Section 3

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TEACHING OPPORTUNITIES FOR RESIDENTS

One of the major goals of the training program is to assist the resident psychiatrist in becoming an effective teacher and supervisor. Thus, all residents are involved throughout the residency program in **teaching medical students**. On the inpatient unit, residents are assigned to supervise the clinical work of medical students. After the medical student has completed an evaluation of an inpatient, the resident psychiatrist discusses with the student the basic formulation and treatment plan. Since most of the medical students are planning to enter primary care, the resident psychiatrist focuses on the principles of proper diagnosis, supportive psychotherapy, pharmacological therapy, and use of community resources. In addition, medical students will closely follow the subsequent progress of patients on the inpatient unit. This involves the resident explaining the course of therapy and the principles underlying the psychotherapy that has taken place. This experience helps the resident to learn how to summarize case material cogently and present it clearly and concisely.

On the Hospital Consultation Psychiatry Service, the medical students conduct psychiatric consultations. The resident both assigns the patients to medical students and also supervises their work with patients. In addition, the resident assists in teaching medical students on the weekly Psychosomatic Consultation-Liaison rounds and conference.

In addition to these training experiences, residents on-call are accompanied by a medical student on-call. The resident provides supervision, reviews and discusses with the medical student all emergency calls for the on-call period.

Medical students evaluate resident teaching and interaction, utilizing the same forms used for attendings, and their feedback is reviewed with residents during the semi-annual evaluation. Excellence is recognized by a resident teaching award at the graduation ceremony.

Residents provide routine medication education to their **patients** throughout their clinical interactions. They have continuous access to a variety of informational resources to provide the most up-to-date information regarding potential side effects, medication interactions, etc., and are expected to provide this to patients as elements of informed consent. Structured supervised teaching occurs via conducting partial hospital psycho-education groups, providing information to families during clinical rotations, and creating the initial draft of the physician's discharge instructions.

Residents must also successfully complete 1-2 evidence-based scholarly presentations given to their **peers.** They are assigned material to read and then present to their peers at various points throughout their didactic curricula.

3rd Year Psychiatry Clerkship Goals & Objectives

1) **Goal:** The student will become adept at performing psychiatric evaluations, formulating a differential diagnosis, and developing a treatment plan using a biopsychosocial approach to patient care.

Objectives: The student will elicit and clearly record at least two complete psychiatric histories including all relevant sections, as well as mental status exam, differential diagnosis, and treatment plan.

- The student will perform at least one mental status exam in the presence of an attending physician successfully covering all primary components.
- The student will accurately use all five Axes of the DSM-IV in recording a diagnosis.
- The student will be able to identify general signs and symptoms (diagnostic criteria) for common mental illnesses in each of the major categories of the DSM-IV.
- The student will demonstrate the ability to form a positive therapeutic alliance with the patient during the psychiatric interview.

2) **Goal:** The student will develop a solid knowledge base in the specialty of psychiatry so he/she will be prepared to address the biopsychosocial issues in all of their patients.

Objectives:

- The student will document clinical interaction with at least one patient for each of the categories of mental illness listed in New Innovations and will explain to their supervisor how the patient meets the criteria for each illness.
- The student will obtain a passing score (equal to or greater than the 10th percentile) on the psychiatry SHELF exam given at the end of the rotation.
- The student will demonstrate familiarity with the use of psychotropic agents, ECT and basic psychotherapy techniques during his/her clinical experience with patients.

3) **Goal:** The student will develop a solid knowledge of how the incorporation of psychiatry as a branch of medicine and the importance of mental health issues can positively affect the care provided to patients.

Objectives:

- Explain the role of the “medical workup” in the evaluation of the patient presenting with psychiatric problems and how psychiatric signs and symptoms can be the result of a medical illness.

- Discuss how mental health factors can affect the course of hospitalization on patients on the general medical/social services.

Scheduled Seminars and Conferences

For each year of residency, list all scheduled seminars and conferences at all participating sites attended by residents using the format below. If attended by residents from multiple years, list in each year but provide a full description only the first time it is listed. Number seminars **consecutively** from the first year through the final year so that they may be easily referenced in later narratives. **Be brief!**

Format:
Year:
No: Title:
a) Required or elective
b) Principal instructor(s)
c) Discipline of principal instructor(s)
d) Full- or part-time status of principal instructor(s)
e) Brief description (three or four sentences)
f) Frequency, length of session and total number of sessions

PGY-I

01. Orientation Program for Psychiatry Residency

a) Required PGY-1, new-to-program PGY-2
b) A Khan MD, A Hameed MD, K. Spangler, chief residents
c) Psychiatry; residency training coordinator
d) Full and part time faculty
e) An overview and orientation to the departmental clinical activities, schedules and policies as well as the academic resources available. ACGME core competencies and psychotherapy competencies are reviewed. Residents are instructed as to how our program evaluates competency attainment. The second day is a hands-on tutorial on defensive techniques and seclusion/restraint of aggressive patients
f) Two full days

02. Principles of Inpatient Psychiatry Seminar

a) Required Inpatient (usually PGY-1, may be PGY 2)

b) A Hameed MD
c) Psychiatry
d) Full and part time faculty
e) An overview and orientation to the principles of the psychiatric interview and mental status examination, resources in the community available for referral and other introductory topics. Additionally, an introduction to the psychiatric emergency room and psychiatry inpatient unit is given. Commitment procedures and the inpatient psychiatry policies as well as guidelines on how to evaluate, diagnose and treat patients are introduced
f) Weekly for 1 hour for 10 weeks during the 6 month rotation.

03. Departmental Grand Rounds

a) Required PGY-1, PGY-2, PGY-3 and PGY-4
b) W. P. Milchak, M.S.W., Coordinator, faculty
c) Psychiatry
d) Full and part time faculty, visiting professors
e) A visiting professor or member of our faculty gives a didactic presentation on a psychiatric topic from a research or clinical perspective. A journal club format is also an option, where faculty member(s) will discuss recent journal articles of interest and focus on methodology and findings with an emphasis on clinical correlation.
f) A one hour session 1st, 3rd and 4th Thursday of each month.

04. Distinguished Educator Invitational Lecture Series

a) Required PGY-1, PGY-2, PGY-3 and PGY-4
b) A Khan, M.D.; W. P. Milchak, M.S.W., faculty
c) Usually Psychiatry
d) Visiting professors
e) A visiting professor may be invited to give the residents a didactic presentation on a psychiatric topic related to his/her Grand Rounds presentation or other area of expertise.
f) 1-2 times/ month, Thursdays for 1 hour 15 minutes; approximately 15/ year

05. Resident Journal Club

a) Required PGY-1, PGY-2, PGY-3, PGY-4
b) A. Khan, M.D., Coordinator, E. O. Bixler, Ph.D., faculty
c) Psychiatry
d) Full and part time faculty
e) For each meeting a resident is assigned to present one journal article pertaining to the treatment of a patient he/she is following during a clinical rotation. The resident will demonstrate the ability to critically review a research article in a systematic manner. After a brief case presentation, the resident will discuss how he or she used the information contained in the article to improve upon the care of the patient. This experience will also aid in demonstrating the resident's competency in the topic of Practiced-Based Learning and Improvement.
f) Once monthly, one hour, 9 sessions per year.

06. The Residents' Didactic Series – Introductory Track

a) Required PGY-1, PGY-2
b) K Dougherty, M.D., Coordinator, psychiatry faculty, institutional faculty
c) Psychiatry
d) Full and part time faculty, guest lecturers
e) This seminar is devoted to covering the fundamentals in general psychiatry from a theoretical and practical standpoint. Each session consists of a didactic presentation. Beginning residents participate in these presentations during their PGY-1 and PGY-2 years. Various teaching seminars occur over this time. The basic areas of psychiatry (diagnostic issues, basic psychopathology, the human life cycle/personality development, psychotherapeutic techniques, psychopharmacology, emergency psychiatry, consultation psychiatry, psychological testing, ethics, the history of psychiatry, etc.) are comprehensively covered. Reading assignments may be included in the materials given.
f) Weekly. Sessions repeat every other year, (approximately 100 sessions total over 2 years). One hour fifteen minutes in length.

07. Psychodynamic Psychotherapy Seminar

a) Required PGY-1, 2, 3, 4
b) A Khan MD, K Dougherty, MD, L Picchio MD, invited faculty
c) Psychiatry,
d) Full and part time faculty
e) Residents improve their knowledge base on psychodynamic psychotherapy by reading both classic and contemporary psychotherapy literature and then discussing the concepts, guided by a faculty facilitator. Classics papers have included works by Freud and Mahler; more contemporary works have included Gabbard's Long-Term Psychodynamic Psychotherapy
f) Weekly, 1 hour 15 minutes.

08. "Careers in…" Seminar

a) Required, PGY-1, PGY-2
b) K Dougherty, MD, Coordinator; psychiatry (clinical) faculty
c) Psychiatry
d) Full and part time faculty, guest lecturers
e) As a way to introduce residents to the spectrum of psychiatric career opportunities, psychiatrists from a variety of settings and specialties speak about their practices, related practice options, and available educational opportunities such as fellowships and certifications.
f) Weekly, 6 sessions, 1 hour 15 minutes, 2 speakers per session. Every other year.

09. General Psychiatry Review

a) Required PGY-1, PGY-2, PGY-3, PGY-4
b) Chief Residents, Coordinator, faculty, residents
c) Psychiatry
d) Psychiatry residents, full and part time faculty
e) This seminar is devoted to providing a brief overview of important areas in psychiatry. The program extends July- September of each year in preparation for the Psychiatric-Resident-In-Training Exam (PRITE). One session per week is led by resident facilitators and faculty. In this way, the basics of psychiatry are reviewed at the beginning of each academic year. This serves as the ground work not only for the PRITE exam but also for the didactic series yet to come.
f) Once a week for three months, 12 sessions, one and one-half hours.

10. Clinical Case

a) Required for residents rotating at PPI (PGY-1, PGY-2)
b) A. Hameed, M.D., Coordinator, faculty
c) Psychiatry
d) Full and part time faculty
e) Residents present a patient in a clinical case conference to faculty and other interested staff on a weekly basis. The topics and discussions are geared toward beginning level residents.PGY-1 residents present on the Adult Inpatient Unit. The resident presents the patient and briefly interviews the patient with the attending physician. Then a general discussion is held on the psychopathology evident in the case as well as problems in treatment in each case.
f) Weekly, Tues AM, 1.5 hours.

11. Psychiatric Symposium

a) Elective PGY-1, PGY-2, PGY-3, PGY-4
b) William Milchak, M.S.W., Coordinator, psychiatry faculty
c) Psychiatry
d) Full and part time faculty, guest lecturers
e) Our faculty and invited visiting professors provide updated information on a variety of psychiatric topics in the field of mental health. Several different topics are presented in each daylong symposium.
f) Two day-long sessions per year.

12. Evidence-Based Medicine Scholarly Presentation

a) Required PGY-1, PGY-2, PGY-3, PGY-4
b) Kathleen Dougherty M.D., Coordinator, R. Singareddy, M.D., faculty
c) Psychiatry
d) Full and part time faculty
e) In these sessions, a resident will present (with attending supervision) an hour long evidence-based medicine scholarly presentation based on the resident's choice of a clinical question arising from an actual case It may be on any topic in psychiatry, but the question formulated must have prior approval of suitability by a faculty member.. The resident will demonstrate the ability to use information technology to locate information in the medical literature as well as appraise, collect and assimilate the evidence from studies into a scholarly presentation. The resident will also discuss how the information obtained contributed to optimum patient care (Practice-Based Learning and Improvement).
f) One session per month, October to June, 9 sessions, one hour.

13. ACGME Core Competencies Lecture Series

a) Required PGY-1, PGY-2, PGY-3, PGY-4
b) Various institutional faculty and invited presenters.
c) Various institutional departments, R. Simons, M.D. (Coordinator, Vice Dean of Education and Training)
d) Full and part time faculty and guest lecturers
e) The Core Competencies Lecture Series provides an institutionally sponsored didactic program, aimed at covering some of the core topics inherent in the ACGME competencies. Competencies to be addressed in the lecture series are identified on the Competencies homepage on the institution's website. The lectures will provide basic information to residents so that they can improve the effectiveness of their care for patients within the context of our health care system. Each presentation will have specific learning objectives that will be assessed by the use of survey questions.
f) 1st Thursday of each month, 12 sessions/year, one hour.

14. Forensic Rounds

a) Elective PGY-1, 2, 3, 4
b) K. Dougherty, M.D
c) Psychiatry
d) Part time faculty
e) Residents are encouraged to present clinical situations during which important and/or difficult clinical forensic questions are involved. The majority of the cases come from the consultation psychiatry service and the emergency psychiatry service. The forensic psychiatrist will then lead a discussion focusing on the principles involved and ways of approaching and addressing these issues.
f) Monthly, 12 sessions, one hour.

15. Ethics Seminar

a) Required PGY-1, 2, 3, 4
b) K. Dougherty, M.D., Coordinator; faculty
c) Psychiatry
d) Full and part time faculty
e) The opinions of the APA Ethics committee are used as a resource for developing discussion themes, and residents are encouraged to present clinical situations where ethical issues are involved. 2 faculty members lead a discussion focusing on the principles involved and ways of approaching and addressing these issues.
f) 3 sessions each year, one hour.

16. Clinical Skills Verification Performance Review

a) Required, PGY-1, 2, 3,
b) A Khan, M.D., Coordinator; full and part-time faculty who have completed the CSV training (attended training lecture or viewed training DVD)
c) Psychiatry
d) Most full time, some part time
e) Once every three months every resident is required to do a clinical skills verification exam consisting of interviewing a patient in front of a faculty member- any clinical service or location. Faculty member then completes a form and utilizes the session to provide feedback on clinical skills

17. Penn State Hershey Neurosciences Institute (PSHNI) Lecture Series

a) Elective PGY-1, 2, 3, 4
b) Rachel Kurtz, B.S., Coordinator, faculty, invited speakers
c) Psychiatry, Neurology, Neurosurgery, Neural and Behavioral Sciences
d) Full time faculty and guest lecturers
e) Faculty from Psychiatry, Neurology, Neurosurgery and Neural and Behavioral Sciences are responsible for coordinating an interdisciplinary lecture series with topics pertinent to the neurosciences. Invited speakers from outside the institution often participate.
f) Monthly, one hour

PGY-2

03. Departmental Grand Rounds
04. Distinguished Educator Invitational Lecture Series
05. Resident Journal Club
06. The Residents' Didactic Series – Introductory Track
07. Theory and Practice of Psychodynamic Psychotherapy
08. "Careers in…" Seminar
09. General Psychiatry Review
11. Psychiatric Symposium
12. Evidence-Based Medicine Scholarly Presentation
13. ACGME Core Competencies Lecture Series
14. Forensic Rounds
15. Ethics Seminar
16. Clinical Skills Verification Performance Review
17. Penn State Hershey Neurosciences Institute (PSHNI) Lecture Series

18. Clinical Case Conference – PGY 2

a) Required for PGY-2
b) A Khan, M.D.
c) Psychiatry
d) Full and part time faculty
e) Residents present a patient in a clinical case conference to the residency training director. The focus in on developing skills in differential diagnosis and case formulations.
f) 5 sessions, one hour and 15 minutes each.

PGY-3

03. Departmental Grand Rounds
04. Distinguished Educator Invitational Lecture Series
05. Resident Journal Club
07. Theory and Practice of Psychodynamic Psychotherapy
11. Psychiatric Symposium
12. Evidence-Based Medicine Scholarly Presentation
13. ACGME Core Competencies Lecture Series
14. Forensic Rounds
15. Ethics Seminar
16. Clinical Skills Verification Performance Review
17. Penn State Hershey Neurosciences Institute (PSHNI) Lecture Series

19. Outpatient Orientation Series

a) Required PGY-3
b) S. Sinderman, M.D., Coordinator, faculty
c) Psychiatry
d) Full time faculty
e) Residents are introduced to the outpatient clinic in regards to structure, documentation and charting, and maintaining accurate records. Psychotherapeutic concepts in regards to therapy are introduced including building a therapeutic alliance and utilizing/managing transference and counter-transference. Concepts involved in the formation of the therapeutic alliance are discussed as a foundation to further elaboration in the Didactic Series.
f) Weekly, three to four hourly sessions in July.

20. Advanced Resident Didactic Series

a) Required PGY-3 and PGY-4
b) K Dougherty M.D., Coordinator, faculty, institutional faculty
c) Psychiatry
d) Full and part time faculty, guest lecturers
e) Areas of subspecialty interest in psychiatry are examined for upper level residents. Advanced level seminars are held in this series. These include Advanced Topics in Psychotherapy, Advanced Topics in Psychopharmacology, Research Issues in Psychiatry, Sociocultural Topics, Cross-Cultural Issues in Psychiatry, Religious and Spiritual Issues, Topics in Forensic Psychiatry, Neurology and Medicine Topics, etc.
f) Weekly, sessions repeat every other year, (approximately 100 sessions total over 2 years). One hour fifteen minutes in length.

21. Outpatient Psychiatry Didactic Series

a) Required PGY-3, PGY-4
b) Chief Residents, Coordinator, faculty, residents
c) Psychiatry
d) Psychiatry residents, full and part time faculty
e) This seminar is devoted to providing a brief an overview of topics specific to outpatient psychiatry. These include seminars focused on improving psychotherapy skills (e.g. Psychodynamic Formulations, Brief Psychodynamic Psychotherapy) as well as discussions of psychopharmacology issues (e.g. Safety of Medications for Bipolar Disorder, Antidepressants and Sexual Dysfunction, Treatment Resistant Depression). More in-depth topics are also covered, such as Cognitive Behavior Therapy and Family Therapy. The program extends all year starting with an extensive psychopharmacology review.
f) Once a week for the entire year, 48 sessions, one hour and fifteen minutes

22. Psychotherapy Case Conference

a) Required PGY-3, PGY-4
b) Chief Residents, Coordinator, faculty, residents
c) Psychiatry
d) Psychiatry residents, full and part time faculty
e) This seminar is devoted to enhancing the quality of psychotherapy provided by the residents in the behavioral health clinic. The residents will take turns presenting a History and Physical along with a Psychodynamic Formulation of a patient they are currently seeing. They will then make audio or video tapes of several sequential sessions. The psychotherapy they are providing will then be discussed by their peers and staff members. There will be ongoing efforts to understand their interventions and the patient's responses in terms of the psychodynamic formulation. Occasionally staff members will present other aspects of psychotherapy (e.g. 4-weeks of videotapes of Cognitive Behavioral psychotherapy).
f) Once a week for the entire year, 48 sessions, one and a half hours

23. Addiction Seminar

a) Required PGY-3 or 4
b) E. Aksu, M.D.
c) Psychiatry
d) Clinical faculty
e) Concepts pertinent to addiction psychiatry, such as motivational interviewing, assessment tools, methods for intervention, phases of recovery, and neurobiological and psychosocial of addiction and relapse, are taught using methods of lecture, article review, and case discussion.
f) 8-10 hourly sessions over the Addiction Psychiatry rotation.

24. Geriatric Psychiatry Lecture Series

a) Required PGY-3 or 4
b) J. Barber, M.D.
c) Psychiatry
d) Full time faculty and clinical faculty
e) This seminar focuses on the following areas of geriatric psychiatry: geriatric psychiatry evaluation, dementia, delirium, psychosis and agitation in the elderly, grief and bereavement, suicide and geriatric depression, and bedside neuropsychiatric testing.
f) Every other week during the VA geriatric psychiatry rotation, 7 hourly sessions.

PGY-4

03. Departmental Grand Rounds
04. Distinguished Educator Invitational Lecture Series
05. Resident Journal Club
07. Theory and Practice of Psychodynamic Psychotherapy
11. Psychiatric Symposium
12. Evidence-Based Medicine Scholarly Presentation
13. ACGME Core Competencies Lecture Series
14. Forensic Rounds
15. Ethics Seminar
16. Clinical Skills Verification Performance Review
17. Penn State Hershey Neurosciences Institute (PSHNI) Lecture Series
20. Advanced Resident Didactic Series
21. Outpatient Psychiatry Didactic Series
22. Psychotherapy Case Conference
23. Addiction Seminar (if rotation is done as PGY-4)
24. Geriatric Psychiatry Lecture Series (if rotation is done as PGY-4)

Competency-Based Goals and Objectives
For Learning Experiences

Orientation program for psychiatry residency (PGY-1, incoming PGY-2 residents)
Goal: Increased awareness of pertinent procedures in the hospital/ community/ governmental systems, and resources in the hospital and community (SBP)
Objectives: Become familiar at the introductory level with HMC Psychiatry Department procedures/ community referral resources/ PA laws governing psychiatric admissions and HMC procedures to comply with them

Departmental Grand Rounds
Goal: Increase psychiatric knowledge (MK)
Objective: resident will be exposed to more in-depth discussion/ review of either a research or clinical topic
Objective: Resident will attend ≥70% of scheduled Grand Rounds

Journal Club
Goal: Increase proficiency in searching published sources for case-specific information that will improve patient care (PBL)
Objectives: Resident will review at least 2 relevant recent journal articles and summarize how the information contained will improve/ has improved the care provided to a patient in his/her current caseload
Objective: Resident will attend ≥70% of scheduled sessions

Goal: Develop appreciation of pertinence of review of the literature and its application to clinical issues in psychiatry (PBL)
Objective: Resident will attend review/ discussion of literature that focuses on treatment applications

Resident Didactic Series- Introductory Track
Goal: Residents will increase their knowledge of psychiatric issues (MK)
Objective: Residents will attend lectures to receive information about basic areas of psychiatry including diagnostic issues, psychopathology, personality development, therapeutic techniques, psychopharmacology and the human life cycle
Objective: Resident will attend ≥70% of scheduled sessions

General Psychiatry Review
Goal: improve medical knowledge (MK)
Objective: resident will obtain information on important areas of psychiatry through format of discussion of multiple-choice questions and answers

Goal: resident will communicate medical information effectively to colleagues (ICS)
Objective: Each resident will present an assigned section of material, lead the discussion for that

area and review rationale for correct / incorrect answers

Clinical Case Conferences
Goal: resident will improve interview techniques (PC, ICS)
Objective (PGY 1-4): resident will interview in front of supervisor/ colleagues and receive feedback
Objective (PGY 3 & 4): resident will tape and present a series of interviews with the same patient, present to colleagues and designated attending and receive feedback

Goal: Improve psychiatric knowledge (MK)
Objective (PGY 1-4): Through discussion, resident will elucidate patient's psychopathology and main treatment issues
Objective (PGY 3 & 4): resident will present a psychodynamic formulation for his/ her patient (MK, PC)
Objective (PGY 3 & 4): Resident will be able to offer an appropriate verbal response to patient statements selected by attending (PC, ICS, P)
Objective: Resident will attend $\geq$70% of scheduled sessions

Psychiatric Symposium
Goal: Increase psychiatric knowledge (MK)
Objective: resident will be exposed to more in-depth discussion/ review of either a research or clinical topic

Evidence-Based Medicine Scholarly Presentation
Goal: The resident will demonstrate the ACGME competencies of Practice-Based Learning and Improvement and Medical Knowledge by demonstrating achievement of Evidence-Based Medicine skills. **(**PBL, ICS, MK)
Objective: The resident will demonstrate the ability to locate information in the medical literature using various types of information technology. (PBL, MK)
Objective: The resident will demonstrate the ability to appraise the information, collect it and assimilate the evidence from scientific studies into a Scholarly Presentation. (ICS)
Objective: The resident will demonstrate how the information obtained through this exercise contributed to optimum patient care. (PBL, PC)

ACGME Core Competencies Lecture Series
Goal: Address some of the core topics inherent in the ACGME competencies (all competencies)
Goal: Provide basic information to residents on topics of system-wide interest (all competencies)
Objective: Residents will attend at least 90% of the lectures and meet the goals and objectives for each specific lecture attended

Forensics Rounds
Goal: Increase familiarity and comfort with the legal principles and state/federal laws governing the practice of psychiatry (SBP; PC)
Objective: Residents will be able to list all essential elements of state commitment laws and confidentiality regulations and will be able to perform competency assessments

Ethics Seminar
Goal: Increase awareness of potential ethical pitfalls and dilemmas in the practice of psychiatry (P, MK, PC)
Objective: Resident will be able to apply the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry to suggest appropriate courses of action in structured hypothetical situations
Objective: Resident will attend ≥70% of scheduled sessions

Family/Couples Therapy Introductory Seminar
Goal: Increase knowledge of couples and family therapy (MK)
Objective: The resident will complete the assigned readings
Goal: Increase skill in couples/family therapy (PC, MK, PBL)
Objective: The resident will successfully lead a session under supervision
Goal: Appreciation of the role of family dynamics (SBP, ICS)
Objective: The resident will be able to elucidate the pertinent issues for the participants both in session and in discussion with the therapist afterwards, as appropriate

Principles of Inpatient Psychiatry Seminar
Goal: Increase knowledge of/ competence in addressing common inpatient issues and problems (PC,MK)
Objective: Residents will attend lectures to receive practical, clinically-based information about basic areas of inpatient psychiatry including how to perform the mental status exam and give a case presentation, specific medication issues (such as choosing antidepressants or monitoring for tardive dyskinesia / metabolic abnormalities), and interventions specific to diagnostic categories (such as eating disorders and substance abuse) and how to perform ECT

Neuroscience Lecture Series
Goal: Increase knowledge of neuroscience (MK)
Goal: Increase appreciation for the overlap between the disciplines (P, SBP)
Objective: Resident will be exposed via attendance at lectures to topics from related fields that may be relevant to psychiatrists

Basic Psychotherapy Principles Seminar
Goal: Develop basic knowledge of psychotherapeutic techniques and theory (MK, PC, P)
Objective: Residents will be able to cite theoretical distinctions and similarities among psychodynamic, cognitive behavioral, behavioral, brief and supportive therapies (MK)
Objective: Residents will demonstrate appropriate initial-phase patient contact for therapy (MK, PC, P)
Objective: residents will appreciate appropriate boundaries and patient interactions (P, PC)
Objective: resident will be able to list benefits and pitfalls to combining psychotherapy and medication management (PC, MK, SBP)

Psychodynamic Psychotherapy Seminar
Goal: Increase knowledge of psychodynamic issues (MK, PC)
Objective: Residents will complete the assigned readings in advance of the lecture and discuss

information contained therein
Objective: By the end of the seminar, the resident will be able to identify an appropriate intervention and the rationale for it (PC)
Objective (PGY 3 & 4): Resident will increase identification of psychodynamic issues in ongoing case presentation. (MK)

Psychosomatic Consultation/Liaison Seminar
Goal: Residents will increase their knowledge of psychiatric diagnostic and treatment issues in medical/ surgical patients (MK, PC)
Objective: Residents will attend didactic lectures and read assigned materials and incorporate this knowledge in their patient care

Outpatient Orientation Series
Goal: Increased awareness of pertinent procedures in the medical center/ community/ governmental systems, and resources in the clinic and community (SB)
Objectives: Become familiar at the introductory level with HMC Outpatient Psychiatry procedures/ community referral resources/ JCAHO regulations regarding psychiatric care and how to comply with them.

Geriatric Psychiatry Lecture Series
Goal: Increase knowledge of psychiatric conditions frequently occurring in the geriatric population (MK, PC)
Objective: The resident will complete the assigned readings, participate in case discussion, and incorporate this knowledge into patient care

Advanced Resident Didactic Series
Goal: Residents will increase their knowledge of psychiatric issues (MK)
Objective: Residents will attend lectures to receive more in-depth information or information about more advanced or subspecialty areas of psychiatry including diagnostic issues, psychopathology, psychotherapy, therapeutic techniques, psychopharmacology, research issues and forensic and cross-cultural series.
Objective: Resident will attend $\geq$70% of scheduled sessions

Interviewing, Diagnostic, and Treatment-Planning Skills
Goal: Develop existing interviewing skills (PC, ICS, P, PC)
Objective: Resident will demonstrate appropriate behavior during a supervised patient interaction (P)
Objective: Resident will obtain necessary information for a preliminary treatment plan and will demonstrate ability to synthesize the information collected into a coherent and pertinent plan of care (ICS, MK, PC)

Addictions Seminar
Goal: Increase knowledge of the process of addiction and recovery (MK)
Objective: The resident will complete the assigned readings and participate in case discussion

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

ELIGIBILITY AND SELECTION OF RESIDENTS POLICY

Penn State Hershey Graduate Medical Education

Eligibility and Selection of Residents:
It is the policy of Penn State Hershey Medical Center and its sponsored residency programs to adhere to the guidelines published by the Accreditation Council for Graduate Medical Education (ACGME). Eligible applicants will be selected on the basis of preparedness, ability, aptitude, academic credentials, communication skills, motivation and integrity. Residents will be selected for the various programs based upon their previous records and accomplishments. Applicants are selected for interviews by the Program Director or Department Chair based on the eligibility criteria.

1. **Resident eligibility:**
    a. Applicants with one of the following qualifications are eligible for appointment to ACGME-accredited programs:
    b. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
    c. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
    d. Graduates of medical schools outside the United States and Canada must have a valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment or have completed a Fifth Pathway* program provided by an LCME-accredited medical school.
    e. Program Director must comply with the criteria for resident eligibility as outlined above and as further specified by the Residency Review Committee (RRC). Residents who are accepted into advanced year programs must successfully complete the RRC requirements prior to entering the program.

2. **Resident selection:**
    a. Penn State Hershey Medical Center residency training programs will select eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, motivation and integrity. Penn State Hershey Medical Center does not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status.
    b. All programs participate in an organized matching program, such as the National Resident Matching Program (NRMP), where such is available.
    c. The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities of the regularly appointed specialty residents.

3. **Transfer of Residents**
    a. Residents who transfer from another ACGME training program must meet the Resident eligibility requirements noted above.
    b. Residents who transfer into Penn State Hershey Medical Center must have the formal summative letter from their previous program(s) for the file. This includes residents who have completed training or are transferring without completing previous residency training.

4. **Financial Support, Benefits, and Conditions of Appointment**
    a. Penn State Hershey Medical Center provides all appointed residents with appropriate financial support and benefits to ensure each resident is able to fulfill the responsibilities of their educational program(s).
    b. Candidates of Penn State Hershey Medical Center residency programs (applicants who are invited for an interview) are provided, in writing or by electronic means, the "Resident Benefit Summary" with includes the terms, conditions, and benefits of appointment, including financial support; vacations; parental, sick, and other leaves of absence; professional liability, hospitalization, health, disability and other insurance provided for the residents and their families; and the conditions under which living quarters, meals, laundry services, or their equivalents are to be provided.

5. **Agreement of Appointment**
    a. Penn State Hershey Medical Center provides each resident with a written Resident Agreement outlining the terms and conditions of appointment. The Graduate Medical Education Committee monitors the implementation of these terms and conditions by the program directors. Penn State Hershey Medical Center and the program directors ensure that residents adhere to established practices, policies, and procedures in all institutions to which residents are assigned. The Resident Agreement includes or provides a reference to the following:
        i. Residents' responsibilities;
        ii. Duration of appointment;
        iii. Financial support;
        iv. Conditions for reappointment;
        v. Grievance procedures and due process;
        vi. Professional liability insurance;
        vii. Health and disability insurance;
        viii. Leaves of absence;
        ix. Duty Hours;
        x. Moonlighting;
        xi. Counseling services;
        xii. Physician impairment;
        xiii. Accommodation for Disabilities
        xiv. Closures and Reductions
        xv. Restrictive Covenant

Footnote for 1.d:

A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions: (1) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school; (2) have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools; (3) have completed all of the formal requirements of the foreign medical school except internship and/or social service; (4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).

Approved By GME Committee: 7/2/96
Approved By GME Committee: 11/25/97
Revised and Approved By GME Committee: 9/18/2000
Revised and Approved By GME Committee: 5/3/04
Revised and Approved by GME Committee: 11/16/2009
Revised and Approved by GME Committee: 11/22/2010

SUSPENSION, DISMISSAL, OR DISCIPLINARY ACTION POLICY

Penn State Hershey Graduate Medical Education

Suspension

Penn State Hershey Medical Center may suspend participation of Resident in Program, for cause for failure to fulfill any obligation of the "Resident Agreement", including but not limited to, those specified in this policy. If the suspension is for a period of fifteen (15) days or more, Resident shall be afforded the procedures set forth in this policy.

Dismissal For Cause

Resident may be dismissed for cause during the period of appointment. Examples of cause for dismissal include, but are not limited to, the following:

1. Failure of Resident to meet the performance or conduct standards of the Residency Program;
2. Violation of the rules and regulations of Penn State Hershey Medical Center or a violation of the directions of the Program Director or of the director or coordinator of the service to which Resident is assigned;
3. Abuse or assault of any patient, colleague or teacher;
4. Refusal of rehabilitation for substance abuse;
5. Any conduct which is or would be detrimental to Penn State Hershey Medical Center operations, activities or interests;
6. Any breach of the "Resident Agreement"
7. Deficiencies in maintaining current medical records, including discharge summaries;
8. Lack of evidence of continuing self-education;
9. Persistent strife in professional relations; or
10. Lack of progress in developing acceptable clinical judgment.

Dismissal Procedure

If the Program Resident Assessment Committee/Advisory Committee or its designate makes the decision that Resident shall not continue in the Program, the Department Chair shall notify Resident in writing immediately. The dismissal notice shall include a summary of the specific charge(s) and shall advise Resident of the right of appeal.

Appeal

Appeal of a dismissal or suspension of fifteen (15) days or more may be filed within seven (7) days of receipt of the dismissal or suspension notice by submitting a written notice of appeal to the Department Chair. If an appeal is filed, the dismissal will be suspended pending conclusion of the appeal; provided, that when the cause of dismissal creates reasonable grounds to believe that there is a threat to the safety of patients, Resident, or other persons or property, or a threat to disrupt the essential operations of the Medical Center, the Department Chair may direct that all or part of Resident's duties be suspended pending conclusion of the appeal. While a dismissal is pending appeal, Resident will receive stipend and benefits. Failure to file written notice of appeal within seven (7) days of receipt of the dismissal or suspension notice shall constitute a waiver of Resident's opportunity to resort to the Appeal Board and Review procedure.

1. Appointment of Appeal Board
   Upon receipt of an appeal, an Appeal Board will be appointed by the Senior Vice President for Health Affairs and Dean, consisting of the following: Vice Dean for Educational Affairs (presiding), the Chief Medical Officer of The Milton S. Hershey Medical Center, a senior resident in the same program as the appealing Resident, a resident designated by the Resident Council, and two senior members of the teaching faculty of the Medical Center.

2. Opportunity to Present Statements
   The Appeal Board shall provide Resident an opportunity to present oral and written statements by Resident and other persons in support of the appeal. The Department Chair, or a designee, shall be responsible for presenting evidence in support of the dismissal. Specific procedures applicable to the appeal shall be adopted by the Appeal Board and furnished to the resident and the Department Chair.

3. Recommendation
   The recommendation of the Appeal Board shall be submitted to the Chief Executive Officer, Senior Vice President for Health Affairs, and Dean, College of Medicine, who shall make the final decision with respect to the resident's continuation in the program.

RESIDENT EVALUATION REMEDIATION AND/OR DISCIPLINARY ACTION PROGRAM

The Resident Evaluation Remediation and/or Disciplinary Action Program is made up of members of the Residency Training Committee. The committee will evaluate and make recommendations concerning residents who have academic or disciplinary problems. Please also refer to Criteria for Selection, Evaluation, Reappointment and Dismissal of Residents as outlined in the Policy and Procedure Manual for Graduate Medical Education for the Penn State/Milton S. Hershey Medical Center.

A resident in difficulty is referred for evaluation to the Residency Training Committee by the Director of Residency Training. Areas of concern may include (but not limited to) clinical performance, ethical or professional issues. Concerns can be brought to the Training Director's attention by any member of the Department (faculty or residents). If indicated, the Training Director will discuss the issue at hand with the identified resident. If the Training Director believes the issue to be appropriate and significant, he/she will formally introduce the issue to the committee at the next scheduled monthly meeting of the Residency Training Committee.

After review of available information any of the following actions may be taken:

A. No sanction is necessary
B. Verbal Warning: A verbal summary of the perceived deficiency is to be presented to the resident by the Program Director or Associate Program Director. This will not become a permanent part of the resident's record.
C. Written Warning: A written summary of the perceived deficiency is to be presented to the resident and will be included in the resident's permanent record.
D. Academic Remediation: An action plan will be determined according to the perceived deficiencies and carried out in conjunction with the Program Administration. This will come from the committee and will outline the expected outcomes along with the time interval for its accomplishment.
    1. If the resident does not successfully complete the outlined remediation plan, the committee may proceed to dismissal from the Program.
E. Professional Probation: A resident may be placed on probation if there is evidence that raises concern for the ethical, impaired, moral or professional behavior of that resident. Appropriate remediation and/or counseling, along with continued reevaluation by the committee, may be required throughout the remainder of the resident's training period.
F. Non-Renewal/ Dismissal from the Program: If a resident has failed to progress in clinical competency or is not promoted to the next level of training, non-renewal/dismissal from the program may be considered. If there is documentation of an egregious act carried out by the resident(s), (e.g., an act felt to be unprofessional or in violation of ethical behavior), then immediate dismissal may also be considered.

The resident will have the opportunity to address the committee concerning any/all sanctions and remediation plans. This may be done in person or in writing at the discretion of the resident. The committee will then review the appeal and render a decision.

DUTY HOUR POLICY

Penn State Hershey Graduate Medical Education

Resident Duty Hour Policy for the Penn State Hershey Medical Center provides residents with a sound academic and clinical education that is carefully planned and balanced with concerns for patient safety and resident well-being. Appropriate limits are placed on duty hours to foster high-quality education and to promote patient safety. Each residency 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 energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

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 related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences.

2. Residents must not be scheduled for more than 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. Individual programs may request an increase in the 80 hour per week limit of up to 10 percent, additionally, if they can provide a sound educational rationale.

3. Residents must have at least one full (24-hour) day out of seven free of all educational and clinical patient care duties, averaged over four weeks, inclusive of in-house and at home call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

4. Duty periods of PGY-1 residents must not exceed 16 hours in duration. Duty periods of PGYY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.

5. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. (In rare circumstances the resident may remain beyond their scheduled duty period to provide care to a single patient. Each such instance must be documented in writing by the resident and the Program Director.)

6. Residents should have 10 hours (and a minimum of 8 hours) free of duty between scheduled duty periods.

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 workday when residents are required to be immediately available in the assigned institution.

RESIDENT DUTY HOUR POLICY
DEPARTMENT OF PSYCHIATRY
PENN STATE/MILTON S. HERSHEY MEDICAL CENTER

PURPOSE:

To provide an appropriate learning environment for residents and maintain patient safety.

POLICY STATEMENT:

Our policy for the Department of Psychiatry of the Penn State/Milton S. Hershey Medical Center places appropriate limits on duty hours, fosters high quality education and safe patient care, and promotes departmental and institutional oversight. These policies are fully compliant with the ACGME duty hour language and institutional guidelines for resident duty hours. They are officially required to begin July 1, 2003. This resident duty hour policy is specifically for duty hours for the residents rotating on Psychiatry services. The duty hour policies for Internal Medicine, Neurology, etc. may differ but should be compliant with ACGME and institutional guidelines. If not, please notify the Program Director.

DUTY HOURS:

- Residents must not be scheduled for more than 80 hours per week averaged over a four week period.
- Residents are required to submit hours on duty in New Innovations on a quarterly basis while on psychiatry rotations.
- The resident is to notify the Program Director if it appears the resident is in danger of working more than 80 hours per week averaged over a four week period.
- Residents must have at least one full (24 hour) day out of seven free of patient care duties averaged over four weeks.
- Residents must not be assigned in house call more often than every third night averaged over four weeks.
- Continuous time on duty (including call) is limited to 24 hours with additional time up to six hours for inpatient and outpatient continuity, transfer of care, educational debriefing and a formal didactic activity.
- On Thursday mornings (didactic day) post-call residents may leave at 1:00 p.m. following Grand Rounds. If previously scheduled, residents may also see patients in their outpatient continuity clinic for a maximum period of six additional hours. No new outpatients may be seen.
- Residents may not assume responsibility for new patients after 24 hours on duty.
- Residents should have a minimum rest period of ten hours between duty periods while on psychiatry rotations. On medicine, a minimum rest period is 8 hours no more than once per week.
- When Chief Residents take call from home and are called into the hospital, the time spent in the hospital must be counted toward the weekly duty hour limit. If the Chief Resident believes he/she is danger of exceeding the four week average of 80 duty hours per week, he/she is to notify the Program Director immediately. The frequency of at home call is

not subject to the every third night limitation; however, at home call must not be so frequent as to preclude rest and personal time for each resident. Residents taking at home call must be provided with one day in seven completely free from all educational and clinical responsibilities averaged over a four week period

MOONLIGHTING POLICY:

The Department of Psychiatry regards psychiatry residency training as an experience that requires the resident's total interest and attention. The department therefore limits residents' involvement in additional, professional work during the residency training. Residents are permitted to perform outside work with the permission of the Program Director and/or Chair. Residents requesting outside work opportunities must be in good standing, performing at a satisfactory level in all areas. **A first year resident in the Child Program is not permitted to moonlight.** Outside work must not interfere with their primary training objectives or performance. The clinical performance of all residents is monitored through individual supervision as well as written evaluations of their performance. Deficiencies and weaknesses in performance are addressed with the resident on an individual basis. Residents may be allowed to work for remuneration outside the scope of their educational activities and regular assigned duties of the training program provided that prior and specific written notification detailing such activities is given to the Program Director. This information should include the location, nature, duties and proposed schedule of the activity. Permission should be requested at the beginning of each academic year and/or whenever a change in moonlighting duties occurs. If approved, the Program Director will write a letter documenting such. This letter will be given to the resident and be placed in the resident's permanent file. Logs documenting the resident's moonlighting hours should be submitted on a monthly basis. Moonlighting work must be performed in accordance with Medical Center policies. In the event that the resident works outside the scope of the educational activities in regular assigned duties, the professional liability insurance coverage is not provided by the Penn State/Milton S. Hershey Medical Center. The resident must provide evidence of a valid unrestricted license to practice medicine in the appropriate state or jurisdiction. It is the responsibility of the institution hiring the resident to determine that appropriate licensure is in place, adequate liability coverage is provided and the resident is appropriately credentialed to carry out assigned duties. Finally, residents are not required to engage in moonlighting activities for the institution.

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

MOONLIGHTING POLICY

Penn State Hershey Graduate Medical Education

Moonlighting is defined as voluntary, compensated, medically-related work performed outside the institution where the resident is in training or at any of its related participating sites.

Resident may not provide physician services to other healthcare institutions for remuneration outside the scope of their educational activities and regularly assigned duties of the training program unless prior and specific written notification detailing such activities is given to and written consent for such activities is obtained from the Program Director. Moonlighting shall not be approved if the Program Director believes such activities may interfere with the Residents ability to perform his/her obligations and duties in the Residency Program. The Program Director's determination in this regard shall be final and does not fall within the scope of the Grievance Procedure outlined in section 5 herein.

In the event that the resident works outside the scope of the educational activities and regularly assigned duties, professional liability insurance coverage is not provided by Penn State Hershey Medical Center. The Resident must provide evidence of a valid unrestricted license to practice medicine in the appropriate state or jurisdiction. It is the responsibility of the institution hiring the resident to determine that appropriate licensure is in place, adequate liability coverage have been obtained by the Resident, and that the Resident is appropriately credentialed to carry out assigned duties.

Professional and patient care activities that are external to the educational program may be inconsistent with sufficient time for rest and restoration to promote the resident's educational experience and safe patient care.

1. Residents are not required to engage in moonlighting activities for the institution.
2. All moonlighting activities (both internal and external) must be counted towards the 80-hour maximum weekly hour limit.
3. PGY-1 residents are not permitted to moonlight.
4. The prospective, written statement of permission from the Program Director will be placed in the resident file.
5. Resident will be monitored by Penn State Hershey Medical Center and the Program Director for the effect of these activities upon performance and adverse effects may lead to withdrawal of permission.

Approved by GME Committee: 2/19/01; 6/4/01
Revised and Approved by GME Committee: 5/19/03
Reviewed and Approved by GME Committee: 5/3/04
Reviewed and Approved by GME Committee: 4/7/08
Reviewed and Approved by GME Committee: 3/14/11
G:/Policies/Moonlighting

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

EVALUATION, RENEWAL AND PROMOTION POLICY

(Including Non-Renewal and Non-Promotion)

Penn State Hershey Graduate Medical Education

Resident Evaluation:

1. Each residency program must demonstrate that it has an effective plan for assessing resident performance throughout the program and for utilizing the results to improve resident performance. This plan should include:
    a. the use of methods that produce an accurate assessment of the residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

    b. mechanisms for providing regular and timely performance feedback to residents that includes at least a written semiannual evaluation that is communicated to each resident in a timely manner and the maintenance of a record of evaluation for each resident that is accessible to the resident;

    c. a process involving use of assessment results to achieve progressive improvements in residents' competence and performance. Appropriate sources of evaluation include faculty, patients, peers, self, and other professional staff.

2. Written evaluation of Resident will be conducted by the applicable department program at the end of each resident rotation, or semi-annually by the Program Director to ensure that residents demonstrate achievement of the six general competencies: patient care; medical knowledge; practice-based learning; interpersonal and communication skills; professionalism; systems-based practice; and/or any other factors deemed necessary or desirable to complete the requirements of the Program. The results of these evaluations will be kept on file in the resident's evaluation folder in each department. The evaluation folder will be available for the resident's inspection.

3. The evaluation process is intended to establish standards for the resident's performance and to indicate the resident's ability to proceed to the next level of training. The process will, to the extent reasonably possible, provide early identification of deficiencies in the resident's knowledge, skills or professional character, and to the extent reasonably possible allow remedial action to enable said resident to satisfactorily complete the requirements of the Program.

4. Program Directors or faculty advisors are encouraged to provide feedback through personal conferences. It is the responsibility of the Program Director to advise the resident of his/her performance in the program.

5. Resident may be required to take the annual in-training examination for Resident's specific program. Other acceptable performance standards will be determined by the Program Director.

6. The Program Resident Assessment Committee/Advisory Committee or appropriately designated body shall meet at least once each residency year to review the performance of Resident and make a determination as to the ability of Resident to continue in the program and/or advance to a higher level of responsibility. Promotion to the next level of training will be based on the Resident Assessment Committee determinations, evaluations and the program director and faculty input.

7. Final Evaluation: The program director must provide a final evaluation for each resident who completes the program. The 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.

Faculty Evaluation:

1. 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. Annual written confidential evaluations by residents must be included in this process.

2. Residents are required to submit to the program director or to the Graduate Medical Education Office, at least annually, confidential written evaluations of the faculty and of the educational experiences.

Program Evaluation:

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

2. Representative program personnel, i.e. at least the program director, representative faculty, and at least one resident, must be organized to review program goals and objectives and the effectiveness of the program in achieving them. The group must have regular documented meetings 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.

3. *Outcome assessment*
    a. ***The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program.***

    b. The program should have in place a process for using resident and performance assessment results together with other program evaluation results to improve the residency program.

    c. ***Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness.***

Conditions and Notice of Renewal, Non-Renewal or Non-Promotion:
Resident contract will be renewed based on the established standards of clinical competence, knowledge, skills, professional character, interpersonal skills, evaluations and/or any other factors deemed necessary to advance to the next level in training.

Renewal of Resident Agreement:
At least one hundred and twenty days (or thirty days if the appointment period is nine months or less) prior to the end of Resident's current appointment period, the Department Chairman or Program Director shall provide a written offer of reappointment detailing the terms and conditions of reappointment.

Non-Renewal or Non-Promotion:
In instances where a resident's agreement will not be renewed, or when a resident will not be promoted to the next level of training, Penn State Hershey Medical Center will provide the resident with a written notice of intent no later than four months prior to the end of the resident's current agreement. If the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, Penn State Hershey Medical Center will provide the resident with as much written notice of the intent not to renew or not to promote as circumstances will reasonably allow, prior to the end of the agreement.

Residents must be allowed to implement the institution's grievance and due process procedure policy if they receive a written notice either of intent not to renew their agreement or intent not to promote them to the next level of training.

Approved By GME Committee: 11/25/97
Revised By GME Committee: 9/18/00
Revised and Reviewed By GME Committee: 05/03/04
Revised and Reviewed By GME Committee: 11/16/09

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

RESIDENT PARTICIPATION IN EDUCATIONAL AND PROFESSIONAL ACTIVITIES

Penn State Hershey Graduate Medical Education

Penn State Hershey Medical Center will ensure that each residency program provides educational experiences for residents that lead to measurable achievement of educational outcomes in the ACGME competencies, in accordance with its Program Requirements. The specific knowledge, skills attitudes, and educational experiences required in order for each resident to demonstrate the following (i.e. written curriculum):

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 (eg, epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
3. **Practice-based learning and improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
4. **Interpersonal and communication skills** that result in effective information exchange and teaming 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 a diverse patient population
6. **Systems-based practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.

In addition, the Sponsoring Institution must ensure that residents:

1. develop a personal program of learning to foster continued professional growth with guidance from the teaching staff;
2. participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervising other residents and students;
3. have the opportunity to participate on appropriate institutional and departmental committees and councils whose actions affect their education and /or patient care;
4. participate in an educational program regarding physician impairment, including substance abuse and sleep deprivation.

Approved and/or Revised by GME Committee: 5/3/04; 06/16/08; 03/22/10
G:/Policies/Education & Prof Activities

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

GRIEVANCE AND DUE PROCESS POLICY

Penn State Hershey Graduate Medical Education

Any Resident (or fellow) serving in an ACGME-accredited program at Penn State Milton S. Hershey Medical Center ("Medical Center") can seek resolution of grievances under this policy. "Grievance" means (a) any difference or disagreement between a Resident and a representative of the Medical Center relating to the Residents participation in his or her residency program; and (b) a Resident's disagreement with non-renewal of the Resident's contract or non promotion. This policy does not apply to appeals from (a) a suspension for a period of 15 days or more, or (b) termination from the residency program during the appointment period. The procedure is as follows:

1. **Resident to Program Director and/or Department Chair** – A Resident should first present the grievance to the Program Director and/or Department Chair in which the resident's training program primarily resides. Issues can best be resolved at this stage and every effort should be made to affect a mutually agreeable solution.

2. **Resident to Ombudsperson** – In situations when the concern relates to the Department Chair or Program Director, and Resident believes that it cannot be presented to the Department Chair or Program Director, Resident may present the grievance directly to the Ombudsperson for guidance. The GME Office will assist the resident in identifying an Ombudsperson.

3. **Resident to Vice Dean for Educational Affairs and/or Associate Dean for Graduate Medical Education** – If, after discussion with the Department Chair or Program Director (and/or Ombudsperson), the grievance is not resolved to the satisfaction of Resident, Resident has the option to present the grievance to the Vice Dean for Educational Affairs, who may delegate consideration of the grievance to the Associate Dean for Graduate Medical Education. The Vice Dean (or Associate Dean) shall meet with the Resident and consult with appropriate representatives of the program as part of consideration of the grievance. In the event a mutually agreeable resolution of the grievance is not possible, the Vice Dean (or Associate Dean) shall render any necessary decision to resolve the grievance and his/her decision will be final.

   The grievance policy shall be utilized for academic or other disciplinary actions taken against resident that could result in non-renewal of resident agreement or non-promotion of resident to the next level of training, or other actions that could significantly threaten intended career development. The grievance policy shall also be used for adjudication of resident complaints and grievances related to the work environment or issues related to the program or faculty.

Suspensions of 15 days or more, or termination from the program during the appointment period, may be appealed in accordance with the provisions of the Resident Agreement relating to suspension and dismissal.

Approved and/or Reviewed by GME Committee: 2/26/96; 11/25/97; 9/18/00; 05/03/04; 11/10/08

PHYSICIAN IMPAIRMENT POLICY

Penn State Hershey Graduate Medical Education

For the purposes of this policy, “impairment” is the inability of a resident to physically or mentally meet his or her responsibilities because of physical illness or injury, psychiatric or behavioral illness, dependency on alcohol and/or controlled substances or overuse of same or other condition.

Program Directors, faculty, and other medical center professionals are encouraged to be observant for signs of impairment from alcohol, drugs, psychiatric or medical disorders among residents.

When impairment is suspected, the appropriate Program Director or Department Chair should be informed and should utilize available resources to investigate the situation and take appropriate actions, including intervention, when warranted.

It is our goal to provide intervention and rehabilitation for impaired residents and to support them during the process. However, dismissal is possible if the resident refuses such (see Resident Agreement).

Resources available to Program Directors, Department Chairs, faculty, or residents with respect to impairment include the Resident Assistance Program, the Student Mental Health Service, the Departments of Psychiatry and Social Services, and the Pennsylvania Medical Society’s Physicians Health Programs.

Approved and/or Revised by GME Committee: 11/25/97; 09/18/00; 05/03/04; 06/16/08
G:Policies\Impairment Policy

VACATION AND LEAVE POLICY

I. Vacation Time

During the first three years, residents receive 15 weekdays or the equivalent of 3 weeks' vacation time. This increases to 20 weekdays or 4 weeks of vacation time during the fourth and fifth years. Residents also get 6 holidays per year (July 4, Labor Day, Thanksgiving, Christmas, New Year's Day and Memorial Day) provided the resident is NOT assigned to be on call on a holiday or the holiday does not fall on a weekend day. Per hospital policy it is assumed that all residents/physicians will at some point work holidays; therefore, **residents who are assigned to be on call on a holiday will NOT get extra vacation days for holidays worked. Likewise, when the holiday falls on a weekend day, residents will NOT receive an extra vacation day. (**Please note this is a change from the 2009-2010 academic year.)

Normally, within each 3-month teaching block, 1 week of vacation may be taken (more with special permission). **Starting in the 2011-2012 academic year, all residents, needing consecutive time off longer than one week, will need to submit their requests to the Program Director 4 months prior to the beginning of the academic year (February 1st) so these requests can be taken into consideration when scheduling resident rotations (i.e. for the 2011-2012 academic year, requests must be received by February 1, 2011).** A 2-week terminal leave (prior to graduation) is the maximum amount of time allowed. Rare exceptions to these policies may be requested through the Residency Training Director.

When requesting vacation time, the resident should discuss his or her plans with the director of their primary service to which they are assigned, and fill out a Resident Absence Request Form with the service attending's signature and forward to Dana Knoster (Rm. C5603). **Please be aware that ALL requests for vacation while rotating on the Adult Inpatient Service must be signed by both your primary attending AND Dr. Hameed.** Specific plans should be made to cover all clinical activities, and patient records should be completed. Arrangements to cover on-call days should be made by the resident when the vacation is approved.

A maximum of one week of vacation is allowed while rotating on Internal Medicine at Pinnacle (IM must be notified in advance before they make up their on call schedules) and Neurology. The Emergency Medicine Department will allow a day or two of vacation during the month long rotation. **NO** vacation time/time off is permitted on the Family Medicine rotation at Good Sam's Hospital in Lebanon. Vacation time during Neurology, Internal Medicine or Emergency Medicine must be approved by the appropriate off service attending and Residency Training Director of that service.

No vacation time may be carried over to the next year. **We follow the academic year schedule (July-June) for ALL residents – even those who are "out-of-sync**.

Starting in the 2010-2011 academic year, residents who do not have an excused absence (vacation, sick, CME, night float, etc.) will be charged vacation time if they fail to attend didactics.

II. CME Time

Five continuing medical education (CME) days are also permitted. Graduating residents may use CME time for interviews.

III. Sick Time

Although residents do not officially get sick time per hospital policy, residents are encouraged to approach their Program Director when they need to call off due to sickness. Program Directors reserve the right to grant sick time on a case-by-case basis. Dana Knoster and your Program Coordinator should be notified when calling off sick as well as your clinical service. Failure to notify our department that you were off and did not attend your clinic service as planned will result in being charged two days' vacation for every day off.

IV. Policy Relating to Weather Emergency Conditions

Inclement weather or other emergency conditions may result in the activation of the weather policy.

In case of weather related or other emergency conditions, please keep the following procedures in mind:

1. **The Hershey Medical Center is always open for business and employees are expected to report.**

2. The Weather Emergency Policy is declared for the Medical Center by the Senior Vice President for Health Affairs and Dean of the College of Medicine, or the Vice President and Chief Operating Officer, in the Senior Vice President's absence.

3. The Office of Public Relations will contact an established list of AM and FM radio and television stations in Dauphin, Cumberland, York, Perry, Lebanon, and Lancaster Counties in the event that a weather emergency is declared. But the two official stations for announcements concerning HMC are WHP (580 AM) and WROZ (101.3 FM).

4. If an authorized radio and/or television announcement specifically states that a "Weather Emergency Plan has been placed into effect for Hershey Medical Center, "those employees designated as "non-essential" for this purpose, may elect to work or to **take accrued annual holiday or personal leave, or leave without pay if accrued leave is not available.** "Essential employees" are not excused during emergency conditions.

   Essential employees are those who provide essential services, such as direct patient care or support to patient care such as departmental staff assistants who answer calls from patients and referring physicians, maintenance, food services, and research support.

V. Maternity/Paternity Leave

A resident may request a maximum of 12 weeks of family leave under the Family Medical Leave Act (FMLA). Please keep in mind that residents are not eligible for FMLA until they have worked for a full year. If the leave is eligible under FMLA, the first 6 weeks minus any vacation the resident has already used will be with full pay and benefits and will include any remaining vacation leave for the contract period. The remainder of the 12 weeks will be without pay. However, benefits will continue to be provided at no cost to the resident. If the period of leave reaches two consecutive contract periods, the amount of paid and unpaid leave will be allocated proportionately, including available vacation days.

All requirements of the resident's respective board must be satisfied in this process, and board requirements will take precedence over this institutional policy. Thus, in order to satisfy ACGME requirements, residents must make up any time missed (beyond vacation time) later on in the residency in order to compile a total of 4 years of post-graduate training for the general psychiatry program.

Revised 6/17/11

CHANGE: When completed, return to Dana Knoster, x6386, fax 6491, mail code H073

Resident Absence Request Form							
NAME:							
Today's Date:							
Dates Requested to be off:							
	VACATION		CME		SICK		WORK-RELATED LEAVE
Indicate # days each:							
Have you cleared your calendar?							

Responsibility (if applicable)		**Initials of person to cover, if applicable**
Inpatient Unit (Child & Adult)		
Clinic patients		
Off Site Rotations		
Consult Liaison		
Interview activities (dinners etc)		
On Call Coverage		
Administrative meetings		
Other…		
*Primary Supervisor Approval:		
**Final Approval Signature:		

Please note:

Residents who are rotating at NE Drive must submit their requests one month in advance

Residents who are rotating at the VA must submit their requests to April Kurtz 3 months in advance.
April.Kurtz@va.gov

Off service time off requests:
Family Medicine -no time off is permitted
Internal Medicine -up to one week off; time must be requested before IM on call schedules are made.
Neurology -up to one week off
Emergency Medicine will allow a day or two

*For Primary Supervisor Approval-- Outpatient at NE Drive, **Dr. Sideman's** signature is required
-- Outpatient at Division St. or former Front St., **Dr. Montanez's** -- Inpatient, Primary supervisor and **Dr. Dust's** -- CL, **Dr. Rapp's** signature.
Final Approval Signature for residents must come from **Dr. Khan & fellows **Dr. Mahr**

On Call procedures (excerpted from the Intern Manual 2012)

First, upon beginning call at 5:00pm, you will need to change the consult/liaison service pager coverage over to your pager. There are two ways to accomplish this:

Call 531-4311,
As soon as you start hearing prompts press *4931
Then press #11
Then enter your pager number
A voice will then tell you that your pager # is now covering the consult pager

Or

Call the HMC operator at 531-8521, state your name and that you are one of the psychiatry residents
Ask them to switch the coverage of the psychiatry consult pager #4931 over to your pager #_ _ _ _.
If you want, you may ask them to send you a test page to confirm that the switch has been made.

Next, you will need to determine which attendings are on call for the night. This information is usually posted on the calendar on the Hershey psychiatry website as well as in the TEC but sometimes changes are made without the posted calendars getting updated. The HMC operator will have the most up to date information.
After changing the consult pager coverage:

1. Page both the child attending and adult attending to check-in and inform/remind them that both of you are on call,
2. Ask how they prefer to be reached, whether by pager, cell phone, home phone, etc. as each attending may have different preferences.
3. Also ask the adult attending if he or she would like to be called for every inquiry or just after an evaluation.

NOTE: You are required to call the attending for all child inquiries prior to accepting or denying the patient. Further, you must always call an attending before denying any inquiry or refusing any admission regardless of adult or child, please see admission procedures section for more information.

If there is no response from the on-call attending initially, try paging them again after 10 minutes. If there is still no response, ask the HMC Operator to connect you to his or her home/cell phone if they have one listed. If you are still unable to contact an attending then the EMERGENCY CONTACTS are Dr. Rapp (ADULT) and Dr. Wilt (CHILD). Keep trying different attendings until someone is reached if need be.

After contacting your attendings, changing pager coverage, and taking sign out, you may begin seeing any patients already waiting in the TEC by order of arrival or by acuity of the patient, such as if the patient is getting agitated. Occasionally, patients may need to be admitted directly to the unit (bypassing the TEC). You will need to do your assessment on the unit instead of down in the TEC in these cases. This typically occurs for patients with MRSA, patients that are acutely agitated upon arrival, or patients that have been heavily sedated prior to arrival.

While evaluating a patient in the TEC, you will gather all information needed to dictate an H&P and write orders for the patient. You may then excuse yourself, and exit the room to organize your thoughts, come up with an assessment and plan, call the attending, discuss the case, finalize your

plan, and write admission orders. If not busy, after admitting the patient you may dictate at that time or keep notes and dictate at a later time, however, if you are going to dictate, it should be done by the end of your shift if at all possible.

Admitting New Patients

Your primary function while on-call will be to admit new patients to the units throughout the night. Please refer to the section on admission procedures for more information.

Floor calls

The units may call you with queries/concerns about currently admitted patients which may be of the following types:

(a) Seclusion/Restraint situations: DROP EVERYTHING and attend to these as a matter of PRIORITY. These patients MUST be seen by a physician within 1 hour of restraint being initiated. Once you have seen the patient, you must complete the seclusion/restraint orders and seclusion/restraint progress note in TIER. BOTH OF THESE MUST BE COMPLETED WITHOUT EXCEPTION. A separate set of orders/progress note will need to be completed for each event (i.e. you cannot combine a seclusion note with a restraint note even though they may have occurred simultaneously). Please refer to the seclusion/restraint section for more information. Much of the orders section will already be completed by the nursing staff.

(b) Medication queries: The floors may call you for medication requests. If you are free to do so please go to the floor, review the chart, evaluate the patient and prescribe medications when appropriate. If you are unable to do so immediately, the nurses will accept verbal orders which you must then go and sign as soon as you have time. WARNING: Before issuing verbal orders YOU MUST REVIEW THE PATIENT'S ALLERGIES AND CURRENT MEDICATION LIST (the nurse can read this to you over the phone). Please refer to the section on verbal orders for more information.

(c) Medical queries: These calls can vary tremendously, ranging from a simple headache, to nausea, to chest pain, etc. Try your best to manage these yourself. However, when in doubt you can always call the internal medicine attending on-call, the attending, or the back-up resident for help. Dr. Limann is usually the day time internist for the adult units and Dr. Prensner for the child unit. After hours, ask the nurses who the on-call internist is and page that attending for advice should you need to consult them.

NOTE: Remember to write a general progress note in TIER for events if you feel that it is indicated, if in doubt; always err on the side of writing a note. If you must write a paper note for patients please make sure you either type or write neatly. A pdf copy of the progress note template can usually be found on at least one the computers on each unit, or a blank pdf progress note can be found on the PPI website. If sending a patient to the ER, write a brief progress note to go with the patient or call the ER and update the physician of the reason yourself.

Outside calls- these should be recorded in the on-call log

These may come from the following sources:

(a) Hershey Medical Center, Harrisburg Hospital, Community General Osteopathic Hospital (CGOH): they may call you for an after-hours consult. Remind them that you are at PPI in Harrisburg and that you would be happy to take down the patient information and pass it on to the consult service at HMC in the morning. However, if they want a patient seen urgently, then make an attempt to

find out if the patient needs to be seen urgently or if the consult can wait until the morning. If the requesting physician insists the consult be urgent, inform them that their attending will have to call and speak to your on-call attending. If the attendings decide that the consult is in fact an emergency, then the psychiatry attending will call the back up on-call resident to see the patient. Keep in mind this is a very rare occurrence and almost never happens.

If they just want some advice on a patient (i.e. telephone curbside), write down as much detail about the case as you can, call and discuss it with your attending, then call the requesting resident/attending back with your recommendations (remember to get their pager number before hanging up). **NOTE:** This is very dangerous ground, as you should not be providing advice on a patient that you have not personally seen and evaluated. The key here is to be very firm in stating that you cannot provide information on that patient, however, you can discuss a 'hypothetical situation' about what you might do if you had a patient with "situation X", but that you are not providing recommendations for their particular patient. However, if they want to include you in their note then they should order an official consult and we can then have that person formally evaluated by the consult service the following day. **NOTE:** some numbers from HMC begin with 28-xxxx or 31-xxxx and these can only be reached by calling 531-8521 (HMC operator) and asking the operator to connect you to the number.

(b) Numbers on your pager which start with 12xx (i.e. 1215, 1221, 1205) means that there is an outside call via the HMC operator and that they are holding for you. You may call 531-12xx (whatever the number was) and listen carefully for the click indicating you are now connected to the caller to begin speaking or you may call 531-8521 (HMC switchboard) and ask the operator to connect you to the number.

(c) If a pt calls you, ask them about the nature of their problem (i.e. if a pt is not feeling well and wants to know what to do… you could advise them to go to the nearest ED or call the crisis team.) Try your best to talk with the patient about their issue and provide advice about what to do. These calls vary widely from anxious patients, to medicine questions, to patients needing prescriptions phoned in. You may even get calls from patients in far away cities simply because they may have heard of Penn State / Hershey. Remember to get the patient's name and telephone number, always assess for harm to self or others and address that accordingly, recommending they go to the ED, call crisis, etc. If you feel uneasy about the situation and think the patient may need immediate help you can also notify crisis yourself. Also, if the patient is one of the Hershey outpatients, you should also send an email to the resident or attending who normally follows that patient, with a brief summary of your phone conversation. If you are not sure what to do then ask the patient for his/her contact details, speak with the on-call attending and then get back to them.

<u>Medical students</u>

Occasionally, while on-call you may have a medical student show up in the TEC or may be waiting on you when you arrive. He or she is there to observe you and help out in any way they can to learn about the emergency psychiatry experience. They should try to observe at least one adult admission and one child admission if at all possible. Make a good effort to teach them something about the case and if time permits have them write the admission orders while instructing them how to do so.

If you have down time, use it to teach them the following topics about psychiatry:

- Components of a Psychiatric H&P including the Mental Status Exam
- Admission orders, including observation status differences
- DSM Criteria for the most common disorders seen in the acute setting (i.e Mood and Anxiety DO's and Psychotic DO's)
- Review the main classes of psychotropic medications

- How to handle an agitated patient (i.e. rapid tranquilization medication protocols)
- How the TEC operates (i.e. Pt's come from one of the three county ED's or others to get evaluated and admitted.
- The differences in 201 versus 302, 303, 304 and the entire process of committing a patient, court hearings, etc.
- Differences between the various psychiatric settings (i.e. Acute inpatient vs. partial vs IOP vs. Outpatient vs. State Hospital vs. ACT/CTT etc.

NOTE: the medical students do review their experiences with the student coordinator and this can reflect back upon you so make sure you treat them well and make a good effort to teach them something. Of course, patients come first and at times things may be too busy to teach a topic thoroughly and this is understandable.

Verbal Orders

Most of the time you should be reviewing the chart and writing your orders in the orders section yourself. However, there will undoubtedly be situations in which an order is needed and you may be tied up and unable to get to the chart right away. It is acceptable to give a nurse a verbal order over the phone during these situations. Always have the nurse give you a brief history of the patient if you are unfamiliar with them including current diagnosis, current meds, and allergies before issuing your verbal order.

NOTE: If the nurse is requesting a medicine, it is helpful to ask if the patient has a preference or is asking for something in particular, or if the patient has previously responded to or not responded to a particular medicine before deciding what medicine to use. You may ask the nurse or call the pharmacist what is available in the PIXIS dispenser to help you make a decision as well. It is also wise to ask the nurse for his or her opinion on what to use or what is typically used in that situation as well, this helps them to feel included in the care of the patient, may help you out if you are unsure of what to do, and you can always decide to use something else despite the nurse's recommendation.

If you issue a verbal order, remember to go and sign the order as soon as you have a chance to do so as all verbal orders should be signed by a physician within 24 hours. You may want to keep a tally of the number of verbal orders you issue in a night and on which floors to make it easier to remember to go back and sign your orders. The nurse receiving the verbal order will write the order on a verbal order sticker which is immediately adhered to the chart and they will also document the order in the verbal orders log.

If you come across an unsigned verbal order in the chart of one of your patients, it is okay to go ahead and sign the verbal in an effort to help out your colleagues and help the hospital stay in compliance. Verbal orders can be signed by any physician, not only the ordering physician. However, if you disagree with the order, you do not have to sign it.

All verbal orders must be read back to the physician by the nurse after the order is written on the physician order sheet and as necessary, points of clarification made.

End of Shift / Sign Outs

The on-call resident's shift will end at 8:00am at which time the consult/liaison resident at HMC will contact the on-call resident to take sign out for the psychiatry C/L service. This will include any new consults received overnight.

Any pertinent information needing to be signed out to the units should be called to the resident assigned to that particular unit at this time as well. On Thursday mornings, instead of signing out to the consult resident, the on-call resident will page Dr Rapp (pager #4557) to give him the sign out for the consult team and change coverage of the consult service pager over to Dr. Rapp's pager at

8:00am. If Dr. Rapp is unavailable, then sign out to Dr. Wilt.

Friday Night Call

Friday night call is similar to call during the week beginning at 5:00pm and continuing until 8:00am the following day. The only difference is that the on-call resident will be called by the Saturday on-call resident in the morning at 8:00am who will take all new consults and will change the consult pager coverage. This resident will not come to the TEC as they have to see patients over at HMC in the morning first.

Saturday / Sunday Call

Saturday and Sunday calls are each a 24-hour shift that starts at 8:00am and ends at 8:00am the following morning. The calendar will usually have two attendings listed as on-call, A and B. Attending A should be called for questions on Saturday until 8:00am on Sunday and Attending B for questions on Sunday until 8:00am on Monday.

The on-call resident will begin the day by paging the previous night's on-call resident and taking sign out, making note of any new consults which need to be seen at HMC. *Be sure to take down the name, MRN, and reason for the consult.* The on-coming resident will then need to change the coverage for the consult pager. The resident will then arrive on the 5th floor of HMC and go to the Psychiatry Consult/Liaison Office. They will check the census board for information on which consult patients need to be seen over the weekend. This will be indicated by a colored "skull and crossbones" symbol next to the patient's name and sometimes will also indicate if the patient needs to be seen both Sat and Sun or only one of the two days. If there are any new consults which were signed out, they will need to be added to the census board and marked with a colored circle symbol next to their name.

Next, the on-call resident should proceed to follow-up with each of the patients that need to be seen on the weekend and write a progress note on each patient in power chart. If any new information presents that might change the current recommendations, contact the attending on call and discuss your recommendations before notifying the primary team for that patient. **NOTE:** The consult resident will not be allowed to write or change orders in power chart as a consulting team member, and can only make recommendations to the primary team.

If there are any new consults from overnight, or if any new consults come in that morning, they will need to be seen then as well, and an H&P dictated for the chart. The on-call resident will need to page the attending on-call and present the patient's history, discuss the assessment and plan, and then contact the primary team to give the recommendations. **NOTE: if you are paged with a new consult, remember that the primary team requesting the consult must have a specific question in mind for you to answer as the reason for the consult.** When seeing new consults remember to complete a suicide risk form, CAM-ICU form, or MOCA / SLUMS as indicated and place in the chart. Consults can vary from depressed patients to suicidal patients to delirious patients to consults for capacity to make decisions to evaluations for transplants, etc.

<u>Transplant Consults</u>

Occasionally the on-call resident may receive a consult for the organ transplant service for which the reason for consult includes evaluation of psychosocial risk related to organ/marrow transplantation.

The HPI should include:

1. the reason for the transplant
2. current level of function
3. any psychiatric symptoms including those related to the illness

4. include that the patient was asked what the decision regarding the transplant is and the reason why that decision.

The assessment should include in addition to the diagnostic impression and 5-axis diagnosis:

1. decisional capacity to consent to the transplant procedure
2. evidence of compliance with medication
3. evidence for or against substance abuse
4. prior exposure to and/or experience with immuno-modulating agents or steroids
5. psychosocial supports
6. overall excess risk including legal issues or other psychiatric diagnosis

The recommendations should address any further recommendations as indicated for the patient.

Decisional Capacity Consults

Occasionally the on-call resident may receive a consult from a primary team to assess a patient for capacity. The important thing to remember here is that we can only assess capacity for one specific decision and only for the time during which the assessment takes place. We do not assess general capacity to make multiple decisions or to care for self, etc. We cannot predict how long the patient will remain in that state of mind and therefore cannot comment on future occurrences. The consult should include:

1. The reason for the consult: "consulted to assess the capacity of the patient to decide _____." It is also good to know from the primary team who will be making the decision for the patient should you find that he/she lacks the capacity to decide on his or her own.
2. The patient must have made a decision and you must state the patient's decision in the HPI, if the patient cannot make a decision, then he/she lacks the capacity to decide.
3. Your assessment of the patient's understanding of what is being asked and what the consequences (risks and benefits) for that decision are as evidenced by _____. It is good to include in the patient's own words why the patient is making a particular decision. The reason(s) given should make sense, if they do not make sense or seem unreasonable then the patient lacks the capacity to decide.
4. Does the patient appear to be exhibiting any signs or symptoms of a mental illness that may be affecting the patient's decision (i.e. A patient with major depressive disorder that wants to have life support withdrawn). It is often helpful to gather collateral information from family, friends, or caretakers to aid in your assessment.
5. The patient should have a normal overall mental status exam and any abnormal findings should be explained as to how they would not be affecting the patient's current capacity to decide. At risk patients should have a standardized assessment such as a MOCA assessment.
6. A statement summarizing your findings and stating clearly if you believe the patient possesses or lacks the capacity to decide on the question being asked.

A general rule of thumb is that any new consults received after 11:00am should be passed on to the next day unless urgent, in order to give time to finish up work at HMC in time to get to PPI after 12:00pm (Noon). If the resident is running behind and does not think he/she will be able to get back to PPI by 1:00pm they should call the TEC at 782-6493 and let them know as soon as possible that he or she is running late so that the TEC can schedule any pending admissions for an appropriate time. After updating the census board with any new information such as room change, discharge, last date seen, etc., the resident will then travel over to PPI preferably at 12:00pm (Noon). Remember, to turn off the lights and lock the consult office door when leaving for the day.

PGY-1 “short call”

(NOTE: Duty periods of PGY-1 must not exceed 16 hours in duration!)

Weekday short calls (Mon/Tues/Wed/Thurs/Fri) 5 PM till 10 PM (14 hour day)

Interns are expected to complete their floor responsibilities by 5 PM. PGY-1s are responsible for admitting any patients that arrive in the TEC between 5 PM and 9 PM. They should not see any new arrivals after 9 PM but use this time to finish up previous admissions, floor calls, dictations, paperwork, etc. They must be out of the building by 10 PM to be in compliance with Duty Hour Restrictions.

PGY-1's will also take calls from the floors (e.g., PRN medication orders, emergent medical and psychiatric evaluations) and field outside-PPI calls (e.g., patient concerns for medications, psychiatric emergencies, psychiatry consult requests). They will sign out face to face to overnight resident on call at the end of their shift @ 10 PM in the TEC.

During the first few weeks, short call residents will receive direct supervision from a PGY-3. The PGY-3 will initially be physically present in the TEC and with the PGY-1 and/or patient during evaluation. As the PGY-1's achieve greater degree of competency to provide independent patient care, they may receive indirect supervision only, where the supervising PGY-3 will be in the building and immediately available by telephone, or may be available for direct supervision or to share the work load as needed.

Saturday calls 4 PM till 8 AM (16 hour overnight call)

Call begins at TEC with a face-to-face sign out @ 4 PM Saturday from the resident on call for the day (location: TEC). During the first few weeks, the PGY-1 will receive direct supervision usually from a PGY-3. They will sign out @ 8 AM to a Sunday resident on call by phone.

Sunday calls / Observed Holiday calls 8 AM till 10 PM (14 hour day)

They will begin the call day at 8 AM @ Hershey Medical Center Consult Liaison Psychiatry service. Take telephonic sign out from Saturday night resident. Responsibilities at HMC consist of new consult evaluations and any follow-ups assigned on census board. It is anticipated the resident will leave HMC around 12 PM (NOON). The remainder of the call hours will be spent at PPI. There is a face-to-face sign out at 10 PM Sunday night to the resident on call in theTEC.

The details of the on call experience and duties will be explained by the PGY-3 taking call with the junior resident.

Eventually, the resident will gain enough experience to be certified to be on call alone and without a PGY-3 present in the building. The call shift hours will be the same as if the resident were doing short call. The goal will be to have each of the PGY-1's certified after two months on service.

STEPS IN COMPLETION OF 302 INVOLUNTARY EMERGENCY COMMITMENT

(Note: It is imperative that the following steps be completed in the order listed)

Page 1:

Fill out patient's name and address. If patient is subject to criminal detention/charges this should be documented on page 1, #7.

Page 2: Part I

Have the petitioner fill out patient's name and check (X) the criteria that applies to the patient's endangering behavior.

Page 3:

Have the petitioner complete the petition section on page 3, including an additional page, if necessary. If the petitioner is a doctor or police officer, the petitioner signs under part B. All other petitioners sign at "A." Be sure to write the patient's name in the appropriate space.

Page 4: Part III:

If the petitioner is other than a doctor or police officer, the mental health delegate is contacted to complete part III. The delegate is reached by contacting Dauphin County Crisis Intervention at 232-7511. If the petitioner is a doctor or police officer and has signed under part B on page 3, it is not necessary to complete part III. It is also not necessary to contact the mental health delegate. However, it is still necessary to contact Crisis Intervention to provide basic demographic information so the case can be documented in MH/MR files.

(Note: If the petition is denied by the MH/MR delegate, the process stops and the patient should be discharged from involuntary custody.)

The mental health delegate will examine the case over the phone and give her/her approval, which is to be documented on page 3 by the O.D.

Page 5: Part IV

Once the petition has been signed by the mental health delegate (if necessary) and the patient is now detained against his/her will, the patient's rights (see attachment) are read to the patient. The person reading the rights to the patient completes part 4. (The patient's rights may be read after the delegate gives oral approval to the petition and prior to the delegate actually coming to HMC to complete part III.)

Page 6: Part V

The person completing the section "Actions Taken to Protect Client's Interests" documents specifically who is responsible for securing the patient's property, etc.

Page 7: Part VI

The examining physician completes this section. The exam should occur within two hours after the approval of the petition or the patient arrives at the emergency room if the petition has been completed prior to patient coming to the emergency room. (Note: If the patient cannot be evaluated within two hours, for instance, due to intoxication or a medical condition, this must be documented in the margins on page 7.) If the patient is to be admitted, a bed-hunt will usually ensue at this point. **(Be sure the 302 document accompanies the patient to the psychiatric unit.)**

If the physician denies the commitment, the patient is released at this point with appropriate referral instructions or discharge recommendations.

If the patient is to be admitted under 302 or 304, the Pennsylvania State Police form "Notification of a Mental Health Commitment" must be completed. The Dauphin County MH/MR Crisis Intervention Emergency Service Form should also be completed. Complete both forms and forward them to Rachel Madden in Room C5603. She will send them to the appropriate agencies. Case specific questions regarding any aspect of the 302 process should be directed to Crisis Intervention and/or a mental health delegate.