TABLE OF CONTENTS

RESIDENCY TRAINING ORGANIZATION CHART

INTRODUCTION

ROTATIONS

SENIOR & CHIEF RESIDENT ROLES, RESPONSIBILITIES AND GOALS

SUPERVISION

DUTY HOURS: WORKING CONDITIONS
Call
Time Off
Annual Leave
Family Medical Leave
Grievances
Sexual Harassment
Monitoring of compliance
FATIGUE POLICY

CALL POLICY

HANDOFFS

MOONLIGHTING

SERIOUS ADVERSE EVENTS (SAVE)

EVALUATION / ADVANCEMENT

TRAINING COMMITTEES

BEST PRACTICES

APPENDICES 1-11

A. Didactics
B. Clinical Rotations
C. Psychiatry Milestones
D. Readings
E. Senior Independent Study Project
F. Research and Community Psychiatry Tracks
G. Industry Policy
H. County, UCSD Medical Center and VA Medical Center
I. Psychiatry RRC Essentials
J. Ethical Guidelines
K. Pabbati’s Pearls for PGY1s
L. UCSD Housestaff Officers Policy and GME Guidelines
Introduction

The primary objective of our residency training program is to train academically knowledgeable, clinically astute and caring psychiatrists. Our clinically based program offers experiences in inpatient, outpatient, consultation-liaison, geriatric, community, forensic, substance abuse, and child and adolescent psychiatry. Throughout training, biological, psychological and sociocultural factors are integrated so that the resident becomes adept at selecting and utilizing the most current methods of biological and psychosocial interventions. While emphasizing clinical psychiatry, the residency program provides ample opportunity for the resident to learn and develop administrative, teaching and research skills.

Our departmental faculty is deeply committed to the intellectual growth and emotional well-being of our residents. Learning is reinforced through careful supervision of all clinical work; comprehensive didactic seminars that build on each other and are integrated with the clinical program, case conferences, grand rounds, journal clubs and the mentorship program. Residents actively participate in all levels of training and planning. Evaluation of the program, its trainees and its faculty, receives the highest departmental priority.

Our four-year residency in adult psychiatry is seen as part of a continuum from medical school, through further fellowship training and/or a career in psychiatry. We expect a high level of clinical competence and a thorough understanding of the principles continued excellence and growth. Upon completion of the program, residents are expected to be competent in the core areas of patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice. In addition, all graduates should be well grounded in sophisticated psychiatric diagnosis and balanced, state-of-the-art treatment. The program takes into account differences in each resident’s prior training, clinical skills, and future interests, and is flexible in tailoring the program to individual needs. Each resident will have the same core clinical and educational experience, as well as some “elective” time in PG Years 3 and 4 to pursue special areas of interest.

The UC San Diego Department of Psychiatry is fully accredited by the Accreditation Council for Graduate Medical Education and offers both a four and three-year residency program. Applicants from medical schools throughout the country are selected in a highly personal way. A limited number of applicants are accepted in order to insure close, personal contact between faculty and residents. Our program has up to 40 residents and 16 fellows. In addition to formal postgraduate psychiatry training, the Department of Psychiatry participates in the training of medical students, primary care physicians, neurology residents, social workers, registered nurses, vocational rehabilitation counselors, psychologists, psychiatric technicians and paraprofessional drug abuse counselors enrolled in affiliated training programs.
ROTATIONS

TRAINING GOALS AND OBJECTIVES

A. Introduction and Philosophy
The Adult Psychiatry Residency Training Program (RTP) at UCSD provides a four-year educational and training program in general adult psychiatry. The General Adult RTP is fully integrated to the Child & Adolescent, Geriatric Psychiatry, Community Psychiatry and Combined Family Medicine and Psychiatry RTPs at UCSD.

Residents join staff in providing superb comprehensive and coordinated care for adult patients. This care is based on best practices and evidence-based treatments framed within the view that no single conceptual framework is sufficient to understand human behavior. Residents are taught to approach patients and their families from a biopsychosocial perspective that integrates biological, psychodynamic, cognitive-behavioral, sociological, and anthropological models and tools. They are challenged to understand clinical issues in depth and to attempt formulations that integrate conceptual models.

Our RTP recognizes that adequate training for the current and future practice of general adult psychiatry is, of necessity, demanding. Beyond attaining essential knowledge, skills and attitudes, residents need to develop a sense of professional identity that includes being a secure physician, an advocate for patients, a sensitive therapist, and a thoughtful participant or consultant within healthcare teams and systems of care. The primary goals of the RTP are to produce leaders in the field of adult psychiatry and to feed well trained psychiatrists into underserved specialty training.

We have designed this program to foster the development of well-rounded, competent adult psychiatrists. Above all we value a serious and passionate commitment to the highest standards of patient care. Our philosophy emphasizes that fact that first and foremost, we are clinicians, dedicated and available to the needs of our patients. Training in brief and long-term individual therapy, couples, family and group therapy as practiced in various orientations (supportive, psychodynamic, pharmacotherapy, cognitive behavioral, systems, motivational interviewing) along with biological therapies (pharmacotherapy, electroconvulsive therapy, light treatment, sleep deprivation) delivered in crisis intervention, emergency, inpatient and outpatient settings is provided through supervised direct patient care, theoretical and evidence-based seminars, and demonstrations by skilled clinical practitioners, consultants, teachers, and administrators. We specifically encourage pilot research protocols and other scholarly experiences. Our philosophy emphasizes the concept that research and scholarship are fundamental extensions of being a physician and a psychiatrist.

We understand that residents will come to our program with different strengths and needs. Our overriding objective is to ensure clinical competence in adult psychiatric diagnosis and treatment, while being flexible enough to support learning opportunities according to a resident’s particular strengths and interests. Ample elective time is provided to encourage exploration and acquisition of skills in specific psychiatric subspecialties.

Clinically based, the RTP offers experiences in inpatient, outpatient, consultation-liaison psychiatry, geriatric psychiatry, community psychiatry, substance abuse, emergency psychiatry, and child and adolescent psychiatry. Throughout the training, biological, psychological and sociocultural factors are integrated so that residents become versatile in selecting and utilizing all current methods of biological and psychosocial interventions. While emphasizing clinical psychiatry, the residency program provides ample opportunity and expects the resident to learn and develop clinical, administrative, teaching, and research skills. The RTP is under the direction and supervision of the Training Director, Sidney Zisook, M.D. and 3 Assistant Training Directors, Sanjai Rao, M.D., Alana Iglewicz, M.D. and Kristin Cadenhead, M.D. The RTP is approved by the Accreditation Council of Graduate Medical Education’s (ACGME) Residency Review Committee for four years of training.
B. General Goals and Objectives
The major goals of the RTP at UCSD are to graduate psychiatrists who have mature clinical judgment; extensive knowledge about diagnosis, etiology, and treatment of all psychiatric disorders and common neurological disorders; competence to render effective professional care to patients; awareness of personal limitations; and recognition of the necessity of continuing their development throughout their professional careers.

The six ACGME general competencies as well as the psychiatry-specific competencies are an organizing principle for the training curriculum and assessment. Thus, we have developed goals and objectives that identify educational outcomes for each competence domain, broken down further into knowledge, skills, and attitudes. In addition, each clinical rotation in the RTP has specific educational objectives in the areas of knowledge, skills and attitudes. Each rotation is designed to provide a balanced mixture of clinical service, didactics, and supervision, which enable residents to attain those educational objectives. We also have identified educational outcomes for goals and objectives in the didactic components of the RTP.

Residents are supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience. The teaching staff must determine the level of responsibility afforded to each resident. By the time of graduation, all residents must demonstrate sufficient competence and the necessary skills, knowledge and attitudes to enter the practice unsupervised practice of psychiatry and maintain lifelong learning.

C. Didactics Goals and Objectives
The didactic curriculum is built around 10 content threads that occur in a graded way over each of the 4-years of training. Each thread has a “thread-leader” and each year of the curriculum has a year coordinator. The thread and year coordinators, along with resident representatives, meet regularly throughout the year to evaluate, improve and coordinate the curriculum. With the exception of the 2 months PGY1 residents rotate on Internal Medicine, all didactics are in “protected” time. For all residents, protected didactics occur on Thursday mornings. The morning begins with Resident Rounds, attending by all residents, and then each class breaks off into its own didactic series, PGY3s also have “protected” seminars on Tuesday mornings. Department Grand Rounds occur monthly on Tuesday mornings. A number of other educational conferences, like case conferences, journal clubs and Chief Resident conferences, occur on all of the major clinical sites. Residents also are invited to a number of optional department, medical school and university seminars and conferences.

Appendix A provides the 2016 schedule and the Goals and Objectives of each major course. The 10 threads include:
1. Child and Development Psychiatry
2. Clinical Disorders
3. Community & Cultural Psychiatry (Including Life After Residency & Quality Assurance)
4. C/L & Psychosomatics
5. Forensics
6. Geropsychiatry
7. Neuroscience
8. Professionalism & Ethics
9. Psychopharmacology
10. Teaching

D. Competency Based Clinical Goals and Objectives by Year and Rotation
In each of the four years of training, residents have day-to-day responsibilities for the care of psychiatric patients. These experiences, along with the corresponding supervision and didactics, comprise the materials around which our core competencies are taught. Specifically, these experiences include:
The rotation schedule is established to provide multiple experiences with diverse patient populations to guide the residents’ trajectory from novice clinicians to independent practitioners. All ACGME and ABPN requirements (other than time in training) are met by the end of the 3rd year to allow for fast-tracking to Child training where appropriate. As residents progress through training, more elective and personalized training is available. The Figure below provides a glimpse of the major rotational components of each year of training. Goals and objectives of each rotation and elective experience are provided in Appendix B.

<table>
<thead>
<tr>
<th>Year 1</th>
<th>6 4-Week Blocks</th>
<th>2 4-Week Blocks</th>
<th>4 4-Week Blocks</th>
<th>4 1 Week Blocks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient Psychiatry*</td>
<td>Neurology</td>
<td>Primary Care</td>
<td>Night Float*</td>
</tr>
<tr>
<td></td>
<td>Forensic experience including commitment, assessment of potential to harm self or others, written forensic reports and providing testimony.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experiences in evaluation, crisis evaluation, management, and triage of emergency psychiatric patients</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>5 4-Week Blocks</th>
<th>1 4-Week Block</th>
<th>2 4-Week Blocks</th>
<th>2 4-Week Blocks</th>
<th>1 4-Week Block</th>
<th>1 4-Week Block</th>
<th>4 1-Week Blocks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient Psychiatry*</td>
<td>Residential Addiction Psychiatry (SAARTP)</td>
<td>Inpatient Child Psychiatry (CAPS) Eating Disorders (ED)</td>
<td>Consultation Liaison/Psychosomatic Medicine (C/L)</td>
<td>Inpatient Geriatric Psychiatry (Geropsychiatry)</td>
<td>Urgent Care Psychiatry Clinic (MHAC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>One afternoon weekly Mental Health Primary Care or other Specialty Clinic (10%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Forensic experience including commitment, assessment of potential to harm self or others, written forensic reports and providing testimony.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experiences in evaluation, crisis evaluation, management, and triage of emergency psychiatric patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Up to 2 4-week blocks research elective for research track residents may replace 2 block of Inpatient Psychiatry.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 3</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outpatient Psychiatry*</td>
</tr>
<tr>
<td></td>
<td>UCSD Gifford Clinic and Resident Psychiatric Service – includes conducting initial diagnostic evaluations, treatment planning, medication management, group therapy, and individual psychotherapy for patients in a County of San Diego-contracted outpatient mental health clinic for low-income and indigent patients and privately insured patients. This rotation provides experience in Community Psychiatry, exposing residents to persistently and chronically-ill patients in the public sector, and providing 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 case managers, crisis teams, and other mental health professionals).</td>
</tr>
<tr>
<td></td>
<td>Forensic experience including commitment, assessment of potential to harm self or others, written forensic reports and providing testimony.</td>
</tr>
<tr>
<td></td>
<td>Experiences in evaluation, crisis evaluation, management, and triage of emergency psychiatric patients</td>
</tr>
<tr>
<td></td>
<td>1-2 half-day off-site Electives that focus on other subspecialties and/or other clinical populations not encountered in the UCSD Gifford Clinic (10%)</td>
</tr>
<tr>
<td></td>
<td>Individual psychotherapy patients - minimum of 4 hours/week (10 - 20%)</td>
</tr>
<tr>
<td></td>
<td>*Includes ~ 4 weeks night float (which provides experience in both Emergency and Psychosomatic Medicine/Consultation-Liaison Psychiatry)</td>
</tr>
</tbody>
</table>

|        | 12 Months |

E. Senior And Chief Resident Roles, Responsibilities And Goals

All Seniors Goals

**Patient Care**

1. Practice, teach and model patient interviewing, chart review, and medical record documentation.
2. Practice, teach and model presenting patients in rounds and completing a mental status exam.
3. Practice, teach and model patient risk assessment skills in terms of safety of patients as well as safety of staff.
5. Practice, teach and model treatment plans.
6. Practice, teach and model individual, group and family psychotherapy.
7. Practice, teach and model discharge summary documentation.
8. Practice, teach and model compassionate care to psychiatric patients and emergency room patients.
9. Practice, teach and model referral and consultation with other medical specialties when appropriate in patient management.
10. Practice, teach and model a biopsychosocial approach in the treatment of individuals with severe mental illnesses
11. Practice, teach and model treating severe mental illness pharmacologically and managing medications, including antipsychotics, mood stabilizers, antidepressants, anxiolytics, and adjunctive medication.
12. Practice, teach and model supportive psychotherapy, CBT, MI and combined psychotherapy and psychopharmacological treatment of patients with mental illnesses.
15. Practice, teach and model physical and laboratory assessments for initial treatment.
16. Practice, teach and model continuing follow-up of patients with mental illness.
17. Demonstrate the ability to independently provide competent and compassionate care for psychiatric patients and to practice without the need for supervision.

**Medical Knowledge**

1. Know the risks, benefits and administration of all psychotropic medication classes including SSRIs, TCAs, MAOIs, first and second generation antipsychotics, mood stabilizers, benzodiazepines, anticholinergic medications, psychostimulants and drugs used in the treatment of substance dependence.
2. Know the risks, benefits and administration Clozapine, long acting injectable antipsychotics, and short acting injectable antipsychotics (including long and short term side effect concerns and monitoring).
3. Know receptors responsible for orthostasis, sedation, weight gain, and sexual dysfunction.
4. Understand complex drug mechanisms of action, receptor blockade profiles, and indications for selection and use of specific agents.
5. Know the risks, benefits, indications and administration of Electroconvulsive Therapy.
6. Familiarity with the routine treatments of medical issues routinely encountered on psychiatric inpatient services including hypertension, hypotension, dyslipemias, tachycardia, urinary tract infections, screening for tuberculosis, evaluation of fevers, and workup of chest pain.
7. Familiarity with medical screening labs tests appropriate to given diagnoses and medications.
8. Understand the importance of checking for CYP 450 mediated drug interactions pertinent to psychotropic medications and know where to find specific interactions.

**Interpersonal and Communication Skills**
1. Ability to co-lead team meetings.
2. Ability to be empathic and develop rapport with patients.
3. Ability to work effectively as part of a multidisciplinary team.
4. Ability to work effectively as a team player with peers.
5. Ability to communicate effectively with supervisors.
6. Ability to be effective and emphatic working with families.
7. Ability to effectively liaison with professional colleagues in other fields.
8. Ability to adapt his/her style of interaction specific to age and cognitive capacity.
9. Ability to model these abilities to junior residents and medical students including the ability to provide appropriate positive and negative feedback to them.
10. Enhance ability to collaborate with other treatment and care providers, including multidisciplinary team members, psychosocial rehabilitation staff, social work staff, administrative staff, junior residents, case managers around treatment of severely mentally ill individuals.
11. Enhance ability to work with patients and their families utilizing approaches including psychoeducation, outreach and liaison with community services.
12. Enhance ability to supervise oral and written presentations, including discussion of the differential diagnosis and biopsychosocial treatments.

**Professionalism**
1. Practice personal and intellectual integrity and an understanding of the ethical values and codes of a member of the medical profession.
2. Obtain and provide cross coverage as needed.
3. Assist with and ask for assistance in emergencies as appropriate.
4. Perform and teach appropriate sign-outs, addressing pertinent issues for patients.
5. Commitment to ethical principles when dealing with faculty, staff, other residents, patients and families.
6. Respect for patients, family members and physician and non-physician colleagues in all interactions.
7. Sensitivity to and awareness of the patient’s culture, age, gender, socioeconomic status, sexual orientation, religion and spirituality, and disabilities.
8. Ability to follow through with patient care recommendations.
9. Ethical behavior with respect for patient confidentiality.
10. Ability to establish and maintain professional boundaries.
11. Maintains a professional appearance appropriate to clinical site.
12. Ability to provide specific and accurate professional feedback to junior residents, medical students, staff, and colleagues in a mature and empathic manner.

**Practice Based Learning**
1. Facilitate medical students’ and junior residents’ learning and practicing evidence based treatment.
2. Use information technology to access on-line medical information and support one’s own education.
3. Locate, critique, and assimilate evidence from scientific studies as it relates to patients’ health problems.
4. Incorporate material discussed in supervision into clinical work.
5. Demonstrate familiarity with using the medical literature to review and assess pharmacologic and nonpharmacologic interventions.
6. Demonstrate motivation and eagerness to learn.

**Systems Based Practice**
1. Understand how types of medical practice and delivery systems differ from one another.
2. Awareness of different costs of health care for different services.
3. Ability to advocate for quality patient care and assist patients in dealing with system complexities.
4. Basic understanding of medical-legal issues as they relate to inpatient psychiatry including: voluntary and involuntary admission procedures, testifying at hearings, court ordered patients, issues of confidentiality, forced medications/medication panels.
5. Know community resources and how to use them to provide optimal care for patients.

**All seniors roles and responsibilities**
1. Pass a clinical skills examination during the senior year.
2. Attend > 70% ‘protected’ seminars.
3. Complete an Independent Study Project.
4. Participate in orientation, graduation, retreats, resident-only meetings and resident ‘recruitment’ activities (interviewing and selection).
5. Supervise junior residents and medical students on rotations and on short, over-night and week-end call.
6. Participate in and help co-lead multidisciplinary teams.
7. Continue providing psychiatric care for selected outpatients.
8. Cover patients on service as needed to assist junior residents, prevent fatigue and over-work, provide vacation and emergency coverage, etc.
9. Receive supervision but gradually progress toward ‘relatively’ independent practice as appropriate for your skill and knowledge level (determined jointly by you and your Site director and supervisor).
10. Complete clinical evaluations (New Innovations) on all residents and students on service.
11. Facilitate both informal and formal didactics and teaching (teaching in rounds, team meetings, informal didactics with medical students, journal club, Wednesday seminars and case conferences at Gifford etc.)

**Chief specific responsibilities**

**All Chiefs**
1. Advocate for junior residents and colleagues while being cognizant of your role as liaison between residents and faculty.
2. Help oversee the well-being of residents and the residency.
3. Working with the Site Director and Attending, set expectations and oversee sign-outs and hand-offs.
4. Attend Faculty Meetings (usually 1<sup>st</sup> Tuesday morning of each month, 8:30-10, BSB Conference Room), Clinical Service Chief Meetings (3rd Monday of each month, noon-1:30, BSB Conference Room), Chief Resident Meetings (1<sup>st</sup> Thursday of the month, RTO), Residency Training Committee Meetings (2<sup>nd</sup> Thursday of the month, Stein 148) and Residency Selection Committee Meetings (usually Friday afternoons, late November thru early February) and various leadership meetings specific to each clinical site.

Help develop and oversee rotation and call schedules related to each site and residents the site Chief specifically over-see (eg, PGY1s for UCSD Hospital Chief, PGY2s for VA Chief and PGY3s and PGY4/5s for OPS Chief).

**VA Specific**

**General**
1. Have fun, consolidate your learning, teach what you know, look up what you don’t.
2. Seek supervision from Sid as needed and at least once per week formally in his office. Seek supervision from 2S attendings and Dr. Kassab as appropriate. They are wonderful resources.
3. Visit Tracy, she is a great help.
4. Provide both positive and constructive feedback as needed.
5. Remember you are the advocate for your junior residents as well as the liaison between staff and residents.

Meetings
1. Faculty meeting - 1st Tuesday of the month. 830-10am Departmental Conference Room in BSB
2. 4th Tuesday of the month: 1215-1230 – 2S meeting with attendings and senior nurses to discuss relevant issues
3. RTC, CSC, Chief Meeting (see above)
4. Call Committee – TBA

Call/Vacations
1. Generate a call schedule for the PGY-2 residents, a backup and secondary backup system. Backups and secondary backups need to be from residents not on 2S, PEC/MHAC or UCSD C/L. Work with the NBMU and Gifford chiefs extensively to assure there are no issues with lack of coverage.
2. Manage a vacation list separate from the Weekly Memo. Approve vacations such that only one resident can be gone from 2S at any given time unless it is absolutely impossible or there are extenuating circumstances (and make sure they are not on the same team!). Senior residents must also get chief approval for vacations. Forward all vacation requests to the RTO for final approval. Vacations are not approved unless they have been approved by the RTO.

Conferences
1. Coordinate, and make sure that junior residents/medical students are familiar with and regularly attend the morning teaching-sign-in rounds (8 – 8:30 am)
2. Coordinate Wednesday noon conferences including journal clubs (the senior assigned to journal clubs should work with Dr. Groban) – this job may be given to Chief Research resident or a senior resident at the VA
3. Set expectations and monitor hand offs, including face-to-face handoffs between shifts

Teams
1. Maintain the new patient assignment list accounting for resident’s clinic days, the number of patients on each team, the level of training and adequacy of the residents on each team, upcoming vacations or missed days, etc
2. Email the attendings and other seniors on 2S the week prior to each block with a list of who will be on each team, and the scheduled vacations or other expected time off during the block. Update and email the 2S Resident Primer with this email.
3. Create a senior VA backup such that there is at least one senior available on 2S until 5pm each day and a backup system for covering PEC during days where the PEC resident is in clinic
4. Orient new housestaff to the unit’s objectives and goals at the beginning of a new rotation
5. Try to take 2 half days per week for your own independent study. No seniors can take a half day on Thursday.
6. 2S Chief and other seniors are expected to cover patients on a short term basis during times of high patient census, especially in the setting of junior resident illness, vacation, etc. During the 1st 3 months of the academic year, interns are expected to maintain 6 or fewer patients. Exceptions to the 6 or fewer rule need to be cleared by the chief and the attending for the given team.
7. Moving patients to different teams is at the discretion of the chief resident. If you move a patient, someone needs to place an order in CPRS, the clerk and relevant attendings and residents need to be made aware.
8. 2S Chief (and Seniors): complete the comprehensive Mental Health Treatment Plan and weekly treatment plan updates on all patients admitted to team.

Suicide Risk Assessment (VA Chief and Seniors)
1. Be familiar with the VA requirements for suicide risk assessment and reporting, including the Comprehensive Suicide Risk Assessment (CSRA), Suicide Behavior Report (SBR), and Suicide Safety Plan.
2. Practice, teach, and model these suicide risk assessments for junior residents.

Medical Students
1. Generate a formal plan for education of medical students at the VA
2. Orient the medical students using the 2S Medical Student Handout at the beginning of each rotation. Medical students will congregate in D-pod on Tuesday at 0730 during their first week for their orientation.

UCSD/NBMU Specific
1. Organize and monitor PGY1 orientation and crash course
2. Organize and monitor PGY-1 call and float schedule (and coordinate with OPS and VA Chiefs for all call)
3. Meet regularly with PGY1s for feed-back and support
4. Help over-see all hand-off and change of service procedures.
5. Administrative meetings
6. SAVE/M&Ms
7. RTC, CSC, Chief Meeting (see above)
8. Call Committee – TBA
9. Faculty meeting - 1st Tuesday of the month. 830-10am Departmental Conference Room in BSB

Outpatient Psychiatric Services (OPS)-Specific
1. Orient PGY3s to outpatient psychiatry and monitor transition to OPS
2. Organize and monitor OPS Crash Course
3. Organize and monitor Summer Grand Round Series
4. Organize and monitor Wednesday Case Conference Series
5. PGY-3-5 call and float schedule at NBMU (and coordinate with VA and UCSD Chiefs for all call)
6. Organize and monitor Fee-For-Service Call Schedule
7. Meet regularly with PGY3s for feed-back and support
8. Help over-see all hand-off and change of service procedures.
9. Admin meetings
10. SAVE/M&Ms
11. RTC, CSC, Chief Meeting (see above)
12. Call Committee – TBA
13. Faculty meeting - 1st Tuesday of the month. 830-10am Departmental Conference Room in BSB
14. Have fun, consolidate your learning, teach what you know, look up what you don’t.
15. Coordinate and oversee 4th year medical student OPS Sub Internship PSY 403 including OASIS scheduling, making weekly schedule, first day orientation, mid-rotation check in, exit interview, and other individual MS4-level didactics and teaching when applicable.
16. Coordinate and oversee other visiting trainees or volunteers (MS3, under graduates, visiting medical students).
17. Maintain therapy waitlist for resident psychotherapy clinic (Gifford and PA patients)
18. Teach and facilitate resident fulfillment of SD county documentation and contract requirements
19. Maintain waitlist for resident psychotherapy and ensure residents have 4 therapy pt minimum in required modalities.
20. Create and maintain clinic based schedules including Walk In, Gifford On Call schedules.
21. Oversee, approve, and submit Vacation/Education requests and maintain schedules in google calendar, provide calendar access to staff and print/provide paper copies monthly.
22. Teaching, supervision, scheduling, and oversight of visiting Navy Residents (with support of Navy attending).
23. Role as direct resident supervisor: monitoring of residents appointment schedules and appointment calendars, maintaining resident caseloads, fielding patient complaints/grievances, facilitating patients' provider transfer request.
24. Coordination of weekly/daily schedules for incoming PGY3s including electives/selective, supervisors, walk-in assignment, and group therapy.
25. Create professors rounds schedule and help oversee and supervise professors rounds preparation.
26. Transition preparations and oversight including comprehensive documentation and transfers summaries, "Bring your PGY2 to work day," "Pizza sign out" with face to face verbal and written handoff communication, coordinating and maintaining high risk / high acuity patient list
27. Arrange, facilitate, and attend in service, research recruitment talks, monthly meetings with clinic director and other lunch meetings outside of formal didactics and formal supervision times
28. Coordination of onsite interviews during interview season (securing offices, conducting interviews, tours, etc).
29. Liaison between PGY3 residents and faculty, clinic staff, allied mental health trainees/supervisions.
30. Coordinate and arrange computer access and Anasazi training dates.
31. Maintain and update orientation binder and resident reference manual (in hard copy and/or soft copy).
32. Supervise residents on specific cases and high acuity/high risk cases from both a clinical and administrative standpoint.
33. Provide feedback and supervision to residents with respect to professionalism, clinical, and performance standards challenges including individual meetings or regular/weekly meetings when applicable.
34. Communicate larger disciplinary issues to supervisors, clinic directors, and training directors.

3. Orient the medical students using the 2S Medical Student Handout at the beginning of each rotation. Medical students will congregate in D-pod on Tuesday at 0730 during their first week for their orientation.

UCSD/NBMU Specific
10. Organize and monitor PGY1 orientation and crash course
11. Organize and monitor PGY-1 call and float schedule (and coordinate with OPS and VA Chiefs for all call)
12. Meet regularly with PGY1s for feed-back and support
13. Help over-see all hand-off and change of service procedures.
14. Administrative meetings
15. SAVE/M&Ms
16. RTC, CSC, Chief Meeting (see above)
17. Call Committee – TBA
18. Faculty meeting - 1st Tuesday of the month. 830-10am Departmental Conference Room in BSB

Outpatient Psychiatric Services (OPS)-Specific
35. Orient PGY3s to outpatient psychiatry and monitor transition to OPS
36. Organize and monitor OPS Crash Course
37. Organize and monitor Summer Grand Round Series
38. Organize and monitor Wednesday Case Conference Series
39. PGY-3-5 call and float schedule at NBMU (and coordinate with VA and UCSD Chiefs for all call)
40. Organize and monitor Fee-For-Service Call Schedule
41. Meet regularly with PGY3s for feed-back and support
42. Help over-see all hand-off and change of service procedures.
43. Admin meetings
44. SAVE/M&Ms
45. RTC, CSC, Chief Meeting (see above)
46. Call Committee – TBA
47. Faculty meeting - 1st Tuesday of the month. 830-10am Departmental Conference Room in BSB
48. Have fun, consolidate your learning, teach what you know, look up what you don’t.
49. Coordinate and oversee 4th year medical student OPS Sub Internship PSY 403 including OASIS scheduling, making weekly schedule, first day orientation, mid-rotation check in, exit interview, and other individual MS4-level didactics and teaching when applicable.
50. Coordinate and oversee other visiting trainees or volunteers (MS3, under graduates, visiting medical students).
51. Maintain therapy waitlist for resident psychotherapy clinic (Gifford and PA patients)
52. Teach and facilitate resident fulfillment of SD county documentation and contract requirements
53. Maintain waitlist for resident psychotherapy and ensure residents have 4 therapy pt minimum in required modalities.
54. Create and maintain clinic based schedules including Walk In, Gifford On Call schedules.
55. Oversee, approve, and submit Vacation/Education requests and maintain schedules in google calendar, provide calendar access to staff and print/provide paper copies monthly.
56. Teaching, supervision, scheduling, and oversight of visiting Navy Residents (with support of Navy attending).
57. Role as direct resident supervisor: monitoring of residents appointment schedules and appointment calendars, maintaining resident caseloads, fielding patient complaints/grievances, facilitating patients' provider transfer request.
58. Coordination of weekly/daily schedules for incoming PGY3s including electives/selective, supervisors, walk-in assignment, and group therapy.
59. Create professors rounds schedule and help oversee and supervise professors rounds preparation.
60. Transition preparations and oversight including comprehensive documentation and transfers summaries, "Bring your PGY2 to work day," "Pizza sign out" with face to face verbal and written handoff communication, coordinating and maintaining high risk / high acuity patient list
61. Arrange, facilitate, and attend in service, research recruitment talks, monthly meetings with clinic director and other lunch meetings outside of formal didactics and formal supervision times
62. Coordination of onsite interviews during interview season (securing offices, conducting interviews, tours, etc).
63. Liaison between PGY3 residents and faculty, clinic staff, allied mental health trainees/supervisions.
64. Coordinate and arrange computer access and Anasazi training dates.
65. Maintain and update orientation binder and resident reference manual (in hard copy and/or soft copy).
66. Supervise residents on specific cases and high acuity/high risk cases from both a clinical and administrative standpoint.
67. Provide feedback and supervision to residents with respect to professionalism, clinical, and performance standards challenges including individual meetings or regular/weekly meetings when applicable.
68. Communicate larger disciplinary issues to supervisors, clinic directors, and training directors.

F. Supervision Guidelines

1) UCSD Guidelines

Purpose: To ensure proper and consistent supervision of house officers in delivery of patient care.

Communication and collaboration between attending physicians and housestaff is required. Identification of the respective duties and responsibilities of attendings and housestaff provides the foundation upon which supervision is based. Housestaff must be supervised by attending faculty in such a way that the housestaff assume progressively increasing responsibility for patient care according to their level of training, ability and experience.

Ambulatory Sites:
- Housestaff will be able to identify an available supervising attending at all times during patient care.
- Attending faculty will be available to housestaff during the entire ambulatory clinic session or outpatient procedure.
- Attending faculty or licensed housestaff physician will personally supervise and appropriately document the care of all patients under the care of unlicensed housestaff.
- A faculty attending member will be responsible for service in each specific ambulatory site. This individual will be responsible for insuring compliance with ACGME policies.
Urgent Care, Emergency Department Sites:
- Housestaff will be able to identify an available supervising attending at all times during patient care.
- Attending faculty will be available to housestaff.
- Compliance with requirements regarding the supervision of housestaff and the care of patients.
- A specific attending faculty member will be assigned to be responsible for compliance with ACGME policies.
- At the request of the emergency medicine faculty, a consulting attending faculty member will personally see the patient and document recommendations for care. Alternatively, licensed resident-level consultation may suffice in some cases. In these cases, supervision by specialist faculty will be routinely expected by telephone.

Inpatient Sites:
- Housestaff will be able to identify an available supervising attending at all times during patient care. Attendings must be available to housestaff and must be able to provide direct consultation patient care when necessary.
- Admissions will be discussed with an attending supervisor on the day of admission.
- Transfers and discharges will be discussed with an attending prospectively.
- As often as medically appropriate, attending faculty (or his/her attending faculty back-up) will personally supervise the care of all hospitalized patients assigned to his/her service, will document as appropriate and will see patients daily.
- An attending faculty will personally see and supervise inpatient consultations referred to his/her service and insure appropriate documentation.
- Compliance with ACGME requirements regarding the supervision of housestaff and the care of inpatients.
- A specific attending faculty member will be responsible for compliance with ACGME policies in the inpatient setting.

2) ACGME Regulations

Components of Attending Supervision:
- Educational objectives are defined.
- The supervisor assesses the skill level of the housestaff by direct observation.
- The supervisor authorizes independent action by the housestaff.
- The supervisor defines the course of progressive independence from performing functions together with decreasing frequency of review. This process starts with close supervision, progressing towards independence as skills are observed.
- Written evaluation and feedback are considered in the progression levels. At all times, the housestaff has access to advice and direction from the supervisor.

Defining Levels of Supervision:
- Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities.
- To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following levels of supervision:
  - Direct Supervision – the supervising physician is physically present with the resident and patient.
✓ **Indirect Supervision:**
  - With direct supervision immediately available – the supervising physician is physically within the other site of patient care, provide Direct Supervision.
  - With direct supervision available – the supervising physician is not physically present within the other site of patient care, but is immediately available to provide Direct Supervision.
  - Oversight – The supervising physician is available to review care delivered.

- The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty member.
  - The program director must evaluate each resident’s abilities based on specific criteria.
  - Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
  - Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence.

3) **USCD Psychiatry: Certifying PGY1s:**

**PGY-1 residents** may progress to being supervised indirectly with direct supervision available only after demonstrating competence in:

a) The ability and willingness to ask for help when indicated;
b) Gathering an appropriate history;
c) The ability to perform an emergent psychiatric assessment; and,
d) Presenting patient findings and data accurately to a supervisor who has not seen the patient.

**Inpatient Psychiatry**

- a-d above are taught in the Crash Course and reinforced in didactics and daily clinical activities
- Each PGY1 observes 1 new patient evaluation done by a senior resident or attending level psychiatrist before being observed doing at least 1 complete intake evaluation.
- After the PGY1 passes at least one 'CSV-like*' evaluation (doing a new patient diagnostic assessment and presenting the case and mental status exam) on the appropriate form and supervised by an attending level psychiatrist, the resident may graduate to performing new patient evaluations with "direct supervision immediately available".
- Thereafter, new patients will be presented to a senior resident or attending level psychiatrist the same day and interviewed by an attending psychiatrist at rounds within 24 hours of admission
- Follow-up and daily interviews can be completed with "direct supervision immediately available" with daily supervision either individually and/or at rounds and sign outs until residents are certified by at least 3 psychiatrists - (1) senior resident, 2) supervising or attending psychiatrist and 3) site director - as competent in a, b and d above. After that, they may see patients "with direct supervision available".

**Call (evenings, nights and week-ends)**

- On call with senior (PGY3 and 4 residents) up to 10 pm initially with Direct Supervision until
- At least 4 (short or long) calls, and
- Pass at least 1 CSV (testing patient relationship, history and presentation)
- At least 1 residents and 1 faculty certify competence in a-d above
- Progress to call with senior (PGY3 and 4 residents) up to 10 pm with direct supervision immediately available until
- Total of 6 calls (long or short), and
- Pass at least 1 CSE (CSV + differential diagnosis and treatment plan)

16
• At least 2 residents and 2 faculty certify competence in a-d above
  a. Progress to call (in-house without senior or attending psychiatrist) with **Indirect Supervision** available
     o Not until > 4 months training, including > 1 month medicine, 1 month inpatient psychiatry and at least 6 short calls and 1 long call with direct supervision immediately available
     ▪ Pass at least 1 CSE (as above)
     ▪ Certified competent on a-d above by 2 residents and 3 faculty attendings, including site director
     o *'CSV like' = can be full CSV or even CSE, but not necessarily fulfilling all requirements of ABPN.*
       Goal is assessing competency to take call with supervision available - not necessarily to practice psychiatry independently

4) **Clinical Supervision Policy for Call at the Medical Center:**

**Purpose:** To ensure proper and consistent supervision to the interns, who take primary call at the university, with senior residents and attendings serving as backup.

- **Prescribing Medications:** In general, this should not be done while on-call. Interns are expected to manage patient’s medications on the unit, and make recommendations when consulting in the ED or on the floor, and should get senior resident input whenever needed. Rarely, an intern may want to prescribe medications to someone who is leaving the ED. The case will be discussed with the senior anyway, and the question of medications can be addressed then. Phone call requests for refills are not in the scope of on-call duties, but in the rare case that it is indicated, the senior will need to call in the Rx with their own license and DEA numbers.

- **Patients Sent Out Of The Emergency Department:** Every patient that leaves the ED to return home (including board and cares, shelters, and others) will be presented in full to the senior resident prior to them leaving. This is important not only for the protection of the patient, but to the intern as well. If needed, the university attending will be called to review the case in addition. The intern will document in the notes who the case was discussed with (e.g. the case was discussed with and treatment plan approved by Dr. Jones).

- **Outside Phone Calls From Patients:** The intern will use their discretion regarding calling the senior backup. Outside calls tend to be straightforward, but can produce a lot of anxiety since you will only get a small part of the picture. In general, situations that require a change in medication or treatment also necessitate a formal evaluation in person. The patient can be asked to come to the ED, or 911 can be called to dispatch assistance to them. Feel free to ask for someone’s number, and call them back with your final decision after talking to the senior resident. All calls will be reviewed in sign-ins the following morning.

- **Floor Consults:** These need to be staffed by an attending within 24 hours. If an intern has concerns that can’t wait until morning sign-ins, they will call the senior resident. On weekends, the intern will inform the oncoming person of the consult so that they can present to the attending during weekend rounds (a copy of the consult note should be given to the oncoming person as well).

- **Patients Admitted To The Unit:** The intern will call the senior for questions about admission orders and medications overnight. If a problem particular to the unit comes up, call the university attending, or chief resident.

- **Patients Sent To Another Facility:** When someone is being admitted to CMH, another hospital, or a crisis house, they are being transferred to a safe environment, and a psychiatrist there will be in charge of
treatment. Therefore, unless there are specific concerns these patients can be presented in sign-ins the following day.

- **Patients Being Discharged From the Unit:** Any unscheduled discharge from the unit needs to be cleared by the university attending on-call. This includes AMA discharges for people who are not detainable.

- **Study Patients:** For questions related to patients enrolled in a research study, calls should go to Dr. Feifel. If any patient in a research study conducted by Dr. Feifel presents to the ED, he should be contacted immediately. If the patient is enrolled in an outside study, they should have a number for the study coordinator, and if not, attempts should be made to reach the attending involved in the study.

- **Patients With Outpatient Doctors:** When a patient with an outpatient doctor presents to the ED or calls, attempts should be made to coordinate care as much as possible. For patients getting care at the UCSD Outpatient Clinic, leave a voicemail with their doctor. For a patient followed by one of our attendings, consider paging the attending or calling them at home, but at the minimum leave a voice mail informing them of the events. For patients with private doctors, the task of getting information and providing appropriate disposition can be expedited by getting in touch with their office. The patient may have the number of their office or answering service, and frequently the private doctor can assist with admitting patients to one of the hospitals they service.

- **When To Call The Attending:** Anytime the intern believes it is necessary! Whenever a resident would like to discontinue a hold prior to discharging a patient. Whenever suicide risk is a concern. Serious or potentially serious adverse events. Prior to discharging a patient from the inpatient service or emergency room. If a resident is unable to reach the faculty attending who is on-call, they will try to reach the attending in charge of that patients care, the Site Director or the Residency Training Director, they will try the university chief resident first, then call the attending if needed.

5) **Supervision Guidelines (for residents): Policy for Graded Supervision and Transition of Care on Inpatient Psychiatry Service**

Effective July 1, 2011, the following policy will be in effect for resident’s duties/responsibilities on the 2-S Inpatient Psychiatric unit at the VA and the NBMU Inpatient unit at the UCSD medical center.

1. **PGY-1 Residents**
   - PGY-1 residents on Inpatient Psychiatry usually will carry no more than six patients at any given time.
   - The PGY-1 resident will see their patients under direct supervision (physical presence) of a senior resident (PGY-4) or the attending physician assigned to the patient.
   - An individual determination of PGY-1 residents will determine if they can move to indirect supervision at the end of the first week. When it is determined that they are able to see patients with indirect supervision, an in-house direct supervisor must be immediately available to discuss each patient seen by PGY-1 residents until they are certified as capable of caring for patients with indirect supervision and “supervision available”.

2. **PGY-2 Residents**
   - PGY-2 residents usually will carry no more than eight inpatient patients at a given time.
   - PGY-2 residents will be able to provide direct supervision to PGY-1 residents as long as documentation has been completed attesting to an individual PGY-2 resident’s ability to provide supervision to junior resident colleagues.

3. **PGY-4 Residents**
• PGY-4 residents will provide direct/indirect supervision to PGY-1 and PGY-2 residents on the unit at any given time. When PGY-1s and PGY-2s under their supervisions have reached their maximum (up to 6 and 8 patients respectively), PGY-4 residents will carry the additional patient assigned to that team.
• When PGY-4 residents are providing direct supervision to PGY-1 residents, the maximum number of inpatients being followed by a PGY-4 resident will be one or two.

6) Lines of Supervisory Responsibility:
• The attending Physician will have the final responsibility for the care of each patient admitted under his/her name or accepted for transfer to his/her care.
• Each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for the patient’s care. This information will be available to residents, faculty, and staff members, and patients. Residents and faculty members will inform patients of their respective roles in each patient’s care.

7) Resident Progression in Responsibility for Patient Care:
A resident will progress through the levels of supervision according to individual ability, based on observation of patient care in the hospital and subsequent evaluation by faculty members. All PGY-1 resident and new residents to the program will begin providing patient care under Direct Supervision. Each resident will be evaluated for progression to Indirect Supervision with Direct Supervision Immediately Available (Level A Supervision) by an assessment form; assessment forms by 2 different faculty members must attest that the resident is capable of providing patient care with Indirect Supervision if Direct Supervision is available within the hospital complex. It is expected that residents might be able to progress to this level of supervision within the first week assigned to an Indirect Supervision with Direct Supervision Available (Level B Supervision), which would permit the resident to provide patient care if phone supervision is available.

8) Resident Supervision of Junior Trainees
A resident who requires Direct Supervision will not be able to independently supervise medical students. Once a resident has progressed to Level A Supervision, he/she will be able to supervise medical students. Subsequently, a resident who has advanced to Level B supervision will be able to supervise junior psychiatric and non-psychiatric residents. These advanced residents will be able to serve in a supervisory role on the Inpatient, Consultation/Liaison, Emergency, Geriatric, and Outpatient Psychiatry rotations.

9) In-house (Attending)
• Each clinical rotation site must assign residents one or more attending supervisors who assume overall responsibility for the clinical care and management of all patients assigned to each resident at a given site (e.g. VA, UCSD).
• These attending supervisors generally are responsible for supervising residents on all administrative matters (e.g. monitoring and/or medical records) during the assigned rotation.
• Although residents frequently will be reviewing their cases with other teaching faculty and education supervisors (e.g. psychotherapy supervisors, case conferences, psychopharmacology rounds), any patient care recommendations generated from those sources should be reviewed and approved as directed by management decisions for that individual patient. Each individual attending supervisor should inform the resident under what clinical circumstances and within what time frame he/she needs to be consulted (e.g. evaluation of suicidality, hospitalization decisions, medication changes, discharge plans).
• Assigned attending supervisors will review and co-sign all required clinical documentation as per individual site/location administrative policies and requirements.

• Frequency of contact will be determined by the assigned attending supervisor in consideration of the specific residency education requirements for a particular clinical rotation. In general, the assigned attending supervisor will lead rounds 3-5 times weekly as well as weekly supervision.

• Attending supervisors generally are required to complete an electronic or written evaluation on each resident supervised. This should be reviewed by the supervisor with the assigned resident. The Residency Training Office and the involved resident should be informed promptly regarding any problems with the resident’s performance on any rotation, so that remediation and improvement are possible.

10) Other Clinical Supervisors
• In addition to attending supervisors, residents may be expected to review patients with a variety of additional individual or group supervisors and teaching faculty for academic purposes. This may include supervisors of various types of psychotherapy, case conference and grand rounds discussants, diagnostic conference leaders, and long-term psychotherapy supervisors.

• These academic supervisors are responsible for teaching residents clinical management techniques, generally in a defined area of expertise (e.g. how to conduct psychodynamic psychotherapy). Although they may make specific clinical recommendations to assigned residents, such recommendations are still subject to review and approval by resident’s assigned attending supervisor.

• Frequency of contact will be based on residency education requirements. In general, each resident has 2 hours of clinical supervision weekly in addition to case conferences, grand rounds and their teaching didactics.

• Academic supervisors are also required to complete an electronic or written evaluation on each resident supervised. This should be reviewed by the supervisor with the assigned resident. The program director and the involved resident should be informed promptly regarding any problems with the resident’s performance, so that remediation and improvement are possible.

11) Long-Term Psychotherapy Supervisors and Clinical Experiences

Residents in the general Psychiatry residency training program are expected to have supervised long-term psychotherapy training experiences of a year or more in duration, beginning in the PGY-2 year. The following principles have been adopted:

• All residents must have at least four supervised long-term psychotherapy experiences of a year or more in duration.

• All residents should become introduced to supervised long-term psychotherapy no later than the second six months of the PGY-2 year. PGY-2 residents are expected to do 2 CBT cases in their PGY-2 year and also have the option of starting a psychodynamic case. PGY-3 residents are expected to do 4-6 hours/week of psychotherapy cases, at least 2 of which are psychodynamic cases.

• Service chiefs, supervisors, and residents should work together to develop schedules that will provide for up to 2 hours a week for psychotherapy cases and associated supervision during the PGY-2 year and 4-6 hours in the PGY-3 and PGY-4 year.
12) Individual Supervision Guidelines for Residents

What follows is a distillation of years of educational wisdom passed on through generations of psychiatrists and psychotherapists, our own experiences, plus empirical data where available. We hope you find this helpful.

1. We believe supervision is a critical method for the acquisition of certain clinical and psychotherapeutic skills, and an integral part of your education. Careful supervision and observation are required to determine the psychiatry residents’ abilities to obtain and interpret psychiatric data and to manage patients. Because residents are not licensed independent practitioners, psychiatry residents must be given graded levels of responsibility while assuring quality care for patients. Supervision of psychiatry residents should be graded to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning credentialed psychiatrist. Any resident who is not receiving an adequate quality and quantity of supervision is being cheated. If you have problems connecting with, contacting, seeing, or getting along with your supervisor, please let Alana or me know immediately.

2. We sometimes use the term “supervisor” interchangeably to refer to 3 separate roles and functions:

- **Mentors** are assigned to provide professional and personal guidance. Before beginning training, each resident is assigned a faculty mentor and a resident “big sib” to help with the transition to physicianhood and acclimation to the training program. Sometimes, these form the nucleus of life-long relationships. During training, the trainee often selects additional mentors, especially for their PGY4 Independent Study Project and for career advice and development.

- At every site, and for every patient, residents have **attending supervisors** who are ultimately responsible for the diagnosis, treatment and care of the patient. The attending supervisor is the immediate supervisor of a resident and is identifiable, appropriately-credentialed and privileged for the specific procedures and activities that are being supervised. This information should be available to residents, faculty members, staff and patients. Residents and faculty members should inform patients of their respective roles in each patient’s care.

- Residents receive additional preceptorship from **clinical supervisors** who may be from the salaried or full time faculty but may also be from our volunteer (“outside”) faculty. Most often, this voluntary clinical faculty is not credentialed by the clinical site, but will meet you at your training site or office. They participate in our training program as key members of our teaching faculty, often sharing their clinical experience and wisdom with our trainees. Many of our best seminar leaders and most seasoned psychotherapy supervisors come from our clinical volunteer faculty. They cannot write orders or dictate treatment, but have a critical teaching and training role.

- During the first year, each PGY-1 is assigned a faculty mentor who should meet with the intern as often as the two see fit. The role of the mentor is to guide the trainee in any area relevant to their training. In addition, interns are always taught by their attending supervisors who have primary diagnosis for the diagnosis and treatment of each patient. These (“in-house”) attending supervisors and senior residents from on your service should be supervising you in rounds as well as individually on a weekly basis. Finally, each intern should have **at least one clinical supervisor** from our volunteer (“outside”) faculty meeting weekly with you, whenever you are on NMBU or 2-S. These supervisors generally meet with you at pre-assigned times. In your PG1 year, supervision is focused...
on your inpatients

- During PGY-2 and PGY-3 years, residents are assigned two clinical supervisors who meet with them weekly. This is in addition to teaching that residents receive from full-time attending faculty, senior residents, specialty and continuity clinic attendings, mini-clinic attendings and faculty and service chiefs. For PGY-2s, the clinical supervisors should meet with residents whenever residents are on a VA psychiatric rotation. Supervisors can and will discuss inpatients or outpatients with you. At least one of these clinical supervisors will have expertise in cognitive-behavioral psychotherapy (usually as part of your continuity clinic). You will see that supervisor each week. This is meant to prepare and assist residents for treating at least 2 CBT patients during the year, often, during clinic time. In most cases, the CBT patient will come from your clinic and can be seen during or immediately after the regular clinic time. As the PGY-2 year progresses, you may choose to also see a dynamic psychotherapy patient who can be supervised by your other supervisor(s). The other supervisor will always meet with you when you are at the VA, but you both may need to be creative and flexible on your non-VA months. If the resident and supervisor can arrange it, we encourage them to try to continue meeting during months away (e.g. Cl, Gero or Child), although we know this isn’t always possible. Do not wait until you have a dynamic psychotherapy patient to begin meeting with the supervisor, as they can assist you with clinical issues and patient management on any patient from any service. Please call your supervisors as soon as assignments are made so you don’t lose any valuable time. Many other services (e.g. MHAC, CL, SAARTP, geriatric psychiatry) also supply additional service-oriented supervisors. Should you have any questions, please address them to Sid, Sanjai (the Site Director) or Alana (the Psychotherapy Director).

- In the PGY3 year, the emphasis shifts more to other evidence based treatments and dynamic psychotherapy and supervisors are assigned accordingly. Should you have any questions, please address them to Sid, Larry (the Site Director) Alana (the Psychotherapy Director) or Charlie (the OPS psychotherapy director).

- PGY-4s should receive supervision from mentors, service chiefs, administrative supervisors and at least one clinical supervisor. The number, nature and frequency of this supervision varies considerably from resident to resident. Supervision from other faculty on an “as needed basis” is always available at your initiation. Senior residents are also assigned 1-2 volunteer faculty psychotherapy supervisors, and we try to honor special requests for senior residents regarding supervisors and mentors.

- Any resident who would like additional supervision should contact Sid, Alana, Kurt Lindemann, their Site Director (Louisa Steiger, Sanjai Rao or Larry Malak), or their Chief Resident immediately. If residents have impasses with their supervisor that cannot be worked out, contact one of us immediately. If you have a particular interest (e.g. forensics, molecular biology, ECT, etc.) and would like to meet with someone around those interests, either contact them directly, if you know who they are, or see Sid. We aim to please.

- Your supervisors serve several important roles in your development as psychiatrists. They can be sounding boards, clinical instructors, mentors, and/or role models. Many of our graduates have rated their supervision among their most valuable learning experiences. You and your supervisors should discuss mutual goals and expectations early on. There are no hard and fast rules on what to discuss, and every resident-supervisor dyad is unique. However, learning about psychotherapy does get personal and some personal issues may become the focus of supervision.
Supervision is what you and your supervisor agree it is and should be. You need to be proactive about discussing this with your supervisor. Ask questions. It is okay and expected that you are not yet an expert psychiatric physician, or, for that matter, an expert in the fine art of using supervision. This can be part of what your supervision is about.

Many residents have found it useful to have supervisors interview selected patients with them, have the supervisor observe the resident interviewing, discuss detailed process notes from one or two psychotherapy patients, discuss clinical problems, discuss questions arising from seminars or reading, discuss areas of perceived weakness, etc. Videotaping and viewing equipment are available at all clinical sites. If you experience difficulties with this, let the Chief Resident or the Site Director know. This is a greatly underutilized learning modality. We encourage you all to videotape at least some patients each year. Many of your supervisors will be happy to review the tapes with you.

The goals of supervision include 1) development of technical (including use of psychotherapy and of medications) and interpersonal skills; 2) support examination and management of clinical work; 3) quality assurance; 4) transmission of professional values.

Although personal psychotherapy is not one of the goals of supervision, given the regular, structured, one-on-one contact between trainee and supervisor, development of rapport, disclosure of personal experiences, and power imbalance (features that are an integral part of both supervision and psychotherapy), the boundaries sometimes can blur. This is not to say that important personal insight and understanding cannot or should not occur during supervision. They should. In both psychotherapy and supervision boundaries crossings (e.g., certain amount of self-disclosure) can be helpful; boundaries violations, in contrast, are hurtful and wrong. What you discuss in supervision is confidential, but supervision does not equate to personal therapy. It is appropriate to discuss your reactions to patients, countertransference issues, and how best to cope with the stresses of patient care and residency training. You should discuss with your supervisor what personal material you feel comfortable discussing.

Some supervisors are better at teaching psychotherapy, some pharmacotherapy, and some are equally adept at helping with both. We try to balance your supervisors to give you both excellence in psychotherapy and psychopharmacological instruction. Try to maximize the unique skills and proficiencies of each of your supervisors. Sometimes you will get conflicting opinions from different supervisors. This can be confusing. Learning to live with ambiguity and uncertainty while developing your own unique style, incorporating the best of your many supervisors and mentors, is part of becoming a psychiatrist.

There are as many types of supervision as there are supervisors. Some see patients with you, some talk and teach, some never say a word until you speak (dreaded silence!), others have a specific agenda and others are there for “whatever you need each and every week”. You may even feel that you “know more than your supervisor”, or you may feel you will never know as much. Chances are, you are wrong on both counts.

Be creative and efficient with you supervision time. Have your supervisor interview a new admission for you. Do you have a difficult patient? Watch how your supervisor handles the problems in real time (this can be more informative than hearing what you “should have said” before the patient refused to talk to you any further, left the room and is now permanently mute, glaring across the room at you). Have your supervisor watch you interview a new, difficult or interesting patient; get feedback on your style as well as patient management.
• **Practical Points:**
  a) Keep your meetings with your supervisors and be punctual and professional. Please always let them know when you will not be able to make your appointment, such as because of illness, vacation, shifting rotations, or clinical or medical emergencies.

  b) For PGY2s, during your time spent at Child, NBMU, Geropsychiatry, or CL, you will need to discuss with your supervisor whether and when to meet. You may elect to touch base by phone, or to meet before or after hours. The supervisor may have even less flexibility than you!

  c) Supervision is not just for psychotherapy. Thus, not having a psychotherapy patient is not an excuse not to meet. Supervision is for all aspects of patient management, including interviewing skills, teaching others, medication management, administration, time management, career advice, etc. Make the most of it!

  d) The RTO has 2 video cameras for your use. NBMU and the Outpatient Psychiatric Services also have video cameras you may use. Please use them. By far the best psychotherapy supervision comes from recording your sessions and reviewing with a supervisor. Let your Chief Resident or one of us know if you need directions on using the cameras or on where to find playback equipment.

• **Supervision is not an option.** It is our responsibility to provide it, and yours to make sure it happens. You will be presented with the names and phone number and e-mails (if available) of your supervisors. In some cases, the first meeting will be already scheduled for you. In others, you will need to call their office to set up the first appointment. Please make sure you do this. Do not let more than one week go by without setting up an appointment for your supervision. Each supervisor has agreed to meet with you on site. They have been pre-assigned on the basis of the geographical location most convenient for them. If you need to change or cancel an appointment with one of your supervisors, always let them know with as much lead-time as possible.

• Your supervisor will be asked to evaluate you and to document that you have attended at least 70% of your weekly supervisory sessions. This is an important part of your training and important for your promotion. You will also be asked to evaluate them. We encourage supervisor and supervisee to share evaluations on an on-going basis and formally during the last session.

We hope this information is helpful. We would be happy to discuss these issues with any of you in more detail. Please provide feedback about any of this to us directly or through your GEC representative. Enclosed is an article on supervision we thought you might find interesting. Please feel free to discuss this document or the accompanying article with your supervisor.

**G. Duty Hours: Working Conditions**

**Policies and Procedures for Residents’ Duty Hours and Work Environment**

**Duty Hours:** Duty hours are defined as all clinical and academic activities related to the residency program, including inpatient and outpatient care, administrative duties relative to patient care, 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.
1) Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. All moonlighting hours, either external or internal, must be logged and included in the 80 hour maximum per week.

2) Residents are provided with at least 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties. At-home call cannot be assigned on these free days.

3) PGY-1 and PGY-2 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

4) Residents in the final years of education, PGY-3 and PGY-4 residents, must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. (a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

5) Duty periods of PGY-1 residents must not exceed 16 hours in duration. (There is no 4 hour transition period).

6) PGY-2-4 residents must be scheduled for in-house call no more frequently than every-third-night. Averaging is not allowed.

7) Duty periods of PGY-2-4 residents may be scheduled to a maximum of 24 hours of continuous duty in the hospital. It is essential for patient safety and resident education that effective transitions in care occur. This period of time must be no longer than an additional four hours.

8) PGY-2 residents must have at least 14 hours free of duty after 24 hours of in-house duty.

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

10) Residents must not be scheduled for more than six consecutive nights of night float.

11) At-home call (or pager call): At-home call is not so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call are provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

12) When residents are asked to assume patient care responsibility as part of the “on-call back up system” (that is, to assume the clinical assignment of another resident because of that resident’s inability to assume that assignment for any reason), the above restrictions on clinical assignment are applied, and the hours worked for the absent resident are included in the “back-up” resident’s duty hours tally.

13) The Program Director and Site Directors will monitor the clinical demands of all residents and will make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue, whatever the reason(s) for that fatigue.

H. Call: Monitoring of Compliance with Duty Hour Restrictions
Residents are required to maintain accurate records of their actual duty hours through use of New Innovations ‘Duty-hours Module’, an on-line, Web-based system for recording actual hours worked. Compliance with duty hour restrictions will be monitored by the Training Director and Training Administrator using the reports available through New Innovations as well as resident surveys, monthly Residency Training Committee (RTC) meetings, reports from Chief Residents’ meetings, semi-annual evaluation meetings and an encouragement for residents to bring any duty hour violations forward.

Faculty and Chief Residents are required to monitor adherence to duty hour policies. Residents will not be scheduled for clinical duties in excess of these policies, and residents must not be requested or required to remain on duty beyond the time periods stipulated below. When patient care needs exceed the availability of residents to care for
those patients within the above duty hours restrictions, alternative staffing will be developed. Residents must notify responsible faculty, the Chief Residents and Program, Associate or Site Director if such circumstances exist. In the short term, however, duty hour restrictions should not serve as a reason to jeopardize patient safety.

**Failure to Comply:** Residents who fail to comply with duty hour restrictions will be reminded of the policies and, whenever possible, sent home. Repeated instances of non-compliance will be regarded as failure to adhere to accepted standards of professionalism.

**Protocol for Episodes When Residents Remain on Duty Beyond Scheduled Hours**

We take duty hours seriously and consider them as important patient care and resident wellness guides. It is the professional responsibility of each resident to avoid excessive fatigue and respect patient safety needs by adhering to duty hours restrictions. Our goal is to have as close as 100% adherence as possible, but we recognize that there might be occasions when this is not possible.

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must:

- Appropriately hand over the care of all other patients to the team responsible for their continuing care.
- Document the reasons for remaining to care for the patient in question on New Innovations and in a written note to the Training and Site Directors describing the nature and reasons for the event.
- The program and site directors will review each submission of additional service and tracks both individual resident and program-wide episodes of additional duty.

I. **Time Off:** Residents, on average, have at least one full day off every week and at least 10 hours off between all scheduled daily duty shifts and often in-house call (see Working Hours for more details).

I. **Annual Leave:** Residents have a total of four weeks of vacation leave annually. Taking vacation leave will be subject to the following guidelines:

1. Forms are available from the Residency Training Office and must be submitted for approval at least 60 days in advance. This will allow adequate time for on-call scheduling and service coverage. Vacation requests will be reviewed on a first-come, first-serve basis.
2. Signatures from the appropriate rotation Attending, Chief Resident and Primary Care or other Specialty Clinic is mandatory prior to submitting vacation request to the RTO for approval.
3. Vacation leave must be taken in a minimum of one-week blocks and no more than a two-week block of time.
4. Vacation leave may not be carried over from one training year to the next.
5. **No terminal vacation leave will be paid.**
6. PGY I & II residents must take **two weeks of vacation in each six-month period** (July-December and January-June). Only one PGY-I/II year resident may be on vacation from any service at a time. Vacation will be allocated among the PGY I & II year clinical services according to the following schedule:
7. UCSD Medical Center Inpatient Service (West Wing): avoided whenever possible.
8. **No vacation last 2 weeks in June unless pre-assigned by RTO.**
9. UCSD Outpatient Psychiatric Services: no vacation in first two months of rotation or last two weeks of rotation.
10. Always remember to notify all of your clinical services of any time away (e.g., Primary Care Clinic) so that they can arrange for patient care. Clinic cancellations must be made at least 2 months in advance.
11. **USE IT OR LOSE IT!! VACATION MUST BE TAKEN ACCORDING TO THESE GUIDELINES.**
K. Educational Leave: up to 3 days yearly (PGY 2-4) with the approval of service chief and arrangement for adequate coverage. Up to 5 days if presenting a paper or an abstract or given an award. This is meant to provide residents the opportunity to attend continuing education meetings to supplement their training. To be excused without having to use your vacation time, the resident must provide the Residency Training Office with a conference brochure and request, signed by the service chief, at least 60 days before the scheduled conference.

L. Family And Medical Leave During Residency

1. Residents are eligible for up to 4 months of pregnancy/childbearing disability leave during residency. It is understood that residents may not be able to anticipate leave needs at the time of this request.
2. Residents may apply their 20 days annual leave (AL) and 12 days of sick leave (SL) toward their family leave. Additional accrued sick leave may be applied up to 30 days total. Maximum AL+ASL = 50 days per year.
3. Any resident wanting to take time beyond the number of AL/SL days also needs to apply for Family Medical Leave Act (FMLA) through the GME. All residents (male and female) are eligible to apply for FMLA and take up to 12 weeks leave that shall run concurrently with FMLA under Federal law. Residents are required to work at least 1,250 hours within a 12 month period and to have 12 cumulative months of residency to be eligible for FMLA.

<table>
<thead>
<tr>
<th>Anticipated Amount of Time Taken for Leave</th>
<th>AL/SL/FMLA days</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 weeks</td>
<td>20 days</td>
</tr>
<tr>
<td>6 weeks</td>
<td>30 days</td>
</tr>
<tr>
<td>8 weeks</td>
<td>40 days</td>
</tr>
<tr>
<td>10 weeks</td>
<td>50 days</td>
</tr>
<tr>
<td>12 weeks</td>
<td>60 days</td>
</tr>
<tr>
<td>&gt; 12 weeks</td>
<td>&gt;60 days</td>
</tr>
</tbody>
</table>

4. Upon termination of a pregnancy disability leave that runs concurrently with FMLA, a House Officer is also entitled to up to 12 work weeks of State family and medical leave (designated as Supplemental Family and Medical Leave).
5. Residents will be paid during their AL/SL/ASL leave but not during FMLA time. During FMLA time the resident is paid with disability insurance at 60% of salary.
6. Whether a resident will need to repeat a rotation or extend the residency depends on how much time was missed and whether the missed rotations were required by ACGME, an Education Plan, or elective. Elective options in your PG4 year may be used to accommodate your residency requirements. ACGME required rotations:

- 4 months Medicine
- 2 months C/L
- 2 months Child
- 2 months Neurology
- 2 months ADTP
- 12 months Consecutive Outpatient
- 6 months Inpatient
- 1 month Geropsychiatry
- 1 month Geropsychiatry

7. Residents are encouraged, when possible, to cover call responsibilities either before or after their leave and work with the clinical services to assure their patients are covered during their leave.
M. **On-Call Facilities:** In-house private and secure sleep and rest space with bathroom facilities is provided.

N. **Grievances:** Residents may bring grievances regarding working conditions to the Department of Psychiatry, Resident Training Committee (RTC), or to the Residency Training Director privately. Residents may also discuss any grievances privately and confidentially with the Executive Vice-Chair of the Department (Dr. Igor Grant), the UCSD Office of the Ombudsman, or with the Institutional Director of Medical Education (Dr. Steve Hayden). In addition, residents may provide anonymous comments on the Department of Psychiatry Resident Training website and/or the institutional anonymous feedback folder on the UCSD GME website.

O. **Sexual Harassment:** No resident should ever be sexually harassed, exploited, or intimidated by another house officer, instructor, or faculty member. Any such intrusion should be reported to the administrative supervisor and/or residency training director immediately. Please refer to the UCSD policy statement.

P. **Monitoring Working Conditions (Including Resident Stress And Fatigue):** In accordance with UCSD and ACGME guidelines, the faculty and Residency Training Office will ensure that resident working conditions are in compliance with the above and that the work environment should minimize undue stress and resident fatigue. To do this, we will:

- Ensure grievances are heard (see “N” above)
- Assign 2 mentors (a faculty and a resident) to each incoming resident to help ease their transition, help with personal issues and monitor well-being.
- Provide support group for all PGY2’s, elective thereafter.
- Provide no cost /low cost psychotherapy for all interested residents.
- Maintain availability of Associate Training Directors, Site Directors and Chief Residents who are available to all residents, in each year, and who meet regularly with each class.
- Maintain meetings of each class with the Residency Training Director (Dr. Zisook) on a regular basis.
- Maintain an open door policy with the Residency Training Office. Residents are always welcome.
- Discuss residency issues, including stress, and working conditions and resident well-being at each monthly RTC meeting. Each class has at least 2 representatives on that committee. The representatives are given the responsibility of bringing information to and from the residents in their year.
- Require residents to regularly complete evaluations of each rotation and of the program which will be reviewed by the Residency Training Director.
- Semi-annual face-to-face meetings (Minimally every 6 months) to discuss resident evaluation of program, stress-levels and evaluation of resident.
- At monthly meetings of CCC and/or ERTC (Program Director, Associate Training Directors, Site Directors and Vice-Chairs for Training and Clinical Affairs) resident performance will be discussed. If any resident’s performance seems to be falling, or if any resident appears overly stressed or fatigued, appropriate action will be taken.
- Empower resident call committee to maintain and update on-call lists, back-up systems, mechanism to relieve fatigued or stressed residents and develop fatigue mitigation policy (in consultation with Dr. Sonia Ancoli-Israel).
- Biannual resident retreats and quarterly “all residents” meetings to discuss work conditions and meet with training leadership as requested by residents.
- Regularly review residents’ anonymous feedback on the training website and discuss responses at “all resident” meetings.

Q. **Fatigue Policy Of UCSD Psychiatry Residency**

1) First and foremost, we emphasize that adherence with each of the ACGME duty-hours requirements is consistent with good patient care as well as resident well-being. Thus, we make adherence with the requirements the professional responsibility of the training administration, chief residents and each and
every resident. We carefully monitor adherence and make adjustments to duty hours as necessary. We recognize that the duty hours don’t, in themselves, guarantee that residents will always be ‘fit for duty’ and are prepared to make accommodations (e.g., more rest time between scheduled activities or reduced call burden) as needed.

2) Faculty and residents are educated to recognize the signs of fatigue, starting with new Residency Orientation and reinforced at (almost) annual grand rounds with Dr. Sonia Ancoli Israel. In 2012-3, we added a PGY1 and 2 didactic sessions in the Crash Course on ‘fatigue management’.

3) The UCSD Office of Graduate Medical Education (OGME) provides a “Core Training Modules” which is available as a link on the OGME website (http://meded.ucsd.edu/gme) and meets ACGME requirements for education in sleep deprivation and fatigue. This module is mandatory for all House Officers at UCSD and participation will be tracked through the online delivery system and provided to program directors and coordinators. In addition, this module is available to all faculty. Faculty will be encouraged to view this training module annually, with particular reminders to those not able to attend the grand rounds presentation noted above.

4) The training program, at the level of both Chief Resident and Program Director, will adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and monitor the demands of call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. Residents are informed of this on arrival and orientation to the program. The Chief Resident and Program Director are charged to monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged.

5) Policies and procedures have been developed to prevent and counteract the potential negative effects of fatigue. If a resident feels fatigued and unable to drive home, he/she will be reimbursed the expense of a taxi/cab home and back to the assigned institution to retrieve their vehicle. We also maintain backup call systems to assist residents when the clinical demands become excessive or to relieve them if they become unable to function effectively.

6) As role models, teaching faculty members must demonstrate an understanding and acceptance of their personal role in the following: assurance of the safety and welfare of patients entrusted to their care; provision of patient- and family–centered care; assurance of their fitness for management of their time before, during, and after clinical assignments; recognition of impairment, including illness and fatigue, in themselves and in their peers; attention to lifelong learning; the monitoring of their patient care performance improvement indicators; and, honest and accurate reporting of duty hours, patient outcomes and clinical experience data.

7) The departmental policy, communicated to residents at orientation, is that all residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.

8) Alertness Management/Fatigue Mitigation: The program educates all faculty members and residents to recognize the signs of fatigue and sleep deprivation, and it educates all faculty members and residents in alertness management and fatigue mitigation processes; the program has a fatigue mitigation process to manage the potential negative effects of fatigue on patient care and learning, such as strategic naps and back-up call schedules. The program has a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties. The sponsoring institution provides sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.
R. On-Call Policy

On Call
The frequency of call varies from time to time, depending on "person power", service needs and educational issues. As a department, we are committed to staying well within the UCSD and ACGME guidelines regarding call frequency. In general, interns (PGY-I's) will have 4 5-day long tandem floats and some weekend at UCSD. Float is done in 5 day increments during a block when otherwise assigned to NBMU. For PGY1s, float and call is always with a more senior resident. PGY-II’s can be expected to be on call at the VA, predominantly as 6-day float rotations, approximately 4 weeks a year in addition to some week-end duty. PGY-III’s will have about 4 weeks of float-call at UCSD and some week-end call, generally with PGY1s. PGY-IV’s provide week-end call no more than about one week-end every six to ten weeks.

Resident Call Committee
The resident call committee sets policy, adjudicates disputes and ensures responsiveness to duty hour regulations and resident fatigue. It is comprised of resident representatives of each year of training and chaired by an elected senior resident (ideally not a chief resident).

Faculty In Charge
The faculty will be available by phone in a supervisory capacity on a rotating basis. Faculty are the physicians in charge’ with ultimate responsibility for patient care and outcome.

Selling Call
The Department expressly forbids selling of scheduled on-call assignments and such activity may serve as grounds for discontinuation of a resident in the program.

Trading Call
All call trades must be presented to the chief residents. It is the responsibility of the residents trading call and the chief resident to ensure there are no service conflicts and that all services (VA psych main office, UCSD Med Center operators, RTO) are informed at least 30 days prior to the change. Until this information is received, the resident originally scheduled is considered the responsible physician.

Back up System
The back up call calendar is listed and maintained on Google calendar. There are two second year residents on back up for every night, a primary back up and secondary back up.

Primary Back Up:
The role of the primary backup is to come in when: 1) someone on call at the VA or UCSD Medical Center becomes ill, has a conflicting clinical emergency, or has a personal emergency, or 2) if the person on call at either location gets overwhelmed with patients that have not been seen (overwhelmed is defined here as having more than 6 patients who are waiting to be evaluated without having been seen yet).

Primary backup should only be called in by a Chief Resident or their designate. If there are more than 6 patients who have yet to be seen in the ER, the Chief Resident should be called to arrange for the backup resident come in to help. Backup residents will be responsible for coming to the hospital to assist the person on call until midnight, at which time they will be expected to leave the on call resident to finish, or until the patient burden is reduced to less than 6, whichever occurs first. If the backup resident is being called in due to an overwhelming number of patients, he/she can only be called in prior to 10pm. Because the backup resident is expected to leave the hospital by midnight, they will be required to come to work the next day, but would not be expected prior to 9am the following day. Should an overwhelming number of patients occur a second time in one week, it will be the responsibility of the senior backup
person to come in to assist, again until midnight or until the burden of patients is reduced below 6 patients who have yet to be evaluated.

**Secondary Back Up:**
This person will likely (hopefully) not be utilized much. The role of secondary backup will be to 1) come in should both people at NBMU and VAMC have emergencies or are sick on the same night, 2) to come in the second night and thereafter should someone have extended illness while on night float.

***The person assigned to back up must be in town, available by pager or phone and respond to page or phone call within 30 minutes of being called. The backup person is then expected to be at the hospital within one hour of being called in.***

**Pay Back**
There is a payback system in place in case the backup resident gets called in to take a call. In general, the resident will be "repaid" 2 calls for each call period worked by the person they relieved.

**Changing Back Up Call**
Residents may switch back up calls only after approval by the chief resident who will update Google calendar. Primary and secondary backup can be anyone on Gero, SAARTP, CAPS, research, or other ‘optional’ rotation blocks. 2S is a “last resort” when necessary. Backups cannot be on PEC or CL.

**Fatigue Mitigation:**
After 16 consecutive hours of duty and/or between the hours of 11pm and 7am, brief strategic napping is encouraged. Clinical judgment should be utilized. The call committee has been asked to recommend a policy and Dr. Sonia Ancoli Israel has agreed to consult and advise. Any time a house officer is too fatigued to safely drive from any clinical duty, including in-hospital call, they should call a taxi, Uber and will be reimbursed by the department or hospital.

**S. 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.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Programs must design clinical assignments to minimize the number of transitions in patient care.</td>
<td>• Implement a standardized approach to &quot;handoff&quot; communications including an opportunity to ask and respond to questions</td>
</tr>
<tr>
<td>• Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes that facilitate both continuity of care and patient safety.</td>
<td>Expectations:</td>
</tr>
<tr>
<td>• Programs must ensure that residents are competent in communicating with team members in the hand-over process.</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Below are our current handoff procedures for the VA, UCSD Hospital and Outpatient Service.

**Sign Outs and Handoffs at the VA – 2S/ADTP/PEC/MHAC 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 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 (i.e., your fellow resident on your team, your senior resident, etc.) – it is not OK for the PEC/MHAC 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/MHAC 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/MHAC resident (if you leave prior to 6:30pm). 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/MHAC 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 (i.e., what to use as prn in case of agitation or pain, allergies or adverse reactions to medications)
5. The PEC/MHAC 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**

1. In the morning, all treating residents, including the PEC/MHAC 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.

2. 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.

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

4. 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/MHAC residents are always expected to attend; other VA-based residents are encouraged to attend. The senior resident or Attending Psychiatrist leaders are:
   - Monday – Best
   - Wednesday – Best
   - Friday – Best and Iglewicz

**Off-Service Hand Offs**

5. 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 CL 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

**T. Moonlighting Policy**

Moonlighting, i.e. medical practice after the workday (8 am to 5 pm) MUST be reviewed and approved by the Residency Training Director. Factors to be considered are: 1) the place of activity, 2) hours worked, 3) the available supervision, and 4) the malpractice/liability coverage. First year residents are not allowed to moonlight. Moonlighting must not interfere with the educational mission of the program. Thus, moonlighting should never occur during regular work hours, limit the resident’s ability to prepare for seminars or read pertinent psychiatric literature, cause the resident fatigue during the day or night call, conflict with clinical responsibilities, or endanger the resident’s health.

Moonlighting is allowed as long as the resident first informs the training director in writing (the document becomes part of the resident’s file) and does not interfere with the ability of the resident to achieve the goals and objectives of the training program. When a resident’s performance falls short of our program’s expectations (as recorded by formal evaluations, attendance at didactics, examination results or personal observations), the resident and training director meet, and moonlighting privileges may be revoked or limited. Residents will be advised that the combination of their residency plus all moonlighting activities should not exceed 80 hours per week.

The Chief Residents will assist the residents and residency training director in keeping an up to date list of all moonlighting opportunities and be available to consult with the residents about any moonlighting concerns. They also will develop and monitor ‘call-lists’ for all moonlighting that occurs within the residency program.
Daylighting, (the leaving of clinical services early for moonlighting jobs) and the selling of scheduled on-call assignments, is expressly forbidden by the Department and such activities may serve as grounds for discontinuation of a resident in the program.

U. Suicide/ Adverse Event Protocol
This protocol was created to ensure that residents get proper support in situations where their patient has had a completed suicide, attempted suicide or serious adverse event. As a junior resident, please follow the following checklists. These are divided based on the site you are at. If you are at the hospital, like WW or VA, you would use the hospital checklist. If you are at Gifford clinic or an outpatient clinic, you would use the outpatient checklist. The checklist and protocol can be found on I-share.

Junior Resident Suicide or Adverse Event Checklist (Hospital)
- Senior resident and attending involved with patient were notified
- Immediate check-in with either senior resident or attending occurred
- Discussion about how patient family interactions should be handled (junior resident, senior resident, attending)
- Resident assisted with immediate duties and given option to leave (If during business hours treatment team and senior resident will facilitate this. If on call, second call system may be utilized)
- Resident offered days off as appropriate and offered up to 5 days without call
- eQVR filed for UCSD cases, Suicide Behavior Report filed for VA cases
- Team debriefing including involved attending, all involved residents, involved medical students, an nursing if appropriate within 1 week of event
- Individual meeting with designated check-in/support person within one week of event
- Follow up meeting with check-in support person within 8 weeks following event
- Additional treatment arranged for resident if indicated (resident/check-in person decide together)
- Completed checklist submitted to quality assurance representative within 10 weeks

Guidelines for Checklist
- Checklist is to be completed after any serious suicide attempt, adverse event or completed suicide.
- Junior resident and senior resident should work together to complete the checklist. On services where there is no senior resident junior resident and attending should work together to complete the checklist.
- Senior resident is responsible for helping junior resident at each step and for turning in completed checklist. On services where there is no senior resident, attending is responsible to helping junior resident and for turning in completed checklist.

Check-In Support Persons Options
- Richard Avery, LCSW 619-543-0064
- Nancy Downs, M.D. 858-232-4660
- David Garmon, M.D.858-535-9121
- Julie Kuck, Ph.D. 619-281-1932

UCSD Outpatient Psychiatric Services Suicide or Adverse Event Checklist
- Residents and Psychology/MFT/Social Work Interns and supervisor/faculty attending involved with patient were notified as quickly as possible. Primary clinician and supervisor/attending assume responsibility to inform other team members
- Supervisors/attendings and trainees (ie residents and/or interns) meet/talk for immediate brief check-in
- Determine how patient family interactions will be handled (intern/resident, senior resident, fellow, supervisor/faculty attending, Medical Director, together)
• Trainee(s) assisted with immediate duties and option to leave was assessed (If during business hours treatment team and senior resident/faculty will facilitate this)
• Trainee(s) offered days off as appropriate and offered days without call
• eQVR filed by trainee or supervisor
• Supervisor or faculty attending telephones Program Director (Gifford or COD) within 24 hours who will report to County QI staff
• Supervisor or faculty attending completes County Serious Incident Report within 48 hours and give to Program Director to fax to County QI staff.
• Department chair’s office was notified by supervisor/attending
• Team debriefing occurred including faculty attending, all involved residents/interns, medical students, other trainees and nursing if appropriate within 1 week of event
• Trainee had an individual meeting with designated check-in/support person within one week of event
• Trainee had a follow up meeting with check-in support person 4-8 weeks following event
• Additional treatment arranged for trainee if indicated (resident/trainee check-in person decide together)
• Case reviewed during team meeting or special meeting to include all trainees, staff and supervisors/attendings involved in patient’s care and the County Serious Incident Report Case Summary completed by supervisor/attending and given to Program Director within 30 days of the event
• Case presented at the Departmental Peer review meeting

Completed checklist submitted to Department of Psychiatry Quality Improvement Representative within 10 wks.

V. Evaluation / Advancement

Evaluation Overview
The UCSD Psychiatry Residency Training Program defines ongoing evaluation of both residents and faculty performance as a mutual obligation. In addition, both residents and faculty must at regular intervals evaluate the Training Program as a whole as to whether it provides the means to meet the overall goals and objectives of residency training. Residents are evaluated in each of their clinical training services before its conclusion. If significant problems are identified they should receive feedback and recommendations for improvement earlier. In turn, each faculty member, seminar, and clinical service is evaluated anonymously by each resident. All evaluations must be supplemented by direct feedback between resident and faculty member during the process of working together.

Evaluations of performance in clinical services and didactic seminars are based on meeting two standards: 1) satisfying the specific goals and objectives of a clinical service or didactic seminar, and 2) satisfying the goals and objectives of six core clinical competencies: patient care, medical knowledge, interpersonal and communication skills, practice-based learning improvement, professionalism, and systems-based practice. The resident must demonstrate increasing competency in each core area, as it pertains to particular clinical techniques or modalities, and in different settings.

It should be noted that “competency” is a relative term and should be assessed at the developmental level for a particular trainee. For example, one would expect the “competency” of a resident at the end of the first year, in the management of a case, to be different from that of a Board certified psychiatrist 5 years out in practice. As physicians, we must see practice in the context of “life-long learning”, and our evaluations should reflect the minimal standards of competent care for the developmental level of the individual being evaluated.

Supervisors’ Evaluations of Residents
At the end of each rotation (or every 6 months for outpatient supervision), individual supervisors, service chiefs and senior residents are asked to provide comprehensive written evaluations of the resident’s progress. We expect the resident and supervisor will discuss the evaluation before or during the last supervisory session. The resident and
supervisor should review and sign the evaluation together, and the evaluation is posted on New Innovations, or, if necessary, returned to the Residency Training Office. In addition, based on the acquisition of phase appropriate knowledge, skills and behavior, as noted in this manual, the service chief or attending ‘in charge for each rotation will certify that the resident has passed each rotation; if deficiencies are noted, the service chief and resident will discuss methods of remediation. Evaluations are reviewed by the Training Director and made a part of the resident’s file. Note: All faculty evaluations are available to residents through New Innovations and residents are always welcome to review summative evaluations and other collated evaluations are kept in each resident’s personal file.

Any failed or conditional evaluations are reviewed at the next Executive Residency Training Committee.

**To successfully progress to the next year in training, residents are expected to pass each rotation.** A failed rotation or 2 ‘conditionally passed’ rotations will automatically trigger discussions/consideration of formal remediation plans and/or a ‘Letter of Warning’ (per UC San Diego House Officer Policy and Procedure Document (HOPPD) which can be obtained from the UC San Diego GME website (http://meded.ucsd.edu/gme).

**Examinations**

In addition to clinical evaluations provided by supervisors, service chiefs and senior residents, all residents participate in yearly oral and written examinations. **Written examinations** are the Psychiatry Residency In-Training Exam (PRITE) given each Fall and the Columbian Psychotherapy Examination given in the Spring. Residents are provided feed-back on their performance, how it changes over time and how it compares to other trainees. Residents are expected to demonstrate progressively greater knowledge. Residents scoring below the 20th percentile on the psychiatry global score will be expected to review areas of difficulty and pass a make-up examination. When necessary, remediation is available. For PGY3 and PGY4 residents scoring below the 20th percentile, there is a mandatory board review class (also available voluntarily to residents scoring between the 20th and 40th percentile). An ‘in-house’ PRITE-like examination is give in the spring after the course. Residents are expected to score > 60% correct. The **oral examinations** (Clinical Skill Evaluations or CSE) are given in the spring of each year and are modeled after actual psychiatry specialty board examinations. Residents interview a live patient followed by an oral review of the history, differential diagnosis, case formulations, treatment plan and prognosis. Residents are expected to pass at least one of these examinations yearly (for progression and graduation).

**Clinical Skills Verification**

**Clinical Skills Assessments** (CSA) Three CSA examinations must be completed on ABPN approved forms by Board certified psychiatrists. We routinely provide these examinations as one component of competency on most PGY2 rotations and on several PGY1 rotations during the latter part of the year. The CSA covers an interview, MSE and case presentation per ABPN guidelines. Residents are required to pass at least 3 of these before entering PGY-3. These can only be counted when the signed ABPN approved form is in your file.

**Clinical Skills Evaluations** (CSE) is an observed patient interview done by a resident which meets the parameters described above (CSA) and also includes an assessment of psychobiological formulation, differential diagnosis and comprehensive treatment planning. We are required by the ACGME and Psychiatry RRC to certify that residents pass at least one CSE each year as a pre-requisite for promotion to the next year and for graduation from the program.

**Clinical Skills Verification** refers to the documentation of competency in clinical interviewing skills required by the ABPN to be eligible to take the ABPN Certifying examination. Therefore, a resident who successfully completes a series of CSAs which results in passing 3 CSAs is credentialied to take the ABPN Boards. Residents must pass at least 3 of these examinations to be eligible for ABPN credentialing. The standard is ‘competent psychiatrist’ (not adjusted for year of training).
Clinical Competency Committee (CCC): Residents are also evaluated by CCC made up of the Program Director, Associate Directors, Site Directors, Community Track Director, Combined Program Director (or Associate Director, Program administrator and Vice-Chair for Education) at least twice each year. During those meetings faculty discuss each resident. Residents who have been identified as having professional or academic difficulty are discussed at each meeting until these issues are resolved.

Biannual Resident Review Meetings
The Training Director will collect all faculty evaluations in an ongoing manner and keep a file for each resident with the other evaluative measures noted above. In addition, the file will contain evaluations from students, staff, patients, other residents, self-reflection as well as logs and attendance records. The Director (or designate) will complete a training summary every six months, based on all the assessments and logs collected at that time. Each resident will meet formally with the Training Director (or a designated Associate Director) at least twice yearly to discuss progress towards the attainment of all the goals and objectives of the Training Program. During those meetings, the resident will also discuss his or her evaluations of faculty and the Training Program.

Longitudinal Resident File
The Training Director keeps a longitudinal file that contains all of the resident’s evaluations, PRITE exams, CVSs and CSEs, checklists, patient care logs, and any other material relevant to the assessment of the resident, (e.g. unsolicited letters of commendation, patient or staff evaluations, presentations given at local and national meetings, publications, and awards, among other documents). This will be part of the resident’s permanent record that also includes all application and preliminary interview material, records from adult residency, and any additional documentation about the resident’s performance past and present. It will also include a checklist of procedures and clinical service rotations that are required as part of the residency program and indication if they were successfully completed. The file will document any evidence of unethical behavior, unprofessional behavior or clinical incompetence. Where there is evidence, it will be comprehensively recorded along with the responses of the resident. If disciplinary or remediation actions were taken, they will be documented with a clear description of the outcome. The record will include a final letter from the Training Director verifying whether the resident has successfully completed the program and has demonstrated sufficient professional ability to practice competently, ethically, and independently (without direct supervision), based on the program’s defined core competencies.

Evaluation Forms (available in Appendix)
- **360 Degree Evaluations** - To obtain a more comprehensive view of professionalism, patient care, interpersonal skills and communication, practice-based learning and improvement, and systems-based care, we have developed written surveys to be completed by peers, patients and unit staff as well as self-evaluations.
- **Portfolios** - A portfolio is a collection of products prepared by the resident that provides evidence of learning and achievement related to a learning plan. The resident can include video or audio recordings, self-reports of experiences or other documents that demonstrate such competencies as therapeutic effectiveness, ethical integrity, professionalism, self-directed learning and skill development, lectures given and continuing education experiences, and written documents such as review or research papers or case formulations. Patient logs may be included in portfolios. For this coming year, we are requiring 1 specific portfolio from PGY2s, 3s and 4s.
  1. **PGY-1**: A forensic case report based on testimony for CERT or Competency trial testimony.
  2. **PGY-2**: A detailed psycho-bio-social formulation of psychotherapy patient. References and all educational endeavors should be included.
  3. **PGY-3**: Synopsis and PowerPoint presentation of a case conference for Professors Rounds. In addition to providing information on what was learned and references, the resident should include documentation of teaching effectiveness.
  4. **PGY-4**: Independent Study Project in a publishable format.

Evaluation of Faculty, Services and Seminars
Residents evaluate faculty, services and seminars in an ongoing manner. Each clinical supervisor and service chief are evaluated every rotation. Each seminar and its leader are evaluated every 6 months and /or at the conclusion of the course. The faculty evaluations are collated by the assistant administrator before being given (in collated form) to the Training Director. Residents also have the opportunity to provide anonymous feedback on all aspects of their training on annual surveys (ACGME and Department of Psychiatry) and on the Training Website. Anonymous comments are regularly collected and discussed at quarterly resident meetings.

It is expected that residents give faculty members feedback in both clinical and didactic areas as to how helpful they are in transmitting knowledge, skills and attitudes relevant to psychiatry. Residents give the Training Director a verbal evaluation of each faculty member in the formal biannual individual review meetings with the Training Director, and at an annual retreat. At the end of each year, The Training Director sends each faculty member an annual review of his or her teaching and supervision, based on the anonymous resident evaluations, the individual discussions with each resident, and the written report of the annual resident retreat.

Program Evaluation
Both residents and faculty are requested to provide evaluations of the overall Training Program. Residents complete a confidential evaluation form biannually. The form asks residents to assess the clinical, didactic and administrative components of the Training Program. It also asks if the educational goals and objectives of the Training Program have been met. We are in the process of moving these questionnaires to New Innovations to maximize their confidentiality and anonymity. In addition, residents evaluate the program in their annual resident Retreat report, and representatives from each class provide ongoing evaluations at the monthly GEC meetings. Similarly, faculty and recent graduates provide program evaluations is annual surveys and discuss the results in an annual faculty retreat. The accumulated clinical service, seminar, faculty summary, and Retreat Report evaluations are a part of the Training Committee’s annual review of the entire Program. These and the direct input of the residents to the Training Committee help it determine what modifications in the teaching program are necessary for improvement in the coming year.

Progression
Housestaff will progress to advanced positions of higher responsibility only on the basis of evidence of satisfactory progressive scholarship and professional educational and clinical growth. Reappointment from one year to the next will be recommended by the Residency Training Director based on performance and reviewed by the ERTC. The Department follows the UCSD Housestaff Policy and Procedure as outlined in the section HOPPD of the titled “UCSD Policy” (http://meded.ucsd.edu/gme). To successfully progress from year to year, residents are expected to:

a. **Pass each rotation** as determined by the clinical service chief on that rotation. If a resident receives an initial grade of “fail”, the service will support specific remediation to re-take part of the rotation or otherwise make up the deficiency. The remediation plan will be reviewed by the ERTC. Residents may file grievances regarding any evaluation or grade they disagree with. Such grievances will be reviewed by the Residency Training Director and the ERTC. Two ‘condition’ passes in the same year will trigger a similar response and action plan.

b. **Score > 30th percentile on the PRITE.** PGY1s and 2s scoring below that level will be expected to develop a self-study plan. If requested, they may receive additional supervision to help guide their study and review. PGY3 and 4 residents scoring below the 20th percentile on the global psychiatry portion of the PRITE will be given offered an additional supervisor to help guide study, will attend a PRITE-based course, and will take an in-house make up examination after a suitable study period. Residents scoring below the 60th percentile on the make-up examination will be discussed at the ERTC regarding their suitability for advancement. Individualized remediation plans may be implemented. Moonlighting privilege will likely be suspended until an acceptable knowledge base is demonstrated.

c. **Attend 70% of all scheduled didactics.** Any combination of scoring below 60% on the makeup written examination or not passing a CSE oral examination for any year and attending <70% of seminars could result in failure to progress to the next year.
d. To progress to the PG -3 year, residents must pass Step III of the USMLE and have a California State license to practice medicine before the end of the PG-2 year. In general, residents also are expected to pass \( \geq 3 \) CSV examinations prior to beginning PGY3. To meet this goal, residents are required to take their USMLE Step 3 by the end of the PG1 year (see section on Department Policy (USMLE Requirements) for more details).

e. To successfully graduate the program, residents are expected to:
   - Pass oral examinations each year.
   - Demonstrate competency in the 6 core competencies and at least 2 of the psychotherapy competencies.
   - Complete an Independent Study Project.
   - Demonstrate competency to practice psychiatry without supervision.

f. Discipline, Dismissal and Due Process follow the UCSD Housestaff Policy and Procedure as outlined in that section of the manual. In brief, the following guidelines will be followed:
   - When a housestaff fails to meet minimal standards of performance, a letter of warning and/or censure will be provided the resident. The letter will document deficiency, the recommended course of action and methods to correct deficiencies. Failure to correct deficiency may lead to suspension or dismissal.
   - Clinical privileges may be suspended for medical record delinquency.
   - Suspension for up to sixty days from the residency program may occur when a house officer’s performance fails to meet the standards set by the Program Director and/or patient well-being is jeopardized.
   - The house officer may be reinstated to regular activities as soon as he/she demonstrates sufficient improvement to the department chairperson.
   - A house officer may be subject to immediate dismissal during the term of appointment only by the Dean, School of Medicine, on the recommendation of the department chair and the Director, UCSD Medical Center, for any of the following reasons:
     - Failure to rectify deficiencies of which he/she had been notified in one or more letters of warning, censure, or suspension;
     - Where his /her performance present a serious compromise to acceptable standards of patient care, including medical documentation of that care, or jeopardizes patient welfare;
     - For unethical conduct;
     - For illegal conduct
   - In matters of discipline and/or denial of privilege or benefit of appointment, the house officer may appeal in accordance with the provisions of UCSD Policy and procedure Manual Section 23-5, “Appeals for Academic Appointees”.
   - For more information on due process procedure, please refer to the “UCSD Policies” section of this manual.

W. New Innovations
The GME Office has incorporated a universal web based residency management system - New Innovations. This software enables all programs to keep more comprehensive records. A few of the highlights of this new system are:
* Duty Hours (Assignments)
* Rotation Schedules (Block schedule)
* Conference Schedules (Didactics, Grand Rounds, etc.)
* Conference Surveys
* Evaluation tracker (rotations, supervision, seminars, etc.)
* Attendance tracker
* Procedure Logs
* Curriculum - Goals and Objectives
*Complete demographics
*Test scores
*Faculty evals on Residents
*Resident evals on Faculty
*Semi Annual Evaluations will be completed using all data provided by New Innovations. Residents and supervisors are now required to evaluate performance on this new system (although not all faculty have yet converted). Our goal is to eliminate paper evaluations.

X. TRAINING COMMITTEES
The Residency Training Committee (RTC)
The RTC shall consist of the following members:
The Executive Residency Training Committee:
  - Residency Training Director (Sid Zisook)
  - 3 Associate Directors (Kristin Cadenhead, Alana Iglewicz, Sanjai Rao)
  - Research Track Director (Neal Swerdlov)
  - Child Training Director (Ellen Heyneman)
  - Combined Program Training Director (Kurt Lindeman, Julie Le)
  - Geropsychiatry Fellowship Director (Steve Huege)
  - Site Directors (Larry Malak, Louisa Steiger, Sanjai Rao)
  - Vice Chairs for Training and for Clinical Affairs
  - Residency Coordinator
  - 2 Faculty members appointed by the Training Director
  - The Chief Residents and 2 Resident from PGY 2 and PGY 3 classes elected by the residents
  - PGY 1 residents rotating at the VA Medical Center the corresponding month

Responsibilities: The Training committee is charged with the following duties:
  - Ongoing review of the overall Training Program, based on resident and faculty evaluations
  - Ongoing review of:
    - The six general clinical competencies
    - The clinical rotations
    - The didactic seminars
    - Resident working conditions and morale
    - Duty hours
    - Administrative policies and procedures
    - Method of evaluation of resident competency, based on the faculty and resident evaluations, retreat, PRITE results and other proposals of individual faculty, residents and clinical services
    - Clinical services in terms of access to a wide variety of patients, quality and quantity of teaching, service and educational balances
  - Facilitation and flow of communication between faculty and residents around training issues
  - Program development
  - Review semi-annual resident evaluations of program and make recommendations for improvement
  - Monitoring of resident safety issues and overall stress levels, person-power issues, fatigue
  - Planning for orientation, retreat, selection, graduation and other issues regarding training
  - Review of PRITE scores and recommendations for curricular improvements based on results
  - Information exchange to and from residents via resident representatives of each class and special programs

Subcommittees:
The RTC includes the following 10 subcommittees:
  1) Clinical Competency Committee (CCC)
1) Clinical Competency Committee (CCC)
Members of the CCC consist of:
- Residency Training Director
- Research Track Director
- 3 Associate Directors
- Research Track Director
- Combined Program Training Director (or ATD)
- Site Directors
- Residency Coordinator
- Community Track Director
- Vice Chair for Training and Education

Responsibilities: The CCC meets at least every other month. Monthly tasks include:
- Review all assessments of each trainee at least semiannually, and for determining each trainee’s current performance level by group consensus. CCC consensus decisions are based on multi-source assessment data, CCC member observations and Milestone evaluations.

a) Report Milestone evaluations of each trainee to the ACGME semiannually.

b) Provide recommendations to the program director on promotion, remediation and dismissal based on consensus decision of trainees’ performance; however, the program director has final responsibility for the evaluation and promotion of trainees.

c) Inform, where appropriate, the Program Evaluation Committee (PEC) of any potential gaps in curriculum or other program deficiencies that appear to result in a poor opportunity for trainees to progress in each of the Milestones.

d) Provide feedback to the program director on the timeliness and quality (e.g., rating consistency and accuracy) of faculty’s documented evaluations of trainees, in order to identify opportunities for faculty training and development.

e) Give feedback to the program director to ensure that the assessment tools and methods are useful in distinguishing the developmental levels of behaviors in each of the Milestones.

2) Program Evaluation Committee (PEC)
The PEC consists of at least the following members appointed by the Program Director:
- Executive Residency Training Committee Members
- Resident Representatives

Responsibilities:
- Planning, developing, implementing, and evaluating educational activities of the program;
- Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
• Addressing areas of non-compliance with ACGME standards;
• Reviewing the program annually using evaluations of faculty, residents, and others.
• Document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation.
• Monitor and track each of the following areas:
  o resident performance;
  o faculty development;
  o graduate performance, including performance of program graduates on the certification examination;
  o program quality.
• Monitor and track progress on the previous year’s action plan(s).
• Prepare a written plan of action to document initiatives to improve performance and delineate how they will be measured and monitored.
• The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

3) Residency Selection Committee (RSC)
The Residency Selection Committee consists of the following members:
• Vice Chair for Education
• Training Director
• Associate Training Directors
• Fellowship Directors (Child, Geriatric Research, Community)
• Director (or Co-Director) of Combined Program in Family Medicine/Psychiatry Program
• 2 additional faculty members selected by the chairman and Training Director
• All Chief Residents

Responsibilities: The RSC Committee will determine and refine the method of selection and structure of interview days, review applications, select applicants for interviews, participate in interviewing and provide input into our selection rank – list (see Residency Selection Procedure below).

Procedures: The Residency Selection Committee (RSC) will meet intermittently through the year, but more regularly from late November to mid-February. It will be charged with developing and refining interview procedures, reviewing each of the applicants' files, reviewing the evaluations completed by each interviewer and coming up with a rank – ordering of applicants for the match.

Each year, we select 10 PGY 1’s for the General Psychiatry Program (2 Research Track and 8 General Psychiatry) and 2 PGY1’s for the Combined Family Medicine/Psychiatry Program. We participate in the National Residency Match Program (NRMP) and the Electronic Residency Application System (ERAS). Based on the applicant qualifications (schools attended, Dean's letter, personal statement, letters of recommendation, grades, special interest and accomplishments) we invite approximately 90 applicants for interviews.

During the interview day, applicants meet several faculty and residents. Each applicant is interviewed by the Training Director and at least two additional members of the Selection Committee, including a mix of faculty and residents. Applicants interested in, and qualified for, the research tract will meet with several research oriented faculty (usually this means interviewing an extra day). Every attempt will be made for applicants interested in a future child fellowship to meet with a faculty member from the Child Division. All applicants will have the opportunity to meet informally with a large number of house staff; they meet residents at an evening reception, over lunch and during tours of our 2 major facilities.
After the interviews, the RSC reviews the applicant’s file and the comments provided by interviewers to come up with a rank order list which is submitted to the NRMP. We are particularly interested in high academic achievement, excellence in clinical skills, a deep career interest in psychiatry and potential for clinical scholarship, research, teaching and leadership. Personal traits of maturity, empathy, decisiveness and high standards of professional performance are very important. We are also very interested in highly qualified minority applicants and seek to enroll a balanced group and diverse group of future clinical and research scholars.

After the match results are posted, the RSC will assign mentors to the new house staff, review the process and begin planning for the next year.

4) Curriculum Committee (CC): The Curriculum Committee consists of faculty and volunteer residents from each year of training. It meets regularly to ensure a comprehensive, coordinated four-year curriculum and that the didactic program meets the evolving needs of the residency. It provides input on development, evaluation and updating the curriculum course syllabi and core readings. It is organized and 10 thread directors and 4 PG year coordinators.

5) Chief Resident Committee (CRC):
The Chief Residents will meet with the Residency Training Director and the Associate Directors for the PG-4 year monthly. This committee will regularly discuss issues related to transitions (e.g., graduation, orientation), resident well-being, curriculum, evaluations, chief resident duties, call, supervision, etc. As relevant, issues brought up in the GEC may be further discussed and resolved in this committee. Co-ordination of clinical care, coverage, communication, etc, between classes will be discussed regularly.

6) Call Committee:
The Call committee is made up of representatives for each year of training and a faculty advisory. It monitors and evaluates residency call activities, monitors program compliance with the ACGME duty Hours requirements, and offers relevant recommendations to the RTC. It maintains call and call back-up schedules, including “fee-for-service” moonlighting schedules. The call committee meets quarterly at minimum. The Chief Residents serve as the Chairpersons of the Call Subcommittee and reports monthly to the RTC.

7) Wellness Committee:
The Resident Wellness Committee is made up of residents from all years of training and is overseen by a faculty chair (Alana Iglewicz) and a resident chair (Cosmina Ciobanu). The committee promotes a holistic sense of health, self-care, and a work-life balance by organizing events that help residents relax, unwind, connect and savor life.

8) SAVE Committee:
SAVE (Suicide and Adverse Events) Committee: This committee was created several years ago in an effort to provide support to clinical trainees who have experienced adverse patient events (patient attempted suicide, patient completed suicide, patient death from other cause, homicide). When an adverse event occurs, the SAVE protocol is initiated. This includes procedures such as debriefing with the trainee, helping the trainee discuss the event with patient's family, and offering the trainee the rest of the day off. Furthermore, the SAVE committee provides support continued support to residents by attending peer review sessions.

9) Executive Residency Training Committee:
The Executive Residency Training Committee is made up of the same members of the CCC and meets at least 4 times each year to focus on any issues from the RTC or department that cannot be fully resolved in the other committees, that need additional discussion, that are optimally discussed without resident involvement or that enhance communication between all training sites and a the training leadership and between clinical and training needs.
10) Residency-Centered Training Workgroup:
In response to unresolved issues from the 2012 Resident Moral Committee’s recommendations and recent concerns raised by residents at the 2014 fall resident retreat, the Department formed a “Residency-Centered Training Workgroup” RCTW). The RCTW was Co-Chaired by the Vice-Chair for Training and Education (Neal Swerdlow) and the Executive Vice – Chair (Robert Anthenelli), and included residents from each of the 4 training years, and faculty who are actively involved in residency training and/or administration. The RCTW systematically assess resident concerns and developed recommendations, some of which were immediately implemented and others requiring longer range planning and fine-tuning. To provide assessment of changes, ongoing monitoring, and to promote longer –term conditions favoring positive resident moral and optimal training, the RCTW will continue to meet quarterly, with membership continuing to represent all residency training classes, Site Training Directors, Program Training Directors and the Department Executive and Education / Training Vice Chairs.

Department of Psychiatry’s Guidelines and Best Practices for Online Social Media Use by Trainees

Introduction
Online blogs, public mailing lists and social network sites such as Facebook and Twitter (hereafter collectively referred to as social media) are popular tools for communication and social interaction. These venues offer excellent opportunities for people to interact and are increasingly being used to potentially augment personal and, recently, professional interactions. The latter has become known as e-Professionalism. Mental health care professionals have a special responsibility to be aware of the perceptions and use of such social media. While these sites have enormous potential to enhance communication, they are also a potential forum for lapses in professional and ethical conduct.

While e-Professionalism is evolving fast and is constantly changing, the following trends are emerging. Increasingly, professionals are using social media as part of hiring criteria and to evaluate other professionals. Clients also often research potential providers via web and social media. While security settings exist within social media to provide information only to those you wish to see it, unintentional access happens frequently.

Increasingly, universities, postdoctoral sites, and even clients are seeking out information about people on the web before they make faculty offers, postdoctoral position offers, or decide to see someone clinically. According to a 2009 CareerBuilder survey, 45% of employers used social networking sites to screen potential employees, and 35% rejected potential job candidates because of content viewed on social networking sites. There are now numerous anecdotes of well-qualified doctoral graduates not getting post-doc or faculty offers because someone viewed something that was considered to be inappropriate or objectionable on the candidate’s webpage.

Policies Specific to UCSD Department of Psychiatry Trainees
• At all times, intentional or otherwise, trainees must be aware that the violation of legal statutes (e.g., HIPAA) and UCSD policies and procedures (e.g., Professionalism Policies, Sexual Harassment Policies) in online activities may result in disciplinary actions ranging from a letter of reprimand up to and including probation or dismissal from a training program. The Department of Psychiatry does not and will not actively monitor the on-line activities of the student body. However, unprofessional issues could be, and have been, brought to the Department’s attention through a variety of mechanisms.

• By identifying themselves publically using social media, UCSD Department of Psychiatry trainees are creating perceptions about UCSD and its associated clinics. Trainees must assure that all public content is consistent with the values and professional standards of the Department and the profession. v.1 – 07/2016
• Social networking sites such as Twitter and Facebook may be accessible from your work computer; however, use of these sites on work time should be limited only to work-related business or to access work-related information and postings.
• If you use your office Outlook email address to send messages outside of your UCSD training program, be sure that your email signature identifies you correctly as a trainee. Indicate the year of your training program so that future searches on listservs identifies you by the year(s) of your affiliation with UCSD. Likewise, any posting you make identifying yourself as a trainee on websites should indicate the year(s) of your training.
• If your webpage/blog does identify you as a UCSD trainee, as affiliated with UCSD, or employed by UCSD, then the Department has an interest in how you and the program are portrayed. Your webpage/blog must meet all legal and ethical guidelines. Your website/blog must be professional in its content and must not contain objectionable material. We will not actively search out trainees' webpages; however, if we become aware of a page or blog that identifies you as a Department trainee or affiliated with UCSD, and that page or blog is considered by the Training Director to contain unethical, illegal, or otherwise objectionable material – we will ask you to modify or remove the problematic material. Should you choose not to modify or remove the material, the Training Director will follow the existing procedures for dealing with trainee misconduct and/or unethical behavior.

**Legal and Ethical Issues in Social Media Use & Client/Patient Confidentiality**

• Accessible postings on social media are subject to the same professional standards as any other personal interaction. The written nature, persistence and potential accessibility of these postings make them subject to particular scrutiny.

• Public postings on social media may have legal ramifications. Comments made by trainees regarding clients, or who portray themselves, other trainees, faculty or other colleagues, in an unprofessional manner can be used by the courts or professional licensing boards.

• HIPAA regulations apply to all comments made on social media sites and violators are subject to the same prosecution as with other HIPAA violations.

• Trainees should take all precautions they would normally use in public forums to maintain client privacy when using social media.

• Online discussions of specific clients should be avoided, unless on secure healthcare related networks, even if all identifying information is excluded. It may be possible for someone to identify the client from the context of the discussion.

• Under no circumstances is it appropriate or legal to post photos of clients or client information on social media without the specific written permission of the client. v.1 – 07/2016

• Trainees should be aware that even if they have permission from the client to use a photo, that photo may be downloaded and distributed by others, which may then violate the terms of the permission.

• Interactions with clients through social media should be avoided. This provides numerous opportunities for violating privacy restrictions and may have legal and/or ethical consequences.

• Decisions to connect socially with former or current clients online should be made as if the client were in person, i.e., by keeping professional boundaries very clear. Under no circumstances should you “friend” a former or current client on social networking sites, or otherwise accept or solicit personal connections with former or current clients online. Your relationships with former and current clients must remain strictly professional.

• Under no circumstances should you discuss client cases or share client identifying information in emails, listservs, websites, web groups, or blogs, include any information that could lead to the identification of a client, or compromise client confidentiality in any way. Even if you think you have de-identified client information, consider how such communication could be viewed if seen by the client or someone who knows the client. You are not in control of this information once it is released to the hundreds or thousands of people on a listserv or web group discussion board, for example, or on a website that will “live” electronically online for years.
Guidelines for Trainees’ Professional Online Presence

• Unprofessional public postings by others on a trainee’s social media account can reflect poorly on the trainee. Trainees should monitor their sites and ensure that the content will not be viewed as unprofessional.

• It is suggested trainees should make sure that any photos in which they are identified (“tagged”) are not embarrassing or professionally compromising. Trainees should “untag” themselves from any embarrassing or professionally compromising photos that they cannot have removed. Trainees should refrain from “tagging” other trainees/co-workers/faculty without the explicit permission of those people.

• Trainees should maintain the privacy of colleagues, faculty and staff unless they have been given permission to use the person’s likeness or name on their site.

Recommendations

• Deletion of material from social media does not necessarily mean it is no longer available since, for example, search engines cache such content. This implies special care should be taken in posting material since it will persist.

• Due to frequent updating of social media sites, it is advisable that trainees regularly check their privacy settings to optimize their privacy and security. v.1 – 07/2016

• Trainees should set their privacy settings so that only people they choose have access to personal information.

• Trainees should consider minimizing personal information on social media profiles. It is suggested trainees not include addresses, phone numbers, social security numbers, PID numbers, passport numbers, driver’s license numbers, birth dates or any other information that could be used to obtain personal records.

• If you use social media and other forms of electronic communication, seriously consider how your communication may be perceived by current and future clients, colleagues, faculty, clinical supervisors, and others. Since all public information is accessible to potential future employers and to current and potential future clients, your online representation can affect you professionally.

Note: Adapted and modified from the Guideline for Use of Online Social Networks for Medical Interns and Physicians-in-Training, Indiana University, Elizabeth Klonoff, Ph.D., at the San Diego State University/UC San Diego Joint Doctoral Program in Clinical Psychology, Jennifer Cornish, Ph.D., at the University of Denver, and Social Media/E-Professionalism Guidelines

Department of Psychiatry’s Guidelines and Best Practices for Online Social Media Use by Trainees

Introduction

Online blogs, public mailing lists and social network sites such as Facebook and Twitter (hereafter collectively referred to as social media) are popular tools for communication and social interaction. These venues offer excellent opportunities for people to interact and are increasingly being used to potentially augment personal and, recently, professional interactions. The latter has become known as e-Professionalism. Mental health care professionals have a special responsibility to be aware of the perceptions and use of such social media. While these sites have enormous potential to enhance communication, they are also a potential forum for lapses in professional and ethical conduct.

While e-Professionalism is evolving fast and is constantly changing, the following trends are emerging. Increasingly, professionals are using social media as part of hiring criteria and to evaluate other professionals. Clients also often research potential providers via web and social media. While security settings exist within social media to provide information only to those you wish to see it, unintentional access happens frequently.
Increasingly, universities, postdoctoral sites, and even clients are seeking out information about people on the web before they make faculty offers, postdoctoral position offers, or decide to see someone clinically. According to a 2009 CareerBuilder survey, 45% of employers used social networking sites to screen potential employees, and 35% rejected potential job candidates because of content viewed on social networking sites. There are now numerous anecdotes of well-qualified doctoral graduates not getting post-doc or faculty offers because someone viewed something that was considered to be inappropriate or objectionable on the candidate’s webpage.

**Policies Specific to UCSD Department of Psychiatry Trainees**

- At all times, intentional or otherwise, trainees must be aware that the violation of legal statutes (e.g., HIPAA) and UCSD policies and procedures (e.g., Professionalism Policies, Sexual Harassment Policies) in online activities may result in disciplinary actions ranging from a letter of reprimand up to and including probation or dismissal from a training program. The Department of Psychiatry does not and will not actively monitor the on-line activities of the student body. However, unprofessional issues could be, and have been, brought to the Department’s attention through a variety of mechanisms.

- By identifying themselves publically using social media, UCSD Department of Psychiatry trainees are creating perceptions about UCSD and its associated clinics. Trainees must assure that all public content is consistent with the values and professional standards of the Department and the profession.

- Social networking sites such as Twitter and Facebook may be accessible from your work computer; however, use of these sites on work time should be limited only to work-related business or to access work-related information and postings.

- If you use your office Outlook email address to send messages outside of your UCSD training program, be sure that your email signature identifies you correctly as a trainee. Indicate the year of your training program so that future searches on listservs identifies you by the year(s) of your affiliation with UCSD. Likewise, any posting you make identifying yourself as a trainee on websites should indicate the year(s) of your training.

- If your webpage/blog does identify you as a UCSD trainee, as affiliated with UCSD, or employed by UCSD, then the Department has an interest in how you and the program are portrayed. Your webpage/blog must meet all legal and ethical guidelines. Your website/blog must be professional in its content and must not contain objectionable material.

We will not actively search out trainees’ webpages; however, if we become aware of a page or blog that identifies you as a Department trainee or affiliated with UCSD, and that page or blog is considered by the Training Director to contain unethical, illegal, or otherwise objectionable material – we will ask you to modify or remove the problematic material. Should you choose not to modify or remove the material, the Training Director will follow the existing procedures for dealing with trainee misconduct and/or unethical behavior.

**Legal and Ethical Issues in Social Media Use & Client/Patient Confidentiality**

- Accessible postings on social media are subject to the same professional standards as any other personal interaction. The written nature, persistence and potential accessibility of these postings make them subject to particular scrutiny.

- Public postings on social media may have legal ramifications. Comments made by trainees regarding clients, or who portray themselves, other trainees, faculty or other colleagues, in an unprofessional manner can be used by the courts or professional licensing boards.
• HIPAA regulations apply to all comments made on social media sites and violators are subject to the same prosecution as with other HIPAA violations.

• Trainees should take all precautions they would normally use in public forums to maintain client privacy when using social media.

• Online discussions of specific clients should be avoided, unless on secure healthcare related networks, even if all identifying information is excluded. It may be possible for someone to identify the client from the context of the discussion.

• Under no circumstances is it appropriate or legal to post photos of clients or client information on social media without the specific written permission of the client.

• Trainees should be aware that even if they have permission from the client to use a photo, that photo may be downloaded and distributed by others, which may then violate the terms of the permission.

• Interactions with clients through social media should be avoided. This provides numerous opportunities for violating privacy restrictions and may have legal and/or ethical consequences.

• Decisions to connect socially with former or current clients online should be made as if the client were in person, i.e., by keeping professional boundaries very clear. Under no circumstances should you “friend” a former or current client on social networking sites, or otherwise accept or solicit personal connections with former or current clients online. Your relationships with former and current clients must remain strictly professional.

• Under no circumstances should you discuss client cases or share client identifying information in emails, listservs, websites, web groups, or blogs, include any information that could lead to the identification of a client, or compromise client confidentiality in any way. Even if you think you have de-identified client information, consider how such communication could be viewed if seen by the client or someone who knows the client. You are not in control of this information once it is released to the hundreds or thousands of people on a listserv or web group discussion board, for example, or on a website that will “live” electronically online for years.

Guidelines for Trainees’ Professional Online Presence

• Unprofessional public postings by others on a trainee’s social media account can reflect poorly on the trainee. Trainees should monitor their sites and ensure that the content will not be viewed as unprofessional.

• It is suggested trainees should make sure that any photos in which they are identified (“tagged”) are not embarrassing or professionally compromising. Trainees should “untag” themselves from any embarrassing or professionally compromising photos that they cannot have removed. Trainees should refrain from “tagging” other trainees/co-workers/faculty without the explicit permission of those people.

• Trainees should maintain the privacy of colleagues, faculty and staff unless they have been given permission to use the person’s likeness or name on their site.

Recommendations

• Deletion of material from social media does not necessarily mean it is no longer available since, for example, search engines cache such content. This implies special care should be taken in posting material since it will persist.
• Due to frequent updating of social media sites, it is advisable that trainees regularly check their privacy settings to optimize their privacy and security.

• Trainees should set their privacy settings so that only people they choose have access to personal information.

• Trainees should consider minimizing personal information on social media profiles. It is suggested trainees not include addresses, phone numbers, social security numbers, PID numbers, passport numbers, driver’s license numbers, birth dates or any other information that could be used to obtain personal records.

• If you use social media and other forms of electronic communication, seriously consider how your communication may be perceived by current and future clients, colleagues, faculty, clinical supervisors, and others. Since all public information is accessible to potential future employers and to current and potential future clients, your online representation can affect you professionally.

Note: Adapted and modified from the Guideline for Use of Online Social Networks for Medical Interns and Physicians-in-Training, Indiana University, Elizabeth Klonoff, Ph.D., at the San Diego State University/UC San Diego Joint Doctoral Program in Clinical Psychology, Jennifer Cornish, Ph.D., at the University of Denver, and Social Media/E-Professionalism Guidelines and Best Practices by UCSD Skaggs School of Pharmacy and Pharmaceutical Sciences.

APPENDICES:
A. Didactics
B. Clinical Rotations
C. Psychiatry Milestones
D. Readings
E. Senior Independent Study Project
F. Research and Community Psychiatry Tracts
G. Evaluation Forms
H. Industry Policy
I. County, UCSD Medical Center and VA Medical Center
J. UCSD Housestaff Officers Policy and GME Guidelines
K. Psychiatry RRC Essentials
L. Ethical Guidelines
M. Pabbati’s Pearls for PGY1s