall coordination by the program director.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.C.1. Associate Program Director

An associate program director is a member of the physician teaching faculty who assists the program director in the administrative and clinical oversight of the educational program. The sponsoring institution must provide additional dedicated time either for the program director or for associate program directors based on program size and complexity of training sites. At a minimum, a total of 30 hours per week, program director or combined program director and associate program director time, is required for an approved complement of 24 to 40 residents, and 40 hours per week for an approved complement of 41 to 79 residents. When a program is approved for 80 or more residents, there must be additional time allocated for directing the program.

II.C.2. There must be a residency coordinator who has adequate time, based on program size and complexity, to support the residency program.

II.C.3. Chair of Psychiatry

The chair of psychiatry must be:

II.C.3.a) a physician who is appointed to and in good standing with the medial staff of a site participating in the program;

II.C.3.b) qualified and have at least three years' experience as a clinician, administrator, and educator in psychiatry;

II.C.3.c) certified in psychiatry by the American Board of Psychiatry and Neurology or possess appropriate qualifications judged to be acceptable by the Review Committee;

II.C.3.d) actively involved in psychiatry through continuing medical education, professional societies, and scholarly activities; and,

II.C.3.e) capable of mentoring medical faculty, residents, administrators and other health care professionals, and possess medical leadership qualifications consistent with other physician chairs within the sponsoring institution.

II.C.4. Education Policy Committee

The director of the residency program should have an educational policy committee composed of members of the psychiatry program teaching staff. This committee should include representation from the residents as well as a member of the teaching staff from each ACGME-approved program.
subspecialty residency that may be affiliated with the psychiatry residency. There should be a written
description of the committee, including its responsibility to the sponsoring department or institution
and to the program director. This committee should participate actively in:

II.C.4.a) planning, developing, implementing, and evaluating all significant features of the residency program,
including the selection of residents (unless there is a separate residency selection committee);

II.C.4.b) determining curriculum goals and objectives; and

II.C.4.c) evaluating both the teaching staff and the residents.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for
resident education, as defined in the specialty program requirements.

II.D.1. All programs must have adequate patient populations for each mode of required education and,
minimally, must include organized clinical services in inpatient, outpatient, emergency,
consultation/liaison, and child and adolescent psychiatry.

II.D.2. Residency programs must have available to them adequate inpatient and outpatient facilities and
other suitable clinical placements where the residents can meet the educational objectives of
the program. The program should specify the facilities in which the goals and objectives are
to be implemented.

II.D.3. All residents must have available to them offices adequate in size and decor to allow them to interview
patients and accomplish their duties in a professional manner. The facility must also provide
adequate and specifically designated areas in which residents can perform basic physical examination
and other necessary diagnostic procedures and treatment interventions.

II.D.4. There must be adequate space and equipment, including equipment with the capability to record and
playback session, specifically designated for seminars, lectures, and other educational activities.

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in
print or electronic format. Electronic medical literature databases with search capabilities should be
available.

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the
Institutional Requirements.

III.A.1. The program director must accept only those applicants whose qualifications of residency include
sufficient command of English to permit accurate and unimpeded communication.

III.B. Number of Residents
The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program’s educational resources must be adequate to support the number of residents appointed to the program.

III.B.1. In order to promote an educationally sound, intellectually-stimulating atmosphere of effective and graded responsibility, programs must have at least three residents at each level of education. Programs that fall below this prescribed critical mass will be reviewed, and if this deficiency is not corrected, they may be cited for noncompliance, except when the number of PG-4 residents is fewer than three because residents have entered child and adolescent psychiatry training.

III.B.2. Any permanent change in the number of approved positions requires prior approval by the Review Committee. Programs seeking interim approval of a permanent increase in the number of approved resident positions should contact the Executive Director of the Review Committee. Prior approval is not required for temporary changes in resident numbers owing to makeup or remedial time for currently enrolled residents, or to fill vacancies. Approval of permanent increases above the approved range of residents will require documentation that didactic and clinical education, including supervision, will not be compromised.

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

III.C.3. Verification must include evaluation of professional integrity of residents transferring from one program to another, including from a general psychiatry to a child and adolescent psychiatry program.

III.C.4. A transferring resident’s educational program must be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents’ education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the
program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a. Patient Care

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:

IV.A.5.a.(1) must have supervised experience in the evaluation and treatment of patients. These patients should be of different ages and gender from across the life cycle, and from a variety of ethnic, racial, sociocultural, and economic backgrounds;

IV.A.5.a.(2) should be familiar with Axis III conditions that can affect evaluation and care (e.g., CNS lesions, HIV/AIDS, and other medical conditions);

IV.A.5.a.(3) should develop competence in:

IV.A.5.a.(3.a) formulating a clinical diagnosis for patients by conducting patient interviews, eliciting a clear and accurate history, performing physical, neurological, and mental status examination, including appropriate diagnostic studies; completing a systematic recording of findings; relating history and clinical findings to the relevant biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment;

IV.A.5.a.(3.b) developing a differential diagnosis and treatment plan for all psychiatric disorders in the current standard nomenclature, i.e., DSM, taking into consideration all relevant data;

IV.A.5.a.(3.c) using pharmacological regimens, including concurrent use of medications and psychotherapy;

IV.A.5.a.(3.d) understanding the indications and uses of electroconvulsive therapy;

IV.A.5.a.(5.d) Child and Adolescent Psychiatry: two month full-time equivalent organized clinical experience in which the residents are:

IV.A.5.a.(5.d.i) supervised by child and adolescent psychiatrists who are certified by ABPN or judged by the Review Committee to have equivalent qualifications; and

IV.A.5.a.(5.d.ii) provided opportunities to assess development and to evaluate and treat a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities.
competencies in areas that are unique to the care of the elderly. These include the diagnosis and management of mental disorders in patients with multiple comorbid medical disorders, familiarity with the differential diagnosis and management (including management of the cognitive component) of the degenerative disorders, an understanding of neuropsychological testing as it relates to cognitive functioning in the elderly, and the unique pharmacokinetic and pharmacodynamic considerations encountered in the elderly, including drug interactions.

IV.A.S.a.(5).f) Addiction Psychiatry: one month full-time equivalent organized experience focused on the evaluation and clinical management of patients with substance abuse/dependence problems, including dual diagnosis. Treatment modalities should include detoxification, management of overdose, maintenance pharmacotherapy, the use of psychological and social consequences of addiction in confronting and intervening in chronic addiction rehabilitation used in recovery stages from pre-contemplation to maintenance, and the use of self-help groups.

IV.A.S.a.(5).g) Consultation/Liaison: two month full-time equivalent in which residents consult under supervision on other medical and surgical services.

IV.A.S.a.(5).e) Geriatric Psychiatry: one month full-time equivalent organized experience focused on the specific

IV.A.S.a.(3).e) applying supportive, psychodynamic, and cognitive-behavioral psychotherapies to both brief and long-term individual practice, as well as to ensuring toward general psychiatry requirements as well as child and adolescent requirements, thereby fulfilling program requirements in both general and child and adolescent psychiatry. The following guidelines must be met for these experiences:

- limited to child and adolescent psychiatry patients;
- no more than 12 months may be double counted;
- there should be documentation from the child and adolescent psychiatry program director for all areas for which credit is given in both programs;
- there will be no reduction in total length of time devoted to education in child and adolescent psychiatry; this must remain at two years; and, only the following experiences can be used to meet requirements in both general and child and adolescent psychiatry:
  - one month full-time equivalent of child neurology;
  - one month full-time equivalent of pediatric consultation;
  - one month full-time equivalent of addiction psychiatry;
  - forensic psychiatry experience;
  - community psychiatry experience; and
- no more than 20% of outpatient experience of the Program Requirements for Psychiatry, will have the required clinical experiences which include the following:

Neurology: two full-time equivalent months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. At least one month should occur in the first or second year of the program.
Inpatient Psychiatry: six but no more than 16 months full-time equivalent of inpatient psychiatry of which there must be a minimum of six months of significant responsibility for the assessment, diagnosis, and treatment of general psychiatric patients who are admitted to traditional psychiatry units, day hospital programs, research units, residential treatment programs, and other settings that meet the following criteria:

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

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

- Evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly under supervision;
- Exposure to multiple treatment modalities that emphasize developmental, biological, psychological and social approaches to outpatient treatment;
- Opportunities to apply psychosocial rehabilitation techniques, and to evaluate and treat differing disorders in a chronically ill patient population;
- No more than 20% of the patients seen may be children and adolescents. This portion of education may be used to fulfill the two-month Child and Adolescent Psychiatry requirements, so long as this component meets the requirement for child and adolescent psychiatry as set forth in and below.

IV.A.5.a.(5).(h) Forensic Psychiatry: This experience must expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competency to stand trial, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others. This experience should include writing a forensic report. Where feasible, giving testimony in court is highly desirable.

IV.A.5.a.(5).(i) Emergency Psychiatry: This experience must be conducted in an organized, 24-hour psychiatric emergency service, a portion of which may occur in ambulatory urgent-care settings, but not as part of the 12-month outpatient requirement. Residents must be provided experiences in evaluation, crisis evaluation and management, and triage of psychiatric patients. On-call experiences may be a part of this experience, but no more than 50%.

IV.A.5.a.(5).(j) Community Psychiatry: This experience must expose residents to persistently and chronically ill patients in the public sector, (e.g., community mental health centers, public hospitals and agencies, and other community-based settings). The program should provide residents the opportunity to consult with, learn about, and use community resources and services in planning patient care, as well as to consult and work collaboratively with care managers, crisis teams, and other mental health professionals.

IV.A.5.a.(5).(k) Addiction, Community, Forensic, and Geriatric psychiatry requirements can be met as part of the inpatient requirements above the minimum six months, and/or as part of the outpatient requirement

IV.A.5.b) Medical Knowledge
Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents must meet the following requirements:
IV.A.5.b).(3).(g) the history of psychiatry and its relationship to the evolution of medicine;

IV.A.5.b).(3).(h) the legal aspects of psychiatric practice, and when and how to refer;

IV.A.5.b).(3).(i) an understanding of American culture and subcultures, particularly those found in the patient community associated with the educational program, with specific focus for residents with cultural backgrounds that are different from those of their patients; and,

IV.A.5.b).(3).(i).(i) use of case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in the diagnosis and management of cases. Each program must provide the following:

IV.A.5.b).(3).(i).(ii) All residents must be educated in research literacy. Research literacy is the ability to critically appraise and understand the relevant research literature and to apply research findings appropriately to clinical practice. The concepts and process of Evidence Based Clinical Practice include skill development in question formulation, information searching, critical appraisal, and medical decision-making, thus providing the structure for teaching research literacy to psychiatry residents. The program must promote an atmosphere of scholarly inquiry, including the access to ongoing research activity in psychiatry. Residents must be taught the design and interpretation of data.

IV.A.5.b).(3).(i).(iii) The program must provide residents with research opportunities and the opportunity for development of research skills for residents interested in conducting research in psychiatry or related fields. The program must provide interested residents access to and the opportunity to participate actively in ongoing research under a mentor. If unavailable in the local program, efforts to establish such mentoring programs are encouraged.

IV.A.5.b).(3).(i).(iv) The program must ensure the participation of residents and faculty in journal clubs.

IV.A.5.b).(3) Didactic instruction must be systematically organized, thoughtfully integrated, based on sound educational principles, and include regularly scheduled lectures, seminars, and assigned readings.

IV.A.5.b).(2) The didactic sessions must be scheduled to ensure a minimum of 70% of resident attendance while adhering to program duty hour policy. Didactic and clinical education must have priority in the allotment of residents' time and energy.

IV.A.5.b).(3) The didactic curriculum must include the following specific components:

IV.A.5.b).(3).(a) the major theoretical approaches to understanding the patient-doctor relationship;

IV.A.5.b).(3).(b) the biological, genetic, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle;

IV.A.5.b).(3).(c) the fundamental principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, sociocultural, and iatrogenic factors that affect the prevention, incidence, prevalence and long-term course and treatment of psychiatric disorders and conditions;

IV.A.5.b).(3).(d) comprehensive discussions of the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, such as neoplasm, dementia, headaches, traumatic brain injury, infectious
diseases, movement disorders, multiple sclerosis, seizure disorders, stroke, intractable pain, and other related disorders;

IV.A.5.b. (3). (e) the use, 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;

IV.A.5.b. (3). (f) the use and interpretation of psychological testing (under the supervision and guidance of a qualified clinical psychologist, residents should have experience with the interpretation of the psychological tests most commonly used, some of which experience should be with their own patients), research conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process.

IV.A.5.c) 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:

IV.A.5.c. (1) identify strengths, deficiencies, and limits in one’s knowledge and expertise;

IV.A.5.c. (2) set learning and improvement goals;

IV.A.5.c. (3) identify and perform appropriate learning activities;

IV.A.5.c. (4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

IV.A.5.c. (5) incorporate formative evaluation feedback into daily practice;

IV.A.5.c. (6) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;

IV.A.5.c. (7) use information technology to optimize learning; and,

IV.A.5.c. (8) participate in the education of patients, families, students, residents and other health professionals.

IV.A.5.c. (9) take primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and rotation-specific goals and objectives, as well as attendance at conferences;

IV.A.5.c. (9). (a) Resident’s teaching abilities should be documented by evaluations from faculty and/or learners.

IV.A.5.c. (9). (a). (i) There must be a record that demonstrates that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. In the case of transferring residents, the records should include the experiences in the prior and current program.

IV.A.5.c. (9). (a). (ii) The record must be reviewed periodically with the program director or a designee, and must be
The record may be maintained in a number of ways and is not limited to a paper-driven patient log.

IV.A.5.d) **Interpersonal and Communication Skills**

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

IV.A.5.d)(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

IV.A.5.d)(2) communicate effectively with physicians, other health professionals, and health related agencies;

IV.A.5.d)(3) work effectively as a member or leader of a health care team or other professional group;

IV.A.5.d)(4) act in a consultative role to other physicians and health professionals; and,

IV.A.5.d)(5) maintain comprehensive, timely, and legible medical records, if applicable.

IV.A.5.d)(6) interview patients and family in an effective manner to facilitate accurate diagnosis and biological, psychological and social formulation.

IV.A.5.e) **Professionalism**

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

IV.A.5.e)(1) compassion, integrity, and respect for others;

IV.A.5.e)(2) responsiveness to patient needs that supersedes self-interest;

IV.A.5.e)(3) respect for patient privacy and autonomy;

IV.A.5.e)(4) accountability to patients, society and the profession; and,

IV.A.5.e)(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

IV.A.5.e)(6) high standards of ethical behavior which include respect for patient privacy and autonomy, maintaining appropriate professional boundaries, and understanding the nuances specific to psychiatric practice. Programs are expected to distribute to residents and operate in accordance with the AMA Principles of Ethics with “Special Annotations for Psychiatry,” as developed by the American Psychiatric Association to ensure that the application and teaching of these principles are an integral part of the educational process.

IV.A.5.f) **Systems-based Practice**

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

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Residents are expected to:

IV.A.S.f).1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

IV.A.S.f).2) coordinate patient care within the health care system relevant to their clinical specialty;

IV.A.S.f).3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

IV.A.S.f).4) advocate for quality patient care and optimal patient care systems;

IV.A.S.f).5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,

IV.A.S.f).6) participate in identifying system errors and implementing potential systems solutions.

IV.A.S.f).7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;

IV.B. Residents' Scholarly Activities

IV.B.1) The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

IV.B.2) Residents should participate in scholarly activity.

IV.B.2.a) Residents will have instruction in research methods in the clinical, biological, and behavioral sciences related to psychiatry, including techniques to appraise the professional and scientific literature and to apply evidence-based findings to patient care.

IV.B.2.a) The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

V.A.1.b) The program must:

V.A.1.b).1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff).
V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,

V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

V.A.1.d) Regular evaluations of the knowledge, skills, and professional growth of each resident, using appropriate criteria and procedures, must be maintained, including complete records of evaluations containing explicit statements on the resident's progress toward meeting educational objectives and his or her major strengths and weaknesses.

V.A.1.e) The program must formally examine the cognitive knowledge of each resident at least annually in the PG-2, PG-3 and PG-4 years, and conduct an examination across biological, psychological and social spheres that are defined in the program's written goals and objectives.

V.A.1.f) The program must formally conduct a clinical skills examination. A required component of this assessment is an annual evaluation of the following skills:

V.A.1.f).(1) ability to interview patients and families;

V.A.1.f).(2) ability to establish an appropriate doctor/patient relationship;

V.A.1.f).(3) ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history;

V.A.1.f).(4) ability to assess mental status;

V.A.1.f).(5) ability to provide a relevant formulation, differential diagnosis and provisional treatment plan; and,

V.A.1.f).(6) ability to make an organized presentation of the pertinent history, including the mental status examination.

V.A.1.g) Performance on all evaluations must be documented and quantified, whenever possible, and provided to the resident. When necessary, remediation opportunities must be provided. Residents must not advance to the next year of education, or graduate from the program, unless the competence for their level of education in each area is documented.

V.A.1.h) In at least three evaluations with any patient type, in any clinical setting, and at any time during the program, residents must demonstrate satisfactory competence in: establishing an appropriate doctor/patient relationship, psychiatric interviewing, performing the mental status examination and in case presentation. Each of the three required evaluations must be conducted by an ABPN-certified psychiatrist, and at least two of the evaluations must be conducted by different ABPN-certified psychiatrists. Satisfactory demonstration of the competencies during the three required evaluations is required prior to completing the program.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This
evaluation must become part of the resident’s permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

V.A.2.a) document the resident’s performance during the final period of education, and
V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.
V.A.2.c) include a summary of any documented evidence of unethical behavior, unprofessional behavior, or clinical incompetence or a statement that none such has occurred. Where there is such evidence, it must be comprehensively recorded, along with the resident’s response(s) to such evidence.

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.
V.B.2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.

V.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
V.C.1.a) resident performance;
V.C.1.b) faculty development;
V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,
V.C.1.d) program quality. Specifically:
V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
V.C.1.d).(2) The program must use the results of residents’ assessments of the program together with other program evaluation results to improve the program.

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

V.C.3. In its evaluation of residency programs, the Review Committee will take into consideration the information provided by the American Board of Psychiatry and Neurology regarding resident performance on the certifying examinations during the most recent five years. The expectation is that the rate of those passing the examination on their first attempt is 50% and that 70% of those who complete the program will take the certifying examination
VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Principles

VI.A.1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.

VI.A.2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

VI.A.3. Didactic and clinical education must have priority in the allotment of residents’ time and energy.

VI.A.4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

VI.B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

VI.B.1. Each resident must receive a minimum of two hours of direct supervision per week, at least one of which is individual.

VI.C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

VI.D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs) Duty hours are defined as all clinical and academic activities related to the program, i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

VI.D.1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

VI.D.2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.

VI.D.3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

VI.E. On-call Activities

VI.E.1. In-house call must occur no more frequently than every third night, averaged over a four-week period.

VI.E.1.a) On psychiatry rotations, in-house call must occur no more frequently than every fourth night, averaged over a four-week period.
VI.E.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

VI.E.3. No new patients may be accepted after 24 hours of continuous duty.

VI.E.3.a) A new patient is defined as any patient for whom the resident has not previously provided care.

VI.E.4. At-home call (or pager call)

VI.E.4.a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.

VI.E.4.b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

VI.E.4.c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

VI.F. Moonlighting

VI.F.1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

VI.G. Duty Hours Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO.

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty-specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Procedures located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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