Harbor-UCLA Medical Center

Psychiatry Residents’ Orientation Manual
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Karl Burgoyne, M.D.
Director, Residency Training

Ira Lesser, M.D.
Chair
DEPARTMENT OF PSYCHIATRY FACULTY

Ira Lesser, M.D.
Chair
Professor

Karl Burgoyne, M.D.
Director, Residency Training
Professor

Paul Arns, Ph.D.
Professor

Armen Djenderedjian, M.D.
Professor

Charles Grob, M.D.
Director, Division of Child and Adolescent Psychiatry
Professor

Lynn McFarr, Ph.D.
Director, Adult Cognitive Behavioral/Dialectical Behavior Therapy Clinic
Professor

Kathleen McKenna, M.D.
Director of Training, Division of Child and Adolescent Psychiatry
Professor

Warren Procci, M.D.
Professor

Mary Read, M.D.
Medical Director, Adult Outpatient Clinic
Professor

David Stone, M.D.
Director, Psychiatric Emergency Services
Professor

Guochuan Emil Tsai, M.D., Ph.D.
Professor

John Tsuang, M.D.
Director, Dual Diagnosis Program
Professor
Marcy Borlik, M.D., M.P.H
Director Pediatric Psychiatry Consultation/Liaison Service
Associate Director, Pediatric Psychiatry Emergency Service
Associate Professor

Samson Cho, M.D.
Associate Professor

Bowen Chung, M.D., MSHS
Associate Professor

Julia Chung, M.D.
Director, Consultation/Liaison Services
Associate Professor

Nadia Del-Pan, M.D.
Associate Professor

Deborah Flores, M.D.
Associate Professor

Michael Makhinson, M.D., Ph.D.
Associate Professor

Astrid Reina, Ph.D.
Chief, Psychology Division
Co-Director of Training, Psychology Division
Associate Professor

Dorit Saberi, Ph.D.
Co-Director of Training, Psychology Division
Associate Professor

Samuel Sessions, M.D., J.D.
Associate Professor

Matthew Wright, Ph.D.
Director, Neuropsychology Service
Associate Professor

Weiguo Zhu, M.D.
Associate Residency Training Director
Associate Professor
Claudia Avina, Ph.D.
Director, Child and Adolescent CBT/Adolescent DBT Programs
Assistant Professor

Lisa Bolden, Psy.D.
Assistant Professor

Andrea Caldwell, M.D.
Assistant Professor

Juliana Gomez-Makhinson, M.D.
Assistant Professor

Stephen Jacobson, Ph.D.
District Chief, Outpatient Clinics
Assistant Professor

Patrick Kelly, M.D.
Assistant Professor

Larisa Litvinov, Ph.D.
Assistant Clinical Director, TIES for Families-South Bay
Assistant Professor

David Rad, M.D.
Assistant Professor

Karen Rathburn, Ph.D.
Program Manager, TIES for Families-South Bay
Assistant Professor

Lynn Yen, M.D.
Assistant Professor

Todd Zorick, M.D.
Assistant Professor

Quinn Durand, Psy.D.
Clinical Instructor

Charles Lee, M.D.
Clinical Instructor
GENERAL INFORMATION AND POLICIES

REQUIRED CALL

All residents who are assigned night call should be in the Psychiatric Emergency Room at 4:30 p.m. Monday through Friday (8:30 a.m. on Saturday, Sunday, and holidays). As a general rule, whenever there is a routine work day the day after call, (ie Sunday, Monday-Thursday), the PGY-II or PGY-III on-call leaves the hospital by 11:00 p.m. the night of call. The resident returns to the Psych ER the morning after call by 9:00 a.m. to sign out to the day team. For Friday, Saturday and holiday call, the PGY-II or PGY-III may leave the hospital grounds after 11:00 p.m. (if the clinical demand allows for this), but they must remain within 30 minutes of the hospital in case they have to be called back in. They are expected back before 8:30 a.m., to present to the day team. PGY-I's remain in the hospital overnight on all occasions until 9:00 a.m. on weeknights and 8:30 a.m. on weekends/holidays. The day following a call night (ie, post-call day) both interns and residents may remain in the hospital up to a maximum of six additional hours (ie until 2:00 p.m.) to complete continuity of care work and to participate in didactics. No new patient care responsibility will be assigned during this post-call period. Beepers are available for housestaff on-call and should be carried at all times. The psychiatric housestaff on-call are responsible for emergency consults both in the emergency-receiving area and the medical-surgical wards. Specific policies are included in the Emergency section of the handbook. When on-call you must remain on the hospital grounds (with the exception of PGY-II or PGY-III non-moonlighting residents after 23:00 if they stay within a 30 minute drive in case they are called back). If you must leave for some emergency, you must inform the other residents on-call and a decision will be made whether to call in the back-up resident.

Interns on call the preceding night are to meet from 8:00-9:00 a.m. (Monday-Friday) in the Emergency Room with the assigned attending faculty member for Emergency Room Rounds. This will facilitate teaching and communication concerning patients seen during the night as well as assist in the disposition of any patients remaining in the emergency area. On Saturday, Sunday and holidays meeting with the attending begins at 8:30 a.m.

More senior residents will have the opportunity to provide clinical teaching for the junior housestaff members and medical students assigned to the psychiatric service. Members of the faculty are assigned to telephone coverage and expect to be contacted not only for administrative problems but also to provide information and teaching. Housestaff should not be reticent about asking for help or just sharing clinical information. No patient should be discharged from the ER without consultation of the
faculty on call. The only exceptions to this are voluntary patients who come in for a medication refill and those patients who are being admitted directly to our inpatient facility.

Back-up residents must keep their schedules clear in order to be available in case of illness or other emergency which prevents the assigned resident from completing his/her duties. The back-up resident may, on rare occasions, be called into the hospital to assist the resident on call when the workload is so great as to preclude adequate medical care by the housestaff on duty. In such a situation, the resident on call should contact the faculty member on call and a joint decision can be made with regard to the necessity of utilizing the back-up resident. In general, the call schedule is prepared by the chief residents according to a prearranged frequency for the PGY-I/PGY-II/PGY-III years.

Over the year the amount of call will be equal for each resident depending on the year of training. Vacations will be factored into this equation so that whether or not vacation time is taken, each resident will still have the same amount of call.

When one call is missed because of a brief illness, the back-up resident will take that call. The back-up resident will have their call reduced in the next month or so, and the resident who missed the call will have one call added (e.g. a "pay back"). This will not apply when call is made up for an intern. If the back-up system is abused (e.g. a resident does not show up for call without notice), this will be taken seriously and handled by administration.

When there is an extended leave, such as maternity or paternity leave, the resident will utilize their vacation and sick time. In these cases, no pay back of call will be required. A similar policy will hold for extended medical leave. There may be times when the education policy committee decides that the amount of time taken off requires that the resident must make up their clinical experience (perhaps extending their training). In these instances, call will be required during this make up period. The call will be assigned at the year level when the time was taken off (e.g. if time was taken off late in the PGY-II year and two months are added to training, when the resident returns, call will be assigned for two months at the PGY-II level regardless of which clinical service they are on). In other words, residents will take call for one year at each level of training.

These guidelines will be followed as carefully as possible. Circumstances may arise which are not covered by these guidelines. In this situation decisions will be made by the chief residents, program director, and the education policy committee.

TIME PRIORITIES FOR POST GRADUATE PHYSICIANS
The issue of the relationship between the clinical services and the formal teaching activities is a complex one. It is the feeling of our department that the primary vehicle for resident education is our rich source of clinical material. Naturally, this must be complemented with appropriate didactic material as well as with formal supervision. On occasion, these different duties and activities will conflict. The following is a set of guidelines outlining priorities concerning these issues:

1. The Chief of each clinical area or team leader has the responsibility for reviewing with each resident his/her schedule. The Chief of a clinical service or the team leader, along with the resident, determines the number of hours and specific times that the resident is responsible to specific service areas.

2. Scheduled lectures and seminars (this includes Grand Rounds) are to be maintained, except in patient care emergencies. Attendance logs will be maintained for required activities.

3. Residents in years II through IV are each assigned a minimum of two hours per week of outpatient supervisors. Chiefs and team leaders recognize that this is a program requirement and residents must participate in this process. Residents are responsible for reviewing the conditions of their supervision with them. Ideally, these supervisory hours should be scheduled at a time that minimally interferes with the activities of the clinical area.

POLICY ON ATTENDANCE AT DIDACTIC CONFERENCES AND SEMINARS

It is recognized that optimal learning occurs with a mixture of didactic and clinical learning experiences. We have no questions that the clinical aspect of the program, with our large number and diversity of patients, provides a sufficient clinical experience. To fulfill the didactic portion, the program provides both required and optional teaching conferences and seminars which are available for residents at each year of training. Some of these are required for residents at a given level of training, while others are required for all residents. The core seminars for each year of training, the interviewing course in the first year, the psychotherapy courses in the second and third years, the continuing case conference in the fourth year, and Departmental Conference are examples of required courses.

Attendance will be taken at each required conference and will be reviewed by the Program Director. If a resident is on a rotation away from the hospital, they will not be required to attend, nor will vacations be counted as absences. Clinical emergencies, though rare, will supersede
attendance at conferences; other reasons for non-attendance should be discussed with the instructor. If a resident’s attendance falls below a threshold of 70%, this will lead to a conference with the program director. If attendance does not improve over the next period of monitoring, this issue will be taken to the education policy committee where this will be assessed and a course of action will be determined.

POLICIES FOR EVALUATION AND PROMOTION OF RESIDENTS

Evaluations are completed for each rotation of residents throughout their training. These evaluations have assessment components of knowledge, skills, and work-related behavior, in accordance with the ACGME core competencies. Faculty are encouraged to comment upon strengths and areas for further work or remediation. Further, faculty are encouraged to discuss the evaluation directly with the resident. For year-long rotations, evaluations are collected at six month intervals. This includes service evaluations as well as evaluations by supervisors.

Residents have a formal meeting with the program director twice yearly. At this meeting, all evaluations are discussed and any problems addressed. All residents must take the Psychiatry Residency In-Service Training Examination (PRITE) in September or October, and the results are discussed individually at the mid-year meeting with the program director. If a resident scores below the 25th percentile in psychiatry, attendance at the PRITE review course will be mandatory. In addition, there is a yearly clinical examination of a patient interview followed by a question and answer session. These are done in the style of the ABPN Oral Board Examination and given by faculty who are Board Examiners.

If there are problems identified in the midst of a rotation, faculty are instructed to either talk with the resident alone or seek consultation of the program director. If there is an unsatisfactory evaluation, the Education Policy Committee (chaired by the program director) considers what course of action to pursue. This may include remediation, repeating the rotation, and/or probation, in accordance with our due process procedures. If there are multiple unsatisfactory evaluations in a given year, and efforts at remediation have been unsuccessful, the Education Policy Committee will evaluate whether the resident will be permitted to advance to the next year of training. This will be an ongoing process, discussed with the resident.

Successful completion of the training program is dependent upon satisfactory completion of all required and elective rotations. In addition, it must be determined that there has not been a pattern of unethical conduct, and that the resident is judged competent to practice independently.
VACATION POLICY

Ours is a small and busy department where the absence of an individual resident has a significant impact upon the operation of a clinical area. It is essential to have general guidelines for Housestaff vacation. Please consider these guidelines so that clinical areas can be run as smoothly as possible:

PGY-I
Vacation scheduling is not an issue during the PGY-I year because vacation time is assigned. In general, this is done in two segments of two weeks each. In practice, trades of time are possible but this must be done through the office of the Medical Director. This involves finding someone who has vacation scheduled during the desired time and then making the appropriate switch.

PGY-II through IV
For years II through IV vacations have not been assigned and residents are free to attempt to take vacation when they please. However, the following guidelines must be kept in mind.

1. It is generally not feasible to take all 24 vacation days together. This would seriously interfere with a resident's ability to derive appropriate educational benefit from a given rotation.

2. The amount of vacation taken on any given service should be proportional to the length of that particular rotation. With advance planning it might be possible to join two blocks of vacation into one longer vacation if one takes vacation during
the final week or weeks of one rotation and the initial week or weeks of a subsequent rotation.

3. In order to be fair to all concerned (the residents and the faculty) vacations should be requested at least thirty days in advance and preferably prior to the start of a rotation so that the Chief of the clinical area or team leader can be aware ahead of time of the needs of that service.

4. Vacation must be approved by the Chief of the clinical area or the team leader, the Chief Resident, and the Director of Residency Training. Vacation request forms are obtained from the office of Residency Training and, after obtaining the necessary signatures, are returned to the office of Residency Training.

5. It must be understood that patient care responsibilities take preference in the scheduling of vacation and the ultimate decision regarding scheduling of vacations rests with the Chief of the clinical area or team leader. (This is in keeping with the Memorandum of Understanding between Housestaff and the Board of Supervisors).

6. Those residents (PGY-II through IV) who so desire may defer up to ten working days of vacation each year and accrue this to the end of their training at which time a lump sum payment will be made for this accrued time (maximum payoff is 10 days for each year). His payment will be calculated at the resident’s highest level of compensation.

7. PGY-IV residents will not be allowed to save all their vacation time for the month of June. Chaos would result if such a practice occurred. Therefore, unless individually approved by the team leader, PGY-IV’s will be limited to 10 days only of approved absence during the month of June.

MEETING TIME

Meeting time is not available to postgraduate physicians. We vigorously encourage postgraduate physicians to attend high quality professional meetings. However, you must understand that this can be done only by utilizing vacation time.
DUE PROCESS PROCEDURE FOR POST GRADUATE PHYSICIANS WITH CLINICAL DEFICIENCIES

There is no issue that is more sensitive and difficult to handle than that of the resident experiencing deficiencies. It is the avowed purpose of the Education Policy Committee to support education, and thus we attempt to help any resident who is experiencing performance difficulty to remedy that deficit. Unfortunately, this is not always possible and, on occasion, it may be necessary for trainees to leave the program. While each particular case is different, the following is a set of general guidelines which the Education Policy Committee will follow in order to be as fair as possible to everyone concerned.

1. Residents receive written evaluations on each of their clinical services. If the Chief of a clinical area or team leader feels that a resident’s performance is deficient, it is the Chief’s responsibility to counsel the involved resident. This is to be done before the end of the clinical rotation and in writing. This will be sent to the Director of Residency Training who will review it. It is obviously not fair to a resident to complete an entire rotation and then find out only then of deficient performance.

2. When the Director of Residency Training receives such an evaluation from the Chief of a clinical area or from a team leader, that clinical area Chief or team leader and involved resident will be invited to the next meeting of the Education Policy Committee for discussion.

3. If after reviewing this information, members of the Education Policy Committee agree with the evaluation that there are serious questions as to the competence or behavior of the involved resident, a period of probation will be initiated.

4. Probation should not be viewed as a period of punishment but rather as a period of evaluation, review and additional teaching of the involved resident. From the point of view of the faculty this is a period during which the resident will be observed more carefully by additional supervisors (as designated by the Education Policy Committee) in order to acquire a more accurate picture of the resident’s performance. For the resident this is a period during which he or she may demonstrate to the department that the suggested deficiencies are exaggerated or that progress is being made to remedy them.

5. There is no fixed time for a period of probation but generally
probation will entail a minimum of at least several months as this is necessary to obtain the appropriate data. Often probation will be for a longer period of time.

6. At the end of the period of probation, all of the individuals involved with supervising the resident will summit written evaluations to the Education Policy committee. The Education Policy Committee will review these evaluations and can propose one of three courses: First, removal of probation; second, continued probation; third, dismissal from the program. Obviously this third course is a serious matter and would only be recommended for the most problematic of cases such as those in which deficiencies are of a major degree, clearly outlined and documented, and where there is an explicit indication of unsatisfactory progress in remedying the deficiency.
MOONLIGHTING POLICY

Moonlighting under the auspices of the department of psychiatry on the grounds of Harbor-UCLA (the psychiatric emergency room) is allowed for all licensed residents.

Outside moonlighting is not under the supervision of the teaching faculty and is not allowed by any residents before their PGY-IV year.

PGY –IV residents considering moonlighting must submit a written proposal to the education policy committee showing that the work is outside of County hours, there is appropriate coverage, and the scope of practice is not outside of the trainee’s abilities (usually medication evaluations and follow up). It is understood that moonlighting is not done under the auspices of the Department of Psychiatry or the Hospital. This means that the County will provide no malpractice, and faculty will do no supervision of the work.

The applying resident must be judged to be up to date with all of their residency duties, and the moonlighting must not ethically conflict with the residency duties. An example of moonlighting, which would not be acceptable, is any freestanding office practice.

If the education policy committee accepts a moonlighting proposal, the resident must complete the County’s outside employment forms as residents are County employees.

We urge you to fully explore the implications of the moonlighting experience, including your malpractice coverage, the method of payment you will receive, the documentation of your work, and to consider whether any legal or ethical boundaries are being violated (such as self referring cases from the county). Again, neither the Department nor the County has any responsibilities (e.g. legal, financial) for your work if you choose to moonlight outside of the hospital.

Failure to obtain moonlighting approval, or misrepresenting moonlighting duties will result in disciplinary action against the resident.

The administrative review for moonlighters is the same as it is for psychiatric trainees in performing their other duties. Moonlighting is a valuable financial resource for residents, and it is not offered or allowed at many other institutions. We want to make sure that assignment of moonlighter shifts is done judiciously and that those who participate in our moonlighting program maintain an acceptable standard of practice and performance.

1. Moonlighters perform an important, valued function in our call system. Therefore, remuneration should be equitable.
2. Moonlighters will be held to the following standards of practice:
   a. Moonlighters will be required to be on campus throughout their assigned shifts.
   b. Moonlighters will be required to be available to the other residents at all times for overflow patient evaluation and management, for advise and second-opinion, and for MER and ward consultations.
A helpful and supportive attitude should be considered standard practice.

c. There will be no “protected time” for moonlighters. The splitting of nighttime and weekend shifts into resident and moonlighter sub-shifts will not be prohibited, but the moonlighter will be expected to provide back-up support to his fellow residents whenever needed, regardless of shift status.

d. Moonlighters will be required to conduct complete and comprehensive evaluations of their patients.
   i. HPI must make every effort to include the “who, what, why, where, and when” with respect to presentation and complaints. HPI must include relevant psychosocial stressors.
   ii. The five-axes diagnostic summary should be backed by sufficient documentation in the body of the database to justify diagnostic assertions.
   iii. Every effort must be made to complete physical exams of patients. Documenting “Refused.” will be considered insufficient.
   iv. Comprehensive medication management and documentation of justification for medications (or lack thereof) will be required.
   v. 5150 involuntary holds and written advisements must be complete and accurate
   vi. Every effort must be made to contact appropriate collateral sources of information.
   vii. Discharge summaries must include sufficient evidence of medical and behavioral stability for transfer or discharge.

e. Moonlighter administrative performance review and evaluation will include all of the following:
   i. Psychiatric ER director will randomly review in the AM documentation of emergency evaluations and treatment plans conducted overnight by moonlighters. Deficiencies in documentation will be recorded.
   ii. Concerns expressed by other residents will be documented.
   iii. All of the above will be evaluated over time for patterns of deficiency.

f. If patterns of deficiency are suspected, administrative review will include the following in the following order:
   i. The moonlighting resident will be privately informed verbally and in writing that a one-month probationary period has been instituted to evaluate suspected deficiencies. During this time, the attending will provide specific recommendations and both positive and negative feedback regarding performance.
   ii. During the probationary period, every evaluation and treatment regimen by the moonlighter will be reviewed and deficiencies will be registered.
   iii. Following completion of the probationary period, The Psychiatric ER Director and the Residency Director will analyze accrued information to assess for continued patterns of deficiency.
iv. If both the Residency Director and the Psychiatric ER Director agree that deficiencies represent an unacceptable pattern of behavior, moonlighter privileges will be suspended for a period of six months.

v. Following suspension period, suspended residents may reapply for moonlighting, but the first month of moonlighting will include another one-month probationary period to reassess performance.
At its February 1999 meeting, the ACGME endorsed general competencies for residents in the areas of: patient care, medical knowledge, practice-based learning and improvement, and interpersonal and communication skills, professionalism, systems-based practice.

Identification of general competencies is the first step in a long-term effect designed to emphasize educational outcome assessment in residency programs and in the accreditation process. During the next several years, the ACGME’s Residency Review and Institutional Review Committees will incorporate the general competencies into their Requirements.

ACGME GENERAL COMPETENCIES Vers. 1.3
(9.28.99)

The residency program must require its residents to develop the competencies in the six areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the competencies.

PATIENT CARE

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

- communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families;
- gather essential and accurate information about their patients;
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment;
- develop and carry out patient management plans;
- counsel and educate patients and their families;
- use information technology to support patient care decisions and patient education;
- perform competently all medical and invasive procedures considered essential for the area of practice;
- provide health care services aimed at preventing health problems or maintaining health;
- work with health care professionals, including those from other disciplines, to provide patient-focused care.
MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:
- demonstrate an investigatory and analytic thinking approach to clinical situations;
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline.

PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:
- analyze practice experience and perform practice-based improvement activities using a systematic methodology;
- locate, appraise, and assimilate evidence from scientific studies related to their patient’s health problems;
- obtain and use information about their own population of patients and the larger population from which their patients are drawn;
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness;
- use information technology to manage information, access on-line medical information;
- support their own education;
- facilitate the learning of students and other health care professionals.

INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient’s families, and professional associates:

Residents are expected to:
- create and sustain a therapeutic and ethically sound relationship with patients;
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills;
- work effectively with others as a member or leader of a health care team or other professional group.

PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:
- demonstrate respect, compassion, and integrity;
- a responsiveness to the needs of patients and society that supersedes self-interest;
accountability to patients, society, and the profession;
a commitment to excellence and on-going professional development;
demonstrate a commitment to ethical principles pertaining to provision or
withholding of clinical care, confidentiality of patient information,
informed consent, and business practices;
demonstrate sensitivity and responsiveness to patient’s culture, age,
gender, and disabilities.

SYSTEMS-BASED PRACTICE

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

Residents are expected to:
understand how their patient care and other professional practices affect
other health care professionals, the health care organization, and the larger
society and how these elements of the system affect their own practice;
know how types of medical practice and delivery systems differ from one
another, including methods of controlling health care costs and allocating
resources;
practice cost-effective health care and resource allocation that does not
compromise quality of care;
advocate for quality patient care and assist patients in dealing with system
complexities;
know how to partner with health care managers and health care providers
to assess, coordinate, and improve health care and know how these
activities can affect system performance.
ACGME Common Program Requirements in BOLD

PROGRAM REQUIREMENTS FOR
RESIDENCY TRAINING IN PSYCHIATRY

I. Introduction

A. Definition

An approved residency program in psychiatry must provide an educational experience designed to ensure that its graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders, together with other common medical and neurological disorders that relate to the practice of psychiatry. Although residents cannot be expected to achieve the highest possible degree of expertise in all of the diagnostic and treatment procedures used in psychiatry in 4 years of training, those individuals who satisfactorily complete residency programs in psychiatry must be competent to render effective professional care to patients. They must, furthermore, have a keen awareness of their own strengths and limitations, and of the necessity for continuing their own professional development. The didactic and clinical program must be of sufficient breadth and depth to provide residents with a thorough and well-balanced presentation of psychological, sociocultural, and neurobiological observations, theories and knowledge of major diagnostic and therapeutic procedures in the field of psychiatry. The program must also provide the education and training necessary to understand the major psychiatric literature, to evaluate the reliability and validity of scientific studies, and to incorporate appropriately new knowledge into the practice of medicine.

Programs are expected to operate in accordance with the AAMA Principles of Ethics with Special Annotations for Psychiatry, and to ensure that the application and teaching of these principles are an integral part of the educational process.

B. Duration and Scope of Education

1. Admission Requirements

Physicians may enter psychiatry programs at either the first-year or second-year postgraduate level. Physicians may enter programs at the second-year postgraduate level only after successful completion of one of the following:

a) one clinical year of training in a program in internal medicine, family practice, or pediatrics accredited by the Accreditation Council for Graduate Medical Education (ACGME);
b) A transitional year program accredited by the ACGME;

c) one year of an ACGME-accredited residency in a clinical specialty requiring comprehensive and continuous patient care;

For physicians entering at the PG-2 level, the PG-1 year may be credited toward the 48-month requirement

2. Length of the Program

a) A complete psychiatry residency is 48 months. Twelve of these months may be spent in an ACGME-approved child and adolescent psychiatry residency. Accreditation by the ACGME is required for all years of the training program. Programs may not permit residents to use vacation time or other benefit time to advance the date of graduation from training. Although residency is best completed on a full-time basis; part-time training at no less than half time is permissible to accommodate residents with personal commitments (e.g., child care).

b) Any program that alters the length of training beyond these minimum requirements must present a clear educational rationale consistent with the Program Requirements and objectives for residency training. The program director must obtain the approval of the sponsoring institution and the Residency Review Committee (RRC) prior to implementation and at each subsequent review of the program.

c) Prior to entry into the program, each resident must be notified in writing of the required length of training for which the program is accredited. The required length of training for a particular resident may not be changed without mutual agreement during his or her program, unless there is a break in the resident’s training or unless the resident requires remedial training.

d) Programs should meet all of the Program Requirements of Residency Training in Psychiatry. Under rare and unusual circumstances, programs of either one-year or 2-year duration may be approved, even though they do not meet all of the above requirements for psychiatry. Such one- or 2-year programs will be approved only if they provide some highly specialized educational and/or research programs. Also, such programs will be approved only if they ensure that residents will complete the didactic and clinical requirements outlined in the Program Requirements.
3. Program Format by Year of Training

a) First Year of Training

A psychiatric first postgraduate-year must include at least 4 months in internal medicine, family practice, and/or pediatrics. This training must be in a clinical setting which provides comprehensive and continuous patient care.

(1) Neurology rotations may not be used to fulfill this 4-month requirement.

(2) One month, but no more, of this requirement may be fulfilled by an emergency medicine or intensive care rotation, provided the experience is predominately with medical evaluation and treatment and not surgical procedures.

(3) A psychiatric first postgraduate-year should not include more than 6 months in psychiatry, and must not include more than 8 months in psychiatry.

(4) A minimum of 2 months of neurology, or its full-time equivalent on a part-time basis, is required prior to completion of training. It is highly desirable that this experience occur during a psychiatric first postgraduate-year, and it may include a maximum of one month of supervised inpatient or outpatient child neurology.

(5) The program director of the Department of Psychiatry must maintain contact with residents during the first postgraduate-year while they are on services other than psychiatry.

b) Second through Fourth Years of Training

Although some of the training described below may be offered in the first postgraduate-year, all must be completed prior to graduation from the program.

(1) The program must have an explicitly-described educational curriculum which covers the broad spectrum of clinical psychiatry as outlined in Section V B 1 a) through m).
(2) The formal didactic instruction must include regularly-scheduled lectures, teaching rounds, seminars, clinical conferences, and required-reading assignments covering the topics identified in Section V.

(3) There must be an educationally-sound balance among time spent in direct patient care, clinical and didactic teaching, and supervision. Formal educational activity shall have high priority in the allotment of the resident's time and energies. Service needs and clinical responsibilities must not prevent the resident from obtaining the requisite didactic educational activities and formal instruction.

(4) Planned Educational Experiences. Each program must offer its residents planned and sufficient educational experiences. These educational experiences should include presentations based on a defined curriculum, journal review, administrative seminars, and research methods. They may include, but are not limited to, problem-based learning, laboratories, and computer-based instruction, as well as joint conferences cosponsored with other disciplines. The program should ensure that residents are relieved of non-emergent clinical duties in order to attend these planned educational experiences. Although release from some off-service rotations may not be possible, the program should require that each resident participate in at least 70% of the planned psychiatry educational experiences offered (excluding vacations). Attendance must be monitored and documented.

II. Institutions

A. Sponsoring Institution

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

1. Programs should be conducted under the sponsorship of an institution that meets the Institutional Requirements that apply to residency programs in all specialties, as outlined in the Essentials of Accredited Residencies.

2. The administration of the sponsoring institution(s) should be understanding of and sympathetic to the attainment of educational goals, and should evidence its willingness and ability to support these goals philosophically and financially. The latter includes a commitment by the
institution and by the program that embraces appropriate compensation for faculty and residents, adequate offices and educational facilities, support services, and opportunities for research.

B. Participating Institutions

1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.

2. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:

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

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

   c) specify the duration and content of the educational experience; and

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

3. It is important that each affiliated institution demonstrate significant commitment to the overall program. The educational rationale for including each institution within the program must be stated. The number and distribution of participating training sites must not preclude satisfactory participation by residents in teaching and didactic exercises. Geographic proximity will be one factor in evaluating program cohesion, continuity, and critical mass. Affiliated training-sites will be evaluated on the basis of whether they contribute to a well-integrated educational program, with respect to both didactic and clinical experiences.

III. Program Personnel and Resources

A. Program Director

1. There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program
director or department chair, the program director should promptly notify the executive director of the Residency Review Committee (RRC) through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education (ACGME).

The program director must devote at least one-half of his or her time to the administration and operation of the educational program, including didactic, supervisory, and clinical teaching activities. Programs with multiple institutions, many residents, and/or large clinical populations will require additional time.

2. The program director, together with the faculty, is responsible for the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents, as well as the maintenance of records related to program accreditation, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership. Frequent changes in leadership or long periods of temporary leadership usually have a negative effect on an educational program, and may adversely affect the accreditation status of the program.

3. Qualifications of the program director are as follows:

a) The program director must possess the requisite specialty expertise as well as documented educational, clinical, and administrative abilities.

b) The program director must be certified in the specialty by the American Board of Psychiatry and Neurology, or possess appropriate educational qualifications judged to be acceptable by the RRC.

c) The program director must be appointed in good standing and based at the primary teaching site, and must be licensed to practice medicine in the state where the institution that sponsors the program is located (certain federal programs are exempted).

4. Responsibilities of the program director are as follows:

a) The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring
appropriate resident supervision at all participating institutions.

b) The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME’s Accreditation Data System.

c) The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.

d) The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents, in order to determine if an adequate educational environment exists to support these changes and if the program’s clinical and academic resources are adequate to support these changes. **Such changes, for example, include:**

(1) the addition or deletion of a participating institution;

(2) a change in the format of the educational program, or the addition of any rotation of 6 months’ full-time equivalent or longer;

(3) a change in the approved resident complement for those specialties that approve resident complement;

(4) any change in the total length of the program.

On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.

e) The program director must make resident appointments and assignments in accordance with institutional and departmental policies and procedures.

f) The program director must supervise residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff.
g) The program director must regularly evaluate residents' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.

h) The program director must provide written information to applicants and residents regarding financial compensation, liability coverage, and the policies regarding vacations, sick leave, parental leave, and other special leaves.

i) The program director must monitor residents’ stress, including physical or emotional conditions which inhibit performance or learning, as well as drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents.

Training situations that consistently produce undesirable stress on residents must be evaluated and modified.

j) The program director must maintain a permanent record of evaluation for each resident that is accessible to the resident and other authorized personnel. These records will be made available on review of the program.

k) The program director will notify the Executive Director of the RRC in writing within 60 days of any major change in the program that may significantly alter the educational experience for the residents, including:

(1) changes in leadership of the department or the program;

(2) changes in administrative structure, such as an alteration in the hierarchical status of the program/department within the institution; and

(3) changes in the resident complement that would bring the number of residents below the required critical mass of 3 residents per year for 2 consecutive years.

B. Faculty

1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.
2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, sound clinical and teaching abilities, commitment to their own continuing medical education, participation in scholarly activities, and must support the goals and objectives of the educational program of which they are a member.

a) The residency must be staffed by a sufficiently-wide variety and appropriate number of capable psychiatrists and other mental health professionals with documented qualifications to achieve the goals and objectives of the training program.

b) A written record of the educational responsibilities of all staff and faculty members (whether full-time or part-time) who participate directly in the education of residents is essential. This record should include the qualifications and experience of each faculty member, and the nature, as well as the frequency, duration, and site, of the teaching activity.

3. Qualifications of the physician faculty are as follows:

a) The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.

b) The physician faculty must be certified in the specialty by the American Board of Psychiatry and Neurology, or possess qualifications judged to be acceptable by the RRC.

c) The physician faculty must be appointed in good standing to the staff of an institution participating in the program.

4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. Scholarship is defined as the following:

a) the scholarship of discovery, as evidenced by participation in clinical and/or basic research, peer-reviewed funding or by publication of original research in a peer-reviewed journal, monograph or book;

b) the scholarship of dissemination, as evidenced by review articles or chapters in textbooks;
c) the scholarship of application, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.

Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.

There must be evidence of scholarly activity among the faculty psychiatrists. Although not all members of a faculty need to be investigators, scholarly activities should be present on a continuous basis. There should also be evidence of participation in a spectrum of academic and professional activities within the institution, as well as within local and national associations.

5. Qualifications of the nonphysician faculty are as follows:

a) Nonphysician faculty must be appropriately qualified in their field.

b) Nonphysician faculty must possess appropriate institutional appointments.

6. The faculty must participate regularly and systematically in the training program, and must be readily available for consultation whenever a resident is faced with a major therapeutic or diagnostic problem.

7. The faculty psychiatrists should actively participate in the planning, organization, and presentation of conferences as well as in clinical teaching and supervision.

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

9. The teaching staff must be organized, and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them. At least one resident representative should participate in these reviews.
C. Other Program Personnel

Additional necessary professional, technical, and clerical personnel must be provided to support the program.

D. Resources

The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.

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

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

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

4. Other Educational Resources
   a) The administration of the facility where the program is located must provide ample space and equipment for educational activities. There must be adequate space and equipment specifically designated for seminars, lectures, and other teaching exercises.
   b) The program must have available audiovisual equipment and teaching material such as films, audio cassettes, and videotapes, as well as the capability to record and play back educational videotapes.
   c) Residents must have ready-access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions. Library services
should include the electronic retrieval of information from medical databases.

d) There must be access to an on-site library and/or to an electronic collection of appropriate texts and journals. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends. This library should provide:

(1) a substantial number of current basic textbooks in psychiatry, neurology and general medicine;

(2) a number of the major journals in psychiatry, neurology, and medicine sufficient for an excellent educational program;

(3) the capability to obtain textbooks and journals on loan from major medical libraries;

(4) the capability to perform MEDLINE or other medical information searches (or ready-access to a library that has this capacity); and

(5) access to the internet.

e) Each clinical service must have a mechanism that ensures that charts are appropriately maintained and readily accessible for regular review for supervisory and educational purposes. Randomly-selected charts will be reviewed at the time of survey.

E. Chair of Psychiatry

The chair of psychiatry must be a physician, and must either be certified by the American Board of Psychiatry and Neurology or judged by the RRC to possess appropriate educational qualifications.

F. Education Policy Committee

The director of the residency program should have an educational policy committee composed of members of the psychiatry program teaching staff that includes representation from the residents as well as a member of the teaching staff from each ACGME-approved subspecialty residency that may be affiliated with the psychiatry residency. There should be a written description of the committee, including its responsibility to the sponsoring department or institution and to the program director. This committee should participate actively in:
1. planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless there is a separate residency selection committee);

2. determining curriculum goals and objectives; and

3. evaluating both the teaching staff and the residents.

IV. Resident Appointments

A. Eligibility Criteria

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

1. The program director is responsible for maintaining a process for selecting resident physicians who are personally and professionally suited for training in psychiatry. It is highly desirable that each program have a residency selection committee to advise the program director.

2. All programs should state specifically and as clearly as possible the objectives and competencies required for successful completion of the program. These objectives and criteria should be made available to residency applicants.

3. The residency program director must accept only those applicants whose qualifications for residency include sufficient command of English to facilitate accurate, unimpeded communication with patients and teachers.

4. All programs should state specifically and as clearly as possible the objectives and competencies required for successful completion of the program. These objectives and criteria should be made available to residency applicants.

B. Number of Residents

The RRC will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.

1. In order to promote an educationally-sound, intellectually-stimulating atmosphere of effective and graded responsibility, programs must maintain a critical mass of at least 3 residents at each level of training. Programs that fall below this prescribed critical mass will be reviewed,
and if this deficiency is not corrected, they may be cited for noncompliance, except when the number of PG-4 residents is below critical mass owing to residents entering child and adolescent psychiatry training.

2. Programs in which the number of residents exceeds the resources of patient population, faculty, or facilities for adequate training will be found deficient on the basis of size.

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

C. Resident Transfers

To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

1. The program must document the procedures used to select residents. Application records must contain complete information from medical schools and graduate medical education programs. A documented procedure must be in place for evaluating the credentials, clinical training experiences, past performance, and professional integrity of residents transferring from one program to another, including from a general psychiatry to a child and adolescent psychiatry program. This procedure must include solicitation and documentation of relevant information from the training directors of the previous programs participated in by the transferring resident. This documentation must specify all clinical and didactic experiences for which the resident has been given credit. Those residents selected at the second postgraduate-year or above must have satisfied the training objectives cited above for reaching that level of training.
2. A transferring resident's educational program must be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.

D. Appointment of Fellows and Other Students

The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed residents.

V. Program Curriculum

A. Program Design

1. Format

The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.

2. Goals and Objectives

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments. All educational components of a residency program should be related to program goals.

a) Objectives of Training

(1) First Year

The training obtained during the first postgraduate-year should provide residents with medical skills most relevant to psychiatric practice. These include being able to:

(a) perform a complete initial history and physical examination, including appropriate diagnostic studies;

(b) diagnose common medical and surgical disorders, and to formulate appropriate initial treatment plans;
(c) provide limited, but appropriate, continuous care of patients with medical illnesses, and to make appropriate referrals;

(d) be especially conversant with medical disorders displaying symptoms likely to be regarded as psychiatric, and with psychiatric disorders displaying symptoms likely to be regarded as medical;

(e) be especially cognizant of the nature of the interactions between psychiatric treatments and medical and surgical treatments; and

(f) be able to relate to patients and their families, as well as other members of the healthcare team with compassion, respect, and professional integrity.

(2) Second Through Fourth Years

The program must provide a well-planned, high-quality curriculum that includes specific, assessable objectives for program components as well as criteria for graduation. These must be stated in writing and provided to each resident and faculty member. Residents must be taught to conceptualize all illnesses in terms of biological, psychological, and sociocultural factors that determine normal and abnormal behavior. They must be educated to gather and organize data, integrate these data within a comprehensive formulation of the problem to support a well-reasoned differential diagnosis, formulate a treatment plan, and implement treatment and follow-up care as required. The program must provide residents with sufficient opportunities to develop knowledge, clinical skills, sensitivity to cultural diversity, and professional principles.

(a) The didactic curriculum should include:

   i) critical appraisals of the major theories and viewpoints in psychiatry, together with a thorough grounding in the generally accepted clinical facts;

   ii) presentation of the biological, psychological, sociocultural, economic, ethnic, gender,
religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle;

iii) presentation of the etiologies, prevalence, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, sociocultural, and iatrogenic factors that affect the long-term course and treatment of psychiatric disorders and conditions;

iv) comprehension of the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, such as neoplasms, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, Parkinson's disease, seizure disorders, stroke, intractable pain, and other related disorders;

v) the use, reliability, and validity of the generally-accepted diagnostic techniques, including physical examination of the patient, laboratory testing, imaging, neurophysiologic and neuropsychological testing, and psychological testing;

vi) the financing and regulation of psychiatric practice, including information about the structure of public and private organizations that influence mental health care;

vii) medical ethics as applied to psychiatric practice;

viii) the history of psychiatry and its relationship to the evolution of medicine;

ix) the legal aspects of psychiatric practice;

x) when and how to refer; and
xi) research methods in the clinical and behavioral sciences related to psychiatry.

b) Clinical training should provide sufficient experiences in:

i) the elements of clinical diagnosis with all age groups (of both sexes, to include some ethnic minorities), such as interviewing; clear and accurate history taking; physical, neurological, and mental status examination; and complete and systematic recording of findings;

ii) relating history and clinical findings to the relevant biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment;

iii) formulating a differential diagnosis and treatment plan for all psychiatric disorders in the current standard nomenclature, taking into consideration all relevant data;

iv) the major types of therapy, including short- and long-term individual psychotherapy, psychodynamic psychotherapy, family/couples therapy, group therapy, cognitive and behavior therapy, crisis intervention, drug and alcohol detoxification, and pharmacological regimens, including concurrent use of medications and psychotherapy;

v) electroconvulsive therapy, a somatic therapy that is viewed as so important that its absence must be justified (Examples of other somatic therapies include biofeedback and phototherapy);

vi) providing continuous care for a variety of patients from different age groups, seen regularly and frequently for an extended time, in a variety of treatment modalities;
vii) psychiatric consultation in a variety of medical and surgical settings;

viii) providing care and treatment for the chronically-mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions;

ix) psychiatric administration, especially leadership of interdisciplinary teams, including supervised experience in utilization review, quality assurance and performance improvement;

x) providing psychiatric care to patients who are receiving treatment from nonmedical therapists and coordinating such treatment;

xi) knowledge of the indications for and limitations of the more common psychological and neuropsychological tests;

xii) critically appraising the professional and scientific literature; and

xiii) teaching psychiatry to medical students, residents, and others in the health professions.

B. Specialty Curriculum

The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.

1. Clinical Experience

Carefully-supervised clinical care of patients is the core of an adequate program. The clinical services must be so organized that residents have major responsibility for the care of a significant proportion of all patients assigned to them, and have sufficient and ongoing high-quality supervision. The number of patients for which residents have primary responsibility at any one time must be adequate enough to permit them to provide each patient with appropriate treatment, and to have sufficient time for other aspects of their educational program. At the same time, the total number must be large enough to provide an adequate depth and
variety of clinical experiences. The amount and type of patient care responsibility a resident assumes must increase as the resident advances in training. Each resident must have major responsibility for the diagnosis and treatment of a reasonable number and adequate variety of patients with both acute and chronic illnesses representing the major psychotic and nonpsychotic categories of psychiatric diagnoses/conditions. Adequate experience in the diagnosis and management of the medical and neurological disorders encountered in psychiatric practice also must be ensured. Each resident must have supervised experience in the evaluation and treatment of patients of different ages throughout the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds. It is desirable that residents have didactic learning and supervised experiences in the delivery of psychiatric services in the public sector and in managed care health systems. The clinical experiences are to be designed to develop the requisite skills as outlined in Section V A 2 a) (2) (b) above. Specific clinical experiences must include the following:

a) Neurology: Two months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. This 2-month experience (or its equivalent if done on a part-time basis) may occur in an inpatient, outpatient, or consultation/liaison setting. A maximum of one month of child neurology may be used toward the 2-month requirement. The 2-month training experience must provide opportunities to conduct initial evaluations, to participate in the subsequent diagnostic process, and to follow patients during the treatment and/or evolution of their neurological disorders/conditions. The training in neurology should have sufficient didactic and clinical experience for residents to develop expertise in the diagnosis of those neurological disorders/conditions that might reasonably be expected to be encountered in psychiatric practice and which must be considered in the differential diagnosis of psychiatric disorders/conditions.

b) Inpatient: Significant responsibility for the assessment, diagnosis, and treatment of an appropriate number and variety of general psychiatric inpatients for a period of not less than 9 months, but no more than 18 months (or its full-time equivalent if done on a part-time basis). In general, it is highly desirable that the minimum general inpatient experience be 12 months, although it is recognized that in some settings other training opportunities might lead to the absolute minimum of 9 months. The experience must provide residents with sufficient opportunities to develop competence in the intensive biopsychosocial assessment and management of patients with acute mental disorders/conditions. It is recognized that the setting in which this care occurs may vary
according to the health care delivery system. Rotations on specialized clinical services such as addiction psychiatry, adolescent psychiatry, forensic psychiatry, geriatric psychiatry, research units, and day and/or partial hospitalization may not totally substitute for the general psychiatric inpatient experience. These may be included to meet the required minimum experiences, with adequate documentation to demonstrate that the experience on such specialized units is with acutely-ill patients, and is comparable in breadth, depth, and experience to training on general inpatient psychiatry units. Up to 3 months of rotations on specialized clinical services as noted above may be applied to the minimum 9-month requirement. However, no portion of this experience may be counted to meet the timed requirement in child and adolescent psychiatry. Experience in any special unit used to provide inpatient psychiatry must be under the direction and supervision of a psychiatrist.

c) Outpatient: An organized, continuous, and supervised clinical experience in the assessment, diagnosis, and treatment of outpatients of at least one year (or its full-time equivalent if done on a part-time basis) that emphasizes a developmental and biopsychosocial approach to outpatient treatment. At least 80% of this experience must be with adult patients. A minimum of 20% of the overall experience (clinical time and patient volume) must be continuous and followed for a duration of at least one year. The outpatient requirement must include experience with a wide variety of disorders, patients, and treatment modalities, with experience in both brief and long-term care of patients, using individual psychotherapy (including psychodynamic, cognitive, behavioral, supportive, brief), and biological treatments and psychosocial rehabilitation approaches to outpatient treatment. Long-term psychotherapy experience must include a sufficient number of patients, seen at least weekly for at least one year, under supervision. Other long-term treatment experiences should include patients with differing disorders and patients who are chronically mentally ill. No portion of this experience may be counted to meet the timed requirements in child and adolescent psychiatry.

d) Child and Adolescent Psychiatry: An organized clinical experience under the supervision of child and adolescent psychiatrists in the evaluation, diagnosis, and treatment of children, adolescents, and their families. Such experiences should be no less than 2 months full-time equivalent and involve a sufficient number and variety of patients, by both age and psychopathology, treated with a variety of interventional modalities. Residents should have experiences in determining the
developmental status and needs for intervention with the children of some of their adult patients, and in consulting with these patients regarding the referral of their children for psychiatric services. Residents must have patient care responsibility under the supervision of child and adolescent psychiatrists who are certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology, or who possess appropriate educational qualifications. This 2-month experience may be provided in a variety of settings (e.g., outpatient). Although adolescent inpatient units may be used to satisfy a portion of this requirement, rotations to student health services may not.

e) Consultation/Liaison: Supervised psychiatric consultation/liaison responsibility for a minimum of 2 months full-time equivalent, involving adult patients on other medical and surgical services. On-call experiences may be a part of this training. Up to one month of pediatric consultation/liaison psychiatry may be credited toward the 2-month requirement.

f) Emergency Psychiatry: Supervised responsibility on an organized, 24-hour psychiatric emergency service that is responsible for evaluation, crisis management, and triage of psychiatric patients. Instruction and experience should be provided in the evaluation and management of suicidal patients. A psychiatric emergency service that is a part of, or works with, other medical emergency services is desirable because of the opportunities for collaboration and educational exchange with colleagues in other specialties. There must be organized instruction and supervised clinical opportunities available to residents in emergency psychiatry that lead to the development of knowledge and skills in the emergency evaluation, crisis management, and triage of patients. This should include the assessment and management of patients who are a danger to themselves or others, the evaluation and reduction of risk to caregivers, and knowledge of relevant issues in forensic psychiatry. There should be sufficient continued contact with patients to enable the resident to evaluate the effectiveness of clinical interventions. Although on-call experiences may be a part of this training, such experiences alone will not be sufficient to constitute adequate training in emergency psychiatry. A portion of this experience may occur in ambulatory urgent-care settings, but must be separate and distinct from the 12 months of training designated for the outpatient requirement.

g) Community Psychiatry: Supervised responsibility for the care of persistently- and chronically-ill patients in the public sector, (e.g., community mental health centers and public hospitals and
agencies, or other community-based settings). Experiential settings may include residential treatment centers, community mental health agencies, vocational rehabilitation centers, and senior citizen agencies. Opportunities should exist to consult with, learn about, and use community resources and services in planning patient care, and to work collaboratively with case managers, crisis teams, and other mental health professionals.

h) Geriatric Psychiatry: One-month FTE-supervised clinical management of geriatric patients with a variety of psychiatric disorders, including familiarity with long-term care in a variety of settings. This may be fulfilled as part of the inpatient or outpatient requirement.

i) Addiction Psychiatry: One-month FTE-supervised evaluation and clinical management of patients within inpatient and/or outpatient settings, and familiarity with rehabilitation and self-help groups. This may be fulfilled as part of the inpatient or outpatient requirement.

j) Forensic Psychiatry: Experience under the supervision of a psychiatrist in evaluation of patients with forensic problems.

k) Supervised clinical experience in the evaluation and treatment of couples, families, and groups.

l) Psychological Testing: Supervised experience with the more common psychological test procedures, including neuropsychological assessment, in a number of cases sufficient to give the resident an understanding of the clinical usefulness of these procedures and of the correlation of psychological test findings with clinical data. Under the supervision and guidance of a qualified clinical psychologist, residents should have experience with the interpretation of the psychological tests most commonly used, some of which experience should be with their own patients.

m) Supervised, active collaboration with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients.

2. Didactic Components

The didactic and clinical curriculum must be of sufficient breadth and depth to provide residents with a thorough, well-balanced presentation of the generally-accepted theories, schools of thought, and major diagnostic and therapeutic procedures in the field of psychiatry.
a) The curriculum must include a significant number of interdisciplinary clinical conferences and didactic seminars for residents in which psychiatric faculty members collaborate with neurologists, internists, and colleagues from other medical specialties and mental health disciplines.

b) Clinical training must include adequate, regularly scheduled, individual supervision. Each resident must have at least 2 hours of individual supervision weekly, in addition to teaching conferences and rounds, except when on non-psychiatric rotations.

c) Didactic instruction must be systematically organized, thoughtfully integrated, based on sound educational principles, and include prepared lectures, seminars, and assigned readings that are carried out on a regularly-scheduled basis. In a progressive fashion, it should expose residents to topics appropriate to their level of training, as outlined in Section V A 2. Staff meetings, clinical case conferences, journal clubs, and lectures by visiting professors are desirable adjuncts, but must not be used as substitutes for an organized didactic curriculum.

d) The curriculum must include adequate and systematic instruction in neurobiology; psychopharmacology, and other clinical sciences relevant to psychiatry, child and adult development; major psychological theories, including learning theory, psychodynamic theory, and appropriate material from the sociocultural and behavioral sciences such as sociology and anthropology. The curriculum should address development, psychopathology, and topics relevant to treatment modalities employed with patients with severe psychiatric disorders/conditions.

e) The residency program should provide its residents with instruction about American culture and subcultures, particularly those found in the patient community associated with the training program. This instruction should include such issues as gender, race, ethnicity, socioeconomic status, religion/spirituality, and sexual orientation. Many physicians may not be sufficiently familiar with attitudes, values, and social norms prevalent among various groups of contemporary Americans. Therefore, the curriculum should contain enough instruction about these issues to enable residents to render competent care to patients from various cultural and ethnic backgrounds. Understanding cultural diversity is an essential characteristic of good clinical care. The program must devote sufficient didactic training to residents whose cultural backgrounds are different from those of their patients, and provide
a suitable educational program for them as well.

f) Didactic exercises must include resident presentation and discussion of clinical case material at conferences attended by faculty and fellow residents. This training should involve experiences in integrative case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in the diagnosis and management of cases presented.

3. Clinical Records

Clinical records must reflect the residents' ability to:

a) record an adequate history and perform mental status, physical, and neurological examinations;

b) organize a comprehensive differential diagnosis and discussion of relevant psychological and sociocultural issues;

c) proceed with appropriate laboratory and other diagnostic procedures;

d) develop and implement an appropriate treatment plan followed by regular and relevant progress notes; and

e) prepare an adequate discharge summary and plan.

C. Residents Scholarly Activities

Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.

1. Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility.

2. The program must promote an atmosphere of scholarly inquiry, including the provision of access to ongoing research activity in psychiatry. Residents must be taught the design and interpretation of research studies, including the responsible use of informed consent, research methodology, and interpretation of data. The program must teach expertise in the critical assessment of new therapies and developments that are described in the literature. Residents must be advised and supervised by faculty members.
qualified in the conduct of research. Programs must have a plan to foster the development of skills for residents who are interested in conducting psychiatric research. This plan should include opportunities for conducting research under the supervision of a mentor and training in the principles and methods of research.

D. ACGME Competencies

The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

1. Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;

2. Medical Knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;

3. Practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;

4. Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;

5. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;

6. Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

E. Other Required Components

1. Progressive Responsibility

Under supervision, resident clinical experience in patient management should demonstrate graduated and progressive responsibility.
2. Teaching Opportunities

Residents must be instructed in appropriate methods of teaching, and have ample opportunity to teach students in the health professions.

3. Electives

All programs should provide residents an opportunity to pursue individually chosen electives.

4. Record of Clinical Experience

There must be a record maintained of specific cases treated by residents, in a manner that does not identify patients, but which illustrates each resident's clinical experience in the program. This record must demonstrate that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. In the case of transferring residents, the records should include the experiences in the prior as well as the current program. This record must be reviewed periodically with the program director or a designee, and must be made available to the surveyor of the program.

F. Resident Policies

1. The program should not allow on-call schedules and activities outside the residency that interfere with education, clinical performance, or clinical patient care responsibilities.

2. Each resident must be given a copy of the Essentials of Accredited Residencies at the beginning of training.

3. Readily available procedures for assisting the resident to obtain appropriate help for significant personal or professional problems should be in place.

VI. Resident Duty Hours and the Working Environment

Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents’ time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

A. Supervision of Residents
1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.

2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

3. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.

B. Duty Hours

1. Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

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

3. Residents must be provided with 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.

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

C. On-call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

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

4. *At-home call (or pager call)* is defined as a call taken from outside the assigned institution.

   a) The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

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

   c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

D. Moonlighting

1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.

3. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.

E. Oversight
1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.

2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

F. Duty Hours Exceptions

An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution’s GMEC, however, is required.

VII. Evaluation

A. Resident

1. Formative Evaluation

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

a) Assessment should include the use of methods that produce an accurate assessment of residents’ competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

b) Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident. These will be made available on review of the program.

Regular, systematic, documented evaluation of the knowledge, skills, and professional growth of each resident, using appropriate criteria and procedures, must be maintained, including complete
records of evaluations containing explicit statements on the resident's progress toward meeting educational objectives and his or her major strengths and weaknesses. Each evaluation should be communicated to the resident in an ongoing and timely manner.

c) Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.

d) The program must demonstrate that residents have achieved competency in at least the following forms of treatment:

(1) brief therapy;

(2) cognitive-behavioral therapy;

(3) combined psychotherapy and psychopharmacology;

(4) psychodynamic therapy; and

(5) supportive therapy.

e) The program must provide documented evidence to demonstrate that the proficiency/competence of each resident is assessed using techniques that may include supervisory reports, videotapes, oral examinations, case reports, patient care observations, or other methods.

f) The program must provide opportunity for and document regularly scheduled meetings between the resident and the program director or designated faculty members. These meetings should be of sufficient frequency, length and depth to ensure that the residents are continually aware of the quality of their progress toward attainment of professional goals and objectives. These evaluation sessions should be held at least semiannually and preferably more frequently. The program should give residents opportunities to assess the program and the faculty in a manner that ensures resident confidentiality. Provision should be made for remediation in cases of unsatisfactory performance.

g) The program must formally examine the cognitive knowledge of each resident at least annually in the PG-2 through PG-4 years, and conduct an organized examination of clinical skills at least twice during the 4 years of training. In a timely manner, the program must develop specific remedial plans for residents who do not
perform satisfactorily. Residents must not advance to the next year of training, or graduate from the program, unless the outcome from the remedial plan results in the attainment of educational and clinical goals established for the program.

h) Residents should be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional, educational, and clinical growth.

i) A written set of due-process procedures must be in place for resolving problems that occur when a resident's performance fails to meet required standards. These procedures must conform to those policies and procedures adopted by the sponsoring institution for the provision of due process to all residents training in sponsored programs, and must include the criteria for any adverse action, such as placing a resident on probation, or for terminating a resident whose performance is unsatisfactory. The procedures should be fair to the residents, to patients under their care, and to the training program. A copy should be provided to the residents at the beginning of training.

j) Upon any resident's departure from a program (including by graduation), the program director must prepare a letter describing the nature and length of the rotations for which the resident has been given credit. If a resident departs the program without receiving full credit for all educational experiences, the reasons for withholding credit must be specified in the letter. The resident must be given the letter, and a copy must be retained in the resident's permanent file.

k) When a resident leaves the program (including by graduation), the program director will affirm in the training record that there is no documented evidence of unethical or unprofessional behavior, nor any serious question regarding clinical competence. Where there is such evidence, it will be comprehensively recorded, along with the responses of the trainee. The evaluation should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record maintained by the institution.

l) For residents transferring to child and adolescent psychiatry, it is essential that the program director document the nature and length of the rotations for which the resident has been given credit and include a listing of any remaining requirements needed to successfully complete the general psychiatry program. The
resident must be informed that eligibility for certification by the American Board of Psychiatry and Neurology is not possible unless all general psychiatry program requirements are met, even if the resident completes the requirements for training in child and adolescent psychiatry. A copy of this notification must be provided to the resident and a copy included in the resident’s permanent file.

2. Final Evaluation

The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident’s performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident’s permanent record maintained by the institution.

B. Faculty

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.

C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents’ confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.

2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the
certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.

3. Programs must demonstrate that they have an ongoing mechanism to evaluate the effectiveness of their didactic and clinical teaching.

VIII. Experimentation and Innovation

Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

IX. Inquiries Concerning Accreditation and Certification

A. All inquiries concerning the accreditation of psychiatry residencies should be addressed to Executive Director, Residency Review Committee for Psychiatry, 515 N. State St. / Ste 2000, Chicago, IL 60610.

B. All inquiries as to whether a physician is qualified to be admitted for examination for certification in psychiatry should be addressed to Executive Vice President, American Board of Psychiatry and Neurology, 500 Lake Cook Rd / Ste 335, Deerfield, IL 60015.

ACGME: February 2000 Effective: January 2001
Minor Revision: ACGME: September 2004 Effective: November 12, 2004
OVERALL PROGRAM GOALS AND OBJECTIVES

The training program in Psychiatry at Harbor-UCLA Medical Center is designed to prepare its residents for the multiple facets of a psychiatric career in the 21st century. This goal is achieved through exposure to rich clinical case material, a structured didactic teaching program, participation in case supervision, and working with multidisciplinary teams.

It is the intention of the program that all residents will attain competency in the following areas:

PATIENT CARE

The resident must be able to:
- Conduct a therapeutic interview
- Develop and document a DSM-IV multiaxial differential diagnosis
- Develop and document case formulation and treatment plans including attention to psychological, social, biologic, family, and cultural considerations
- Assess and document patient’s potential for self harm and harm to others
- Engage in a variety of psychotherapy modalities
- Utilize pharmacologic agents appropriately
- Assess the medical aspects of patient’s illness

MEDICAL KNOWLEDGE

The resident must demonstrate knowledge of the following:
- Epidemiology, etiology, phenomenology, diagnostic criteria, treatment, course and prognosis of the major mental disorders
- Principles of ethical practice
- Understanding of administrative medicine and health care delivery systems
- Human growth and development throughout the life cycle
- Basic principles of behavioral science and social psychiatry
- Patient evaluation and treatment selection for inpatients, outpatients, patients displaying psychiatric emergencies, substance abusing patients, medically ill patients
- Patient evaluation and treatment selection for children and adolescents
- Patient evaluation and treatment selection for geriatric
age patients
· Principles of forensic psychiatry

INTERPERSONAL AND COMMUNICATIVE SKILLS

The resident must demonstrate the following abilities:
· To interview and transmit information to patients and their families in a clear and meaningful fashion
· To understand the impact of the resident’s own feelings and behaviors on the treatment situation
· To communicate effectively and work collaboratively with other health care professionals and colleagues
· To work effectively in a multidisciplinary team environment
· To work effectively as a consultant with non-psychiatric physicians
· Demonstrate cultural sensitivity in dealing with patients and their families
· Understand the principles of confidentiality in the therapeutic arena

PRACTICE-BASED LEARNING AND IMPROVEMENT

The resident must demonstrate ability to recognize the extent and limits their knowledge base and clinical skills. They must acquire skills of:

· Accessing medical literature (e.g. libraries, computerized searches, etc.)
· Learning to critically evaluate the psychiatric literature
· Understanding the principles of quality improvement and how it relates to their practice
· Facilitating the learning of students and colleagues

PROFESSIONALISM

The resident must demonstrate responsibility for all aspects of patient care. They must demonstrate behavior in accord with ethical principles including the following:

· Demonstrating respect, compassion and integrity
· Responding to patient communications
· Completing and maintaining medical records in a timely manner
SYSTEMS-BASED PRACTICE

The resident must have a working knowledge of:

- the diverse systems (private and public) involved in the care of patients and how to utilize these systems as part of a treatment plan
- utilization review and economic principles of health care delivery systems
- the range of community services available to patients and how to assist patients to navigate amongst them
- the legal aspects of patient’s illness and the impact of this on the patient and family

The specifics comprising these broad competencies will be taught and assessed in the context of the various rotations throughout the training experience. Methods of assessment will vary by rotation and site, and could include such measures as standardized in-service examination, direct observation of patient interviews, viewing video-taped patient encounters, American Board of Psychiatry and Neurology style “mock” oral examinations, observation during multi-disciplinary team meetings, etc.

At the completion of training, residents will have had experiences working with patients throughout the life cycle - experiences in child and adolescent psychiatry, adult psychiatry and geriatric psychiatry. They will develop competence in interviewing, diagnosis, and the design and implementation of treatment plans for all these age groups through direct clinical supervision supplemented by didactic material and case conferences. Residents will be able to evaluate social, psychodynamic, cultural, family, and biological aspects of the patient's illness. For each of these, skills will be taught regarding the collection of relevant information and the integration of such information into a database from which a treatment plan will emerge. Importantly, exposure to patients from multiple ethnic groups will be provided throughout training.

Residents will develop proficiency in assessment and treatment planning, multi-axial diagnostic evaluations, pharmacological therapy, the integration of psychotherapy and psychopharmacology, and principles of psycho-social rehabilitation. In addition, residents will become competent in a number of different psychotherapeutic modalities including: individual psychotherapy (brief, intermediate, and long-term), cognitive/behavioral therapy, supportive psychotherapy, and crisis intervention. Additional modalities they will be exposed to and may become competent in will be: play therapy for children, group therapy, conjoint and family therapy, hypnotherapy, and
electroconvulsive therapy. They will develop skills in providing consultation both to non-psychiatric physicians and to non-medical mental health practitioners. Principles of ethics and awareness of forensic issues will be stressed throughout the training. Through clinical rotations and supervision, they will acquire a knowledge base and be able to participate in treatment in acute inpatient, emergency room, and outpatient psychiatric and rehabilitative settings, as well as in the provision of psychiatric care in medical-surgical inpatient settings. They will be exposed to patients exhibiting a wide range of psychopathology, including patients with comorbid drug and alcohol problems and medical and neurological illnesses.

The primary objectives in the didactic program are not only to impart current knowledge about the many aspects of psychiatry, but to teach skills that will enable the resident to think conceptually and maintain the ability to think critically in the years after residency training. This will be accomplished through exposure to a wide variety of topics, through review of pertinent literature, and through experiences in the critical evaluation of research. In addition to learning the theoretical and practical aspects of psychiatry, residents will learn about the economics of health care and various service delivery paradigms. They will participate in multidisciplinary teams, being exposed to various aspects of the provision of mental health care, and learn administrative and managerial skills in the team setting. Assessment of this knowledge acquisition will include yearly in-service examinations and “board-style” oral examinations.

In order to graduate from the training program, the resident will have successfully completed all required clinical rotations, and the elective program agreed upon; not had evidence of unethical or unprofessional behavior; and demonstrated sufficient professional ability to practice competently and independently.

Finally, it is the goal of the training program to be in substantial compliance with the Program Requirements of Accredited Residencies and to maintain full accreditation through the residency review process of the Accreditation Council for Graduate Medical Education.
GOALS & OBJECTIVES
Psychiatric Emergency Room

PGY-I goals and Objectives:

1) Patient Care
   - Perform a focused psychiatric exam with particular attention to patient’s complaints and functional ability
   - Formulate a management plan
   - Clearly document patient management in the medical record
   - Formulate differential diagnosis for common psychiatric diseases
   - Use diagnostic and therapeutic options appropriately
   - Recognize when patient needs referral to behavioral medicine or other medical services
   - Perform suicide assessments

2) Medical Knowledge
   - Understand the presenting symptoms of common psychiatric problems, including but not limited to:
     - Depression
     - Anxiety and panic disorder
     - Somatization disorder
     - Substance abuse
     - Schizophrenia
     - Bipolar Disorder
     - Adjustment disorders
     - Antisocial Personality disorder
     - Malingering
   - Understand the medical emergencies in psychiatry such as:
     - NMS
     - Serotonin syndrome
     - Hypertensive crisis (“cheese reactions” to MAOIs)
   - Understand the risk factors for suicide

3) Practice-Based Learning and Improvement
   - Be able to perform a literature search to answer clinical questions
   - Identify deficiencies in knowledge base and develop independent means to address them
4) Interpersonal and Communications Skills

- Communicate effectively and compassionately with patients
- Effectively communicate patients’ needs to other providers
- Facilitate functioning of multidisciplinary team
- Communicate effectively with the med. ER and other interfaces within the medical community.

5) Professionalism

- Interact with patients, colleagues and hospital staff in a respectful manner
- Maintain patient confidentiality and HIPAA guidelines

6) Systems-Based Practice

- Understand the role of multidisciplinary care for the management of patients with psychiatric problems
- Understand appropriate referrals for psychiatric emergency care
- Understand LPS laws and how they affect placements among the different levels of care in the overall system (IMDs, nursing homes, step down units, board and cares, state hospitals, jails, and prisons).

PGY-III Goals and Objectives:

In addition to the above PGY-I goals and objectives, PGY-III residents on a PER rotation are expected to develop / learn the following:

3) Patient Care

- Function as a charge resident with patient care responsibilities over the interns and medical students on service
- Contribute to the supervision of treatment plan formulations.
- Organize and supervise the more medically complicated cases with input from allied medical specialties.

4) Medical Knowledge
• Understand not only the presenting symptoms of common psychiatric problems, but the theoretical etiology, epidemiology and evidenced based literature on treatment of:
  o Depression
  o Anxiety and panic disorder
  o Somatization disorder
  o Substance abuse
  o Schizophrenia
  o Bipolar Disorder
  o Adjustment disorders
  o Antisocial Personality disorder
  o Malingering
• Understand the management and care of medical emergencies in psychiatry such as:
  o NMS
  o Serotonin syndrome
  o Hypertensive crisis (“cheese reactions” to MAOIs)
• Understand the risk factors for suicide and be able to independently perform a risk assessment.

3) Practice-Based Learning and Improvement

• Be able to perform a literature search to answer clinical questions as they arise from the clinical work and from the supervision and teaching of interns and medical students.
• Identify deficiencies in knowledge base and develop independent means to address them

4) Interpersonal and Communications Skills

• Communicate effectively and compassionately with patients, patient’s families and outside providers
• Effectively communicate patients’ needs to other medical services
• Lead a multidisciplinary team

5) Professionalism

• Interact with patients, colleagues and hospital staff in a respectful manner
• Maintain patient confidentiality and HIPAA guidelines

6) Systems-Based Practice
• Understand the role of multidisciplinary care for the management of patients with psychiatric problems
• Understand appropriate referrals for psychiatric emergency care
• Understand LPS laws and how they affect placements among the different levels of care in the overall system (IMDs, nursing homes, step down units, board and cares, state hospitals, jails, and prisons).
• Understand law regarding the appropriate transfer of cases between hospitalize, and how to manage these referrals.
Harbor-UCLA’s department of psychiatry residency training program includes outpatient work in the PGY-II (50%), PGY-III (40%), and PGY-IV (50%) years. PGY-II residents will be assigned a core group of outpatients at the beginning of their year. This caseload will grow throughout the year as they complete an initial evaluation every week. PGY-II residents are expected to obtain skills in diagnostic evaluations, which are different from those of the acute setting (ER and inpatient services) that they have experienced as PGYIs. They are also to obtain competence in a broader range of ambulatory psychiatric disorders including anxiety disorder, personality disorder, mood and psychotic disorders in acute and chronic phases. Supervision will consist of individual psychotherapy supervision 2 hours a week and additional administrative and clinical supervision from the psychiatry faculty in the outpatient clinic. Residents are required to maintain individual therapy cases in order to utilize the psychotherapy supervision. The supervisors will help determine the appropriateness of cases and help to maintain a variety of different types of cases for different types of therapy. Psychotherapy skills develop over all three years, but the PGY-II year should at least provide skill levels capable of supportive, cognitive and brief psychotherapies.

PGY-III residents will not be expected to complete new evaluations as they are primarily on other services. They will maintain their caseloads developed in their PGY-II year, and care for these patients in the hospital should they require hospitalization. Individual psychotherapy supervision will continue 2 hours per week and the team will provide administrative supervision. PGY-III residents will maintain enough psychotherapy cases to continue to utilize this supervision and new cases will be assigned if caseloads drop below a reasonable level.

PGY-IV residents are expected to expand responsibilities and are given administrative duties as well as clinical duties. They are expected to participate and be an active part of the multidisciplinary team. Their duties include working in the split treatment model by providing medication “back up” for patients in therapy with social workers and psychologists. They will be an active part of teaching PGY-II residents and will be available for consultation with difficult or confusing new evaluations. Individual psychotherapy supervision continues at 2 hours per week and residents will be assigned enough cases to obtain competence in a wide range of psychotherapy techniques. These skills include cognitive behavioral and psychoanalytic psychotherapy.
Year Specific Goals and Objectives

PGY-II

Patient care

Develop effective working alliances and facilitate empathic doctor-patient relationships

Demonstrate the ability to take a complete psychiatric history, including a mental status examination, past history, family history, social history, and medical history

Effectively evaluate ongoing treatment

Demonstrate knowledge of theory and an ability to work with the appropriate treatments for substance abuse disorders

Provide continuous care to a caseload of 20-40 patients including caring for them in the emergency room, inpatient unit, and on the consult service if patients are admitted to other services in the hospital

Medical Knowledge

Demonstrate knowledge of the major DSM-IV disorders of adulthood, including signs and symptoms, differential diagnosis, and natural history and treatment

Demonstrate knowledge of the basic theories of psychiatric disorders

Demonstrate knowledge of the major forms of psychotherapy including psychoanalytic, cognitive behavioral, and issues of transference and countertransference

Demonstrate knowledge of biological, including monoamine theories of mood disorders, psychotic disorders, anxiety disorders

Demonstrate knowledge of psychopharmacologic agents used in the treatment of adult psychiatric disorders; indications, contraindications, side effects and drug interactions.

Demonstrate knowledge about indications for psychiatric treatments

Demonstrate an ability to properly utilize psychological testing, including when to order and how to interpret results.

Demonstrate knowledge of the indications and contraindications of hospitalization, and the appropriate outpatient management of violence and suicide.
Practice-Based Learning and Improvement

Use supervision and feedback to improve interaction with patients and to improve diagnostic, treatment, and assessment skills.

Consult medical literature as needed to improve knowledge base and care of patients.

Demonstrate an understanding of the skills required to interface with other services including medical, neurological, and other consultation.

Demonstrate an ability to utilize Q/A findings and make appropriate changes as indicated.

Demonstrate an ability to utilize the principles of ethics and how they relate to the practice of psychiatry.

Interpersonal and Communication Skills

Communicate effectively with patients and families from a broad range of socioeconomic, demographic, ethnic, and racial backgrounds.

Demonstrate the skills required to effectively involve family members and significant others in the patient’s evaluation and treatment.

Demonstrate the skills required to interface with administrative, clinical and paraprofessionals on the multidisciplinary team.

Demonstrate the ability to establish rapport and a working alliance with patients in order to elicit sensitive information.

Professionalism

Maintain appropriate professional attire and demonstrate timeliness for patient appointments and supervision.

Demonstrate appropriate demeanor meeting ethical standards with patients, peers, faculty, and staff.

Demonstrate respect, compassion and integrity and is accountable to the needs of patients, society and the profession.

Maintain required charting and other documentation with diligence to risk management and the expected high level of excellent patient care needed to be a valued member of the medical community.

Systems-Based Practice

Document in a timely and accurate manner.
Effectively manage patient scheduling and triage

Demonstrate a working understanding of the appropriate California State Laws, including Tarasoff, confidentiality, reporting of sexual abuse and physical abuse with children or the elderly, and how changes in these laws effect practice.

Demonstrate and understanding or implementing preventive interventions with patients and their families.

PG-III and PG-IV

**Patient care**

Provide competent clinical management, psychopharmacological and psychotherapeutic treatment to patient

Manage a clinical practice, collaborating with other professionals, balancing the needs of patients in the practice and the resources available

Demonstrate competency in group treatment, including the theory, indications, and implementation of supportive, cognitive, and psychodynamic group therapy

Demonstrate knowledge of theory and an ability to perform couples and family therapy.

Demonstrate competency in evaluating patients for and providing psychopharmacologic treatment to patients receiving psychotherapy from another practitioner in the outpatient clinic

**Medical Knowledge**

Demonstrate knowledge about the epidemiology, natural history, neurobiology, psychology, and systems aspects of the major psychiatric illnesses

Demonstrate knowledge about psychotherapies, indications, and potential pitfalls

Demonstrate knowledge of cross cultural issues and how they affect diagnosis and treatment

**Practice-Based Learning and Improvement**

Use supervision and feedback to improve interaction with patients and to improve diagnostic, treatment, and assessment skills

Consult medical literature as needed to improve knowledge base and care
of patients

Participate in quality improvement activities appropriately

**Interpersonal Communication Skills**

Communicate effectively with patients and families from a broad range of socioeconomic, demographic, ethnic, and racial backgrounds

Collaborate effectively with other mental health and medical professionals, peers, and support staff

Communicate effectively with patients and families using an interpreter when necessary

**Professionalism**

Maintain appropriate professional attire and demonstrate timeliness for patient appointments and supervision

Demonstrate appropriate demeanor meeting ethical standards with patients, peers, faculty, and staff

**Systems-Based Practice**

Document in a timely and accurate manner

Effectively manage patient scheduling and triage

Demonstrate system-based knowledge including a working knowledge of social service agencies (DCFS, Department of Mental Health policy, Regional Center and the Department of Health Service’s array of service providers)

Demonstrate a working understanding of the appropriate California State Laws, including Tarasoff, confidentiality, reporting of sexual abuse and physical abuse with children or the elderly, and how changes in these laws affect practice

Demonstrate the knowledge of the different levels of care in the outpatient setting and the ability to appropriately refer to those services
PSYCHIATRY - INPATIENT
Inpatient Goals and Objectives:

PG-1

1. Patient Care

Residents should gain comfort in taking psychiatric histories and conducting physical exams as part of a comprehensive psychiatric evaluation.

Residents should gain comfort with the diagnostic process, including how to recognize signs and symptoms, how to approach the board categories of DSM-IV diagnosis, and how to understand differential diagnosis.

Residents should be comfortable working within context of an interdisciplinary inpatient psychiatric team and with the flow of group communication and decision-making.

Residents should gain familiarity with the broad categories of psychiatric medications and their use, including antidepressants, antipsychotics, mood stabilizers, benzodiazepines, and other psychotropic agents.

Residents should gain comfort working both with mentally ill patients and with their families, incorporating both into the treatment process.

Residents should gain familiarity with the legal system and its role in voluntary and involuntary inpatient treatment.

2: Medical Knowledge

Residents should be comfortable with the broad categories of DSM-IV psychiatric diagnoses, including mood disorders, psychotic disorders, anxiety disorders, substance use disorders, and personality disorders.

Residents should understand current thought about biological underpinnings of major mental illness and how this informs the chemical actions of major medications used on the inpatient psychiatric service.

Residents should start to gain familiarity with the major types of side effects of psychiatric medications and how to recognize and screen for them.

Residents should understand the legal aspects of involuntary treatments, including psychiatric holds, Riese hearings, and LPS conservatorships.
Residents should gain familiarity with the biopsychosocial model of mental illness and how these three sets of factors may interplay to create distress and psychiatric pathology.

Residents should become familiar with the highest risk behaviors in inpatient psychiatry, suicide and violence, and should be comfortable routinely screening for them.

3. Practice-Based Learning and Improvement

Residents should learn how to read clinical journals and to evaluate them, so that they may start incorporating scientific evidence into their practice. They should also learn to conduct a literature search and learn where to find medical information.

Residents will learn to improve the quality of their practice by learning to use feedback from inpatient supervisors.

Residents will begin to teach third-year medical students, so they will gain familiarity with the use of didactics and supervision in teaching.

4. Interpersonal and Communications Skills

Residents will learn to deliver clear and organized case presentations and to synthesize their clinical assessments through presenting cases in interdisciplinary team rounds and in individual clinical supervision.

Residents will reinforce effective presentation skills by preparing case presentations in the monthly departmental case conferences.

Residents will learn the foundation of interviewing techniques to optimize their assessment and history-taking from inpatients.

Residents will become familiar with the roles of other personnel involved in the care of the psychiatric inpatients, including nurses, social workers, psychologists, therapists, and consulting physicians. They will become comfortable working and communicating with them.

5. Professionalism

Residents will maintain proper attendance, punctuality, demeanor, and behavioral standards expected of a medical professional.

Residents will be aware of ethical principles in medicine and will learn to implement them in practice.

Residents will learn professionalism in clinical practice and medical documentation.
6. Systems-Based Practice

Residents will understand the flow of patients through the levels of care in the mental health system, including the inpatient service, the emergency service, and the various levels of outpatient care.

Residents will gain an understanding of the elements of the community mental health system in Los Angeles County and a broad familiarity with its components and their roles in patient care.

Residents will be familiar with the balance between the costs and benefits of treatments and learn to deliver cost-effective care.

PG-2

1: Patient Care

Residents should comfortable and competently be able to take comprehensive psychiatric histories and to interpret laboratory studies and physical exam and use these data to guide diagnosis.

Residents should be able to use the exam and data available to them to arrive at a differential diagnosis and independent clinical thought process.

Residents should lead the interdisciplinary treatment team in guiding the treatment planning process for their patients on the inpatient service.

Residents should demonstrate a working knowledge of pharmaco-dynamics, pharmaco-kinetics and drug to drug interactions of psychotropics and other drugs used in the treatment of the mentally ill.

Residents will learn the basics of ECT and participate in ECT interventions.

Residents will become exposed to brief inpatient psychotherapeutic interventions as well as to family interactions such as psychoeducational interventions.

Residents should understand the legal, ethical and economic ramifications of treatment.

2. Medical Knowledge
Residents should demonstrate knowledge of the major DSM-IV disorders that afflict psychiatric inpatients, including signs and symptoms, differential diagnosis, and natural history and treatment.

Residents should have familiarity with the explanatory models for psychiatric illness, such as the biological, biopsychosocial, psychodynamic, and cognitive models.

Residents should have an understanding of cross cultural issues and how they affect diagnosis and treatment in the inpatient psychiatry setting.

Residents should have an understanding of interplay between psychiatric treatment and the law in California, including the Lanterman-Petris-Short Act and the resulting practice requirements.

Residents should have a facility with risk factors for suicide and violence and for how to put this knowledge into practice in well-conducted and documented safety assessments.

3. Practice-Based Learning and Improvement

Residents will understand the hierarchy of quality and types of medical evidence and learn how to research literature and evidence, incorporating it into their practice.

Residents will learn to improve the quality of their practice by learning to use feedback from various supervisors, inpatient and psychotherapeutic. The feedback in the second-year will involve more self-awareness and incorporation of discussion of technique and practice style.

Residents will teach interns and third/fourth year medical students and perfect the principles of teaching and clinical supervision. They will improve their own learning through the facilitation of that of others.

4. Interpersonal and Communications Skills

Residents will learn effective communications and listening skills to build rapport with patients. This will facilitate the building of therapeutic alliances and lay the groundwork for effective history-taking and participation in treatment.

Residents will learn more in-depth interviewing techniques, such as motivational interviewing, mirroring, and recognition of transference/countertransference in order to further strengthen rapport and understanding of the physician-patient interaction.

Residents will learn the principles of effective psychoeducation in three contexts: in individual sessions with patients, in family psychoeducation groups, and in weekly psychoeducational groups for inpatients on the ward.
Residents will demonstrate communications skills with colleagues as they learn to effectively interface with other non-physician members of the interdisciplinary treatment team and with non-psychiatric physician consultants.

5. Professionalism

Residents will maintain proper attendance, punctuality, demeanor, and behavioral standards expected of a medical professional. Second-year residents will become comfortable with an increased role in team leadership.

Residents will be aware of ethical principles in medicine and be able to demonstrate more in-depth thought and discussion of specific principles such as autonomy, beneficence, non-malfeasance, and justice, and learn how to apply these principles to treatment decisions.

Residents will learn to document appropriately as required for effective communication of assessment and treatment decisions with attention to professional, legal, and utilization review requirements.

6. Systems-Based Practice

Residents will take an active role in following patients through the systems of health delivery, from the emergency setting, to the inpatient ward, to following some discharged inpatients through their outpatient courses.

Residents will understand the structure of the community mental health care system in California and in Los Angeles County, including the mental health clinics, hospitals, urgent care centers, and field-capable case management teams such as full-service partnerships (FSPs). They will interface will all of these pieces of the system.

Residents will be aware of the choice, cost, and feasibility of treatments and interventions and their impact on the public health care system. They will be able to guide their treatment within the bounds of rational and compassionate cost-effective care.
A. The PURPOSE of these rotations is to develop the knowledge base, clinical skills, and critical approach to cost-effective and cultural/personally sensitive care that a general internist or internal medicine subspecialist needs to learn for today's challenging clinical environment. It is expected that the clinical and instructional experiences of these rotations and curriculum will prove useful in the variety of academic and/or community based settings in which graduates will work. Clinical experiences will provide exposure to a wide range of problems that internists commonly confront in outpatient practice, involving knowledge both in internal medicine and in other specialties pertinent to primary care. Evidence-based clinical decision making will be encouraged. Didactic sessions and conferences will provide a structured approach to core knowledge in these fields, with the goal of completing a basic curriculum in ambulatory medicine over the course of the three-year residency training program. The curriculum is designed to cover the topics considered essential for general internists by the American College of Physicians, the Society of General Internal Medicine, and the American Board of Internal Medicine, with a focus on the challenging range of problems presented by patients at Harbor-UCLA Medical Center.

This curriculum describes the several rotations in Ambulatory General Internal Medicine, including R1 Ambulatory Medicine, R2 General Medicine Clinics, and R1-R3 Continuity Clinics. Residents also participate in Urgent Care Clinic. R1s will be tasked with learning the general principles of ambulatory medicine, and will be provided with close supervision of patient care, prescribing, ordering diagnostic tests, and scheduling of return visits. R2 and R3 residents will have progressively more independent decision-making given to them at the discretion of the attending physician, including diagnosis, therapy, and followup.

B. GOALS AND OBJECTIVES RELATED TO THE COMPETENCIES

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Goal: Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</th>
<th>Assessment: Achievement of these objectives will be evaluated by:</th>
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</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td><strong>Actions:</strong> To achieve these objectives during this rotation, DO these:</td>
<td><strong>Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation,</strong></td>
</tr>
<tr>
<td>• plans an appropriate diagnostic and therapeutic program for ambulatory patients</td>
<td>See patients in your Block Ambulatory Rotation and in your Continuity Clinic.</td>
<td></td>
</tr>
<tr>
<td>Establishes priorities for evaluation and management of ambulatory patients, including evaluation of severity, likelihood of deterioration, and response to treatment</td>
<td>Identify the chronic and ongoing problems and develop a diagnostic (or monitoring) plan and therapeutic plan for each. Identify new problems that require attention. Review your medical records documentation with an attending physician.</td>
<td>Review of the medical records, and progress in achieving objectives.</td>
</tr>
<tr>
<td>Performs and documents an appropriate (general and focused) medical history and physical examination</td>
<td>Perform the procedures likely to be encountered in taking care of ambulatory medical patients (including documentation of required procedures). Review your medical records documentation with an attending physician.</td>
<td></td>
</tr>
<tr>
<td>Performs the procedures likely to be encountered in taking care of ambulatory medical patients (including documentation of required procedures)</td>
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<tr>
<td>Provides appropriate follow-up of medical problems and patient concerns</td>
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<tr>
<td>Has the skills needed to manage a panel of patients on a continuity basis</td>
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<tr>
<td>Uses suitable referral to internal medicine subspecialists and non-medicine specialists, including framing questions, incorporating consultative advice, and maintaining a collegial relationship</td>
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<td></td>
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</table>

### 2. Medical Knowledge

**Goal:** Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

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<tr>
<td>Demonstrates increased knowledge of pathophysiology, diagnosis, and treatment of medical illnesses</td>
<td>Read textbooks, articles, handouts about ambulatory medicine. Attending conferences scheduled for the ambulatory medicine areas and Department of Medicine conferences during block rotations.</td>
<td>Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.</td>
</tr>
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<td><strong>Curriculum: Goals and Objectives</strong></td>
<td><strong>Department of Medicine</strong> Harbor-UCLA Medical Center</td>
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<td>------------------------------------</td>
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</tr>
<tr>
<td>• demonstrates awareness of areas of needed improvement in ambulatory internal medicine knowledge</td>
<td>Present, review, and discuss patients with ambulatory medicine attending physicians.</td>
<td></td>
</tr>
<tr>
<td>• understands the basics of health maintenance, including periodic health evaluation, perioperative risk assessment, and disease prevention</td>
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<tr>
<td>• learned about aspects of geriatric evaluation and treatment</td>
<td></td>
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### 3. Systems-Based Practice

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

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<tr>
<td>• appreciates the relationships between different levels of outpatient care</td>
<td>Manage your panel of continuity patients, with appropriate use of consultants as needed.</td>
<td>Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.</td>
</tr>
<tr>
<td>• understands basic information about cost-effectiveness care in the ambulatory setting and knows where to seek further information</td>
<td>Identify areas of improvement in providing cost containment and effective outcomes in your patients.</td>
<td></td>
</tr>
<tr>
<td>• demonstrates awareness of the outcomes of ambulatory care</td>
<td>Learn when your patients require hospitalization and identify areas for improvement in care, if any.</td>
<td></td>
</tr>
<tr>
<td>• appreciates emerging health policy issues, including managed care, national and state health program proposals, barriers to health care access, and pertinent ethical issues in outpatient medicine.</td>
<td>Participate in Ambulatory Medicine Quality Improvement activities.</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Practice-Based Learning and Improvement

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

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</table>

- Use evidence from the medical literature to answer clinical questions
- Identify areas for potential improvement in personal delivery of care
- Maintain a positive attitude towards learning, including attendance and participation on rounds and conferences, and evidence of reading or other methods of gaining knowledge
- Is acquainted with current principles of cost-effective, evidence-based clinical decision making, clinical guidelines, and outcomes research, including the systematic process of evaluating the indications for diagnostic tests, specific treatment options, and consultation/referral

### 5. Interpersonal and Communications Skills

**Goal:** Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates.

**Objectives**

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<tr>
<td>Present patients in the clinic to attending physicians.</td>
<td>Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.</td>
</tr>
<tr>
<td>Present new patients with sufficient information to make decisions. Present patients in followup concisely, emphasizing changes, and results of diagnostic studies.</td>
<td></td>
</tr>
<tr>
<td>Be sure to get feedback on your presentations and entries in the medical record from attending physicians.</td>
<td></td>
</tr>
</tbody>
</table>

**Actions:**

- Identify clinical questions concerning patients assigned to you. Read about your patients, look up relevant literature and present your findings to others.
- Use the information you learned by applying to subsequent patients.
- Develop your personal strategies and systems to follow your outpatients.
- Identify useful guidelines for management of outpatients, including blood pressure control, glycemic control, cholesterol management.

**Objectives:**

- Participate actively in teaching students and residents
- Attend conferences, present topics assigned. Take an active role in learning, including taking notes, reading provided handouts.
<table>
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<th>Curriculum: Goals and Objectives</th>
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<th>Harbor-UCLA Medical Center</th>
</tr>
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</table>

- work constructively as part of a team

| Write notes in the medical record that reflect your thinking and your plans. Review some of your notes—ask yourself if there is sufficient information for someone else to see the patient in followup. Is there anything more that you would like to include next time? |

### 6. Professionalism

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

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<tr>
<td>• focus on issues of appropriate and adequate pain management</td>
<td>Include pain as a problem list item. Address patient’s satisfaction with pain management. Learn strategies for pain management as an outpatient.</td>
<td>Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.</td>
</tr>
<tr>
<td>• recognize the importance of a patient’s cultural, language, or family background and support</td>
<td>Identify relevant social and cultural issues and include them on the problem list.</td>
<td></td>
</tr>
<tr>
<td>• understand the impact of illness on patient and family, including medical ethical decision-making, end of life issues, and forgoing of care</td>
<td>Review the need of some your patients for advance directives, including durable power of attorney. If needed, implement a California Advance Health Care Directive.</td>
<td></td>
</tr>
<tr>
<td>• demonstrate respect and compassion for patients, including issues of informed consent</td>
<td>If necessary, read about Informed Consent. Be able to explain how a patient who declines a study should be informed about his/her choice.</td>
<td></td>
</tr>
<tr>
<td>• interact consistently with other health care workers in a professional manner</td>
<td>Arrive at clinic on time, including conferences. Learn to see patients at an appropriate rate, so as to minimize the waiting time for other patients.</td>
<td></td>
</tr>
<tr>
<td>• is punctual to scheduled clinic sessions and educational forums</td>
<td>Ask how to get 360 evaluations from patients and co-workers.</td>
<td></td>
</tr>
</tbody>
</table>

### C. The CLINICAL EXPERIENCE may include patients having common problems in the following areas:

1. Endocrine disorders: diabetes mellitus (Type 1 and 2), hypothyroidism, hyperthyroidism, hypercholesterolemia/ hyperlipidemia, metabolic syndrome.
2. Cardiovascular disorders: hypertension, congestive heart failure, ischemic heart disease, chest pain (differential diagnosis), peripheral arterial insufficiency, venous insufficiency, stroke.

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revised GIM 3/99; reviewed 4/00, 4/02, 1/05, 7/07, draft 7/10
3. Neurologic problems: headache, dizziness, vertigo, peripheral neuropathy, cervical and lumbosacral disk disease, pain management.
4. Musculoskeletal and rheumatologic disorders: back pain, bursitis, acute and chronic arthritis (osteoarthritis, rheumatoid arthritis, gout), osteoporosis, common sports injuries, foot disorders.
5. Obstetrical and gynecologic disorders and issues: pelvic pain, menopause, estrogen replacement therapy, breast lump*, vaginal bleeding, amenorrhea/ dysmenorrhea, vaginitis, contraception.
9. Gastrointestinal problems: diarrhea, constipation, dyspepsia (epigastric distress/ peptic ulcer disease/ gastritis), gastroesophageal reflux disease, rectal bleeding, hepatitis, irritable bowel syndrome, evaluation of abnormal liver function tests.
10. Infectious diseases: sexually transmitted diseases, tuberculosis, ENT infections (pharyngitis, sinusitis), skin infections.
11. Problems in behavioral medicine: smoking cessation, substance use and withdrawal (narcotics, cocaine, alcohol), obesity, unsafe sex and the sexual history.
14. *Common problems in outpatient surgery: ophthalmology (retinopathy, the red eye, glaucoma, conjunctivitis, foreign body, corneal abrasion), ENT (otitis media and externa, hearing loss, other infections, hoarseness), orthopedics (see above), general surgery (laceration repair, simple biopsies), podiatry.
16. Problems of special populations: immigrants and refugees (cross-cultural medicine, infectious diseases, post-traumatic stress, traditional healing, culturally-specific syndromes); geriatric medicine, adolescent medicine*.
17. Clinical pharmacology pertinent to primary care: formulary principles and variations, generic prescribing, drug resistance, allergic reactions, drug interactions, polypharmacy, patient utilization of over-the-counter medications, cost considerations, ethics of relationships with pharmaceutical corporations and representatives, complementary and alternative medicine.
18. Travel medicine: immunizations, motion sickness, air travel, altitude sickness, traveler's diarrhea, malaria.

D. Exposure to these PROCEDURES, including indications, contraindications, and complications, is expected:

1. Skin biopsy
2. Flexible sigmoidoscopy
3. Gynecology exam, pap test, lab tests for infection, pregnancy test.
4. Cryotherapy
5. Outpatient spirometry and interpretation
7. Joint aspiration of knee; synovial fluid analysis with use of polarizing microscope.
E. EDUCATIONAL RESOURCES available during these rotations include:

1. General Medicine Clinic.
2. Urgent Care Center.
3. Outpatient skills rotations: flexible sigmoidoscopy, dermatology clinic, adolescent medicine, geriatric medicine, medicine consult clinic.
4. General internal medicine teaching conference (weekly, Wednesday noon).
5. Pre-clinic morning conference.
6. Computer and data base resources in the clinics and libraries.
7. Kaiser Harbor City general internal medicine clinics and specialty clinics pertinent to primary care.
8. Outpatient morbidity and mortality conferences.

F. During this rotation, SUPERVISION will be provided by: Qualified physician/faculty who are appointed by the Division of General Internal Medicine to include:

1. General internal medicine attending physicians at Harbor UCLA
2. Kennamer fellow(s)
3. Department of Medicine Chief Residents (inpatient and ambulatory)

G. EVALUATION of performance will be provided by oral and written feedback and evaluation by the general internal medicine attending staff and ambulatory chief resident. Written evaluation of the rotations by the residents will be requested. Competence in procedures is documented through written appraisal by supervising faculty.
INPATIENT MEDICINE (R1)

A. The PURPOSE of this rotation is to provide clinical experience with patients having a variety of acute illness requiring inpatient hospitalization. Patients will be followed from admission (most patients admitted from the Emergency Department), through the ward and/or ICU, and until discharge. Medical, psychosocial, ethical, and other aspects of acute illness will be discussed. At the conclusion of this rotation, residents will have gained insight into the diagnosis and management of acute inpatient medical problems, the role of subspecialty consultation, diagnostic methods, the natural history of disease, and strategies for efficient workup and treatment. The relationship between ambulatory and inpatient medicine will be examined through patient encounters and discharge planning.

B. GOALS AND OBJECTIVES RELATED TO THE COMPETENCIES

<table>
<thead>
<tr>
<th>1. Patient Care</th>
<th>Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</th>
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<tr>
<td>Objectives</td>
<td>To achieve these objectives during this rotation, DO these:</td>
</tr>
<tr>
<td>• demonstrate an effective approach to management of medical problems requiring hospitalization</td>
<td>Admit assigned patients from emergency department, clinics, or scheduled admissions. Ask to see patients with different problems if you have seen these before. Complete the admission history and physical examination; discuss with your resident to confirm your findings. With your resident, decide on a plan for diagnosis and treatment. Write orders.</td>
</tr>
<tr>
<td>• plan a diagnostic and therapeutic program for acutely ill patients</td>
<td>Plan each day to optimize efficient patient care, including arranging consultation, procedures, discharge planning, and laboratory tests. Write orders early.</td>
</tr>
<tr>
<td>• establish priorities for evaluation and management, including time management, organization, written documentation, and discharge planning documentation</td>
<td>Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.</td>
</tr>
<tr>
<td>• perform an appropriate (general and focused) inpatient medical history and physical examination</td>
<td>Mini-Clinical Evaluation Exercise, to include an observed focused physical examination with opportunity for feedback.</td>
</tr>
<tr>
<td>• write appropriate admitting and daily orders based on diagnostic and therapeutic plans</td>
<td></td>
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<tr>
<td>• make a discharge plan</td>
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</tbody>
</table>
### Curriculum: Goals and Objectives
Department of Medicine
Harbor-UCLA Medical Center

#### 1. Clinical Skills
- **Perform the procedures likely to be encountered in taking care of hospitalized medical patients** (including documentation of required procedures)
- **Respond to unanticipated emergent problems of inpatients (cross-coverage)**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracentesis, paracentesis, lumbar puncture, naso- or orogastric tubes, central venous catheters</td>
<td>Identify patients who need thoracentesis, paracentesis, lumbar puncture, naso- or orogastric tubes, and central venous catheters. Perform these procedures under supervision and document the key information, including indications, informed consent, and complications.</td>
</tr>
<tr>
<td>Be sure that you have adequate and timely cross-coverage information (“sign-outs”). When called, see patient quickly and identify important issues. Document your findings and your plans for treatment and followup.</td>
<td></td>
</tr>
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</table>

#### 2. Medical Knowledge
Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

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<td>Acquire knowledge of pathophysiology, diagnosis, and treatment of common inpatient medical illnesses</td>
<td>Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.</td>
</tr>
<tr>
<td>Be able to explain the indications for and complications of commonly used diagnostic tests and medical therapy</td>
<td></td>
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<td>Demonstrate awareness of areas of needed improvement in inpatient internal medicine knowledge</td>
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#### 3. Systems-Based Practice
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

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<td>Appreciate the relationships between different levels of inpatient care, including general wards, progressive care, and ICU care.</td>
<td>Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.</td>
</tr>
<tr>
<td>Follow your patients through these levels of care, observe level of nursing care and capabilities and limitations of each.</td>
<td></td>
</tr>
</tbody>
</table>
• **provide continuity of care between levels of care both entering and leaving the inpatient environment (including followup ambulatory care)**

<table>
<thead>
<tr>
<th>Action</th>
<th>Arrangement of general medicine and subspecialty followup.</th>
<th>Objectives.</th>
</tr>
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</table>

• **understand basic information about cost-effectiveness and knows where to seek further information**

<table>
<thead>
<tr>
<th>Action</th>
<th>Review summary of costs of medications.</th>
<th>Objectives.</th>
</tr>
</thead>
</table>

• **demonstrate awareness of resources for optimal patient care, including ancillary services, guidelines, patient education, social services, and non-physician care specialists**

<table>
<thead>
<tr>
<th>Action</th>
<th>Work with social services, respiratory care, patient educators (diabetes, for example), dietitians, and others for future care planning and discharge planning.</th>
<th>Objectives.</th>
</tr>
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**4. Practice-Based Learning and Improvement**

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

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<td>• request and use consultation appropriately with medical and non-medical services</td>
<td>Learn to ask specific questions, use consultation judiciously, and follow recommendations.</td>
<td>Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.</td>
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<tr>
<td>• obtain and use evidence from the medical literature to answer clinical questions</td>
<td>Identify clinical questions concerning patients assigned to you. Read about your patients, look up relevant literature and present your findings to the team during rounds.</td>
<td></td>
</tr>
<tr>
<td>• identify areas for potential improvement in personal delivery of care</td>
<td>Learn from other patients on your team, including physical examination findings.</td>
<td></td>
</tr>
<tr>
<td>• have a positive attitude towards learning, including attendance and participation on rounds and conferences, and evidence of reading or other methods of gaining knowledge</td>
<td></td>
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</tr>
</tbody>
</table>
### Curriculum: Goals and Objectives

Department of Medicine  
Harbor-UCLA Medical Center

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Actions</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>participate in teaching others, including students, residents, and faculty</strong></td>
<td>Organize rounds to see patients efficiently and early to optimize patient care. Identify needs of learners on the team and provide appropriate level of up-to-date information. Assume increasing responsibility for decision-making along with interactions with attending physicians.</td>
<td>Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.</td>
</tr>
<tr>
<td><strong>demonstrate leadership skills, decision-making, and use of evidence-based medicine while directing and teaching team members (for PGY2 and PGY3 residents).</strong></td>
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</tr>
</tbody>
</table>

#### 5. Interpersonal and Communications Skills

**Goal:** Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates.

**Objectives**  
Actions: To achieve these objectives during this rotation, **DO** these:

- **present a patient effectively and efficiently, avoiding jargon, and concisely summarizing pertinent information and plans**  
  Present patients on rounds and in the clinic to fellows, attending physicians and the rest of the team. Present new patients with sufficient information to make decisions. Present patients in followup concisely, emphasizing changes, input from other consultants, and results of diagnostic studies.  
  Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.

- **write accurate, complete, and legible entries in the medical record**  
  Be sure to get feedback on your admission and followup entries in the medical record from your resident and attending physician.  

- **can provide accurate and concise cross-coverage information**  
  Keep “sign-outs” up-to-date, especially with most relevant and timely information. Identify and discuss likely scenarios for the cross-coverage period.

**6. Professionalism**

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

**Objectives**  
Actions: To achieve these objectives during this rotation, **DO** these:

- **assess and manage pain**  
  Include pain management as a (potential) problem on problem lists. Discuss success of pain management with patient on rounds and with the team as needed.  
  Competency-Based Evaluation by attending physicians and supervising residents based on patient and staff interactions, bedside encounters, case presentation, review of the medical records, and progress in achieving objectives.
Curriculum: Goals and Objectives
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| • recognize the importance of a patient's culture, language, or family background | Identify particular issues related to delivery of patient care across cultural, language, or family barriers. | review of the medical records, and progress in achieving objectives. |
| • aware of end of life issues, including decision-making and forgoing of care | When addressing end-of-life issues, discuss DNR, forgoing therapy decisions, hospice options, pain management with residents, social service, attending physician. |  |
| • show respect and compassion for patients, including issues of informed consent | Be sure that you understand issues involved with informed consent. If necessary, review policies for informing patients and documenting consent. |  |
| • interact with other health care workers in a professional manner | Participate in patient care on a professional and collegial level. Observe and identify role models for professional behavior. |  |
| • complete medical records (admission notes, progress notes and discharge summaries) in a timely manner | Complete admission notes as soon as possible. Write progress notes daily. For PGY2-PGY3, dictate discharge summaries on the day of discharge. |  |

C. The CLINICAL EXPERIENCE may include patients having:

1. acute respiratory failure (ARDS, COPD, asthma)
2. acute and chronic renal failure
3. gastrointestinal bleeding
4. complications of cancer
5. sepsis
6. pneumonia, tuberculosis, empyema
7. congestive heart failure
8. acute myocardial infarction
9. bacterial endocarditis
10. complications of AIDS and other immune compromised states
11. electrolyte disturbances
12. severe hypertension
13. cirrhosis, hepatitis, biliary disease, pancreatitis
14. altered mental status, cerebrovascular disease, meningitis
15. medical diagnostic problems, including fever of unknown origin

reviewed/revised 5/99, 3/00, 4/02, 1/05, draft 3/09; 7/21/2010
16. diabetic ketoacidosis  
17. drug overdose or toxicity, drug/alcohol withdrawal

Reading, discussion, and other educational activities should be directed at understanding the pathophysiology, clinical course, and management of the disorders listed under C.

D. Exposure to these PROCEDURES, including indications, contraindications, and complications, is likely on this rotation:

1. thoracentesis  
2. lumbar puncture  
3. phlebotomy  
4. urinalysis  
5. examination of peripheral blood smear  
6. arterial puncture

Exposure to and experience with indications and decisions regarding: hemodialysis, fine needle aspiration, bone marrow aspiration and biopsy, gastrointestinal endoscopy, fiberoptic bronchoscopy, cardiac catheterization, echocardiography, pulmonary function testing, exercise tests. These procedures are performed by subspecialists.

E. EDUCATIONAL RESOURCES available during this rotation include:

1. Work rounds with residents  
2. Attending physician teaching rounds  
3. Department of Medicine Grand Rounds (weekly)  
4. Medical M&M Conference (weekly)  
5. Medicine Housestaff Discussion Series (weekly)  
6. Subspecialty residents, fellows, and attending physicians providing consultation  
7. Morning Report (daily, optional for R1)  
8. Medicine Ethics Discussion Series  
9. 5E ICU Rounds, daily if patients admitted to this area  
10. Interns’ Report (weekly)  
11. Other Department of Medicine conferences  
12. Primary Care Lecture Series (weekly)

F. During this rotation, SUPERVISION will be provided by:

1. Ward Attending Physician
2. Ward Resident (R2 or R3)

G. EVALUATION of performance will be provided by written evaluation by the Attending Physician and Ward Resident. R1s will evaluate teaching performance of Attending Physician and Senior Residents.

H. ON-CALL SCHEDULE: During this rotation, the R1 will be on-call in the hospital every 5th day (including weekends and holidays) to accept patient admissions and to provide coverage for other patients on the inpatient service. On other days, R1 will accept patient admissions until 2 PM unless that day is a Saturday, Sunday, holiday, or the day before or after an on-call day. There will be a maximum of 5 new admitted patients per R1 on an on-call day. Days off are assigned to meet ACGME requirements at a minimum.

I. OTHER: During this rotation, resident physicians may participate in teaching medical students assigned to the inpatient service.
Introduction
The outpatient subspecialty clinics rotation is designed to familiarize and educate the resident about common pediatric conditions that present in the ambulatory setting. Residents are exposed to various outpatient clinical experiences in the pediatric clinic and are supervised by subspecialty attendings and fellows in the following fields: adolescent medicine, allergy/immunology, cardiology, endocrinology, gastroenterology, genetics, infectious diseases, neurology, nephrology, and rheumatology. In addition, residents participate in multidisciplinary clinics such as ISAM (infants of substance abusing mothers) and MZ (acquired immunodeficiency) clinic.

1. Patient Care
   a. Obtain the necessary historical information and perform the appropriate physical examination pertinent to the patient’s complaint and/or medical condition.
   b. Provide the patient with compassionate, appropriate medical treatment.
   c. Develop and carry out patient management plans.
   d. Communicate effectively and demonstrate caring and respectful behavior when interacting with patients and their families.
   e. Counsel and educate patients and their families in a culturally appropriate manner.
   f. Interface with other health care professionals, including those from other disciplines, to provide patient-focused care.

2. Medical Knowledge
   a. Demonstrate an understanding of the basic pathophysiology related to an individual patient’s medical condition.
   b. Know and apply basic scientific principles appropriate to the specific subspecialty.
   c. Know common pediatric medical conditions that present in the ambulatory setting.
   d. Perform the appropriate laboratory studies necessary to evaluate common pediatric ambulatory conditions.

3. Practice-based Learning and Improvement
   a. Investigate and evaluate patient care practices and guidelines.
   b. Locate, appraise, and assimilate scientific evidence pertinent to the patient’s medical condition.
c. Use information technology in the outpatient setting to manage scientific information, educate patients and their families, and support the resident’s own education.

4. Interpersonal and Communication Skills
   a. Elicit the appropriate historical information pertinent to the patient’s presentation.
   b. Develop effective listening and communication skills.
   c. Provide culturally competent and sensitive health care to a diverse patient population.
   d. Work effectively with others as a member of the health care team, including patients, their families, ancillary staff, and medical colleagues.
   e. Provide appropriate, timely, legible written documentation of all patient encounters.

5. Professionalism
   a. Demonstrate a commitment to deliver the highest quality of care possible to all patients.
   b. Demonstrate respect, compassion and integrity toward patients and their families.
   c. Demonstrate sensitivity and responsiveness to a patient’s culture, ethnicity, age, gender, and disabilities.

6. Systems-based Practice
   a. Develop an awareness of and responsiveness to the larger context and system of health care and how it relates to the ambulatory setting.
   b. Understand the resources available in the ambulatory setting to deliver cost-effective health care.
   c. Serve as an advocate for patients evaluated in the outpatient setting by assisting them to navigate the complex health care system.
   d. Demonstrate a commitment to prevent medical errors in each subspecialty clinic.

M.Sifuentes, MD
2009
Patient Assessment - to be discussed with the senior resident or attending

- Perform a complaint-based history and physical exam
- Develop an appropriate differential diagnosis for each of the patient’s presenting complaints
- Develop an appropriate and cost effective assessment plan based on the patient’s presenting complaints
- Determine initial treatment interventions necessary to stabilize the patient
- Establish a final diagnosis based on the patient’s history, physical and ancillary test results
- Delineate the definitive care needed by the patient after all pertinent data (xrays, laboratory values, etc) are available
- Determine appropriate disposition and follow-up for the patient
- Document clearly and completely
- Be able to recognize a critically ill medical or trauma patient
- Effectively manage at least three patients simultaneously

Patient Complaints - Types of patients to be evaluated during the rotation:

Abdominal Disorders
- Abdominal pain
- Gastrointestinal bleeding

Cardiovascular Disorders
- Chest pain

Cutaneous Disorders
- Rashes
- Infections

Endocrine and Metabolic Disorders
- Acid-base disturbances
- Fluid and electrolyte disturbances
- Complications of diabetes

Head and Neck Disorders
- Infections

Immune System Disorders
- Immune deficiency syndromes
- Hypersensitivity reactions

Musculoskeletal Disorders
- Acute arthritis
- Low back pain

Nervous System Disorders
- Altered mental status
- Seizures
- Headache

Obstetric Disorders
- First trimester complications

Psychobehavioral Disorders
- Abnormal behavior
- Depression and suicide
GOALS AND OBJECTIVES FOR THE NEUROLOGY INTERN ROTATION

PGY-1 Interns Assigned to Neurology

GOALS
The purpose of this assignment is to increase the neurology resident’s experience in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communications skills, professionalism and systems-based practice.

This rotation will provide you postgraduate education in the evaluation and management of patients who have diseases of the nervous system which will be of use to you in your future career. This is implemented by your participation in patient care as a member of the ward team and in the clinic, by the guidance and supervision of senior resident physicians, by rounds with attending faculty, by didactic activities including discussion on ward rounds, neuroradiology conference, neuroscience conference, neuropathology/neuroanatomy conference, and journal club. Also, you will participate in the teaching of medical students assigned to the service. Postgraduate education, of course, should involve some independent study and the senior residents and faculty are available to guide it. Note that faculty attending physicians carry a beeper and are available twenty-four hours a day, seven days a week.

Specific goals of the rotation are to increase skills in obtaining a neurologic history, to increase skills in performing the neurologic examination and lumbar puncture, to increase the understanding of indications for EEG, nerve conduction, EMG, neuroimaging and other neurologic tests, to increase your medical knowledge and its application to medical care with particular reference to the nervous system, to foster practice-based learning and improvement (involves the investigation and evaluation of your own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care), to gain experience in systems-based practice (manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value), to promote interpersonal and communication skill that result in effective information exchange and teaming with patients, their families, and other health professionals, and to promote professionalism as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Your patients come from an unselected population of diverse ethnic composition which provides a great variety of neurologic disease. However, common things are common for admissions to the neurology service, so you can count on experience in stroke, TIA,
dementia, seizures, neuromuscular disease and metabolic disturbances. Also, it is likely you will be involved with the interface between psychiatric and neurologic disease.

Evaluations are required of the program for house staff and faculty and will be accomplished through the use of forms, a process which you undoubtedly already are used to.

**Call Schedule:** Generally q3. Call schedule is posted each month in the EEG Lab.

1. The call schedule will be posted well in advance. Any changes in the final call schedule **must** be approved by your Ward Chief.
2. You will be on call with a junior resident from neurology, family medicine, or psychiatry.
3. It is **strongly recommended** that you see each consult in the ER with the junior resident, especially the neurology residents. The choice is yours, but this will expose you to a much larger variety of neurological disease than if you only see the admissions. If the patient is admitted, you will do your own H&P write-up and write the orders with the resident. If the patient is not admitted, you do not have to do any write-up nor any other paperwork.
4. You should not be left on your own in the ER by the resident. If this occurs, notify your chief the next day.
5. You will provide cross-cover for the Neurology ward service when you are on call. This is usually not difficult. If you have any questions, ask the resident on call with you. If you still have questions, one of you should call the back-up chief at home.

**Work Schedule:**

1. Teamwork rounds occur every day. The time will be determined by your Ward Chief. You should pre-round on your patients before team rounds.
2. Attending rounds are generally Monday, Tuesday, and Wednesday mornings and Thursday and Friday afternoons. Attendings are also readily available during the week as needed.
3. You should be in-house until 4:30 each day. Post-call, you will be able to go home by at least 24 + 6 hours. Slow days are good times to ask the chief or junior to provide additional teaching or to do reading.

**Clinics:**

- **General Neurology Clinic:** Thursday 8:30 am – 12:00 pm
- **Specialty clinics:** Tuesday 8:30 am – 12:00 pm (when on consult service)
  - **First Tuesday:** Headache
  - **Second Tuesday:** Botox
  - **Third Tuesday:** Multiple Sclerosis
  - **Fourth Tuesday:** Neuromuscular Disorders
  - **Fifth Tuesday:** No specialty clinic
- **Neurogeriatric/Neurobehavior Clinic:** Monday 1:00 pm – to be staffed by PGY-3 and 4 residents as scheduled.
Usually you will rotate only through the general clinic on Thursdays. If things are slow, you can ask about going to the other clinics. Headache and MS clinics may be particularly useful to you.

**Important Locations:**
- **Neurology/EEG Lab:** 8E room 12; ext 2492
- **Neurology Ward:** 6W
- **N-24 Clinic:** ext 8251, 8252 or 8253
- **N-25: Neurology Department (office):** ext 3897
- **6W: Neurosurgery/Neurology ICU**
- **6W ICU** (beds approved by neurosurgery resident on call – can get name from ER)
- **Neuroradiology:** 2nd floor, room 42
- **Radiology File Room:** 2nd floor
- **CT scanners:** ER and Basement
- **MRI scanner:** Imaging Center
- **Ultrasound:** Basement
- **Echo:** 8E (Cardiology)

**Paperwork:**
1. **CT:** Fill out request form; get approved by neuroradiology attending or fellow (page radiologist on call on nights/weekends/holidays); take to CT scanner – They will call for patient when they are ready.
2. **MRI:** Fill out form; get approved by neuroradiology; take to basement to be scheduled.
3. **Ultrasound:** Fill out form; take to basement for approval and scheduling.
4. **PT/OT:** Fill out green form; put order in chart. Outpatient needs a separate green form. Each service needs a separate form.
5. **Speech:** Fill out normal yellow consult sheet; write order in chart. Outpatient fill out form and send to Box 493.
6. **Rancho:** see attached sheet.
7. **EEG:** Fill out EEG form; drop it off in EEG Lab (after hours, slide it under the door).
8. Your name and pager number should be on all of these forms (legibly).

**Friday Conferences:**
1. **Neuroradiology:** 8:00-9:00 am. It helps to check the patient list in the radiology conference room (across the hall from the radiology file room) on Thursday late afternoon.
2. **Neuroscience Conference:** 9:30-11 am. 7th floor conference room (opposite the stairwell).
3. **Neuropathology:** 11:00 am – 2:00 pm. 2nd floor pathology conference room.

These conferences are *mandatory* and you should be on time.

2004; 7/15/08; oaa
GOALS & OBJECTIVES

Harbor-UCLA Neurology Program
Neurology Inpatient Consultation PGY-2 Rotation

The overall goal of this rotation is to augment the PGY-2 neurology resident’s patient care experience, medical knowledge, practice-based learning, interpersonal communications skills, professionalism and systems-based practice exposure. This rotation will provide postgraduate education in the evaluation and management of patients with dysfunction of the nervous system, consistent with building a career in this field. These aims are implemented chiefly by participation in inpatient consultative care as a member of the Consult Team, under the guidance and supervision of chief resident and attending physicians. Didactic activities will include formal discussions on ward rounds, neuroradiology, neuroscience and neuropathology/neuroanatomy conferences, and journal clubs. Residents will participate in teaching rotating residents and medical students assigned to the service. Postgraduate education should involve a component of independent study, often based on patient care issues. Chief residents and faculty are available to guide the participant’s identification and organization of supplementary learning material gleaned from print and electronic media. Faculty attending physicians are available by phone or pager 24 hours a day, 7 days a week.

Specific objectives of the rotation include:
1) increasing skills in obtaining a neurological history and examination;
2) augmenting medical knowledge and its application with particular reference to nervous system conditions;
3) an increased understanding of the indications for and interpretation of EEG, nerve conduction testing, EMG, CT and MRI scanning and other neurologic tests;
4) learning to safely and effectively perform lumbar puncture;
5) promoting interpersonal communication skills that result in effective information exchange and collaboration with patients, families, and other health professionals;
6) developing the highest sense of professionalism, as shown by a commitment to one’s professional responsibilities, adherence to ethical principles and sensitivity to our diverse patient population;
7) gaining experience in systems-based practice, as demonstrated by awareness of the larger context of the health care system and use of the system’s resources to produce optimal patient outcomes; and,
8) fostering practice-based learning and improvement by evaluating one’s own patient care methods and by appraising and assimilating scientific evidence, always seeking to improve.

Patients at Harbor-UCLA Medical Center arise from across the entire spectrum of human race, gender, national origin and gender identity. This diversity results in a very wide range of primary and secondary neurological illness. Common causes of inpatient neurological consultation include acute confusion of toxic-metabolic origin, cardioembolic stroke, hypoxic-ischemic encephalopathy, seizure disorders due to medical
illness, traumatic and metabolic peripheral neuropathy, endocrinological and inflammatory myopathy and complications of cancer, HIV and nutritional deficiency.

**Competency-based Objectives for the PGY-2 Consult Rotation:**

1. **Patient Care**
   - Performs an appropriate neurological and general medical history and physical examination for each new consultation patient
   - Formulates initial diagnostic and therapeutic recommendations for consult inpatients, demonstrating consideration for cost- and time-effectiveness; finalizes recommendations under supervision of chief resident and attending
   - Writes clear, concise and appropriate consult and follow-up notes based on this formulation
   - Communicates neurological assessment and suggestions in a timely and respectful nature with primary service inpatient team, making certain that written notes have been effectively transmitted
   - Makes and documents follow-up visits as expected by primary team (daily unless specified) and makes clear any plans to discontinue follow-up visits
   - Responds promptly and adequately to urgent and emergent problems arising in his/her consult patients and those of other residents for whom one is covering, and in other hospital areas like the emergency room after-hours
   - Consults with neurosurgical, diagnostic and other services appropriately

2. **Medical Knowledge**
   - Shows training level-appropriate knowledge of pathophysiology, differential diagnosis, evaluation and treatment of neurological illnesses as they relate to medical, surgical and psychiatric disease
   - Can explain the indications for and complications of commonly used neurodiagnostic tests and treatments
   - Demonstrates awareness of gaps in his/her fund of information regarding conditions appropriate to consultative hospital neurology and of methods to fill those gaps

3. **Practice-Based Learning and Improvement**
   - Identifies, reviews and prioritizes medical scientific evidence to address questions relevant to the care of neurological disorders arising in a general hospital population
   - Finds and begins to address areas for potential improvement in his/her personal delivery of care
   - Maintains a positive attitude toward learning, including satisfactory attendance and participation in rounds and conferences, and demonstration of self-directed education through print and electronic media
   - Eagerly participates in teaching others, including students, fellow residents and faculty
4. Interpersonal and Communications Skills
• Presents patients effectively and efficiently, concisely summarizing pertinent information and plans
• Communicates with patients and families compassionately and accurately
• Writes accurate, complete and legible entries in the medical record
• Works constructively as part of a team, taking each member’s contributions into account
• Communicates productively with peers in other disciplines
• Completes paperwork in a timely manner

5. Professionalism
• Demonstrates respect and compassion for patients, including issues of informed consent
• Recognizes the importance of a patient's cultural, language and family background in their medical care choices and options
• Consistently interacts with physicians, nurses, therapists, technicians, clerical personnel and other health care workers in a courteous and thoughtful manner
• Reliably addresses issues of appropriate and adequate pain management
• Recognizes and discusses important end-of-life issues, including palliative care and decisions to limit or end medical interventions

6. Systems-Based Practice
• Appreciates the relationships between different levels of inpatient service, including ward, step-down unit and ICU care
• Understands the limitations of patient evaluation and treatment in urgent care and emergency room settings and suggests admission when appropriate
• Develops plans to assure continuity of neurological care after discharge, ideally assuming personal ambulatory clinic follow up of one’s hospital consult patients
• Understands basic concepts of cost-effective system-wide management and knows where to seek further information regarding resources for optimal patient care, including ancillary services
**GOALS AND OBJECTIVES FOR GENERAL PSYCHIATRY RESIDENT CHILD PSYCHIATRY ROTATION**

**Outcome:** Residents will appreciate ways in which child psychiatry requires an understanding of both development and psychopathology and will know how to apply knowledge of these areas in a medical setting with considerable supervision.

**MEDICAL KNOWLEDGE**

**Goals:** To identify psychiatric issues that present in the emergency room and on a consultation service and work with a supervisor to intervene in an appropriate manner.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Expectations</th>
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<tbody>
<tr>
<td>Knowledge</td>
<td>Respond in a timely manner to requests to consult as assigned</td>
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<tr>
<td></td>
<td>Present consultation case to appropriate supervisor</td>
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<td></td>
<td>Pursue reading about conditions assessed on rotation</td>
</tr>
<tr>
<td>Attitude</td>
<td>• Maintain a desire to acquire knowledge about the psychiatric issues of children, even if not intending to pursue a fellowship in child psychiatry</td>
</tr>
<tr>
<td>Skills</td>
<td>• Learn to apply fund of knowledge to specific cases seen during this rotation</td>
</tr>
</tbody>
</table>

**INTERPERSONAL SKILLS AND COMMUNICATION**

**Goals:** To work as a team member with clinicians in the emergency room and consult service
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
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<tr>
<td>• Learn how to communicate effectively with clinicians, patients and</td>
<td>• Demonstrate effective communication, both listening and speaking in ways that promote</td>
</tr>
<tr>
<td>families</td>
<td>excellent care of the patient and sensitivity to needs of clinicians</td>
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<tr>
<td>• Learn how to consider cultural aspects of interpersonal communication</td>
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</tr>
<tr>
<td>• Learn how to function as a consultant</td>
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<tr>
<td><strong>Attitude</strong></td>
<td></td>
</tr>
<tr>
<td>• Demonstrate an openness to feedback about communication style</td>
<td>• Display an attitude of conscientiousness and openness to learning during supervision</td>
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<tr>
<td><strong>Skills</strong></td>
<td></td>
</tr>
<tr>
<td>• Be able to elicit accurate data from patient, families and clinicians</td>
<td>• Demonstrate successful data collection and feedback to patients, families and clinicians</td>
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<tr>
<td>in a manner that is perceived as sensitive and competent</td>
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**PATIENT CARE**

**Goals:** To learn how to care for child psychiatry patients in an acute care medical setting

<table>
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<tr>
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<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
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<tr>
<td>• Learn how to conduct an interview with a child and family and to</td>
<td>• Conduct interview with patient, family and clinicians in an organized and sensitive manner</td>
</tr>
<tr>
<td>understand the concerns of the child’s clinicians</td>
<td></td>
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<tr>
<td>• Learn how to synthesize data gleaned during a consultation to generate</td>
<td>• Give feedback to patient, family and clinicians about diagnosis and proposed treatment plan</td>
</tr>
<tr>
<td>a bio-psych-social understanding of the child leading to an appropriate</td>
<td>after consultation with supervisor</td>
</tr>
<tr>
<td>treatment plan</td>
<td></td>
</tr>
<tr>
<td>• Learn appropriate types of therapeutic interventions for children who</td>
<td>• Conduct therapy with patient when appropriate as</td>
</tr>
<tr>
<td>present in the emergency room or consultation service</td>
<td></td>
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<tr>
<td>• Learn that children often have concerns that are developmentally</td>
<td></td>
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<tr>
<td>different than adults and that they communicate these concerns</td>
<td></td>
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<tr>
<td>differently, depending on developmental level</td>
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<tr>
<td>• Learn that children often have concerns that are developmentally</td>
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<td>different than adults and that they communicate these concerns</td>
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</tr>
<tr>
<td>differently, depending on developmental level</td>
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<tr>
<td>Practice-Based Learning and Improvement Goals: To gain ability to use scientific literature in guiding the assessment and treatment of children in medical care settings</td>
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<td></td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td><strong>Expectations</strong></td>
</tr>
</tbody>
</table>
| Knowledge | • Learn how to use literature to obtain knowledge in a new field  
• Learn the most common texts and journals used by child psychiatrists to promote life-long learning | • Use internet, texts and journals to enhance learning about cases seen during rotation |
| Attitude | • Appreciate that each case seen on rotation offers an opportunity to expand knowledge by reading  
• Be open to learning more about the case seen in a medical setting that is necessary to meet minimal requirements of the consultation task request | • Request suggestions from supervisor regarding how best to gain further knowledge from the literature about cases seen |
| Skills | • Be able to apply knowledge obtained from texts and literature searches to the child seen in a medical setting | • Demonstrate ability to synthesize reading to apply to children assessed in the medical setting  
• Demonstrate ability to conduct literature search to gain knowledge about the issues presented by child seen in the medical setting |

### PROFESSIONALISM AND ETHICAL BEHAVIOR

**Goals:** To be able to demonstrate professionalism and ethical behavior in the medical care setting while functioning as the child psychiatry consultant

<table>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td>• To understand appropriate conduct to be demonstrated when functioning as the child psychiatry team member in a medical care setting</td>
</tr>
</tbody>
</table>
| **Attitude** | • Approach consult as an opportunity to relieve suffering, to promote education and to work collaboratively with other clinicians to provide excellent care to patient and families  
• Appreciate that cultural characteristics of patients and caregivers require the child psychiatrist to maintain an attitude of openness and humility in dealing with the child in a medical setting | • Demonstrate interpersonal skills that reflect an openness and humility when assessing and caring for a child in the medical setting  
• Discuss issues of professionalism and ethical behavior with supervisor as such issues arise |
### Skills
- Develop the ability to apply standards of professional behavior and ethical behavior and decision-making in the emergency room and when consulting to the child’s health care team
- Demonstrate professional and ethical behavior during clinical work on rotation
- Ask for assistance in developing skills of professionalism and ethical decision making and conduct when appropriate

### SYSTEMS BASED CARE
**Goals:** To understand the importance of systems of care in child psychiatry and to develop some skill in utilizing community systems of care to respond to the needs of the child seen in the acute medical setting

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<th>Expectations</th>
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<tr>
<td>- Learn about what systems of care are important in this geographical area</td>
<td>- Ask about systems of care when interviewing child and family and address these issues with supervisor as appropriate</td>
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<td>- Learn the resources that can assist patients and families to address the issues presented by the child and family seen during this rotation</td>
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<tr>
<td><strong>Attitude</strong></td>
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<tr>
<td>- Appreciate that appropriate psychiatric care for a child often involves coordinating care and obtaining services in the community</td>
<td>- Utilize supervisor to learn about typical providers of care to children and families in the community</td>
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<td>- Be open to expertise of other professions and disciplines and respect the fact that they may use different terms than psychiatrists to describe the child’s condition and needs</td>
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<tr>
<td><strong>Skills</strong></td>
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<tr>
<td>- Be able to assess and refer child appropriately using systems of care resources with assistance of supervisor</td>
<td>- Demonstrate the ability to use systems of care to assess and obtain treatment for a child and family with assistance of supervisor</td>
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<td>Competency</td>
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Nature of Setting and Population Served

Dual Diagnosis Treatment Program (DDTP) at the Harbor-UCLA Medical Center is a comprehensive integrated treatment program that provides care for patients who suffer from concurrent psychiatric and substance abuse disorders. The patient population includes adult men and women from a variety of ethnic groups.

Goals and Objectives for DDTP

1. Patient Care:

   1. Psychiatry interns will be taught assessment skills involving patients with substance abuse and psychiatric issues. They will demonstrate the ability to perform a relevant history and physical exam in a substance abusing patient who is also suffering from concurrent psychiatric disorders

   2. Psychiatry interns will know the DSM-IV-TR diagnoses of substance abuse/dependence, criteria for various substances and symptoms present during intoxication and withdrawal

   3. Psychiatry interns will demonstrate knowledge on the basic theories of psychiatric disorders and addictive disorders (biological, psychological and psychosocial theories)

   4. Psychiatry interns will have firm knowledge of the psychopharmacologic agents used in the treatment of substance abuse disorders, including dosing, adverse drug effects, and drug-drug interactions (it will include medications such as buprenorphine, naltrexone, and antabuse)

   5. Psychiatry interns will know the comprehensive treatment strategy for substance abuse patients with psychiatric disorders, including total abstinence and harm reduction modalities, as well as motivation interviewing, relapse prevention, skill training strategy, and other psychosocial intervention strategies

   6. Psychiatry interns will recognize the typical signs and symptoms of intoxication and withdrawal from various substances of abuse

   7. Psychiatry interns will be able to see dual diagnosis outpatients for medication assessment, write medication progress notes, order appropriate laboratory tests, and monitor patients over time

   8. Psychiatry interns will be able to demonstrate the skills necessary to run psycho-education groups
9. Psychiatry interns will have understanding of different treatment modalities that may be used for treatment of dual diagnosis patients, including cognitive-behavior therapy, brief individual therapy, supportive therapy, crisis intervention, family therapy and self-help groups such as AA and NA group treatment strategy.

10. Residents will co-facilitate medical consequences and process groups. Individual therapy as well as pharmacological interventions for substance abuse and psychiatric disorders will be available. Residents will also have the opportunity to perform initial dual diagnosis intakes and assessments. Residents also will be encouraged to teach psychology and social work externs on a weekly basis.

2. Medical Knowledge:

1. Psychiatry interns will demonstrate an understanding of the pathophysiology, epidemiology, diagnostic criteria and clinical for common dual diagnosis patients including:
   I. alcohol abuse and dependence
   II. cocaine abuse and dependence
   III. stimulant abuse and dependence
   IV. marijuana abuse and dependence
   V. opiate abuse and dependence
   VI. OTC pills abuse and dependence
   VII. Hallucinogen abuse and dependence

2. Psychiatry interns will demonstrate an understanding of the relationship between substances of abuse and psychopathology

3. Practice Based Learning and Improvement:

1. Psychiatry interns will be able to evaluate their patient care practices for substance abusing patients, assimilate scientific evidence and improve their patient care

2. Psychiatry interns will seek feedback from their supervising attending regarding their pharmacological skills and improve their performances

3. Psychiatry interns will seek feedback from other health care providers about their skills in groups and improve their performances

4. Psychiatry interns will facilitate the learning of medical students and other health care provider trainees

4. Interpersonal and Communication Skills:

1. Psychiatry interns must be able to demonstrate interpersonal and
communication skills that result in effective information exchanges with team members and able to work in a multidisciplinary team

2. Psychiatry interns will communicate effectively and demonstrate caring behaviors when interacting with patients and their families

3. Psychiatry interns will quickly develop therapeutic alliance with dual diagnosis patients and able to demonstrate empathy towards them

4. Psychiatry interns will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries

5. Psychiatry interns will use effective listening skills in interactions with patients, their family members and other health care providers.

6. Psychiatry interns will demonstrate proficiency in conveying difficult information to patients and their families

7. Psychiatry interns will effectively elicit information from and provide information to other health care providers, including nurses, social workers, and other mental health workers

8. Psychiatry interns should be able to set appropriate limits and give advise regarding the management of psychiatric and substance abuse disorders

5. Professionalism:

1. Psychiatry interns must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principals and sensitivity to a diverse patient population

2. Psychiatry interns will demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers

3. Psychiatry interns will demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersede self-interest

4. Psychiatry interns will demonstrate a commitment to excellence and on-going professional development

5. Psychiatry interns will demonstrate sensitivity and responsiveness to each patient’s age, gender, culture, ethnicity, religion and disabilities

6. Systems-Based Practice:
1. Psychiatry interns must demonstrate an awareness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.

2. Psychiatry interns will gather data from appropriate sources, including chart, family, and other relevant individuals.

3. Psychiatry interns will demonstrate understanding of how their patient care affects and is affected by other health care providers, the health care organization and the health care system.

4. Psychiatry interns will practice cost-effective health care that does not compromise quality of care.

5. Psychiatry interns will advocate for quality patient care and assist patients in dealing with the complex mental health and drug/alcohol treatment system.
Educational Rationale:

This elective rotation with Full service partnership will expose third year residents to the experience of working as general psychiatrist directly in the community.

The “Full Service Partnership” (FSP) is a field based psycho–social rehabilitation program for patients with severe and multiple concurrent psychopathologies. The psychiatrist goes to visit the patient wherever he or she is, literally (shelter, jail, hospital, board and care, or the street), and figuratively, i.e. where the patient/client stands in her/his ability to recognize, discuss, and address their mental illness. This approach stresses the importance of creativity and flexibility in patient care.

In addition to the opportunity for residents to evaluate and treat individuals with a wide variety of diagnoses, residents will have the opportunity to work in a system of care that addresses various therapeutic approaches which include intensive case management, educational services, vocational rehabilitative services, residential services, and other psychosocial treatment modalities found in the community. The resident will be expected to be an active and vital part of the treatment team as well as working with individuals who are part of a patient’s treatment team in the community (i.e. residential staff or case managers from outside agencies). Residents will be expected to also communicate with a variety of medical providers given the high rate of various medical problems often faced by individuals who are severely mentally ill. Learning to identify and locate various family or community supports is an integral part of the educational experience for the resident.

In addition to learning to navigate the community system of care, the resident will be exposed to the concepts of recovery and community integration. Residents will become familiar with the Psychosocial Rehabilitation (PSR) model which focuses on individual strengths and skills along with providing necessary supports to assist individuals in gaining empowerment over their lives.

Patient Mix:

This patient population comes from the larger Los Angeles community which itself is culturally diverse. The rotation provides care to African American, Hispanic, Caucasian, Asian and other minority populations in the city of Los Angeles. This cultural diversity provides residents with an important opportunity to develop skills in cultural competency. In this rotation, cultural competency is highlighted as a prerequisite to providing comprehensive psychiatric care. Residents will be caring for individuals with major mental disorders as well as mental health issues typically seen in a general psychiatry
practice. Residents will also be working with individuals with substance abuse disorders and developmental disorders

Procedures

Residents will have the opportunity for perform initial assessments and use their pharmacological and supportive psychotherapy skills. In addition, residents have the opportunity to work with nursing staff to observe and learn how to administer depot therapy with deaconate psychotropic medications. Residents also will be expected to perform routine AIMS tests for their patients. In addition to the general practice of pharmacology for various diagnoses, residents will have the opportunity to work with individuals who are prescribed clozapine.

Principal Teaching Methods/Learning Venues

The curriculum in the Community Psychiatry rotation includes didactic, supervisory, clinical care, and QI components. The principal teaching/learning activity is through direct patient care. Supervision, Didactic, and QI activities will complement the skills and knowledge base obtained from the clinical care of patients on this rotation.

Principal Educational Goals by Relevant Competency

Patient Care

1. Psychiatry residents will be taught psychiatric assessment skills involving a wide range of complexes and multiple concurrent psychiatric presentations in the specific population deserved by the Full service Partnership Services
2. Psychiatry residents will understand the impact of illness and multiple psychosocial impediments and stressors in the occurrence, development and presentation of the psychiatric illnesses.
3. Residents will be able to conceptualize a comprehensive formulation regarding psychiatric diagnoses in patient with multiple concurrent mental illnesses and multiple social stressors.
4. Psychiatry residents will demonstrate a variety of interventions and therapies relevant to underserved and poorly engaged patients, including psycho social rehabilitation, supportive psychotherapy, pharmacotherapy, behavioral techniques, family interventions, and multidisciplinary team approaches.
5. Residents will demonstrate the ability to evaluate cognitive ability in patients with severe and multiple mental illness including long history of addiction.
6. Residents will demonstrate the ability to perform – as indicated and in a way that facilitate patient engagement with the program- a relevant history and physical exam on culturally and socially diverse patients, including; chief complaint, history of present illness, past medical history, a comprehensive review of systems, a biological family history, a socio-cultural history, a developmental history and a germane general and neurological examination. This will be done in a wide variety of settings and because the patients are generally very difficult to engage, it is understood that the goal is to get as much information possible while
preserving and protecting the therapeutic alliance. This may initially preclude the ability to get a detailed history. The resident will learn not only to work with what the patient tells them but also with the untold.

7. Residents will recognize the typical signs and symptoms of psychiatric disorders including substance abuse.

8. Residents will understand the connections between socio-cultural environment and psychiatric illnesses.

9. Residents will monitor the patients’ course during their rotation and provide continuing input as needed.

10. The resident must be able to:
   a. advise and guide the patients about their psychiatric problems, the role of medication and general life “hygiene such as sleep, avoiding toxic substance etc
   b. understand the use of psychotropic medications with patient with multiple illness, addiction problems and general poor adherence to treatment
   c. understand, utilize, and instruct regarding the use of non-organic treatments, including brief psychotherapy, behavioral management techniques, family therapy, and psycho-education.
   d. work as a member of a multidisciplinary team to maximize the care of complex medically ill patients.

Medical Knowledge

Residents will demonstrate an understanding of the pathophysiology, epidemiology, diagnostic criteria and clinical course for common psychiatric conditions they encounter including:

   a. schizophrenia
   b. schizoaffective disorder
   c. bipolar disorder
   d. personality disorders including borderline personality disorder
   e. substance abuse and dependence
   f. depression
   g. post traumatic stress disorder
   h. dementia
   i. assess drug-drug interactions germane to psychiatry
   j. understand the data required to be able to contribute to hospitalization of patient against their will via 5150 (Psychiatric Hold)

Practice-Based Learning and Improvement

   a. Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
   b. Residents will seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.
c. Residents will apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.

d. Residents will use information technology to manage information, access online medical information and support their own education.

e. Residents will facilitate the learning of medical students and other health care providers. This will include, but not be limited to, seeking appropriate reference material pertinent to physician duties, reading articles with critical assessment as recommended by faculty and continuing to learn to use modern information systems to identify, information in reference to patient issues.

Interpersonal and Communication Skills

1. Psychiatry residents will learn to promote communication among mental health and other medical specialties that their patient are using. They will promote as much as possible awareness, assessment, and management of psychiatric disorders in medical patients.

2. Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients’ families and other health care providers:
   a. Residents will interact effectively with a variety of consultants, in particular Primary Care Physician involved in patient treatment. This should include determination of consultation questions, and reporting of findings and recommendations.
   b. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
   c. Residents will work respectfully and repetitively at developing a therapeutic alliance with our patients
   d. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
   e. Residents will use effective listening skills in interactions with patients, their family members and other health care providers
   f. Residents will demonstrate proficiency in conveying difficult information to patients and their families. This including discussing openly the difficulties and possibilities of recovery in terms of long term treatment and care. This may vary from being able to convey a very optimistic message (for instance conveying the confidence that patient will be able to get a job eventually) to a very tragic one (for instance: serious risk for patient to kill themselves or a family member)
   g. Residents will demonstrate an ability to work as a member of a multidisciplinary patient care team.
   h. Residents will effectively elicit information from and provide information to other health care providers, including nurses, social workers, psychologist,
case workers, and other physician from their team or from another agency or hospital temporary in charge of our patient.

**Professionalism**

1. Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principals and sensitivity to a diverse patient population.
2. Residents will demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers.
3. Residents will demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersedes self-interest.
4. Residents will demonstrate a commitment to excellence and on-going professional development as they prepare for the transition to independent practice.
5. Residents will appreciate the ethical issues that can arise in the care of patients with concomitant psychiatric and medical/surgical conditions. Such issues include for example, transplant decisions in psychiatric patients and issues of capacity and consent.
6. Residents will demonstrate sensitivity and responsiveness to each patient’s age, gender, culture, ethnicity, religion and disabilities.

**Systems-Based Practice**

1. Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.
2. Residents will gather data from appropriate sources, including chart, hospital staff, family, team members and other relevant individuals.
3. Residents will demonstrate understanding of how their patient care affects and is affected by other health care providers, the health care organization, the health care system, legal (such probation) and economical issues.
4. Residents will know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
5. Residents will practice cost-effective health care that does not compromise quality of care.
6. Residents will advocate for quality patient care and assist patients in dealing with the complex mental and medical health systems.
7. Residents will know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.
PSYCHIATRY RESIDENCY ROTATION GOALS AND OBJECTIVES
ROTATION: Consult-Liaison

1. Patient Care

1. Psychiatry residents will be taught psychiatric assessment skills involving a wide range of neuro-psychiatric presentations in medical and surgical patients.
2. Psychiatry residents will understand the impact of illness, hospitalization, and medical care on the psychological functioning of patients and will be able to conceptualize a comprehensive formulation regarding psychiatric diagnoses in medical and surgical patients.
3. Psychiatry residents will learn to promote liaison relationships with medical and surgical services that emphasize awareness, assessment, and management of psychiatric disorders in medical patients.
4. Psychiatry residents will demonstrate a variety of interventions and therapies relevant to medically ill patients, including time-effective psychotherapy, somatic therapies, behavioral techniques, liaison methods, and multidisciplinary team approaches.
5. Residents will demonstrate the ability to evaluate for psychopathologic processes in patients with concomitant medical and surgical conditions.
6. Residents will demonstrate the ability to evaluate cognitive ability in medically ill patients.
7. Residents will demonstrate the ability to perform a relevant history and physical exam on culturally diverse patients, including; chief complaint, history of present illness, past medical history, a comprehensive review of systems, a biological family history, a socio-cultural history, a developmental history and a germane general and neurological examination. This will be done in a wide variety of medical and surgical patients.
8. Residents will recognize the typical signs and symptoms of psychiatric disorders including substance abuse in medical and surgical patients.
9. Residents will assess and interpret laboratory and medical data as it relates to psychiatric illness.
10. Residents will understand the connections between medical and psychiatric illnesses and the special issues that arise in specific patient populations, including cancer, cardiac disease, HIV disease, organ transplantation, and dementia.
11. Residents will write pertinent and useful consultation notes.
12. Residents will monitor the patients’ course during hospitalization and provide continuing input as needed.
13. The resident must be able to:
a. advise and guide consultants about the role of the medical disease and medications in the patients’ presenting psychiatric symptoms.
b. understand the indications for a variety of somatic therapies in medical and surgical patients.
c. understand the use of psychotropic medications and ECT in medical/ surgical patients, and appreciates physiological effects, contraindications, drug interactions, and dosing concerns.
d. understand, utilize, and instruct regarding the use of non-organic treatments, including brief psychotherapy, behavioral management techniques, family therapy, and psychoeducation.
e. work as a member of a multidisciplinary team to maximize the care of complex medically ill patients.

2. Medical Knowledge:
   a. Residents will demonstrate an understanding of the pathophysiology, epidemiology, diagnostic criteria and clinical course for common consultation conditions including:
      i. dementia(s)
      ii. delirium of multiple etiologies
      iii. drug induced psychiatric state
      iv. affective change in the face of chronic or life threatening illness
      v. factitious disorders and somatic disorders
      vi. malingering
      vii. chronic pain
      viii. assessment of conversion disorders
      ix. assess drug-drug interactions germane to psychiatry
      x. understand the data required to be able to contribute to capacity assessments

3. Practice-Based Learning and Improvement:
   a. Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
   b. Residents will seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.
   c. Residents will apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.
   d. Residents will use information technology to manage information, access on-line medical information and support their own education.
   e. Residents will facilitate the learning of medical students and other health care providers. This will include, but not be limited to, seeking appropriate reference material pertinent to consultation/ physician duties, reading articles with critical assessment as recommended by faculty and continuing to learn to use modern information systems to identify, information in reference to patient issues.

4. Interpersonal and Communication Skills:
a. Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients’ families and other health care providers:
b. Residents will interact effectively with a variety of consultants, including determination of consultation questions, and reporting of findings and recommendations.
c. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
d. Residents will quickly develop a therapeutic alliance with medically ill patients.
e. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.
f. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.
g. Residents will demonstrate proficiency in conveying difficult information to patients and their families.
h. Residents will demonstrate an ability to work as a member of a multidisciplinary patient care team.
i. Residents will effectively elicit information from and provide information to other health care providers, including nurses, social workers, occupational therapy staff, hospital unit coordinators and consulting physicians.
j. Residents should be able to make a determination regarding the consultation questions, and report findings and recommendations about the role of the medical disease and medications in the patients’ presenting psychiatric symptoms.
k. Residents should be able to advise and guide consultants regarding managing psychiatric disorders in a medical/surgical setting including the management of behavioral disorders.

5. Professionalism:
a. Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principals and sensitivity to a diverse patient population.
b. Residents will demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers.
c. Residents will demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersedes self-interest.
d. Residents will demonstrate a commitment to excellence and on-going professional development as they prepare for the transition to independent practice.
e. Residents will appreciate the ethical issues that can arise in the care of patients with concomitant psychiatric and medical/surgical conditions. Such issues include for example, transplant decisions in psychiatric patients and issues of capacity and consent.
f. Residents will demonstrate sensitivity and responsiveness to each patient's age, gender, culture, ethnicity, religion and disabilities.

6. Systems-Based Practice:
   a. Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.
   b. Residents will gather data from appropriate sources, including chart, hospital staff, family, and other relevant individuals.
   c. Residents will demonstrate understanding of how their patient care affects and is affected by other health care providers, the health care organization and the health care system.
   d. Residents will know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
   e. Residents will practice cost-effective health care that does not compromise quality of care.
   f. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system.
   g. Residents will know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.
GOALS AND OBJECTIVES

Patient Care

1. Psychiatry residents will be taught psychiatric assessment skills involving a wide range of psychiatric presentations in HIV patients.
2. Psychiatry residents will understand the impact of HIV on medical care and on the psychological functioning of patients and will be able to conceptualize a comprehensive formulation regarding psychiatric diagnoses in HIV patients.
3. Psychiatry residents will learn to promote liaison relationships with a patient’s primary care and/or infectious disease specialist that emphasize awareness, assessment, and management of psychiatric disorders in medical patients.
4. Psychiatry residents will demonstrate a variety of interventions and therapies relevant to medically ill patients, including psychotherapy, somatic therapies, behavioral techniques, liaison methods, and multidisciplinary team approaches.
5. Residents will demonstrate the ability to evaluate for psychopathologic processes in patients with concomitant medical illness.
6. Residents will demonstrate the ability to evaluate cognitive ability in medically ill patients.
7. Residents will demonstrate the ability to perform a relevant history and physical exam on culturally diverse patients, including chief complaint, history of present illness, past medical history, a comprehensive review of systems, a biological family history, a socio-cultural history including complex psychosocial histories in gay, transgender and bisexual patients. This will be done in a wide variety of medical patients.
8. Residents will recognize the typical signs and symptoms of psychiatric disorders including substance abuse in medical patients.
9. Residents will assess and interpret laboratory and medical data as it relates to psychiatric illness.
10. Residents will understand the connections between medical and psychiatric illnesses and the special issues that arise in the HIV patient populations, including hepatitis C, cancer, diabetes, cardiac disease, and dementia.
11. Residents will write pertinent and useful progress and consultation notes.
12. Residents will monitor the patients’ course during outpatient treatment and provide continuing input as needed.
13. The resident must be able to:
   a. advise and guide consultants about the role of the medical disease and medications in the patients’ presenting psychiatric symptoms.
   b. understand the indications for a variety of somatic therapies in HIV patients.
c. understand the use of psychotropic medications in HIV patients and appreciate physiological effects, contraindications, drug interactions, and dosing concerns.

d. understand, utilize, and instruct regarding the use of non-organic treatments, including brief psychotherapy, behavioral management techniques, family therapy, and psychoeducation.

e. work as a member of a multidisciplinary team to maximize the care of complex medically ill patients.

Medical Knowledge:

a. Residents will demonstrate an understanding of the pathophysiology, epidemiology, diagnostic criteria and clinical course for common consultation conditions including:
   i. HIV dementia
   ii. drug induced psychiatric state
   iii. affective change in the face of chronic or life threatening illness
   iv. hepatitis C and interferon treatment
   v. manage pre-existing psychiatric illness
   vi. substance abuse/dependence
   vii. assess drug-drug interactions germane to psychiatry
   viii. co-manage psychiatric complications of other medical illness
   ix. contraindicated medications with ARV

Practice-Based Learning and Improvement:

a. Residents will be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

b. Residents will seek feedback from their supervising attending and from other health care providers about their own practice and will use this feedback to improve their performance.

c. Residents will apply knowledge of study design, statistical methods and evidence-based medicine to the appraisal of clinical studies.

d. Residents will use information technology to manage information, access on-line medical information and support their own education.

e. Residents will facilitate the learning of medical students and other health care providers. This will include, but not be limited to, seeking appropriate reference material pertinent to consultation/physician duties, reading articles with critical assessment as recommended by faculty and continuing to learn to use modern information systems to identify, information in reference to patient issues.
Interpersonal and Communication Skills:

a. Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients’ families and other health care providers:

b. Residents will interact effectively with a variety of consultants, including determination of consultation questions, and reporting of findings and recommendations.

c. Residents will communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.

d. Residents will quickly develop a therapeutic alliance with medically ill patients.

e. Residents will create and sustain therapeutic and ethically sound relationships with patients, including the use of open and honest communication, the maintenance of an empathic stance and the establishment of appropriate boundaries.

f. Residents will use effective listening skills in interactions with patients, their family members and other health care providers.

g. Residents will demonstrate proficiency in conveying difficult information to patients and their families.

h. Residents will demonstrate an ability to work as a member of a multidisciplinary patient care team.

i. Residents will effectively elicit information from and provide information to other health care providers, including nurses, social workers, case managers, and consulting physicians.

j. Residents should be able to make a determination regarding the consultation questions, and report findings and recommendations about the role of the medical disease and medications in the patients’ presenting psychiatric symptoms.

k. Residents should be able to advise and guide consultants regarding managing psychiatric disorders in an outpatient medical setting.

Professionalism:

a. Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principals and sensitivity to a diverse patient population.

b. Residents will demonstrate respect, compassion and integrity in all their interactions with patients, families and other health care providers.

c. Residents will demonstrate accountability to patients, to other health care providers and to the medical profession and will demonstrate responsiveness to the needs of patients that supersedes self-interest.
d. Residents will demonstrate a commitment to excellence and on-going professional development as they prepare for the transition to independent practice.

e. Residents will appreciate the ethical issues that can arise in the care of patients with concomitant psychiatric and HIV disease.

f. Residents will demonstrate sensitivity and responsiveness to each patient’s age, gender, culture, ethnicity, religion and disabilities.

**Systems-Based Practice:**

a. Residents must demonstrate an awareness of and responsiveness to the larger context of the mental health care system and the ability to effectively call on system resources to provide care that is of optimal value.

b. Residents will gather data from appropriate sources, including chart, hospital staff, family, and other relevant individuals.

c. Residents will demonstrate understanding of how their patient care affects and is affected by other health care providers, the health care organization and the health care system.

d. Residents will know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

e. Residents will practice cost-effective health care that does not compromise quality of care.

f. Residents will advocate for quality patient care and assist patients in dealing with the complex mental health system and medical system.

g. Residents will know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.
Forensic Psychiatry Rotation Goals and Objectives:

1. Patient Care
   - Residents will understand the variety of psychiatric patients encountered in the forensic and correctional setting.
   - Residents gain competence in developing multi-axial differential diagnoses; and will understand that patients treated in the forensic/correctional setting often suffer from multiple co-occurring disorders on multiple DSM-IV axes. They will be able to develop comprehensive treatment plans with attention to biological, psychological, and social foci of treatment.
   - Residents will achieve competence in distinguishing genuine psychopathology from non-credible presentations.
   - Residents will gain competence in psychopharmacologic treatment in the correctional setting, with special attention to commonly abused psychotropic medications.
   - Residents will observe, or conduct under supervision, evaluations of individual’s competence to stand trial, restoration to competence, or amenability for community-based treatment.

2: Medical Knowledge
   - residents will understand the relevant case law
   - residents will understand the rules of evidence as they apply to psychiatric testimony
   - residents will know the laws pertaining to involuntary treatment and detention.
   - residents will understand the laws that pertain to competency
   - residents will know how to distinguish forensic psychiatry from jail mental health services.

3. Practice-Based Learning and Improvement
   - residents will complete at least one mock forensic report, with special attention to medico-legal writing, concision, and evaluation of the evidence in forming a medico-legal opinion.
   - residents will understand the differences between medical thinking and writing (as contained in a history and physical) and medico-legal thinking and writing.
   - residents will learn to use the psychiatric literature and relevant case law and statutes to shape their medico-legal opinions.
4. Interpersonal and Communications Skills

- Residents will deliver clear and organized case presentations and to synthesize their clinical assessments through presenting cases in individual clinical supervision.

- Residents will work and communicate effectively with members of a multidisciplinary team, including nurses, social workers, psychiatric techs, psychologists, and psychiatrists.

- Residents will work and communicate effectively with personnel involved in the correctional maintenance of the patient, including judges, attorneys, and correctional officers.

5. Professionalism

- Residents will maintain proper attendance, punctuality, demeanor, and behavioral standards expected of a medical professional during the rotation.

- Residents will be aware of ethical principles in the practice of forensic psychiatry and will implement them during their rotation.

- Residents will represent mental health disciplines appropriately in their interactions with attorneys, judges, and peace officers.

6. Systems-Based Practice

- Residents will understand the large overlap between their traditional community psychiatry treatment populations and forensic psychiatry treatment populations.

- Residents will understand the flow of forensic patients through the criminal justice system, including arrest, arraignment, jail mental health treatment, assessment of trial competence, conviction and disposition, prison mental health treatment, forensic state hospital treatment, conditional release programs, parole outpatient mental health treatment.

- Residents will understand how California mental health law and its due process rights derive from criminal law and probate law.

- Residents will understand what components of the recovery model, adopted by the community mental health system of Los Angeles County, identify and interface with potential forensic patients, including psychiatric mobile response
teams (PMRT), emergency rooms, full service partnerships (FSP’s), wellness centers, and geographically based in-reach programs in the jail.

- Residents will increase their understanding of health care costs associated with preventative mental health programs versus incarcerated care.
Goals and Objectives
Geriatric Psychiatry Rotation at VAGLAHS for Harbor-UCLA Residents

The **goal** of this training experience is to develop skills in the psychiatric care of older adults who are receiving treatment on inpatient medical units, outpatient settings, and skilled nursing care units. These training experiences occur at the West Los Angeles VA Healthcare Center.

Compassionate care for older adults with a wide range of psychiatric disorders is emphasized. The rotation develops expertise in collaborative care with physicians from other disciplines, as well as with professionals in psychology, nursing, social work, rehabilitation, occupational therapy, discharge planning, and community care.

Objectives:

**Patient care**

- Gather essential clinical information accurately in the inpatient hospital, outpatient clinic, and nursing home settings
- Perform thorough mental status examinations, including cognitive skills and functional abilities
- Develop and communicate a set of recommendations regarding psychiatric management, in the consultant role
- Develop, implement, and monitor a treatment plan for psychiatric care of patients in the nursing home or outpatient setting
- Use laboratory tests and neuroimaging effectively and appropriately
- Assess capacity to give informed consent

**Medical Knowledge**

- Understand the relationships among medical illness, cognitive skills, and psychiatric symptoms
- Understand psychopharmacology and psychotherapy treatments in older adults with medical illnesses in the inpatient, outpatient, and nursing care setting
- Understand medication interactions
- Understand the course of psychiatric illness over the life span
- Understand end of life issues; ethical issues in medicine and psychiatry
- Understand proxy consent policies

**Practice-based Learning and Improvement**

- Understand best practices as they apply to consultative care, nursing home care, and outpatient care of older adults

*Revised 1/2010*
- Understand evidence-based findings related to psychiatric care of older adults
- Apply the knowledge base to teaching activities with junior trainees
- Adjust diagnostic and treatment strategies in consultation, nursing home, and outpatient settings, in response to evolving evidence-based findings and personal experience

**Interpersonal and Communication Skills**
- Include family and caregiver input in history-taking and consultation
- Provide feedback and education to patients and families
- Teach students and junior psychiatry trainees effectively
- Communicate effectively with allied health professionals

**Professionalism**
- Respond efficiently and respectfully to consultation requests
- Communicate collaboratively with other health professionals
- Understand and demonstrate the principles of shared clinical care
- Demonstrate a commitment to quality care

**Systems-based Practice**
- Understand how one’s professional practice affects other health care providers
- Actively and effectively participate in interdisciplinary treatment planning and collaborative care
- Understand links to mental health care in the medical/surgical hospital, and links to community systems for mental health care delivery
PSYCHIATRIC EMERGENCY ROOM

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DAVID RUSKIN, M.D.
Director

ARMEN DJENDEREDJIAN, M.D.
Attending

NADIA DEL-PAN, M.D.
Attending
INTRODUCTION

The Psychiatric Emergency Room (PER) at Harbor-UCLA is one of four in the County of Los Angeles with a dedicated ER for handling psychiatric emergencies. Approximately 10.2 million people reside in our County with a significant portion presenting to public hospitals because of lack of insurance or difficulty in accessing other resources. Therefore, our PER potentially provides emergency psychiatric services to 2.5 million people, or close to one percent of the entire U.S. population.

This effectively translates to 500-700 patients being evaluated each month by our PER. It is a high pressure environment that sees the gamut of psychological, medical, and social issues. Acute psychotic episodes, mania, depression, substance intoxication, malingerers, and personality disorders are seen daily. Anxiety disorders, dementia, mental retardation, sleep disorders, somatic disorders, and significant co-morbid medical disorders are often seen as well. Patients present both voluntarily and involuntarily, and the core of our work is in utilizing limited resources for some of the most acutely impaired patients in psychiatry.

During your residency, you will be spending a significant amount of time in the PER. Besides introducing you to a wide range of disorders, your PER experiences will guide you in dealing with psychiatric emergency situations throughout your career, providing you with solid crisis management skills wherever you may end up practicing your craft. These include psychopharmacological knowledge, identifying co-morbid medical disorders, supportive psychotherapy, behavioral intervention, counseling, etc.

The PER will also give you the opportunity to learn about and interface with almost every aspect of the County mental health system – ie, mental health clinics, psychologists, social workers, caseworkers, law enforcement, the Department of Child & Family Services, Regional Centers, conservators, insurance companies, board and cares, nursing homes, other medical departments, prisons, dual diagnosis specialists, recreational therapists, and other medical centers.

With that, welcome to Harbor-UCLA and the Psychiatric Emergency Room. Believe it or not, we try to have fun despite the sometimes chaos that beleaguer people working at the front line of acute psychiatry. We look forward to having you.

CAST OF CHARACTERS

The Psychiatric Emergency Room (PER) team is composed of attendings (full-time in the PER), residents, nurses, social workers, caseworkers, nursing attendants, and a part-time recreational therapist. At times medical students, nursing students, psychologists, and other also rotate in the PER.

Besides Harbor-UCLA psychiatry interns and residents, we also have interns from UCLA/NPI, family practice residents from California Hospital, and Harbor-UCLA transitional interns.
The primary purpose of our Psychiatric Emergency Room (PER) is to complete an initial psychiatric evaluation, assess for primary or co-morbid medical issues, stabilize the patient, and determine the next step in diagnosis/treatment/disposition.

Patients who are stable and do not meet criteria for hospitalization are discharged, those who clearly need inpatient treatment are admitted to our inpatient units or transferred to other psychiatric facilities, and those who need further initial evaluation will remain in the PER. The last category can include patients with substance intoxication who will likely clear in a matter of hours, patients with adjustment disorders who need a short period to time to stabilize, patients with psychotic exacerbations that may quickly return to baseline with medications, etc. Ideally, patients remain in our PER for 12 hours or less. However, as you will discover, this can vary widely.

Patients present to our PER via:
- police/law enforcement
- PMRT (Psychiatric Mobile Response Teams)
- Sheriff’s MET (Mental Evaluation Teams)
- SMART (Systemwide Mobile Assessment Response Teams)
- medical ER transfers/consults
- pediatric ER transfers/consults
- transfers from outside non-psychiatric emergency rooms
- Twin Towers (jail) discharges
- voluntary walk-ins
- etc.

Approximately 70% of patients arrive involuntarily on 5150 (72-hour) holds. As these patients arrive, they are initially screened by a nurse. When you are assigned to a patient, it is often efficient to listen in on the nurse’s assessment and also question those who brought in the patient.

At that point, a determination should be made as to whether a patient will require an immediate medical evaluation in the medical ER, immediate medications for dangerous behavior, placement in restraints/seclusions for dangerous behavior, or placement in the general PER patient areas (holding rooms).

The patient interview and physical assessment (which usually consists of a brief physical exam) follow. After presenting and discussing the case with an attending, further evaluation, treatment, and disposition plans are determined.

Voluntary patients are assessed in much the same manner except that you may decide to start your evaluation before the nurse, a physical exam may not be required, and the paperwork differs.

Speaking of paperwork…
PAPERWORK

In some ways, mastering paperwork in the PER can be more challenging than actually working up a patient. However, keep in mind that anything you write is considered a medico-legal document. Proper documentation has always been a must and is even more important as “if you don’t write it down, it never happened.”

There are 4 main elements to PER paperwork:

a) Advisements – There are separate advisement forms for involuntary and voluntary patients. These forms cover issues regarding their legal status (as mentioned, involuntary or voluntary) and medications.

b) Physical Assessments – A physical assessment must be made of every patient that is seen in the PER. This can range from a full physical exam for an involuntary patient to a brief note stating that a patient is without physical complaints for a quick voluntary patient. The physical assessments are documented on a 254 form.

c) Psychiatric Assessments – The psychiatric assessment (history, mental status exam, diagnosis) is usually documented on the Emergency Psychiatric Evaluation Form or on a 254 form.

d) Billing – An “encounter form” is used for billing purposes.

Other paperwork you will become familiar with include: PER order sheets, transfer forms, admission order sheets, seclusion/restraint forms, DCFS referrals, mental health clinic referrals, CT request forms, etc.

HOURS OF OPERATION

As with any emergency room, our PER is staffed 24 hours per day. During regular weekdays, the AM shift begins at 8:00 a.m.; an attending will conduct a morning interview of a patient followed by a discussion and then sign-out rounds at 9:00 a.m. Sign-out rounds occur again at 4:30 p.m. when the PM shift begins. During Saturdays, shifts are from 8:30 a.m. to 8:30 a.m. the next day. During Sundays, shifts are from 8:30 a.m. to 8:00 a.m. the next day. (There are exceptions/variations, especially during holidays).

CONCLUSION

Obviously, this guide only briefly touches upon the details of working the PER, where things evolve and change at an unusually rapid pace. The evaluation form, order sheets, resource lists, and transfer policies have all be revamped in the space of two years; the integration into the countywide MAC diversion program and the formation of a new Code Green policy have taken place during the last year. Therefore, please feel free to ask questions of anyone on the team. You may refer to the Policy & Procedures Manual and A Resident’s Guide to Harbor-UCLA Psychiatry Call (which is already a bit outdated), as well. Most importantly, use your clinical judgment to maintain safety for the patients, those around you, and yourself at all times.
AMBULATORY CARE SERVICE

ADULT OUTPATIENT PSYCHIATRIC SERVICES

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ADULT OUTPATIENT PSYCHIATRY

Adult Outpatient Psychiatry (AOP) is a program of the Department of Psychiatry of Harbor-UCLA Medical Center which is administratively responsible to the Los Angeles County Department of Mental Health (DMH), the Department of Psychiatry of UCLA, and the Harbor-UCLA Medical Center Department of Health Services administrator.

AOP is a Primary Linkage and Coordination Program (PLCP) for the Los Angeles County DMH Local Mental Health Plan for Medi-Cal beneficiaries. As a PLCP, AOP screens, triages, directs, authorizes, and reviews services provided by enrolled fee-for-service practitioners. AOP also serves as a mental health treatment site for CalWORKS and GROW, welfare-to-work programs for AFDC and General Relief recipients respectively.

AOP is organized into multidisciplinary teams which include members and trainees of all the major disciplines (psychiatrists, psychologists, clinical social workers, and nurses) and psychiatric residents in PGY years II through IV. Residents have the opportunity to follow their patients at whatever level of care they need within Harbor’s system. As much as possible, patients assigned during the second year of a resident’s training will be treated by the same resident until services are no longer needed or the resident completes training.

As a county operated program, AOP primarily serves the indigent population of Los Angeles County within our geographic service area. The patients are multicultural, and AOP strives to provide culturally competent treatment to each individual. Although AOP’s primary target population is people suffering from serious and persistent mental illness, treatment also is provided to people with a wide variety of ambulatory psychiatric diagnoses. Services include evaluation, medication, individual, group and family treatment, and case management.

The focus of AOP’s program is to assist patients to improve their level of functioning whatever their diagnoses. Services focus on individual needs and strengths, and clients are involved in service planning and implementation. The goal is to help people take charge of their lives through informed decision making. Family members and significant others are involved in the treatment process whenever possible.

Because the ambulatory care service uses the system mandated by the state and county Departments of Mental Health while the inpatient service uses the hospital county Department of Health Services system, you will need to learn two different methods of recordkeeping. AOP will provide you with training, a manual, and on-going assistance with documentation. Keeping your records accurate and current is essential. Although the paperwork may seem burdensome, keep in mind that our systems are no more difficult that you will find in the private managed care environment.

Please see goals and objectives section.
A. PURPOSE AND FUNCTIONS

The psychiatric inpatient units function as locked, acute care psychiatric programs. The 8-West unit has 24 beds and the Crisis Resolution Unit has 14 beds. The purpose of both units is to provide brief intensive hospitalization for a variety of voluntary and involuntary patients. New admissions are assigned in a manner directed to provide equal patient loads and a mixed variety of treatment problems for each resident physician. Resident physicians are also assigned to any patients being seen by a psychologist.

B. ACTIVITY SCHEDULE

1. Staff Activities:
   a. Supervision: Each resident has two formal weekly inpatient supervision hours with the faculty. However, each house officer is expected to be able to discuss each of his/her patient’s in detail with the attending physician at any time. Attending physicians review and countersign all histories, physical examination findings, and treatment plans within 72 hours of admission. Attending or resident physicians also review and countersign all psychologists’ notes.
   b. Interdisciplinary Treatment Team Meetings: Each resident is expected to attend all of his/her team meetings which are generally held a minimum of three times weekly.
   c. Milieu Meetings: Each resident is expected to attend the regular milieu meetings scheduled to discuss administrative matters and staff issues.
   d. Outpatient Services: Each resident provides four hours per week (3 patient hours and 1 hour supervision) to the Adult Outpatient Department. Schedules are arranged individually.

2. Patient Activities:
   a. Individual Therapy: Patients meet with their primary therapist on an individual schedule based on the patients’ needs.
   b. Group Therapy: Various types of groups are held on the units based on patient population and needs. Examples include medication, psychotherapy, discharge planning groups.
   c. Multi-Family Groups: This group meets once a week on each of the two units. Families and/or close friends of the patients are invited to attend. The group is led by an AMI (Alliance for the Mentally Ill) member and nursing staff. The group is to acquaint
families with our program, community support programs, and to allow discussion about dealing with mental illness in the family.
d. Occupational Therapy: The occupational therapy program strives to maintain or improve skills needed to function in daily life. Patients are evaluated in the areas of self care, social skills, cognitive functioning and task behavior.
e. Recreational Therapy: Recreational therapy is a purposeful process used as an intervention in effecting a desirable change in patient behavior. Groups offered can include cooking, exercise, socialization, movies, outdoor activities, parties, etc.
f. Milieu Therapy: Milieu therapy is a part of every patient’s treatment. The program provides a consistent, caring environment which fosters safety, structure, support, socialization, and self-understanding. The focus is on the common aspects of crisis and hospitalization for patients and their families.

C. ADMISSION PROCEDURES

1. Patients are admitted to the inpatient units from either the Psychiatric Emergency Room or the Consultation/Liaison Service (for patients on the inpatient medical units). Occasionally patients are transferred between the 8-West unit and the Crisis Resolution Unit.
2. All patients must have a current hospital registration before coming to the units. A physical exam must also be completed prior to the admission. Either a Psychiatric Emergency Room Evaluation/Consultation or a Consultation/Liaison Evaluation note must also be completed prior to admission.
3. All patients admitted to the inpatient units must meet State Department of Mental Health criteria for medical necessity. Specifically, the individual, who as a result of a suspected or established diagnosis of mental disorder, poses substantial danger to self/others or property meets the criteria of medical necessity. Also a person who, as a result of a suspected or established mental disorder exhibits seriously disordered behavior accompanied by impaired reality testing. In both cases symptomology must interfere with daily functioning to the extent that the individual is not capable of caring for himself/herself in less than an acute hospital setting. In addition, medical necessity may be shown in the need for planned medical evaluation, drug therapy, or special treatments if the patient as a result of his/her symptoms has been unable to follow through with such tests, evaluations, or procedures as an outpatient. The patient must also have a DSM-IV diagnosis on Axis I.
4. Whenever possible and keeping in mind the above criteria, patients admitted will represent a reasonable variety of psychopathology for resident training.
5. The psychiatric inpatient units treat ambulatory care acutely mentally ill patients. The units are not routinely able to accept patients requiring bedcare, intravenous therapy, or acute medical treatment.

D. INITIAL WORKUP

1. The Psychiatric Data Base which includes the psychiatric history, mental status, physical exam, diagnostic formulation, and initial treatment plan must be completed within 24 hours of admission to the unit. The Psychiatric Data Base is generally completed by a resident physician. If the primary therapist is a PhD, a back-up resident physician is also assigned to the patient. The PhD may complete pages 1, 2, 4, and 5 of the Psychiatric Data Base. The resident must complete page 3 which includes the medical history, review of systems, physical, and neurological exams. The resident also reviews and countersigns the pages completed by a psychologist.

2. The following laboratory tests are routinely ordered on admission: CBC with differential, RPR, UA, Chem-20, TFT, and ECT for patients over 40 years of age.

3. Initial contact with the patient’s family, provided the patient does not refuse this contact, should be made as soon as possible after admission. This contact is generally first initiated by the resident, but may be made by any other member of the team. Early family contact is valuable to corroborate and/or add to the history, evaluate family dynamics, and establish possible discharge alternatives.

4. Psychological testing and/or clinical consultation is requested as necessary to establish diagnosis or treatment alternatives.

5. If indicated, consultation from other medical services and specialties should be initiated on admission. Additional laboratory tests deemed necessary should also be ordered as soon as possible.

E. INTERDISCIPLINARY DATA BASE

The complete data base includes evaluations by physicians, registered nurses, and psychiatric social workers. Occupational/recreational therapy evaluations are also completed for most patients. Psychological tests and consultations are part of the data base when indicated.

1. A Psychiatric Data Base completed by a physician or, in some cases, a physician and a psychologist includes the following:
   --Identifying Data - age, gender, ethnic background, etc.
   --Chief Complaint - quote from the patient/family as to why they came or were brought to the hospital
--History of Present Illness - length, symptoms, possible stressors, etc.
--Substance Abuse - type, route, frequency, duration, past treatment, and associated psychiatric/legal problems
--Past Psychiatric History - age of onset, number of hospitalizations, and response to treatment
--Social History - educational level, occupational functioning, criminal activity, cultural considerations, and relationships including possible abuse, if any
--Family History - of psychiatric and/or medical illness including response to treatment
--Past Medical History - allergies, review of systems, major illnesses/operations, current medications
--Physical Exam
--Neurological Exam
--Documentation of available laboratory results
--Mental Status Exam
  Appearance and behavior - including motor activity
  Mood and Affect - intensity, range, stability, appropriateness, and relatedness
  Speech - range, rhythm, volume
  Thought Process
  Thought Content - theme, delusions, preoccupations
  Suicidality - plan and intent
  Homicidality - target, plan, and intent
  Perceptions - hallucinations and illusions
  First Rank Symptoms
  Cognition - orientation, general knowledge, and abstraction/proverbs
  Memory - registration, recall, recent and remote
  Insight and Judgement
--DSM-IV Diagnosis - include all 5 axes
--Initial Treatment Plan
  Psychopharmacology - the name and dose of the medications must be specified on the treatment plan. If medication is not indicated this must also be specified on the treatment plan.
  Medical/specialty Consultations - specify type of plan, include laboratory studies, EKG, etc.
  Legal - voluntary or involuntary hold processes to be implemented
  Therapy - individual, group, conjoint, family, occupational, recreational, etc.

3. Psychiatric Nursing History completed by a registered nurse.
F. FORMULATION OF THE INTERDISCIPLINARY TREATMENT PLAN

The units are staffed by three teams. Each team is composed at a minimum of a resident physician, attending physician, registered nurse, psychiatric social worker, psychologist, and occupational/recreational therapist. On admission patients are assigned to one of the three teams. Individualized, interdisciplinary treatment plans are formulated during team meetings. The first interdisciplinary treatment plan must be completed within 72 hours of admission. A nursing care plan based on diagnosis and compatible with the interdisciplinary treatment plan is completed by a registered nurse. The patient is the primary focus of the treatment plan and should be apprised of and participate in the plan as much as possible. The family should also be involved in treatment planning whenever possible unless the patient refuses such involvement. The interdisciplinary treatment plan is reevaluated during each team meeting and revised as necessary.

G. PATIENT CARE/ACTIVITIES

1. As a rule, no passes out of the unit are given. Therapeutic passes may be necessary at times for a preplacement interview or a family emergency. No pass may extend for more than 12 hours or overnight.
2. A patient’s privilege level determines their access to off unit activities on hospital grounds with staff. Patients on Level A are restricted to the unit at all times. Patients on Level B may attend off unit activities with staff supervision.
3. A patient’s Suicide Level determines the level of observation, assessment, and timeframes for renewal of orders. These are defined in the Suicide Level policy and procedure.
4. Routine vital signs including temperature, blood pressure, pulse, and respirations are taken once a day by nursing staff. If additional vital signs are indicated the physician must write an order documenting the required frequency.
5. All narcotic orders including those for benzodiazepines must be renewed every 7 days.
6. Whenever a patient on a neuroleptic complains of sore throat or develops a temperature of 100F or more, a CBC must be done within 24 hours of the onset of symptoms.
7. In the absence of contraindications, it is generally advisable for patients to have PRN orders for medications to alleviate constipation, indigestion, and minor pain (ie Tylenol for headache).
8. No patient is to ever be left alone in the examination room.
9. Potentially dangerous objects such as matches, scissors, glass containers, etc. cannot be kept at the bedside. These belongings must either be sent home with family or locked up on the unit. Patients may request to use such items, ie make-up in glass containers with staff supervision.

H. RE-EVALUATION ASSESSMENTS AND PROGRESS NOTES
Patients must be reassessed daily and progress notes written by a physician or psychologist daily Monday through Friday. In addition, a progress note must be written by a physician whenever there is a change in the patient’s diagnosis, medication, legal status, and/or treatment plan. Any adverse treatment reaction and/or other significant change in the patient’s condition also requires an evaluation and progress note by a physician. Progress notes must clearly identify specific behaviors and symptoms which continue to meet medical necessity for acute hospitalization. At the time the patient no longer meets necessity for acute care he/she is placed on Administrative Days. The Psychiatric Utilization Review nurse is available on the units Mon-Fri to provide consultation on medical necessity and administrative day criteria. A weekly note documenting required placement activities must also be entered for patients on administrative days.

I. DISCHARGE PLANS

It is essential that discharge planning begin on the day of admission. Hospitalization is only a temporary, short departure from the patient’s daily life. Discharge alternatives should be identified as early as possible and tentative discharge plans made at the first interdisciplinary team meeting. It can at times take days to weeks to secure needed resources or supports to implement an identified discharge plan. These initial activities can and should be initiated prior to the patient’s discharge in an effort to have a placement available for the patient as soon as he/she no longer requires acute inpatient care. Several factors must be taken into consideration in any tentative discharge plan.

--Shelter - home, open or locked board and care, state hospital, etc.
--Finances - SSI, Medi-Cal, pension, family support, etc.
--Job/Tasks - return to work, care of home/children, school, etc.
--Family/Community Support - family issues or concerns, education, case manager, etc.
--Outpatient Referral - to public or private programs/clinics to provide ongoing treatment.

No resident can discharge a patient between 4:30 p.m. - 8:00 a.m. and during the weekend without consulting the staff physician on call.
J. DISCHARGE

A discharge order must be written for each patient prior to discharge. The order specifies the type of discharge ie regular, AMA, release by court, etc. It is very important to always know expiration dates of any involuntary holds as patients may never be held beyond those dates without a new legal status being initiated, ie voluntary or another involuntary hold. See the policy on involuntary hospitalization for dates and times of all holds. All patients discharged will be provided discharge medication and referrals as indicated by the patient’s needs. Patients have the right, however, to refuse all follow-up.

K. CONTINUING CARE

Referral for continuing care follow-up is planned individually for each patient. The follow-up care may be provided at the Department of Mental Health Harbor-UCLA Medical Center Adult Outpatient Clinic, another Department of Mental Health Clinic, or by a private practitioner based on the patients’ resources, geographic area of residence, and/or the patient’s wishes. Appointments are made with the follow-up clinic by a team member, usually a resident or social worker. The patient’s awareness and acceptance of the continuing care plan is documented on the Psychiatric Discharge Record. A copy of the Discharge Record which includes a summary of the care provided and treatment recommendations is sent on the day of the patient’s discharge to the Department of Mental Health Clinic where the patient will receive ongoing care. The outpatient clinic will provide outreach in an attempt to ensure that the patient makes the scheduled outpatient linkage.
HARBOR-UCLA MEDICAL CENTER
DEPARTMENT OF PSYCHIATRY

CONSULTATION/LIAISON SERVICE

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Julia A. Chung, M.D.
Director

PSYCHIATRIC CONSULTATION/LIAISON SERVICE
Function

The Psychiatric Consultation/Liaison Service provides psychiatric consultation for patients in the general hospital inpatient units. As part of this role, the psychiatrist also provides liaison and educational services to non-psychiatric housestaff. Additionally, The Psychiatric Consultation/Liaison Service provides consultation on an outpatient basis to patients referred by their physicians in the medical/surgical clinics.

PROCEDURE FOR REQUESTING AN INPATIENT CONSULTATION

Consultations During "Working Hours"

The physician is to call extension x3128 and provide the following information:

- Name and age of patient
- HH number
- Location of patient
- Language spoken by patient (if not English)
- Reason for consultation/specific question(s) to be answered
- Name and beeper number of physician requesting consultation

The physician requesting a psychiatric consultation must also complete a yellow "Psychiatric Consultation-Inpatient" form and place it in the front of the patient's chart. If a weekday consultation is emergent, the physician can page the psychiatry consultant on beeper 501-3986.

Consultations at Night and on Weekends

To request weekend/evening (after 4:00 p.m.) consultations, the treating physician is to call extension x3144 (Psychiatric Emergency Services) and speak to the psychiatric resident on call. Evening and weekend consultations will be completed by a psychiatric resident on call. The senior resident on call is responsible for consultations in the general hospital. If a consultation is done by PGY-I or PGY-II, the case must be presented to a third year resident or the attending on call. After the psychiatric resident on call has seen the patient, the resident should leave a message for the C/L Service (x3128) so that the C/L Service can provide follow-up care for the patient.
PROCEDURE FOR REQUESTING AN OUTPATIENT CONSULTATION

When a physician in a Harbor/UCLA medical/surgical outpatient clinic wishes consultation regarding the psychiatric diagnosis and management of a patient, that patient can be referred to the Consultation/Liaison Service and will be seen on an outpatient basis. If the patient is to be referred for ongoing psychiatric treatment, the patient should be referred to the local mental health outpatient clinic closest to his/her house.

To request an outpatient consultation, the referring physician should complete the "Psychiatric Consultation Request (Outpatient)" form and send it to the Service secretary, Maria Andrade, in 1-South (Box 497). The following information should be supplied:

Name and age of patient
HH number
Language spoken (if not English)
Reason for consultation/specific questions to be answered
Pertinent laboratory studies/results
Name and beeper number of physician requesting consultation

RESIDENT DUTIES AND RESPONSIBILITIES

Working Hours

While assigned to the Consultation/Liaison Service psychiatric residents are expected to be on the hospital grounds from 8:30 a.m. until 4:30 p.m. in order to be available for routine and emergency consultations. During these hours, the resident should be available by beeper to the service secretary except when the resident is seeing psychotherapy patients. If the resident must be away from the hospital during these hours, the resident must make arrangements with another resident for coverage, and the service secretary should be informed of the coverage arrangement. The “on call” resident MUST be available to respond to emergencies at all times during the workday.

Inpatient Consultation Procedure

Consultations will be distributed every morning in 1-South at 8:30 - 8:45 a.m. It is the responsibility of the “on call” resident to come to the C/L office at that time to select consults that are appropriate for the Family Medicine/Neurology residents that are rotating through the C/L Service. Consults received later in the day will be given to the resident who is “on call” for further assignment. When a consult is received, the service secretary will page the “on call” resident on the C/L beeper (501-3986). The “on call” resident must carry this beeper during his/her shift. The purpose of the beeper is to enable the service secretary and consulting residents to always be able to contact a psychiatry consultation/liaison resident.
After being assigned a consult, the resident will then contact the resident who requested the consult to establish the priority of the consult (emergency or routine). If the consult is an emergency, the “on call” resident will do the consult at that time. The psychiatric resident should also discuss the reason(s) for the consultation and the specific questions to be answered.

Note that patients who are treated at the Harbor-UCLA Adult Outpatient Psychiatry Clinic by a psychiatry resident will be continued to be followed by that AOP resident on the medical/surgical wards (for continuity of care).

Psychiatric Evaluation

Before seeing the patient, the resident should review the patient's chart, paying particular attention to medications, abnormal labs, and charting about behavior. The psychiatric evaluation is a standard evaluation including current and past psychiatric history, social history, family history, and mental status exam, including a complete Mini Mental Status Examination if there is any question of a cognitive/organic disorder. In addition, the psychiatric resident should obtain a brief summary of the patient's medical status, including all medications that the patient is taking.

Consultation Report

The consultation report should be completed as follows:

1. Identifying information
2. Reason for consultation
3. History of present illness (brief summary of medical/surgical status, including dx, meds, pertinent labs), and current psychiatric symptoms, relationship of psychiatric symptoms to medical status.
4. Past psychiatric history
5. Family history
6. Social history including substance abuse
7. Mental Status exam
8. Psychiatric Diagnoses (DSM-IV)
9. Treatment recommendations, including the following:
   a. Answer to question asked by primary team
   b. Behavioral recommendations, if any
   c. Psychopharm recommendations, if any
   d. Legal issues, if any
   e. Psychiatric follow up plan

(The diagnostic and treatment recommendation sections are to be completed after the patient is discussed in rounds or individually with the attending).
Psychiatric Follow up

After the initial consultation, if the patient needs ongoing psychiatric services while on the medical/surgical wards, the psychiatric resident should see the patient and write a chart note at least 3 times a week. In certain clinical situations, a patient may need to be seen and a progress note written daily, including weekends/holidays. (Acute suicidality, agitation, pt on 5150/5250, etc.)

Involuntary Psychiatric Holds in the General Hospital

If a consultation is received for a patient who has been placed on a 5150 by the police, the consultation/liaison resident is to evaluate the appropriateness of the hold. If the hold is accepted, the patient needs to be advised (unless already advised). If the patient needs longer involuntary treatment, the psychiatric resident can place the patient on a 5250 (14 day hold) and inform the service secretary (x3127) so that the court can be notified and a probable cause hearing can be scheduled. The resident must also be sure that the firearms prohibition report and the medication advisements have been done, when appropriate. Patients must also receive a patients’ rights handbook when placed on an involuntary psychiatric hold.

The psychiatric resident may receive a request from a referring physician to place a patient on a 5150 hold simply so that the patient can receive medical treatment. It is important to note that this is not appropriate nor is it legal to do this. A 5150 is indicated for psychiatric treatment if the patient has a psychiatric disorder. A 5150 cannot be used to hold a patient who does not have a mental disorder in the hospital for medical treatment, nor can it be used to force medical treatment on a patient with a psychiatric disorder. For information about consent and refusal of medical treatment, see the handout entitled "Role of Psychiatric Consultant in the Evaluation of An Adult Patient Regarding Ability to Provide Informed Consent".

Disposition of Patients Needing Inpatient Psychiatric Treatment

Once a patient has been medically cleared by the primary team, the psychiatry resident may determine that the patient will require inpatient psychiatric hospitalization.

Those patients who have a source of funding (such as Medi-Cal, Medicare, HMO or private insurance, or VA coverage) will be placed by the medical case worker and/or clinical social worker from the hospital’s CSW department (refer to Policy 221B, Clinical Social Work Department).

Patients without a source of funding will need transfer arranged to one of the Harbor-UCLA psychiatric wards (8-West or 1-South). The psychiatric ER should be contacted to determine bed availability. Once a bed has been allocated by psychiatric ER staff, the psychiatry resident must contact the attending physician for the accepting team and discuss the patient with him/her. Once the patient has been approved for
transfer, orders are written by the consultation-liason psychiatry resident.
CONSULTATION ASSIGNMENTS & ON CALL RESPONSIBILITIES

INPATIENT CONSULTATIONS will be distributed as follows:

1. Each day one Psychiatry resident will be “on call”.

2. Between 8:30-8:45 a.m. each day, the “on call” resident will come to the C/L office and distribute the consults, evaluating which consults are appropriate for the Family Medicine and/or Neurology residents.

3. When a Family Medicine resident is on service, he/she will be available to take consultations M all day, and Tu/W/F in the a.m. They are not available on Thursdays; the on-call psychiatry resident will need to assign coverage for the Family Medicine resident’s patients.

4. When a Neurology resident is on service, he/she will be available M, Tu, & W all day and Th & F p.m. only.

5. The consults received in the afternoon will be given to the resident who is “on call” to distribute.

6. During his/her “on call” days, the Psychiatry resident will not see any outpatients between 8:30a.m. and 4:00 p.m., as it is essential to be available for emergent consultations.

C/L BEEPER:
It is the responsibility of the “on call” resident to carry the C/L beeper and answer it when paged. The C/L beeper is to be carried at all times by a Psychiatry resident between 8:30 a.m. and 4:00 p.m. M-F. It is never to be given to a Family Medicine Resident, a Neurology Resident, a medical student, or the Service Secretary.

OUTPATIENT CONSULTATIONS will be assigned as follows:

1. Each resident will select a one-hour block that will be his/her weekly time to see a C/L outpatient. The Service Secretary will schedule patients accordingly.

2. Normally, outpatients are seen only for consultation, not for ongoing treatment. If after the initial evaluation, the resident feels it is important to see the patient again, the resident can schedule the patient at his/her convenience, and inform the Service Secretary of that appointment. Patients meeting criteria for LA County DMH Services should be referred to the appropriate Mental Health Clinic. Patients needing therapy whom do not meet criteria for LAC DMH should be referred to a counseling center.
PSYCHIATRY CONSULTATION/LIAISON SERVICE

Documentation Guidelines

1. After receiving a consult and evaluating the patient, the psychiatry resident will write a brief progress note indicating that the patient has been seen and the full consultation is to follow. The full consultation will be placed in the chart after review with the psychiatry attending. The consultation will include the following “at the request of Dr. X (physician requesting consult) I have reviewed the history and interviewed the patient under the supervision of Dr. Y (Psychiatry Attending) and set forth his/her recommendations and or options.”

2. The following patients will be seen daily and have daily documentation by the psychiatry consultation resident:
   a. Patients who are on holds (5150, 5250, etc.).
   b. Patients who are suicidal
   c. Patients who are in danger of hurting themselves or others.
   d. Other patients as determined by clinical evaluation to need daily psychiatric services.
   *These patients will need to be signed out for weekend/holiday coverage in the Psychiatric E.R.

3. Patients who are relatively stable will be seen a minimum of 3x each week and have progress notes written by the psychiatry resident on the days they are seen. Progress notes must include the date and time of the evaluation, activity code, and face-to-face and total times. This information is also recorded on the face sheet for each patient.
Transfer Procedures from Medical-Surgical Units to Psychiatry Units

Any patient considered for transfer from a Medical-Surgical Unit to an Inpatient Psychiatry Unit, at Harbor-UCLA Medical Center, should have a full evaluation done by the C/L Psychiatry team.

The patient should meet medical necessity criteria for acute psychiatric inpatient treatment and be medically cleared and stable for transfer.

A member of the C/L team should call the Psych. ER to confirm the availability of a bed on the Inpatient Psychiatry Unit.

A member of the C/L team should contact the Inpatient attending on 8-West (X-3113) or 1-South (X-3292) to present the case, discuss the situation and obtain approval for the transfer. Once the transfer has been approved, the Inpatient attending will notify his/her nursing staff and pertinent team members. A member of that nursing staff may evaluate the patient and assess the patient’s nursing needs, as well as ensure that patient can ambulate, has no IV lines, NGTs or foley catheters or other devices.

A member of the C/L team will write a transfer summary note (documenting medical necessity) and the transfer orders. We’ll also request that the physician from the treating team write a medical clearance note and provide the name/number of a contact person.

A member of the C/L team should verify that all psychiatric documentation is in the medical record, including Psychiatry evaluation form(s) (Psychiatry ER and/or C/L), progress notes, any pertinent legal documents (5150, 5250, advisements…) 

Once the transfer orders have been written, a member of the C/L team will inform the treating physician and the nursing staff on the medical/surgical unit to encourage a timely transfer to the Psychiatry unit.

Once the patient is on the Psychiatry Unit, his/her care will be transferred to the Inpatient Team.
CHILD AND ADOLESCENT OUTPATIENT PSYCHIATRY

CHARLES S. GROB, M.D.
DIVISION CHIEF
All PGY-III’s rotate through child and adolescent psychiatry (CAP) for a 6-month partial block. During this time the resident does clinical work under supervision in the child and adolescent psychiatric clinic. The educational goal is to develop knowledge, skills and comfort in clinical evaluation, treatment planning and crisis intervention for children, adolescents and families. During the course of the rotation, many other facets of child psychiatric knowledge and skills enrich the core goals. Following the six months rotation, residents have the opportunity to continue clinical work with supervision.

In addition, the Division of Child and Adolescent Psychiatry offers an academically structured two-year CAP fellowship program that results in board eligibility in child/adolescent psychiatry as well as in general psychiatry. This combination maximizes future employment and practice options for the graduate. The CAP fellowship is often undertaken after the completion of the general psychiatric residency. For general psychiatric residents at Harbor, there is an abbreviated integrated five year program which renders graduates eligible for dual certification by devoting PGY-IV to Child/Adolescent Psychiatry. Residents interested in this opportunity should contact Drs. Grob and Burgoyne by September of their PGY-III year.

The CAP fellowship consists of a core conceptual and experiential program that has been designed to serve as a foundation upon which graduates can build in any of a multitude of directions. The unifying developmental framework is a dynamically integrated biopsychosocial one. In addition to involvement with the expanding faculty at Harbor-UCLA, CAP fellows participate actively in selected seminars at UCLA’s Neuropsychiatric Institute’s Child Psychiatry Division.

Teaching is accomplished by means of a variety of approaches including seminars, workshops, clinical conferences and lectures. These courses cover such areas as diagnosis and treatment, development, psychopathology, consultation/liaison, social issues, cross-cultural issues, substance abuse, child abuse, and forensics. Emphasis, however, is placed on careful individual supervision of a wide range of clinical work. Principles of consultation are taught in three major arenas: as supervised consultants to Harbor’s pediatric department and as supervised consultants to selected community schools and to selected child serving agencies in the community including the courts. Inpatient child/adolescent psychiatric experience is accomplished at Metropolitan State Hospital. In addition, there are opportunities for research and for experience in teaching medical students and others.

Residents interested in exploring the possibility of a CAP residency should speak with Doctors Grob and Burgoyne as early as is feasible.
PSYCHOLOGY DIVISION

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DAVID MARTIN, PH.D.
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<tr>
<th>Compensated Faculty</th>
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<th>Harbor-UCLA</th>
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<tr>
<td>David Martin, Ph.D.</td>
<td>Professor</td>
<td>Chief, Psychology Division</td>
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<td>Director of Training</td>
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<td>Director, HIV/MH</td>
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<tr>
<td>Michele Berk, Ph.D.</td>
<td>Assistant Professor</td>
<td>Director, Adolescent Cognitive Behavior Therapy Clinic</td>
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<tr>
<td>Kyle Boone, Ph.D.</td>
<td>Professor</td>
<td>Director, Neuropsychology</td>
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<tr>
<td>Harriet Boxer, Ph.D.</td>
<td>Emeritus Professor</td>
<td>Family Medicine</td>
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<tr>
<td>Robert Chernoff, Ph.D.</td>
<td>Clinical Instructor</td>
<td>HIV Mental Health Service</td>
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<td>Freda Cheung, Ph.D.</td>
<td>Assoc. Professor</td>
<td>Psychobiology of Ethnicity Center</td>
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<tr>
<td>Carol Edwards, Ph.D.</td>
<td>Asst. Clin. Professor</td>
<td>Director, Adult Psychiatry Testing Services</td>
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<td>Michael Maloney, Ph.D.</td>
<td>Professor</td>
<td>Twin Towers Jail</td>
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<tr>
<td>Lynn Marcinko McFarr, Ph.D.</td>
<td>Asst. Professor</td>
<td>Director, Cognitive-Behavioral Therapy Clinic</td>
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<tr>
<td>Marcel Ponton, Ph.D.</td>
<td>Asst. Clin. Professor</td>
<td>Director, Mobile Neuropsychology Clinic</td>
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<td>Karen Rathburn, Ph.D.</td>
<td>Asst. Professor</td>
<td>Pediatrics</td>
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<td>Astrid Reina-Patton, Ph.D.</td>
<td>Asst. Professor</td>
<td>HIV Mental Health Service</td>
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<td>Dorit Saberi, Ph.D.</td>
<td>Clinical Instructor</td>
<td>Co-Director, AMI/ABLE</td>
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<td>Janine Shelby, Ph.D.</td>
<td>Clinical Instructor</td>
<td>Coordinator, Child &amp; Adolescent Testing Service</td>
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<td>Volunteer Clinical Faculty</td>
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<td>Andrew Blew, Ph.D.</td>
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<td>Zecharia Oren, Ph.D.</td>
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<td>Linda Philpott, Ph.D.</td>
<td>Asst. Clin. Professor</td>
<td>Neuropsychology</td>
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<td>Jill Razani, Ph.D.</td>
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<tr>
<td>Dan Sherman, Ph.D.</td>
<td>Asst. Clin. Professor</td>
<td>Rehab/San Pedro Hospital</td>
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<tr>
<td>Darlene Skorka, Ph.D.</td>
<td>Assoc. Clin. Professor</td>
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PSYCHOLOGY DIVISION

I. General Description

The Psychology Division functions as an independent discipline whose members may be assigned to various services and treatment teams. Clinical psychologists in the Department of Psychiatry, contribute to patient care, to teaching, and to research. They manage clinical programs and individual cases, and perform psychological and neuropsychological evaluations, psychotherapy, consultation, and other specific duties depending upon their level of training and specific competencies.

The Psychology Division at Harbor-UCLA Medical Center is an American Psychological Association (APA)- accredited post-doctoral clinical psychology training program. Its neuropsychology program is also accredited by the Association of Postdoctoral Programs in Clinical Neuropsychology (APPCN).

II. Teaching

The Psychology Division provides teaching for psychiatric residents on psychological issues in the PGY series, through case conferences, courses, and individual supervision on the various services. The Psychology Division trains psychologists at two levels: Postdoctoral Fellows in clinical psychology, who are at Harbor-UCLA full time for 12 months, and Psychology Externs, who are Masters Level psychology trainees undergoing a 15-20 hour a week placement at Harbor-UCLA Medical Center as part of their Clinical Psychology Doctoral Training.

Psychology trainees at Harbor are supervised by Psychiatry Department faculty, and attend a regular program of case conferences, seminars, and specific courses tailored to their own discipline. These courses and presentations are open to other faculty and trainees in the Psychiatry Department.

Psychology Courses include: Case conferences on psychological assessment and treatment by Postdoctoral Fellows; guest presentations by psychologists in the LA area on research, clinical practice, and other psychological topics; neuropsychological assessment; personality assessment; program evaluation; cognitive-behavioral therapy, dialectical behavior therapy; and behavioral medicine/health psychology.

III. Research

Psychologists participate in departmental research and design and conduct research under the auspices of the Los Angeles Biomedical Institute. They may also apply for outside funding for research and serve as consultants to the department faculty and to other departments in the hospital.

Psychologist members of the UCLA faculty may participate in departmental research as principal investigators, co-investigators or consultants. Trainees
may also be investigators or serve as research associates in ongoing departmental research projects. Psychologists are available for consultation on questions of research design, statistics, program evaluation, special populations, and other issues relevant to psychiatric research. Residents interested in the areas of specialty represented among Psychology faculty are encouraged to visit the Psychology Division website (http://psychology.labimed.org) or to contact the individual faculty members directly to discuss interests.

IV. Identification of Psychology Personnel at Harbor-UCLA

A. FACULTY: Psychologists at Harbor are typically David Geffen School of Medicine Faculty in Medical Psychology (A Division of the UCLA Department of Psychiatry and Biobehavioral Sciences). Faculty must be graduates of American Psychological Association (APA)-accredited doctoral programs in psychology and licensed in California. They may be appointed to the In Residence or Clinical professorial series.

B. CLINICAL PSYCHOLOGISTS: All Harbor-UCLA psychologists who treat or supervise patient care (whether part or full time, volunteer or compensated) must be appointed through the Department of Psychiatry to the hospital’s Professional Staff Association, and are peer reviewed through the Psychology Division of the Department of Psychiatry.

C. OTHER PSYCHOLOGISTS: Sometimes psychologists are hired for specific non-clinical positions that do not require a license (e.g. research or organizational work). Such psychologists are not members of the clinical faculty of the Department of Psychiatry, or on the hospital’s professional staff.

D. POSTDOCTORAL FELLOWS: Fellows in Clinical Psychology are competitively recruited nationally from graduates of APA-accredited doctoral psychology programs and internships. They serve in a full time training program during their 12 months (neuropsychology fellowships are 24 months) at Harbor-UCLA Medical Center. They come to the program after having completed their doctoral degrees in psychology, including a full year of internship, and 5-7 years of clinical experience in psychology. During their training year(s) at Harbor-UCLA, they specialize in a particular population or setting such as child or adolescent psychology, pediatric psychology, adult inpatient and emergency, HIV Mental Health services, or neuropsychological assessments. The year at Harbor typically represents their final training requirement for licensure. All post-doctoral fellows at Harbor-UCLA Medical Center are supervised by licensed psychologists in accordance with California State Law.

E. EXTERNS: Psychology Externs (field placement students) are Masters level graduate students matriculated in local APA accredited Doctoral Programs in Clinical Psychology. Currently, Harbor-UCLA has training affiliations with programs at Azusa Pacific University, Fuller Graduate School of Psychology, Loma Linda University, Pepperdine University, Rosemead Graduate School of Psychology, and UCLA. Externs are selected from among applicants from these programs for a 15-20 hour a week placement, primarily for training in psychological assessments and in psychotherapy. Currently, externs are placed in Child Psychiatry, Adult Psychiatry Treatment Teams, Pediatrics, Dual...
Diagnosis, and Neuropsychology. Externs perform psychological assessment and psychotherapy undersupervision by post-doctoral fellows or licensed psychologists.

V. Procedures for Requesting Psychological Assessments

On 8-West. Psychological assessments should be requested directly from the Adult Psychiatry psychologist.

On Child Psychiatry. Psychological assessments should be requested from the designated facult psychologist in charge of testing.

On the CRU. Psychological assessments should be requested from the AOP-designated post-doctoral fellow or the Adult Faculty Coordinator.

On the Adult Outpatient Clinic. Psychological assessment should be requested from the AOP-designated post-doctoral fellow or the Adult Faculty Coordinator.

On Consultation-Liaison. Psychological assessments should be requested from the Adult Faculty Coordinator.

Neuropsychological Testing. Requests for neuropsychological assessments of outpatients or medical inpatients should be made by directly contacting the department neuropsychologist. Neuropsychological testing as part of a personality battery may be requested through regular unit procedures.

Faculty Testing Coordinators

Adult Inpatient or Outpatient: Dr. Carol Edwards (ext. 1743)
Child Psychiatry: Dr. Janine Shelby (ext. 3121)
Neuropsychology: Dr. Kyle Boone (ext 3672)
Family Medicine: Dr. Bernice Kotkin (534-6251)
HIV Mental Health Service: Dr. Astrid Reina-Patton (ext. 3195)
Pediatric Clinics: Dr. Traci Critton-Mastandrea (2328)
Adult Psychological Testing at Harbor-UCLA Medical Center

The adult psychological testing service at Harbor-UCLA Medical Center tests patients who are seen in outpatient mental health clinic, patients referred from the Consultation-Liaison Service, or patients hospitalized on the inpatient psychiatric units.

Patients are referred by their treating therapists or by the teams coordinating the intake processes. Written referral forms are used and are supplemented by telephone consultations between the therapist and testing personnel. The faculty member in charge of the service determines the appropriateness of testing and the priority of testing cases. Follow-up quality review is conducted on an annual basis and assesses both the testing procedures and the quality of completed reports.

All testing is conducted in response to specific referral questions and tests are selected to address those questions. Typically, the questions relate to diagnostic clarification and treatment planning. All reports include both a five-axis DSM-IV diagnosis and specific treatment recommendations. In addition to test results, reports include other relevant information obtained through interviews, behavioral observations, and chart review, as well as that obtained from other professionals. In some cases, testing is performed prior to initiation of medication and assists physicians in determining the type of medication indicated. In other cases, testing is used to measure the effectiveness of ongoing medication regimens.

When an evaluation is complete, a copy of the report is provided to the treating therapist and is placed in the patient’s file. The individual who administered the testing meets with the therapist to review the results. Frequently, the patient is also included in the feedback session. The patient is encouraged to continue to discuss test results with the therapist during future therapy sessions. If further questions arise, the evaluator is available to further consultation. Copies of reports and raw data are kept in the Psychology Division offices. Therefore, if a student evaluator has left the program, ongoing consultation is available from the supervisor or service director.

The tests used by the Division are well known and respected instruments. Most commonly used are the MMPI-2, the MCMI-III, the PAI, the Rorschach, and the WAIS-III. In addition, self-report symptom inventories and structured interviews are used. For the most part, the tests are used in their entirety. At times, however, selected portions will be used. For example, when individuals are being considered for the DBT group for Borderline patients, only three WAIS-III subtests (Vocabulary, Comprehension, and Similarities) are administered in order to answer the question of whether they have the language development and verbal reasoning skills to function effectively as group members.

Inpatient psychological testing procedures.

The following procedures are used for authorizing and conducting psychological testing on the inpatient wards at Harbor-UCLA Medical Center.
For the most part, they are consistent with outpatient testing procedures. Some modifications are used, however, because of the short duration of inpatient stays and the need for immediate information to be used in treatment planning.

1. When patients are discussed at the interdisciplinary team treatment rounds (which occur four times weekly), the team identifies those patients who could benefit from testing.

2. The psychologist on the ward interviews the patients to determine the appropriateness of testing and, if appropriate, assigns the patient to an extern or postdoctoral fellow for assessment.

3. The patient is tested on the ward. Typically the assessment involves a review of the chart, clinical interview, and administration of appropriate instruments.

4. The extern consults with his/her supervisor as soon as possible after the tests are administered and scored.

5. Within three working days, the results of each individual test administered are placed in the patient’s hospital chart. Notes are written by the extern and countersigned by the psychologist on the ward.

6. After all tests are administered, the extern prepares the final report, integrating all information obtained in the assessment.

7. The supervisor provides input as needed during the report writing and signs off on the final draft.

8. Because the patient has frequently left the ward by the time the comprehensive report is completed, the results are placed in the chart in medical records. In addition, with the patient’s consent, a copy may be sent to the mental health facility providing follow-up care.

Outpatient Testing Procedures.

Referring provider’s responsibilities.

1. The provider completes a consult form describing the referral question and relevant patient information and submits it to the faculty coordinator. The form may be faxed to the faculty coordinator at (310) 320-3521.

2. The faculty coordinator reviews the request. If appropriate, the patient is placed on the testing list.

3. The provider notifies the patient that a psychological examiner will contact him/her to set up an appointment.

Psychology examiner’s responsibilities.
1. The examiner checks with testing coordinator to obtain testing assignments.

2. The examiner notifies the referring therapist that case has been assigned to him/her and will obtain any additional information needed about the patient.

3. The examiner and supervisor determine the tests to be included in the battery, considering the referral question, the patient’s physical and cognitive abilities, and the time available for testing.

4. The examiner calls the patient to schedule testing appointments.

5. If an MMPI or MCMI is included in the battery, the examiner leaves a copy of the test and answer sheet at the desk in the AOP (Patient completes the test in the waiting area and returns it to the receptionist, who calls the adult coordinator for pick up).

6. The examiner administers, scores, and interprets the test results and completes a draft report with appropriate supervision.

7. After conferring with the supervisor, the examiner offers verbal feedback to the referring therapist within one week of testing. If there are delays, they are communicated to the referring therapist as soon as the examiner is aware of them.

8. Final written report is completed within two weeks of completion of the test administration.

9. One copy of the report is given to the referring therapist to be placed in the patient’s file. One copy and the raw data are filed in the Psychology offices.

10. If desired, the examiner meets with the referring therapist and the patient to review the testing results.

Child and Adolescent Psychiatry Testing Procedures

All referrals for psychological testing are referred directly to the Child and Adolescent Psychiatry faculty coordinator who reviews the case for medical necessity. Other factors determining whether the case will be approved for testing include the presence of recent testing, current crisis (e.g., recent home displacement), current emotional status (e.g., acute psychosis) of patient, or any possible referral-out sources (e.g., school for IEP). If any of these conditions holds, testing is not conducted. If the case is accepted for testing, the referral source receives written information concerning the current wait time for testing. When an examiner becomes available, the faculty coordinator assigns the case to the student or staff member. The process for testing is as follows:

1. In the first week the student presents the case to the supervisor, the referral source is contacted to clarify the referral question, and the
patient’s chart is reviewed for any available information and/or results from previous testing, the family is contacted to schedule testing sessions.

2. In the second and third weeks, the student completes the psychological testing over the course of three or four 2-hour sessions for an estimated six to eight hours of direct patient contact to complete the testing, the student receives ongoing supervision weekly to review the case, test administration, scoring, and interpretation.

3. During the fourth and fifth weeks, the student completes the testing, completes scoring and analysis of test results and begins writing the test report, the supervisor reviews the report and provides edits and revisions for the student, the student schedules feedback session with the family and referral source.

4. During the sixth week, the student completes writing of the test report and hands it in to close the case, the Satisfaction Survey is submitted along with the report to gain feedback from the referral source regarding the testing process, the supervisor completes the Psychological Assessment Report Evaluation Form to provide formal feedback to the student.

Neuropsychological Testing Procedures

Referring therapist’s responsibilities.

1. The therapist completes a consult form describing the referral question and relevant patient background and submits to the faculty coordinator.

2. The faculty coordinator reviews the request. If the request is appropriate, the patient is contacted to set up an appointment time.
Psychology examiner's responsibilities.

1. The examiner checks with the testing coordinator to obtain testing case assignments.

2. The examiner notifies the referring therapist that the case has been assigned to him/her and obtains any additional information needed about the patient.

3. The examiner and the testing coordinator determine the tests to be included in the battery, considering the referral question, the patient’s physical and cognitive abilities, and time available for testing.

4. The examiner calls the patient to schedule the testing appointments.

5. The examiner administers, scores, and interprets test results and completes a draft report with supervision from the testing coordinator.

6. After conferring with the supervisor, the examiner offers verbal feedback to the referring therapist within two weeks of testing. If there are delays, they are communicated to the referring therapist as soon as the examiner becomes aware of them.

7. The final report will be completed within three weeks of completion of the test administration.

8. One copy of the test report will be faxed to the referring therapist. One copy of the report and the raw data will be filed in the Neuropsychology office.

9. If desired, the examiner will meet with the referring therapist and patient to review the testing results.

HIV neuropsychology testing.

Referring therapist responsibilities

1. The referring therapist completes a consultation form describing the referral question and relevant patient background and submits it to the neuropsychological testing coordinator on HIV Mental Health Service together with a verification of HIV diagnosis form.

2. The neuropsychological testing coordinator reviews the request, and, if appropriate, the patient is placed on the testing list.

3. The examiner and supervisor determine the tests to be included in the neuropsychological test battery considering the referral question, the patient’s physical and cognitive abilities, and the time available for testing.

4. The patient is contacted to schedule testing appointments.
5. The examiner administers, scores, and interprets the test results, and completes a report. In the case that a non-licensed psychological examiner conducts the testing, the aforementioned tasks are conducted by the examiner under the supervision of a licensed psychologist.

6. Unless test feedback is provided solely by the referral source, the feedback to the patient is provided within two weeks of completion of test administration. Patients are given a summary of the test results and recommendations.

7. If desired, the examiner meets with the referral source and patient to review the testing results.

8. The final written report is completed within two weeks of completion of the test battery.

9. One copy of the report is given to the referring therapist and one copy is placed in the patient’s chart. One copy of the report is filed separately in HIV Mental Health Service with the raw testing data.

HIV Mental Health Service responsibility.

1. The HIV Mental Health Service conducts case conference on the patient’s neuropsychological assessment results as they relate to coordination of medical and mental-health services. The case conference includes the patient’s other service providers as appropriate.
CLINICAL SOCIAL WORK DIVISION

I. General Description

The Division of Clinical Social Work represents an independent mental health discipline comprised of clinical social workers, medical case workers, and student interns who participate as team members, primary therapists, family therapists, case managers, and client and family advocates within each of the service programs at Harbor UCLA. The Division acts to support the participation of Social Workers in the overall patient/client care, training, and research missions of the Department of Psychiatry.

Social Workers within the Department of Psychiatry will be encountered on most service units and may be found participating in direct service, community consultation, program development, program linkage, administration, teaching, and research.

II. Teaching

The individual members of the Social Work Division participate in the learning process for psychiatric residents, post-doctoral psychology fellows, psychology fellows, psychology externs, nursing students, and social work interns with a particular emphasis on the conceptual issues and pragmatic skills necessary to understand and to intervene in the psychosocial aspects of patients' lives. This is accomplished through social workers' participating in seminars, rounds, case-conferences, supervision, and co-therapy relationships with other disciplines.

III. Research

Social workers participate in departmental research projects. Social Workers apply for outside research and consultation funding; participate as consultants to department and hospital faculty on research projects. Social Work interns may conduct the research for their master’s thesis on the Harbor UCLA campus.

IV. Social Work Internship Training Program

Social work interns within the Division at Harbor-UCLA may be beginning or completing their academic and clinical training toward their masters or doctoral degree in social work. The interns are chosen from among the most qualified candidates from UCLA, USC, Cal State LA, and Cal State Long Beach. Trainees are placed throughout the Department in the following areas: inpatient psychiatric units; stepdown psychosocial rehabilitation unit; case management and psychosocial rehabilitation program; child crisis field response team; adult outpatient clinic; HIV mental health service; child and adolescent outpatient clinic; ABLE program.

Social work interns receive primary clinical supervision from one of the licensed clinical social work staff, but are also monitored on site by preceptors who are masters' level social
workers. Interns participate fully in clinical, programmatic and training activities throughout the Department of Psychiatry. They are an active and critical part of primary service delivery in the Department. The Los Angeles County Department of Mental Health provides training to interns on a variety of subjects, but mandates all students to training on sexual harassment policies and HIPAA privacy practices.

V. Description of Services

AOP: Clinical Social Workers participate as primary therapists providing individual, group, and family therapy, intake, case consultation, and case management, and as a part of the administrative team on the Adult Outpatient service. They are able to provide consultation, collaboration, and to participate as co-therapists with other staff and trainees.

CAP: Clinical Social Workers participate as primary therapists providing individual, family, and group therapy, intake screening and assessment, case-management and community consultation. They are the core component of the permanent full-time staff on this service. They are able to participate in and to provide consultation, collaboration, and co-therapy with other staff and trainees.

8W and CRU: Clinical Social Workers provide psychosocial assessment, group and family therapy, and participate in the discharge planning process on the inpatient services. Medical Caseworkers are a critical component of the social work staff, particularly in terms of implementing discharge plans, and developing and maintaining community linkages. They also participate as member of the milieu and as a part of the interdisciplinary clinical, administrative, and teaching team. Consultation, collaboration, and co-therapy relationships are strongly encouraged by the core social work staff on the units.

Integrated Services ABLE: Clinical Social Work staff participates with other core staff and disciplines as case managers with the members of this intensive psychosocial rehabilitation program. This is a program in which the seriously mentally ill member and their family become an equal partner with the mental health staff toward the goal of achieving the best quality of life possible.

VI. Social Work Staff

Supervisory Staff:

Ulises Ramirez, LCSW
Supervisor- Adult Outpatient Clinic

Susan Baltimore, LCSW
Supervisor-Acute Services (8-West, CRU, FSP)

Denise Maguire, LCSW
Child/Adolescent Outpatient Clinics
AOP:

Psychiatric Social Workers

Max Nuñez, LCSW
Tuyet Chen, LCSW
Eduardo Carrasco, LCSW
Elizabeth Gonzalez-Jaskulak, LCSW

Medical Caseworker

Cristina Vega, BA

Child/Adolescent Outpatient Clinic:

Psychiatric Social Workers

Victoria Butler, LCSW
Tomas Croucier, LCSW
Sushila Desai, LCSW
Norma Moreno, LCSW
Antonio Bañuelos, MSW
Adriana Carrillo, MSW

Medical Caseworkers

Mynor Acevedo, BA, MPA
Perla Cabrera, BA
Michael Cook, BA

Community Case Management Linkage Services:

Delia Doherty, LCSW
Carolyn Baum, LCSW
Enrique Sanchez, LCSW
Patty Dugan, LCSW

Dual Diagnosis:

David Haponski, LCSW
Ken Siers, MSW

Integrated Services/ ABLE

Zari Zagarbashi, LCSW
Brad Stevens, LCSW
Medical Caseworkers

Gurney, Gloria, MCW
Bridget Walker, BA

**HIV**

Jim Yandell, LCSW

**8-West**

Genevieve Fowler, MSW
Robin Rumack, MSW

Medical Caseworkers

Lisa Pham, BA
Claire Gaines, BA

**CRU**

Sonia Flores, MSW

Medical Caseworkers

Nina Singh, MA

**Psychiatric Emergency Room**

Clotee Mitchell, BA
Shobha Gautam, MA

**FSP**

Carina Garcia, MSW
Sandy McClelland, LCSW