GENERAL PSYCHIATRY RESIDENCY TRAINING POLICIES AND PROCEDURES

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Section 1: Psychiatry On-Call Duties and Responsibilities

- PGY-1 residents on call responsibilities in psychiatry are in the KCH CPEP throughout their internship year. When they start, they are on 1:1 direct supervisory call with an attending physician and senior resident (PGY2-4) until they have completed a minimum of three supervisory calls and are deemed to be able to work more independently under indirect supervision with direct supervision immediately available. The ability to progress from direct supervision to indirect supervision will be documented and noted in the resident's file. Residents must have three supervision forms (see Appendix C) showing they are qualified for indirect supervision with direct supervision immediately available signed by the attending supervising. Final advancement will be approved by residency training office (RTO).

- PGY-1 residents are responsible for completing psychiatric evaluations (child as well as adult), documentation and orders under the supervision of the Physician in Charge (PIC) or assigned supervising attending, and participating in sign-out meetings.

- Toward the end of the PGY1 year, the interns will begin supervisory call on the Consultation and Liaison (C&L) service. They will be on direct supervisory call with the C&L attending and senior resident until they have satisfactorily completed a minimum of three calls and are deemed able to work more independently under indirect supervision, with direct supervision immediately available. Residents must have three supervision forms (see appendix C) showing they are qualified for indirect supervision with direct supervision immediately available signed by the attending supervising. Final advancement will be approved by RTO.

- PGY2 and PGY3 residents will primarily be on call in the Consultation and Liaison service. They will be responsible for seeing consults (both new and follow-up cases), liaising with other medical services, and documentation under the supervision of the attending psychiatrist. They will work under the indirect supervision of the C&L attending, with direct supervision immediately available. Their duties will also include CPEP call coverage as needed.

- PGY3 and PGY4 level residents are able to do call as supervising senior residents for both C&L and CPEP calls with junior residents. PGY2s may supervise PGY1 residents in CPEP at the discretion of the RTO.
Section 2: Psychiatry On-Call Policies and Procedures

When the Call Will Schedule Come Out

- The call schedule will be released to all residents and relevant staff in three month blocks to allow for better access and schedule management. July-September, October-December, January-March, April-June.
- Call tallies will be sent out with each release of the call schedule. Chiefs will attempt to equalize the call tally (within 2 points) at every 3 month tally. For PGY1s, this will not be possible every 3 months due to scheduling of Medicine/Neurology. Also, the PGY2 tally will likely be skewed due to Research month and KJMC, however will equalize as the year progresses.
- Chiefs will do their best to release the call schedule by the second week of the month.

Who Will Be On Call and Where Will They Be Stationed

- All residents who are eligible will be placed on call for each month.
- Chiefs cannot guarantee that residents of each class will have the exact same amount of call at each site vs CPEP vs overnights.
  - Chiefs cannot do this for many reasons (Evening clinic on Fridays means no DL call. Religious obligations exempting Sundays and Saturdays, etc.)
  - Chiefs will attempt to make it as fair as possible.
- When PGY2 residents are on Minkin 3 or M5 Inpatient Psychiatry, will be placed at KJMC Weekend Long Call for all weekends except one for each month. This is to allow for continuity of inpatient care.
- PGY3 residents will receive priority for DL call.
- PGY1 residents will take most of the CPEP calls, PGY2s will then be utilized to fill remaining slots.

Call Requests

- All requests must be sent in by the 5th of the month prior to the release of the next 3 month schedule. Late call requests will not be accepted.
  - Residents get 5 call requests a year.
  - Chiefs will keep track of requests, so use them wisely.
- Call requests do not hold over into the next year.
- Call requests should be mailed to sunypysychcall@gmail.com. Call requests sent to either the Downstate Residents Google Group or to sunypysychchiefs@gmail.com will NOT be accepted.
- A call request can be for any reason, and is either 1 day or one weekend
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- Requests such as “don’t put me on call the first two weeks of the month” or “try not to put me on Thursdays” will not accepted.
- All requests are subject to final approval by the chief residents.
- Please send chiefs reminders for vacations when asked for call requests every scheduling block.
- Residents will get one abutting weekend for a 1 week vacation; they must make a call request to get the second. Chiefs may not always be able to approve that request.
- The following activities do not require the resident to use a call request:
  - SUNY Evening Training Service (SETS) and Psychopharmacology Clinic (1 night per week for SETS, 1 night per week for Psychopharmacology Clinic)
  - NYU IPE course, MPH courses, PhD courses, other extracurricular training as approved by the training office
  - Recurring medical appointments (will be kept confidential)
  - Religious obligations (as approved by RTO)
  - Other exceptions may be made on a case-by-case basis with approval in writing from the residency training office
- The above exemptions must be approved in advance of the call schedule coming out.
- Please send chiefs a reminder for approved exemptions when asked for call requests every scheduling block.
- Exceptions DO NOT include: weddings, graduations, trips to Zanzibar, family reunions, etc.

Switching Call (Call Swap)

- Residents may call swap as much as needed.
- Call swaps must be sent to sunypsychcall@gmail.com. Call swap requests sent to either the Downstate Google Group, individual chiefs or sunypsychchiefs@gmail.com will NOT be accepted.
- A call swap or replacement is NOT valid until a confirmation email is received from the official sunypsychcall email address.
- If a resident wants to take a call without a payback (e.g. I’ll take your call on Sunday and you can pay me back later) they may do so. However, there will be no change to the call tally and it is THAT RESIDENT’S responsibility to arrange a payback call. These swaps must be approved by both parties and chiefs via sunypsychcall@gmail.com.
- This will keep the call tally as even and fair as possible.
- Any unofficial call swaps will result in 1 penalty call point for both residents involved.
- Call swaps may not violate duty hour regulations.
Missed Calls

- The person on the official call schedule will be held responsible for attending and completing the call on the schedule.
- If a resident cannot make a call, it is their responsibility to find a swap/replacement.
- Only once a replacement is found, THEN the chief resident on call (located on each monthly call schedule) should be contacted to alert them.
- A call swap or replacement is NOT valid until a confirmation email is received from the official sunpsychcall email address.
- If a swap cannot be found, the backup will be activated.
- The resident activating backup will have to makeup that call, plus do two additional calls which will not count toward the call tally. 3 calls total.
- The person activated by backup will get one extra call point added to their tally.
- Both first and second backups must be available by pager and phone to take call on days they are scheduled to be on backup. Failure to be available for backup will result in 1 makeup call.
- Extenuating circumstances will be dealt with on an individual basis by the chiefs and residency training office (RTO).

Points
0.5 points KCH Short Call
0.5 points CPEP Short Call
1 point for KCH Weekend call
1 point for KJMC Weekend call
1 Point for CL Overnight weekend call
1 point for Research call
1 Point for CPEP day call
1 Point for CPEP overnights
1.5 points for Friday Long (FL) Call

Supervision

- When on supervisor/supervisee call, the supervisor gets the points not the supervisee.
- Number of supervisions for independent:
  - CPEP – at least 3.
  - Consult – At least 3 total. At least 1 short call is mandated at KCH. One long call at both KJMC and KCH will be required for supervision purposes.

ACGME and New York State Duty Hour Requirements/Limitations

- Chiefs will assure that no ACGME or New York State rules for duty hours are violated.
Should you notice scheduling that would result in a violation, notify the chiefs immediately so that it can be corrected.

Violations Include:
- <10 hours between shifts as per NY State law (<8 federal law)
- Working >16 hours in a row in PGY1
- Working >24 hours in a row in PGY2+
- Having less than 1 day (24 contiguous hours) off in 7 days, every week Sunday-Saturday (NOT averaged over the month) as per NY State law
- Being on call more frequently than 1 day in 3 (Q3), averaged over the month

All these regulations also apply to medicine and neurology services. Please notify the chief residents and RTO immediately should you be forced violate these on other services.

On Call Frequency
- PGY 1:
  - Up to a 6 times a month for a maximum of 48 psychiatric calls/yr
  - Residents rotating to Ambulatory Medicine (Behavioral Health Primary Health Clinic (BPHC), Pediatrics (Peds OPD), STAR Clinic, or Neurology Clinic have same amount of calls as those rotating in Psychiatry.
  - Residents rotating through Neurology General/Stroke Units or Inpatient Internal Medicine (IM) rotation do calls according to the policy of the Departments of Internal Medicine and Neurology. These calls cannot violate the duty hour rules.
  - Residents take a minimum of 3 directly supervised C&L calls during the second half of the year while on Psychiatry call.
- PGY2:
  - Up to 6 times a month.
- PGY3:
  - Up to 5 times a month
- PGY4:
  - Up to 3 times a month for a maximum of 14 calls per year as senior residents or supervisors to junior residents.

Note: The maximum number of calls does not include calls that have to be made up for any reason. Fulfilling the minimum requirement is required but not necessarily sufficient.

During the months of July and August PGY2, 3 & 4 residents will be assigned greater number of calls to provide adequate coverage so that the incoming PGY1s may obtain adequate supervision in the CPEP and the incoming PGY 2s in the Consultation Liaison Service.
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- The on-call schedule will be emailed to residents by the end of each month, and copies will be posted outside the CPEP.
- All residents MUST have one day off every 7 working days as per GME policy.

Current On-call Working Hours and Policies
Kings County CPEP Call Policy
The resident should arrive before call starts to attend morning huddle and is required to stay until the end of the shift to deliver sign out during the evening huddle during the weekend or sign out to an attending Monday-Friday. Residents on all shifts are to remain on the KCH campus at all times. Residents are not to use their license to sign legal admission paperwork, even if they are licensed.

Weekend CPEP Call
On weekends and holidays PGY 1, 2 or 3 residents will take call at Kings County CPEP service from **8AM-8PM**.
Overnight calls in CPEP are from **8PM-8AM**. They include 8 working hours and a protected 4 hour rest period, if overnight. The on call resident is required to attend the 8 AM morning report at the end of their shift.

Weekday CPEP Call
Monday – Thursday weekdays from **5-10PM** a PGY 1, 2 or 3 resident will cover the Kings CPEP service.

Kings County Consult Call Policy
The resident should arrive before call starts to receive sign out and is required to stay until the end of the shift to deliver sign out to the next resident on service. For all consult services the attending should see the patient with the resident during the same shift. STAT consults should be seen within 30 minutes of the consult coming in and routine consults within 24 hours. In order to adequately finish consults during the shift (see page 9), routine consults that come in <1 hour from end of shift (<2 hours for child consults) may be signed out to the next shift. If a resident reaches their cap on a shift, they are NOT excused from call and must remain on site until the end of shift. If a resident is excused from call early by the attending, they MUST give a verbal in-person sign out to the incoming resident. Residents on all shifts are to remain on the KCH campus at all times. Residents are not to use their license to sign legal admission paperwork, even if they are licensed.

Weekend Consult Call
On weekends and holidays a PGY 2, 3 or 4 resident will take call at Kings County Consult & Liaison service from 8AM-8PM.
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In order to ensure that residents are able to appropriately work and learn in their role as student physicians there is a cap on the number of new consults seen while on duty. The cap for NEW Consults is six during the 12 hour shift, not including follow-ups. Child consults count for two consults due to the nature of child work. In addition, in order to help balance the flux of incoming consults, if back to back consults come in (with less than one hour in between), every 3rd consult should be picked up by an attending for initial evaluation, documentation and plan execution. The cap of 6 does not change and should a 4th consult come in, it would be assigned to the resident.

Overnight Consult Call (C/L Overnight and Research Call)
Saturday and Sunday nights, as well as overnight during long weekends, a PGY 2, 3 or 4 resident will be on call from 8PM-8AM the following morning. From 8PM-12PM the resident will cover both Downstate and Kings County ED and inpatient floors and from 12PM-8AM will cover Downstate ED/floors and any STAT consults on the inpatient medical/surgical units at KCH (the resident does not cover the S1 ED, or any routine consults). The cap for NEW consults is six during the 12 hour shift, not including follow-ups between both Downstate and KCH.

Weekday Consult Call
Monday – Thursday weekdays from 5-10PM a PGY 2, 3 or 4 resident will cover the Kings County Consult & Liaison service. In order to ensure that residents are able to appropriately work and learn in their role as student physicians there is a cap on the number of new consults seen while on duty. The cap for NEW consults is three during the 5 hour shift, not including follow-ups. Residents on weekday call should see STAT consults and routine consults which will time out overnight [A1]. The resident may see other routine consults if the attending on call agrees to supervise, but are not responsible for these to be completed during their shift.

Consult Resident Being Pulled into CPEP
If the consult service is idle and CPEP has 20+ patients, the consult resident may be asked to take CPEP cases. These CPEP cases count toward the cap of patients seen that shift (1 for adult cases, 2 for child/adolescent). The educational objective and responsibility of the consult resident is to consult service. Should a consult come in during a CPEP evaluation, the resident is to alert the attending to take over the CPEP case and tend to the consult.

Psychiatry Calls During Ambulatory Medicine Rotations (e.g. STAR):
- **PGY1 residents doing their BHPHC, STAR Clinic, Pediatrics OPD, Neurology Clinic months will have on-call commitments in Psychiatry.**
No Post-Call Policy

- This residency program had adopted a “No Post-Call” policy to ensure continuity of care to patients, except in case of an emergency.
- Monday-Thursday are short calls.
- All Sunday night C&L calls will be covered by PGY2s rotating in Research Month with no clinical duties on the Monday following the call.

CPEP On-Call Supervision:
Supervision by Psychiatrist in charge
At all times, residents on call in the CPEP are under supervision of the psychiatrist-in-charge (PIC) or another attending assigned by PIC. The PIC must be available by cell phone/pager/telephone extension at all times. All new cases seen in the CPEP are to be reviewed with the PIC who is to discuss the case with the resident and co-sign all evaluations, physical assessments, notes, legal papers and orders written by the resident. **All patients seen by residents must be seen by an attending psychiatrist.** Residents should not sign legal admission paperwork using their own license even if they are licensed.

Incoming PGY1 residents are under individual direct supervision for up to the first 3 months. They are expected to do up to 3 supervised calls up to the first 3 months of CPEP calls. During this initial 3 month supervised period, residents will be assessed to determine their ability to do calls without direct 1:1 supervision. Determination of residents’ ability to do calls without this type of supervision will be done based on supervisors evaluation using standardized evaluation forms. Residents may require additional supervision beyond first 3 months until the evaluations demonstrate that resident is able to function independently while on call. **There must be a minimum of 3 direct/indirect forms filled out per PGY1 resident and signed by Attending. In addition to this, evaluations must be submitted by the resident to the RTO on each of their supervised calls.**

Consult & Liaison (C&L)-Call supervision

- All new cases seen on the C&L service must be evaluated by the attending covering the C&L service of that particular hospital site during that shift.
- As per current KCH policy, residents may only do capacity assessments under direct attending supervision, with attending present in the room. The resident may still write the note with an attending co-signature.
- The attending is to be contacted concerning all follow-ups. The attending must be available via pager/cell phone/telephone extensions at all times.
- Residents should request the attending to evaluate the patient in person immediately after they finished interviewing the patient. The attending psychiatrist is required to evaluate the patient in person within 30 min after
receiving the call from the on call resident. The resident may start composing the consultation report while waiting for the attending psychiatrist to evaluate the patient. However, no management recommendation, except emergency management, should be made to the primary care team before the attending psychiatrist evaluates the patient in person. Discussion by solely phone is inadequate and unacceptable. Any violation in this policy should be reported to chief resident and KCH administration on call immediately.

- The upcoming PGY2s are required to start supervised C&L calls before June. They must have at least 3 supervised calls before starting individual C&L calls. At least one call must be at KCH, and at least one must be at KJMC. When on supervised calls, the senior resident is responsible for on-call responsibilities. The C&L attending shall evaluate the competency of the junior resident. If the upcoming PGY2 is determined not ready for individual calls after 3 supervised calls, the resident can continue on supervised C&L calls. However, the extra supervised C&L calls will not count toward the supervisee’s call tally. **PGY1 residents may not do unsupervised C&L call in the first year.**

SUNY Evening Training Service (SETS) supervision

- In addition to the ambulatory training at KCH, residents carry and treat patients in the SUNY Evening Training Service (SETS).
- It operates from 5pm to 8pm Monday through Friday. This clinic is for long-term psychotherapy, with or without medication management. All PGY 2, PGY 3 and PGY 4 residents are assigned to at least one of the five evenings and each carries an average of two patients. Onsite supervisors include a mix of attending psychiatrists and PhD psychologists who sit in with residents during initial consultations and then meet weekly during the day for supervision with each of their assigned residents individually or in-group. Supervision formats can include process notes and audio or DVD recording of live session.
- PGY-2 residents start the SETS in middle of the PGY-2 academic year.
- All residents are required to keep timely, updated records of each patient session and have their supervisor co-sign each note. In addition, a psychodynamic formulation must be completed within a few months after each new patient intake. Thereafter, a psychodynamic formulation must be completed on each of the residents SETS patients.
Section 3: On Call Safety Issues

CPEP:
- Resident must ask the triaging nurse about the patient’s past history of violence and current level of agitation, in order to anticipate any potential current risk of violence.
- Resident must inform a nursing staff/ BHA (Behavioral Health Associate) before seeing every patient.
- Residents must ask for a BHA (Behavioral Health Assistant) to accompany them while interviewing patient if the anticipated potential current risk of violence is high. Residents can refuse to see potentially violent patients if such assistance is not provided.
- Office’s door must not be locked while interviewing a patient, and BHA/nursing staff should be aware of which office the resident is using if outside of the main CPEP.
- While interviewing, if patient’s level of agitation escalates, interviewing session must be terminated and help must be sought immediately to ensure resident’s own safety.
- If in doubt, Physician-in-change must be consulted regarding any safety issues.

Consultation & Liaison Call:
- Resident must inform on call attending about location of the patient, when attending any calls from the floors/ER.
- Resident should ask for a nursing assistance while attending calls from floor/ER, if the anticipated potential violence risk is high.
- Resident can refuse to see potentially violent patient if such assistance is not provided and the consulting physician and on call attending should be informed.

Hospital police assistance:
- When approaching a patient in the CPEP holding areas, residents should always first inform nurse/BHA if they intend to remove a patient from that area to a consultation or exam room.
- If a resident deems additional assistance is necessary, they should ask the hospital police to escort them and the patient to their destination and to remain with them until the conclusion of the consultation or examination.

Safety while commuting to and from hospital:
1. Residents should ask for a hospital shuttle at 718-270-2626 (Hospital Police) to get to/from Winthrop station or garages. Hospital shuttle can pick resident up from KCH (R, D, B building entrances) and DMC
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(Clarkson and Lenox Avenue entrances) and KJMC (Winthrop Ave. and
Schenectady Ave. entrances).
2. After hours, it is not advised to walk to the subway station. For safety,
avoid using unlicensed car services aka “gypsy” cabs. While taking a
cab, resident should inform any colleague or family member about the
intention of taking same and its details to ensure safety.
Section 4: Affiliates and Escalation Policies

COMMUNICATION AND ESCALATION GUIDELINES: BEHAVIORAL HEALTH

In case of any issues, the first line of escalation in any service or during call would be the individual year chief in case of any weekday issues or the chief on call in case of any weekend issues or during call.

Comprehensive Psychiatric Emergency Program (CPEP):
1. All assigned cases will be supervised by the CPEP attending after hours & weekends/weeknights. Treatment plan will be discussed.

2. Change of mental status, increased violence, suicidal thoughts or exacerbation of medical conditions will be discussed immediately with the CPEP attending.

3. If the assigned attending on the case is not available, call
   a. The PIC (Physician In Charge) of CPEP (917-219-3707)
   b. The Director of CPEP (Dr. Paul O’Keefe: 347-728-3807)
   c. Director of Acute services (Dr Combs: 347-408-5672)
   d. The Chief of Service to discuss the case (Dr. Ananthamoorthy: 347-231-5950)

KCIH Adult Inpatient Service:
1. All assigned cases will be supervised by the Adult Inpatient attending daily. Treatment plan will be discussed.

2. Change of mental status, increased violence, suicidal thoughts or exacerbation of medical conditions will be discussed immediately with the Adult Inpatient attending.

3. If the assigned Adult Inpatient attending on the case is not available, call
   a. The covering attending on the floor
   b. The unit chief (4 West – Dr Belyayeva ext. 2303)
   c. The Medical Director (Dr. Herbert: 347-245-7915)
   d. Director of Acute services (Dr Combs: 347-408-5672)
   e. The Chief of Service to discuss the case (Dr. Ananthamoorthy: 347-231-5950)

CIC Adult Inpatient Service:
1. All assigned cases will be supervised by the Adult Inpatient attending daily. Treatment plan will be discussed.
2. Change of mental status, increased violence, suicidal thoughts or exacerbation of medical conditions will be discussed immediately with the Adult Inpatient attending.

3. If the assigned Adult Inpatient attending on the case is not available, call
   a. The covering attending on the floor
   b. The unit chief (Dr Kagan 718-616-5505)
   c. The Chairman (Dr. Goldberg, 718-616-5309)

**Chemical Dependency – Project Access, Detox:**
1. All assigned cases will be supervised by the Chemical Dependency attending. Treatment plan will be discussed.

2. Change of mental status, increased violence, suicidal thoughts, worsening of withdrawal symptoms or exacerbation of medical conditions will be discussed immediately with the Chemical Dependency attending.- Dr Blanchard: 718-245-4871/347-231-5907

3. If the assigned Chemical Dependency attending is not available, call
   a. Director of Service (Dr. Whitley: 347-203-3386)
   b. The Chief of Service to discuss the case (Dr. Ananthamoorthy: 347-231-5950)

**Partial Hospitalization Program:**
1. All assigned cases will be supervised by the Partial Hospitalization attending. Treatment plan will be discuss.

2. Change of mental status, increased violence, suicidal thoughts, worsening of withdrawal symptoms or exacerbation of medical conditions will be discussed immediately with the Partial Hospitalization attending- Dr. Iqbal: 718-245-5607.
   a. The Medical Director (Dr. Iqbal: 718-245-5607)
   b. Director of Acute services (Dr Combs: 347-408-5672)
   c. The Chief of Service to discuss the case (Dr. Ananthamoorthy: 347-231-5950)

**Medical Consultation-Primary Care Behavioral Health Clinic:**
1. All assigned cases will be supervised by Medical Consultation attending. Treatment plan will be discusses.

2. Change of mental status, increased violence, suicidal thoughts, worsening of withdrawal symptoms or exacerbation of medical conditions will be discussed immediately with the Medical Consultation.

3. The following are the attendings whom you can contact at BHPCC.
   a. Dr. Braslavskaya 917-205-5438
   b. Dr. Salimi 646-996-3353
4. If the assigned attending is not available, call
   a. The Medical Director Dr. Estes 347-885-7462
   b. The Chief of Service to discuss the case (Dr. Ananthamoorthy: 347-231-5950)

**KJMC Adult Inpatient Service:**
1. All assigned cases will be supervised by the Adult Inpatient attending daily. Treatment plan will be discussed.

2. Change of mental status, increased violence, suicidal thoughts or exacerbation of medical conditions will be discussed immediately with the Adult Inpatient attending.

3. If the assigned Adult Inpatient attending on the case is not available, call
   a. The covering attending on the floor.
   b. The unit chief (Dr. Ellen Tabor : 718-604-5677)
   c. The Chief of Service to discuss the case (Dr. Ellen Tabor : 718-604-5677)

**Consultation Liaison Service (Adult):**
1. All consults will be supervised by the CL attending before any disposition done from Medical ER / Medical floor consults.

2. If the attending is not available, call the Director of Service during the daytime (Dr. Tusher 917-760-1236)). For after hours, weekends, holidays call:
   a. Physician in Charge (917-219-3707)
   b. Director of CPEP (Dr. Paul O’Keafe: 347-728-3807)
   c. Director of Acute services (Dr Combs: 347-408-5672)
   d. Chief of Service to discuss the case (Dr. Ananthamoorthy: 347-231-5950)

**Child and Adolescent Psychiatric Inpatient Service (CAPIS):**
1. All assigned cases will be supervised by the CAPIS attending daily with focus on mental status findings, diagnostic formulation and treatment plan changes.

2. Sudden changes in mental status, incidents of assault, suicidal thoughts or newly diagnosed or exacerbated medical problems will be discussed immediately with the CAPIS attending.

3. If the CAPIS attending on the case is not available, call
   a. Director for CAPIS (Dr. Toteja: 631-678-2032)
   b. The Director for Child and Adolescent C&L Service (Dr. Toteja: 631-678-2032)
   c. The Chief of Service to discuss the case (Dr. Ananthamoorthy: 347-231-5950)
Child and Adolescent Consultation Liaison Service / Peds ER:
1. All consults will be supervised by the CL attending (during business hours) before any disposition is recommended for Peds ER / Peds floor consults. Child & adolescent CL service (pager 917-760-1277)

2. Off business hours (5pm - 8am and weekends and holidays) consults will be supervised by the CPEP attending assigned to CL coverage. If the attending is not a child and adolescent psychiatrist, the child and adolescent psychiatry fellow on call should be contacted for consultation.

3. If the attending is not available, call the Director for Child & Adolescent CL during the daytime: Dr. Toteja: 631-678-2032 and Dr O’Keefe: 347-728-3807. For after hours, weekends, holidays call:
   a. Physician in Charge (917-219-3707)
   b. Director of CPEP (Dr. Paul O’Keefe: 347-728-3807)
   c. The Director of Child & Adolescent Service (Dr. Toteja: 631-678-2032)
   d. The Chief of Service to discuss the case (Dr. Ananthamoorthy: 347-231-5950)

Child Outpatient Services (OPD and Developmental Evaluation Clinic - DEC):
Mon-Fri, 8am - 5pm
1. All assigned cases will be supervised by the Child OPD/DEC attending. Treatment plan will be discussed.

2. Change of mental status, increased violence, suicidal thoughts or exacerbation of medical conditions will be discussed immediately with the Child OPD/DEC attending.

3. If the assigned Child OPD attending on the case is not available, call
   a. The Medical Director of Child OPD (Dr. Green: 917-760-1042) or DEC Medical Director (Dr. Jacques: 917-760-1283, 718-245-1076 as appropriate)
   b. The Director of Child & Adolescent Service/Associate Chief of Service (Dr. Toteja: 631-678-2032)
   c. The Chief of Service to discuss the case (Dr. Ananthamoorthy: 347-231-5950)

Adult Outpatient Department (AOPD):
Mon-Fri, 8:30 AM - 5:00 PM
1. All assigned cases will be supervised by an AOPD attending. Treatment plan, safety plan and risk assessment will be discussed during supervision.

2. In the event of an acute change of mental status, aggressive behavior, decompensation or an exacerbation of medical condition, you can press the yellow button
that will be located under your desk or in the room to activate Code Orange. Code White (Doctor White) and Code Orange (Doctor Orange) can be called into the front desk. Contact your supervisor immediately, either in person or by phone.

3. In the event that your supervisor is not available, call
   a. Supervisor (Dr. Huangthaisong 917-754-8203)
   b. The Assistant Director of OPD (Dr. Singh: 917-205-2932)
   c. The Director of OPD (Dr. Adebisi: 646-533-1002)
   d. The Director of Ambulatory Services (Dr Whitley: 347-203-3386)
   e. The Chief of Service (Dr. Ananthamoorthy: 347-231-5950)

**SUNY Evening Training Services (SETS):**
Mon-Fri, 5:00 PM - 7:00 PM
1. All assigned cases will be supervised by Dr. Garrett for PGY-3s, and Dr. Friedman for PGY4s. Treatment plan will be discussed during supervision.

2. In the event of an acute change of mental status, aggressive behavior, decompensation or an exacerbation of medical condition contact the supervisor available.

3. You should also contact your supervisor when it is appropriate to do so by phone.
   a. PGY-3 Supervisor: (Dr. Garrett: 646-522-4324)
   b. PGY-4 Supervisor: (Dr. Friedman: 917-923-9240)

4. In the case your supervisor is not available, please call
   c. Program Director (Dr. Branch: 718-270-4627)

In the event Dr. Ananthamoorthy is not available you must contact The Chief Medical Officer Ghassan Jamaeddine, MD, office (718)-245-2235/2237, cell (347)-992-1480.
Section 5: Vacation/Sick Leave Policy for the Department of Psychiatry

All leave must be used during the respective academic year. One cannot carry over any unused leave time to the next academic year.

SICK LEAVE

CLINICAL SERVICES:
All residents must notify all of the following persons each morning they are off service due to illness:

- **Chief resident for their assigned year must be notified by email AND**
- **Attending, team leader or unit chief where the resident is on rotation (contacting only a fellow resident, medical students, clerical or nursing staff is not acceptable) AND**
- **Residency Training Office (Juliet.Arthur@downstate.edu) must be notified by email**

Failure to email or notify all 3 of the above may result in the resident having to spend vacation days in lieu of sick leave or escalation to labor relations due to unexcused work absence.

DIDACTICS:
If sick leave falls on a didactic day, the chief resident of academics/research, Residency Training Office and didactic instructors must be notified together via common email. Failure to notify the above may result in deduction of vacation days. You must also notify any clinical supervisors.

- Residents are allowed a maximum of **12 days** of annual sick leave.
- If a resident is out sick for 3 consecutive days, the resident is required to bring in written documentation from their physician outlining the nature of their illness.
- Each absence beyond 5 days/year will be examined closely and the physician treating the resident's illness may be contacted for further information.
- **Sick leave taken abutting other time away (Vacation, Educational Leave, etc) requires written documentation dated during those days from a physician outlining the nature of their illness. Failure to do so may result in escalation to labor relations due to unexcused work absence.**

To ensure that residents satisfactorily complete the time and service requirements of each rotation, if it is deemed that a resident has missed a portion of their required responsibilities they will be asked to repeat the rotation or a portion thereof. This policy
is enacted to ensure that residents satisfy departmental training requirements for promotion and graduation.
Please refer to policy on missed calls or call switches in the section on On-Call Responsibilities for policy regarding the same.

**VACATIONS:**
Each resident is given **20 working days of paid vacation annually**.

No Resident may take more than 10 consecutive weekday working days as scheduled vacation without specific approval from the residency training office, their chief resident and the chief of service they are taking time away from.

Vacation requests must be submitted on time away request forms (Appendix C) and be approved by the Residency Training Office, the chief resident on the service from which vacation time is requested and the attending/service chief of that service by **July 31st** of the academic year. These forms **MUST** be submitted in writing to the Residency Training Office. Failure to take the above steps may result in vacation requests being denied and Residency Training Office assigning vacation.

All residents must submit their vacation requests for the entire academic year by July 31st.

PGY1 and PGY2 residents must take vacation time in Monday-Friday 5 day blocks. PGY3-4 must take at least 10 days as Monday-Friday 5 day blocks.

All changes in vacation requests must be approved by the Residency Training Office and the chief residents at least **30 days prior to the time of vacation, otherwise changes will not be approved**.

Time away request forms are located in the Residency Training Office and with the chief residents. Residents must fill out the EXACT working days of vacation. This does not include additional days (i.e. the weekend pre- or post-vacation). Any requested changes within the 30 days must be approved by the training director or designee, and cannot be only be approved by Chief Residents and Chief of Service.

No retroactive vacation requests or changes will be approved.

NO vacation time will be granted during the last two weeks of June, the month of July and during PRITE/Columbia Psychotherapy exam dates unless pre-assigned or prior approval has been obtained from the Residency Training Office.

No resident may take off a 4 day week returning only for Thursday didactics. All requests of this nature will be denied.
PGY1:
- PGY1 residents must take their vacation in 5 day Monday-Friday week long blocks.
- PGY1 residents may not take a week that starts in one month and ends in the next unless pre-approved.
- If a residents vacation coincides with an existing holiday, the extra day granted must be a Monday or Friday preceding/after the week so the resident is still gone for one solid block,
- A resident may not take off the first week of a rotation without specific approval from the residency training office, the chief resident and the chief of service
- No vacation will be allowed on Inpatient Medicine, Pediatrics or Neurology rotations
- Vacation will be granted during the following rotations
  - One week during the two months of R4 West Inpatient Psychiatry
  - One week during the two months of Coney Island Inpatient Psychiatry
  - One week during either the month of Partial Hospitalization Program or Addiction Psychiatry
  - If the resident is assigned to Outpatient Pediatrics then one week during Behavioral Health Program Outpatient Medicine
  - If the resident is assigned to STAR Clinic then one week during STAR Clinic

PGY2:
- PGY2 residents must take their vacation in 5 day Monday-Friday week long blocks.
- If a residents vacation coincides with an existing holiday, the extra day granted must be a Monday or Friday preceding/after the week so the resident is still gone for one solid block,
- A resident may not take off the first week of a rotation without specific approval from the residency training office, the chief resident and the chief of service
- No vacation will be allowed during Geriatric Psychiatry or CPEP rotation
- Vacation will be granted during the following rotations
  - One week during the month of Kingsboro
  - One week during the month of Forensic Psychiatry
  - One week during the 3 months of Child and Adolescent Inpatient Psychiatry
  - One week during either the 2 months of Consultation Liaison Psychiatry or the 2 months of Kingsbrook Jewish Inpatient Psychiatry or 1 Research Month
- Exceptions to the above rules will require specific approval from the residency training office, the chief resident and the chief of service
PGY3&4

- PGY3-4 must take at least 10 days as Monday-Friday 5 day blocks.
- The Training Office reserves the right to deny any vacation dates that consistently fall on a Monday or Friday. Residents are not allowed to take off one day of the week more than two weeks in a row. (e.g. A resident cannot take Fridays off for more than two weeks in a row)
- No vacation will be granted from the VA (PTSD Clinic, Chapel Street, etc.) during the month of July and the first two weeks of January. At the VA, no more than two days may be missed from VA rotations, including sick days. Any additional absences may be explored by the TO.
- As highlighted above, requests for interview and changes of vacation/educational days for interviews must be requested in the format of any vacation changes (e.g. 30 days in advance). Sudden changes needed for interviews must be approved directly by the Training Office, chief resident and chief of service, and may require proof of interview from the institution.

FLOATING HOLIDAYS

- If a resident is assigned to NON CALL work on a departmental holiday from the department of their pay source (Kings County, Downstate, Kingsboro), they receive a makeup vacation day, referred to as a “floating holiday”.
- Residents who fall in this category must contact RTO and their chief resident IN ADVANCE of working on this holiday for approval and verification of day worked.
- This applies to work done during medicine and neurology rotations as well as psychiatry rotations
- Residents must submit a vacation request indicating they are taking a floating holiday as they would with any other vacation request. This vacation request must be approved in writing by the residency training office, their chief resident and the chief of service from which they are taking time away.
- Requests must be submitted at least 7 days prior to the time of the floating holiday or they may be denied.

EMERGENCY/BEREAVEMENT LEAVE
Each resident may be allowed up to 3 days annually for emergency/bereavement purposes. Residents must notify services, service chiefs, the chief residents, and the Residency Training Office if using this leave. Additional days taken for emergency/bereavement purposes will be taken as vacation days.
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Time away request forms are located in the Residency Training Office and with the chief residents. Residents must fill out the **EXACT working days of leave. These forms must be filled out within 30 days after the resident returns.** Please refer to policy on missed calls or call switches in the section on On-Call Responsibilities for policy regarding the same.

**EDUCATIONAL LEAVE**
Each resident will be given up to 4 days annually if prior approval is granted by residency training office. These days can be used for licensing exams, **fellowship interviews,** conferences or research seminars. A request form must be filled out 30 days prior to taking educational leave and should include event attended, location of the event and exact days gone. Exceptions to 30 day notification (and no other requirements) will be made as needed for fellowship interviews. **Proof of educational activity (registration, ID badge, proof of interview request, etc.) is required and must be submitted to the Residency Training Office upon return from leave or time taken off will be transferred from resident’s unused vacation time.**

Residents accepted to honorary fellowships requiring attendance at association meetings will be handled on a case-by-case basis.

**MATERNITY LEAVE**
Female residents are allowed 4 weeks of paid maternity leave for any uncomplicated pregnancy. These 4 weeks can also be combined with a **maximum of 2 weeks’ vacation leave** if a resident wishes additional time off postnatal. If one should use 2 weeks of their vacation time added to their 4 weeks of maternity leave, they will still have an additional 2 weeks of vacation to utilize during the remainder of that academic year.

The Family and Medical Leave Act (FMLA) guarantees to eligible employees a total of 12 weeks of unpaid leave during a 12-month period for one or more of the following reasons:
- The birth and care of the newborn child of the employee;
- Placement with the employee of a son or daughter for adoption or foster care; or
- To care for an immediate family member (spouse, child, or parent) with a serious health condition.

Any leave during residency will impact on one’s ability to finish their residency during the specified 48 months of training indicated by the ABPN. It most certainly will impact on the ability to transfer to any fellowship after the PGY3 year of training.

Time away from residency for leaves of absences will result in remaining longer in residency in order to make up missed time during the post training period.
All maternity leave requests must be pre-approved by the Residency Training Office and a request form for this leave needs to be filled out and approved prior to maternity leave. The resident must make up all service requirements and on-call duties for time taken off.

**Paternity Leave**
Each male resident will be given up to 3 working days of paid paternity leave annually. A request form must be filled out and submitted to Residency Training Office for such leave.

**Other FMLA Leave**
Please refer to GME SUNY Downstate resident handbook for details on FMLA. In general, all vacation, educational and sick leave must be exhausted in order to use FMLA leave.

**Terminal Leave**
All graduates will be granted up to 2 days of terminal leave to transition/credential at new sites of employment. Any additional time required must be taken out of vacation leave.

**Total Days Off Service, Missed Education**
Residents who, for any reason (including vacation, sick leave, maternity leave and any other time off) accumulate 45 or more working days off service and training during an academic year of training will be considered as not having fulfilled the minimum attendance requirements for promotion/graduation.

**Policy Violations**
If a resident does not take appropriate steps to change their vacation days (see above), and comes into service on a day scheduled as vacation by the training office, that resident forfeits those vacation days.

If a resident takes unapproved vacation time they will forfeit twice the number of remaining vacation days. If the resident does not have remaining vacation days they will be required to take a number of weekend calls equal to the number of unaccounted for days.

If a resident continues to take unapproved leave, they will be referred to the residency training office and consequences will be dealt on an individual basis. This is including, and not limited to, remediation of the rotation from which they were absent, academic probation, and referral to labor relations for unexcused work absence.
Section 6: Promotions and Graduation

Residents will be required to satisfy all of the following criteria in order to be promoted or graduated:

- Satisfactory completion of clinical work in each clinical rotation as evaluated by the service chief/supervisor and reviewed by the Residency Training Office.
- Satisfactory performance on all areas of the 6 core competencies: Patient Care (PC), Medical Knowledge (MK), Professionalism (P), Interpersonal and Communication Skills (ICS), Practice Based Learning (PBL) and System Based Practice (SBP).
- Satisfactory academic performance as evaluated by the training director(s) in the following:
  - A minimum 50 percentile score on the Psychiatry Residents In-Training Examination (PRITE) on both Psychiatry and/or Neurology sections for the same PGY level nationwide or successful remediation in case the above requirement is not met. Remediation may include A.) Receiving a passing score on a remediation exam to be administered as per training office, B.) Successful completion of remediation assignments, which may include a written report, submission of exam questions in subsections where a 50 percentile score is not met. If a resident scores under 30% in either psychiatry and/or neurology sections on the PRITE exam for two consecutive years, they may be required to do additional remediation at the discretion of the RTO.
  - Acceptable performance on clinical skills evaluations in the form of CSVs, which will be administered throughout each academic year, as well as an acceptable performance on the Annual Departmental Clinical Skills Assessment (CSAs/Mock Boards).
- Acceptable performance in academic course work, which includes adequate attendance, preparation and participation in didactic courses.
- Successful completion of program privilege procedure requirements.
- **Successful completion of USMLE step 3 by the end of PGY 1 year.** Failure to provide evidence of the aforementioned will result in the resident meeting with the Residency Training Office on a case-by-case basis.
- Residents who, for any reason, accumulate a total of 45 or more days off service and/or training during any academic year will be considered as not having fulfilled the minimum attendance requirements for promotion/graduation. The resident will only be promoted/graduated pending a review by the Residency Training Office.
Core competency Goals and Objectives are distributed to each resident upon entering residency, and at the start of each rotation, and at the beginning of each the academic year.

Unsatisfactory performance in the above may result in the following, to be determined on a case-by-case basis by the Residency Training Office:

- Remedial assignment
- Repeat of academic course/service assignment
- Probation
- Repeat of academic year (PGY)
- Dismissal

Any disagreements regarding the above outcomes may be handled through the department and hospital wide DUE PROCESS procedures, described in Appendix A and B.

Problem Resolution

In case of problems that are encountered during clinical work or during residency training, residents must follow the following procedure:

1.) Each resident will contact their year’s respective Chief Resident in order to inform them of the problem at hand. The Chief Resident will work with the resident to review the problem and seek a solution.

2.) If an adequate solution cannot be found, or if refractory contentious issues continue to occur, the Chief Resident may escalate the problem to the attention of the Residency Training Office. The Residency Training Office will review the problem and may contact the resident directly in order to facilitate an adequate response.

3.) If there continue to be problems that persist in spite of the involvement of the Residency Training Office, or if there occur interdisciplinary problems beyond the purview of the RTO (such as those that involve other departments outside the Department of Psychiatry), the Training Director(s) may seek the advice of the Chair of the Department as well as the Educational Committee to work further towards a solution.

4.) Failure to follow this Problem Resolution Procedure may cause undue conflict and/or delay in the resolution of the aforementioned problem. Note that the Department of Psychiatry will adhere to the hospital’s “DUE PROCESS” procedures.

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Residents must take the PRITE offered by the American College of Psychiatrists, in all years of training. It is also taken by post-residency trainees and practitioners at participating training programs. The primary objective of the PRITE is to make comparisons with peers in specific areas of knowledge.

A global score of 50% or more (compared to US General Psych 2nd/3rd/Advanced Psych Residents) is required in both psychiatry and neurology sections to pass the PRITE. Those scoring below 50% will be required to take the PRITE remediation exam.

All those residents who score below 50% in the global sections of either psychiatry or neurology (compared to US General Psych 2nd/3rd/Advanced Psych Residents), they will have to prepare and submit the following to the Training Director:

- On any subsections of psychiatry, if the score is between 26-49% (compared to US General Psych 2nd/3rd/Advanced Psych Residents), 5 questions with answers for each subsection should be submitted.
- On any subsections of psychiatry, if the score is 25% and below (compared to US General Psych 2nd/3rd/Advanced Psych Residents), 5 questions with answers and a summary of that particular topic chosen for the question is to be submitted to the Training Director.
- Miscellaneous subsection is exempt for the above.

For those residents who have scored below 50% in the global sections of Neurology alone and 50% or more in global psychiatry score (compared to US General Psych 2nd/3rd/Advanced Psych Residents), they will have to prepare and submit the following to the Training Director:

- 25 questions with answers in neurology.
- These residents are exempt from preparing summaries or questions for psychiatry (as 50% or above is pass).

If a resident scores under 30% in either psychiatry and/or neurology sections on the PRITE exam for two consecutive years, they may be required to do additional remediation at the discretion of the RTO.

All residents who fail to take the PRITE remediation within the allotted time will be asked to meet with the RTO for additional remediation planning.
Clinical Skills Assessment/Verification (CSA/CSV)

In addition, PGY2 – PGY4 residents take an annual formal (CSA/CSV) The exercise consists of a live patient interview. Residents receive a pass or fail grade. The purpose of the exam is to assess the clinical competency of the resident and is also a preparation for assessing interviewing skills, techniques and presentation which is a requirement for graduation from general residency training. Results of the examination are shared with the resident by the examiners after the exam and also by the program director(s) during the semi-annual evaluation. Remedial actions may be enforced if necessary. Should a resident score below average on any of the major categories of the formal CSA, they will be asked to perform an additional CSA with the RTO. Continued remedial activity may be enforced pending the results of each remedial CSA.

Completion of CSA/CSV's are required by every resident on each of their clinical services throughout their residency training. A pass is required and will be counted as part of a resident’s overall evaluation on their clinical rotations.

The American Board of Psychiatry and Neurology (ABPN) requires that residents demonstrate mastery of the following three components of the core competencies to apply for certification in the specialty of psychiatry. They are:

- Physician-patient relationship
- Psychiatric interview, including mental status examination
- Case presentation

All three competency components will be assessed during a Clinical Skills Assessment, which will be performed in front of and graded by an ABPN-certified psychiatrist.

Dress Code

Proper business/professional attire is expected. This refers to all time on campus - including Thursday didactics and non-clinical services like research month.

1. Business attire is always acceptable.
2. Jeans, shorts, and tee shirts with or without logos are unacceptable.
3. Clothing that is revealing, provocative or inappropriate in the workplace is unacceptable.
4. Good grooming and neatness is required at all times.
5. No open-toed shoes are to be worn on hospital grounds.
6. Hospital scrubs are not considered acceptable attire on daytime psychiatric rotations. Scrubs may be worn while on call.
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While on medicine or on call, the resident follows the regulations of the department in which they are rotating.

Non-Workplace Related Activities While in Residency

Outside Educational Activities (MPH, PhD, Etc)

Any extracurricular activities related to training must be pre-approved in writing by Residency Training Office, and is conditional upon:

1. Not interfering with residency requirements.
2. Being in good academic and professional standing within the program.

Personal and Professional Behavior

There is to be no consumption of alcohol or illicit substances on hospital grounds. Any questions related to this should be directed to the RTO.

Fraternization Policy

While on campus, all residents are expected to behave in a professional manner as outlined by the policies outlined in the appendix 1.
Section 7: Due Process Policy

1. On each assigned clinical rotation, the resident will receive an evaluation administered by their clinical supervisor and/or service chief. The clinical supervisor and/or service chief should discuss the results of this evaluation directly with the resident.

2. The Education and Policy Committee (EPC) meets monthly in order to review resident evaluations as well as any problems that have been identified regarding a resident’s clinical and academic performance.

3. The EPC meets at least semiannually to review all resident files in order to make recommendations regarding resident improvement, progress, renewal of contract and promotion. Residents who are promoted to the next level of training will have Promotion forms placed in their file at time of advancement.

4. The Clinical Competency Committee (CCC) periodically reviews the evaluation process and makes recommendations to the Residency Training Office for ways to improve the quality of the evaluation and educational process. These discussions are documented in the minutes of Committee meetings.

5. If the CCC recommends that additional support be made available to a resident, written documentation that such services were recommended and made available to the resident will be placed in the resident’s file.

6. If the CCC determines that a resident has not met the academic requirements of a component of the Residency Training Program, or has not achieved sufficient professional competence to advance to a higher level of training, the first action recommended by the committee will be to implement a plan for remediation of the resident’s deficiencies. The Training Director or appropriate RTO staff will meet with the resident, discuss the remediation and document this on a resident Remediation Form which will become part of the resident’s file. This resident will review and sign this document and receive a copy as official notification. The plan will be reviewed at specific times. If the Committee determines that the resident has a problem that cannot be corrected by remediation, or that adequate remediation has been tried and has not been successful, the Committee may recommend disciplinary actions, such as non-renewal of contract, academic probation, restriction of the resident’s clinical duties, or termination. The Committee may also decide to deny credit in part or in full for a clinical rotation or academic year of training.
7. A resident has the right to challenge an evaluation of academic performance in a required educational activity or an unfavorable academic status and may request a review of the evaluation or academic status. Requests to review or challenge an evaluation or academic status will be submitted in writing to the Training Director(s) who will meet with the resident in an attempt to resolve that resident’s grievance. If this is not adequate for resolution of the grievance, the resident may formally appeal the decision of the Residency Training Director(s) with the Chair of the Department or his designee (e.g. Vice Chair of Clinical Services) who can in turn adjudicate the matter or convene a grievance committee to conduct a review and make its recommendations to him/her. The Grievance Committee will gather the information they deem necessary, meet with the resident and write a report of their findings and recommendation to the Chair. The Chair may reach a final decision which shall be submitted to the resident in writing.

8. If the grievance is not resolved to the resident’s satisfaction through the procedures of the Department the resident may then address a petition to the GME Committee for a review of the case and the Department’s decision through the GME due process procedures. The petition is considered by an Ad-Hoc Residents Grievance Subcommittee appointed by the GME committee, utilizing procedures that the Committee believes will provide the parties involved with an opportunity to present their sides of the issue to the Committee and allow the committee to gather the information it deems necessary to make its decision. Action taken on resident grievances by the Ad-Hoc Committee is reported to the GME Committee and action accepted by the GME Committee is final and not subject to further formal review within the University.

9. Any written records of the grievance procedure within the Department and the GME Committee, and all written communication to the resident become part of the resident’s file and are open to review by the resident.

10. Departmental Due Processes are independent of those set forth by the HHC Collective Bargaining Agreement and employee agreements between residents and other affiliated hospitals, and they do not deny residents any rights they may have under those agreements.

11. All residents should follow the departmental due process policy and have the opportunity to further appeal through formal approved policies. See appendices.
Section 8: Milestones

The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME-accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

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

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

Has not Achieved Level 1: The resident does not demonstrate the milestones expected of an incoming resident.

Level 1: The resident demonstrates milestones expected of an incoming resident.

Level 2: The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.

Level 3: The resident continues to advance and demonstrate additional milestones; the resident demonstrates the majority of milestones targeted for residency in this sub-competency.

Level 4: The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.*

Level 5: The resident has advanced beyond performance targets set for residency and is demonstrating “aspirational” goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

*Level 4 is designed as the graduation target and does not represent a graduation requirement. Making decisions about readiness for graduation is the purview of the
residency program (See the Milestones FAQ for further discussion of this issue: “Can a resident/fellow graduate if he or she does not reach every milestone?”). Study of Milestone performance data will be required before the ACGME and its partners will be able to determine whether Level 4 milestones and milestones in lower levels are in the appropriate level within the developmental framework, and whether Milestone data are of sufficient quality to be used for high stakes decisions.

Selecting the Appropriate Milestone Level for your Residents: The Role of Supervision

Faculty supervisors, especially those overseeing clinical care, will directly assess many milestones. The CCC assessment is based on evaluations completed by these clinical supervisors along with other assessments, including performance on tests and evaluations from other sources. The process of Milestone assignment assumes that all residents are supervised in their clinical work, as outlined in the ACGME’s supervision levels and requirements. For the purposes of evaluating a resident’s progress in achieving Patient Care and Medical Knowledge Milestones, though, it is important that the evaluator(s) determine what the resident knows and can do, separate from the skills and knowledge of his or her supervisor.

Implicit in milestone level evaluation of Patient Care (PC) and Medical Knowledge (MK) is the assumption that during the normal course of patient care activities and supervision, the evaluating faculty member and resident participate in a clinical discussion of the patient's care. During these reviews the resident should be prompted to present his or her clinical thinking and decisions regarding the patient. This may include evidence for a prioritized differential diagnosis, a diagnostic workup, or initiation, maintenance, or modification of the treatment plan, etc. In offering his or her independent ideas, the resident demonstrates his or her capacity for clinical reasoning and its application to patient care in real-time.

As residents progress, their knowledge and skills should grow, allowing them to assume more responsibility and handle cases of greater complexity. They are afforded greater autonomy - within the bounds of the ACGME supervisory guidelines - in caring for patients. At Levels 1 and 2 of the Milestones, a resident's knowledge and independent clinical reasoning will meet the needs of patients with lower acuity, complexity, and level of risk, whereas, at Level 4, residents are expected to independently demonstrate knowledge and reasoning skills in caring for patients of higher acuity, complexity, and risk. Thus, one would expect residents achieving Level 4 milestones to be senior residents at an oversight level of supervision. In general, one would not expect beginning or junior residents to achieve Level 4 milestones. At all levels, it is important that residents ask for, listen to, and process the advice they receive from supervisors, consult the literature, and incorporate this supervisory input and evidence into their thinking.
Section 9: Supervision and Evaluation

The following are categories of supervisors:

PGY 1 – PGY 4

Clinical Rotation Supervisor/Educator – On every clinical service, residents evaluate their supervisors, clinical site and didactics accompanying these rotations. Additionally all residents are evaluated on their performance on these rotations and didactics by their clinical supervisors/educators. This is done through an electronic web-based application (New-innovations) and is done at the midpoint of a rotation as well as at the end of a rotation. All supervisors should review their evaluations with residents in person. All evaluations are reviewed by the residency training directors (RTD’s) as they come in, and RTD’s meet with each individual resident in the program in person, semi-annually, to review their performance during that six (6) months period. If there is an unsatisfactory evaluation on a resident at any time, RTD are notified immediately by resident’s service/ supervisor/educator, and meet directly with the resident to review their performance and determine what if any measures need to be undertaken for improvement.

PGY-1

Mentorship - Helps residents deal with professional identity and adaptation issues. The mentor has contact with the residents at least monthly. Mentors are not responsible for submitting a FORMAL detailed evaluation on the trainees assigned to them, however they must inform training office if there are any concerns over professional/clinical or personal areas that may impact their functioning and impair their ability to provide adequate professional and clinical care in the workplace. A general semiannual and final evaluation will be submitted by the mentor attesting that they met with their assigned trainee over the assigned period and have no concerns of professional or other concerns that would impair their abilities to perform their professional duties.

PGY-2

Outpatient Supportive Therapy Supervisor - The supervisor helps residents successfully negotiate the systemic issues inherent to the practice of psychotherapy on an outpatient SUNY Evening Clinic Training Service (SETS) setting. They begin to explore issues dealing with outpatient psychotherapy. The emphasis in the supervision is to expose residents to the principles and practices of supportive psychotherapy. The supervision occurs at least one hour per week. PGY 2 Outpatient therapy is done on
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SUNY Evening Training Service (SETS). All supervisors are onsite. Each PGY 2 receives supervision on their supportive ambulatory patients either onsite or additionally, during the work week. All patients in SETS are the direct responsibility of the resident under the guidance of a supervisor.

PGY-3

**Group Supervisor** - Will provide theoretical framework for treatment of patients in a group setting. Supervision will take place weekly or biweekly, depending on the frequency of the group, and as needed.

**R-AOPD Supervisors** - On-site supervision will be conducted in the clinic of R-AOPD. Supervisor will be responsible for final pharmacological and other psychosocial treatment decisions and signing the charts electronically within one week of the documentation. Supervisors will also sit with residents during the intake sessions, and follow up sessions when needed, to provide direct supervision. Supervisors are responsible for evaluations completed semi-annually and annually.

**VA: PTSD Outpatient Clinic/ Home Based Primary Care (HBPC)/Telepsychiatry/ACT Team Supervisors** - Responsible for evaluations completed semiannually and annually based on weekly observation and supervision. Supervisors will meet with residents for on-site supervision on a weekly basis.

PGY-3 and PGY-4

**SETS SUNY Evening Training Service (SETS)** - This supervisor incorporates different modalities of including psychodynamic and psychotherapy for appropriate patients through the use of process notes, audiotapes and video recordings. When supervised by an M.D., the supervisor will review the general medical coverage for all psychotherapy patients that the resident is responsible for. When supervised by a PhD there will be an MD provided for medical backup. All supervisors are onsite. PGY 3’s and 4’s have an additional hour of supervision outside the SETS weekly, with an assigned supervisor. All patients in SETS are the direct responsibility of the resident under the guidance of supervisor.

OTHERS

Research Supervisor - Supervises residents at least weekly on initiating, conducting and publishing psychiatric research.

Elective Supervisor - Provides supervision at least weekly on the principles and practice of the specified elective.
Team Leadership Supervisor - Provides supervision at least weekly on administrative issues, clinical leadership issues and issues dealing with supervision of medical students and junior residents.

Administration Supervisor – Supervises chief residents on administrative issues dealing with residents, services, and training needs.

Each supervisor is expected to meet once a week (30-60 minutes) either individually or in a group with the resident(s) assigned to them.

To all residents: All residents MUST contact their supervisors within 1 week of notification of assigned supervisors to arrange for weekly meetings throughout the year.

To all supervisors: All supervisors must conduct a mid and final evaluation for each resident. For rotation over 6 weeks, both evaluations must be submitted to the Residency Training Office. For rotations under 6 weeks, the final evaluations must be submitted to the Residency Training Office, with indication that a mid-rotation evaluation was performed and discussed with the resident. All final evaluations must include remarks pertaining to the residents' acquisition of knowledge and clinical skills and their attitude and professional demeanor, and must be done in milestone format. All evaluations should be completed and submitted to the Residency Training Office through the online evaluation software New Innovations.

For Outpatient Supervisors: The first evaluation will be a mid-year evaluation due by December 15th and a final evaluation by June 15th.

Semi-annual Evaluation: Each resident will meet with the RTO minimally twice per year for direct semi-annual evaluation of 6 months clinical and professional duties. A formal semi-annual form including completion of rotations, CSVs, in-service training exam, didactics, case logs, procedures, attendance, and portfolio will be addressed. See appendix.
Section 11: New Innovations Responsibilities

See Attached
A new innovation in medical devices

- Improved patient outcomes
- Streamlined treatment processes
- Enhanced diagnostic capabilities
- Increased patient satisfaction
- Reduced treatment costs
- Peregrine Medical Inc.

- Revolutionary technology
- Latest advancements
- Medical device development
- Patient care improvement
- Medical device manufacturing

- Medical devices
- Advanced technologies
- Patient care solutions
- Medical device innovations
- Peregrine Medical Inc.
Section 11: Directory

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Section 12: Handoff Policy

Kings County (KCH) Consultation Liaison (CL) On-Call Handoff Policy

WHAT: Face to face exchange of patient information between outgoing and incoming residents to include a verbal and written component with completion and hand-off of On-Call consult sign out sheet for each shift.

WHERE: CPEP Behavioral Health Building. This is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging. If a resident reaches their consult cap for the shift, they must remain on site to provide sign-out.

HOW: Use of a printed template, which must include patient names, diagnosis, MR Number, specific location, 1:1 status, disposition, and follow up requirements for every patient. In addition a verbal sign out must be done to allow for incoming resident to ask questions regarding cases. Hand-off is to be conducted both verbally and in written format from resident to resident (PGY-2 level or above) and from attending to attending at end and beginning of call, during weekends. During weekdays, hand-off is to be conducted in the above format both verbally and in written format between resident (PGY-2 level or above) and attending covering call.

KCH CPEP On-Call Handoff Policy

WHAT: Face to face exchange of patient information during CPEP huddle at end of shift.

WHERE: CPEP Behavioral Health Building, chart room. Incoming residents must arrive on time for shift and be present for entire huddle. Outgoing residents may leave, with attending approval, after signouts for their patients are completed. CPEP on-call residents must remain on site to provide sign-out at end of shift.

HOW: Hand-off is to be conducted both verbally and in written format via CPEP “whiteboard” printout from quadramed by residents (PGY1 level and above), attendings as well as support staff during beginning and end of shift huddles. During weekdays, hand-off is to be conducted verbally and in written format between resident (PGY-1 level
or above) and the CPEP attending. Residents may not sign out to NPs, PAs or other support staff without also signing out to the CPEP attending.

**KCH Inpatient R4 West (R4W) Handoff Policy**

**WHAT:** Face to face exchange of patient information between outgoing and incoming residents (PGY-1), R4W team leader and attending, including a written portion (template), verbal sign out and opportunity for questions. Incoming residents (PGY-1) receive information about patients from outgoing residents, R4W team leader, and attending physician in an organized and comprehensive fashion including verbal and written hand off.

**WHERE:** R4 West R Building, residents’ office. This location is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging.

**HOW:** Use of a printed template, which allows for recording of patient names, diagnoses, MR numbers, room number, 1:1 status, orders and disposition for all patients. As per above, incoming residents (PGY-1) receive information about patients from outgoing residents, R4W team leader, and attending physician in an organized and comprehensive fashion including verbal and written hand off.

**KCH Child and Adolescent Psychiatry Inpatient (R6W, R6E and R7W) Handoff Policy**

**WHAT:** Face to face exchange of patient information between outgoing and incoming residents (PGY-2), and attending physician, including a written portion (template), verbal sign out and opportunity for questions. Incoming residents (PGY-2) receive information about patients from outgoing residents, and attending physician in a comprehensive fashion including verbal and written hand off.

**WHERE:** R 6 East, R 6 West or R 7 West Units at R Building KCHC. This location is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging.

**HOW:** Use of a printed template, which allows for recording of patient names, diagnoses, MR numbers, room number, 1:1 status, orders and disposition for all patients. As per above, incoming residents (PGY-2) receive information about patients from outgoing residents, and attending physician in a comprehensive fashion including verbal
and written hand off. Charts are comprehensively reviewed by incoming residents under the supervision of attending physician.

KCH Addiction Psychiatry Handoff Policy

WHAT: Face to face exchange of patient information between outgoing and incoming residents (PGY-1), and attending physician, including a written portion (template), verbal sign out and opportunity for questions. Incoming residents (PGY-1) receive information about patients from the outgoing resident and attending physician in an organized and comprehensive fashion including verbal and written hand off.

WHERE: Residents rotate through several services including, Project Access, CD Tops, KCHC methadone clinic and inpatient detox unit. Sign-outs may occur at each of these locations individually or in a central location. This location is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging.

HOW: Outgoing residents must ensure adequate verbal and written sign-out (notes in quadraxed or in paper charts where applicable) to attending physicians at each site for each patient they evaluate. Incoming residents must receive a verbal sign out from the attending physician as well as perform a comprehensive chart review for each patient they receive.

KCH Outpatient (OPD) Handoff Policy

WHAT: Face to face exchange of patient information to including a sign off template, verbal sign out, opportunity for questions from incoming residents and individual sign off notes by outgoing residents.

WHERE: R Building 4th Floor OPD. This is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging.

HOW: Use of a printed template, which allows for recording of patient names, age, gender, diagnoses, MR numbers, frequency of treatment, phone number(s), next scheduled appointment, medications, risk level, treatment goals and high risk flags for all patients. Hand-off is to be conducted both verbally and in written format from resident to resident (PGY-3 level or above) and from attending to attending. Charts are comprehensively reviewed by incoming residents under the supervision of attending physician.
Coney Island (CI) Inpatient Handoff Policy

WHAT: Face to face exchange of patient information between outgoing and incoming residents (PGY-1), CI team leader and Attending, including a written portion (template), verbal sign out and opportunity for questions. Incoming residents (PGY-1) receive information about patients from outgoing residents, CI team leader, and attending physician in an organized and comprehensive fashion including verbal and written hand off.

WHERE: CIH, Inpatient Psychiatric Unit. This location is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging.

HOW: Use of a printed template, which allows for recording of patient names, diagnoses, MR numbers, room number, 1:1 status, orders and disposition for all patients. As per above, incoming residents (PGY-1) receive information about patients from outgoing residents, CI team leader, and attending physician in an organized and comprehensive fashion including verbal and written hand off.

Kingsbrook Jewish Medical Center (KJMC) Inpatient Minkin 5 (M5) Handoff Policy

WHAT: Face to face exchange of patient information between outgoing and incoming residents (PGY-2), M5 team leader and attending, including a written portion (template), verbal sign out and opportunity for questions. Incoming residents (PGY-2) receive information about patients from outgoing residents, M5 team leader, and attending physician in an organized and comprehensive fashion including verbal and written hand off.

WHERE: Minkin 5 Inpatient Unit at KJMC, 5th floor. This location is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging.

HOW: Use of a printed template, which allows for recording of patient names, diagnoses, MR numbers, room number, 1:1 status, orders and disposition for all patients. As per above, incoming residents (PGY-2) receive information about patients from outgoing residents, M5 team leader, and attending physician in a comprehensive fashion
include verbal and written hand off. Charts are comprehensively reviewed by incoming residents under the supervision of attending physician.

**KJMC Geriatric Inpatient Minkin 3 (M3)**

**WHAT:** Face to face exchange of patient information between ongoing and incoming residents (PGY-2), and attending physicians, including a written portion (template), verbal sign out and opportunity for questions. Incoming residents (PGY-2) receive information about patients from outgoing residents and attending physician in an organized and comprehensive fashion including verbal and written hand off.

**WHERE:** Kingsbrook Jewish Medical Center – Minkin 3, Geriatric Psychiatry Unit. This location is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging.

**HOW:** Use of a printed template, which allows for recording of patient names, diagnoses, MR numbers, room number, 1:1 status, orders and disposition for all patients. As per above, incoming residents (PGY-2) receive information about patients from outgoing residents, and attending physician in a comprehensive fashion including verbal and written hand off. Charts are comprehensively reviewed by incoming residents under the supervision of attending physician.

**SUNY Downstate and KCH Consultation Liaison Rotation Handoff Policy**

**WHAT:** Face to face exchange of patient information between outgoing and incoming residents (PGY-2), and attendings, including a written portion (template), verbal sign out and opportunity for questions. Incoming residents (PGY-2) receive information about patients from outgoing residents and attending physician in a comprehensive fashion including verbal and written hand off.

**WHERE:** CL Psychiatry Conference Room A Building 1st Floor KCH or CL Office at SUNY Downstate, 3rd floor Basic Science Building.

**HOW:** Use of a printed template, which allows for recording of patient names, diagnoses, MR number, specific location, 1:1 status, disposition, and follow up requirements. As per above, incoming residents (PGY-2) receive information about patients from outgoing residents and attending physician in a comprehensive fashion including verbal and written hand off.
SUNY Evening Training Service (SETS) Handoff Policy

WHAT: Face to face exchange of patient information to including a verbal and written sign out, opportunity for questions from incoming residents and individual sign off notes by outgoing residents.

WHERE: SUNY Downstate OPD, 5th Floor. This is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging.

HOW: Hand-off is to be conducted both verbally and in written format from resident to resident (PGY-3 level or above) and from attending to attending. Charts are comprehensively reviewed by incoming residents under the supervision of attending physician.

Kingsboro CL Rotation Handoff Policy

WHAT: Face to face exchange of patient information between outgoing and incoming residents (PGY-2), and attending, including a written portion (template), verbal sign out and opportunity for questions. Incoming residents (PGY-2) receive information about patients from outgoing residents and attending physician in a comprehensive fashion including verbal and written hand off.

WHERE: Kingsboro building 2, 3rd Floor. This location is flexible and can be amended to where convenient to the parties involved respecting that it is quiet, with limited interruptions, allows for confidentiality, has phone and computer access to records/lab/imaging.

HOW: Use of a printed template, which allows for recording of patient's names, diagnoses, MR number, specific location, 1:1 status, disposition, and follow up requirements. As per above, incoming residents (PGY-2) receive information about patients from outgoing residents and attending physician in a comprehensive fashion including verbal and written hand off.

Veterans Affairs (VA) PTSD Clinic/ACT/HBPC/Telepsychiatry Handoff Policy

Hand-off done on individual services at VA as per VA policy

Medicine, Neurology and Pediatrics Handoff Policy

Handoffs done on medicine, pediatrics and neurology rotations will occur in accordance to those departments' individual policies.
Section 13: Moonlighting

PGY4+ residents in good standing are permitted moonlighting opportunities. PGY3 residents and below will not be allowed to moonlight.

Prior to moonlighting, the resident must receive approval from the Program Director or their designee in a face-to-face meeting. Then the resident must submit a Moonlighting Request Form (available in the residency training office). GME must also approve this request once submitted by the RTO.

PGY4 Moonlighting requirements

- Unrestricted medical license in New York State and DEA number issued
- In good standing
  - Pass all prior rotations in PGY1-3 in all 6 core competencies (milestones)
  - PRITE: Greater or equal to 50th percentile rank on both sections (neurology and psychiatry) of US general residents and/or completed remediation in all years.
- Not on academic probation
- Submission of monthly written verification of all moonlighting activity
- Exact days and hours spent moonlighting
- Location where moonlighting will take place. Institution as well as address where clinical work will take place

Moonlighting must not interfere with clinical or academic duties of residency. Residents must not violate 80 hour work week with moonlighting hours.

Residents may not moonlight on weekdays. Only permitted Friday PM to Sunday PM.

Residents may moonlight within the institution (Downstate UHB) or in outside institutions. A resident will not be permitted to open a private practice.

Malpractice must be arranged by the moonlighter and/or the designated moonlighting facility.

Any violations, breaches or failure to adhere to the above policy will result in an automatic, non-negotiable suspension of these privileges for at least 6 months. As per Downstate GME policy, evidence of excessive fatigue will trigger a review of moonlighting privileges.
Section 14: Didactics

Attendance is required at all didactic lectures. A minimum of 70% attendance in each course is required.

If a resident falls below 70% attendance on any course with 4 or more sessions they may be required to complete make-up material provided by the instructor. The residency training director also has the authority to assign work based on missed didactic lectures.

Attendance sheets must be printed out at the beginning of each didactic day, filled out and returned to the training office after 5PM that day. Lecturers will sign in for each resident present with their signature (not check marks, Xs, etc). They will also note if a resident is absent from the class. At the beginning of the academic year, one resident will be assigned each month to be responsible for submitting that attendance sheet. Two backup residents will also be assigned should that resident be absent.

If an attendance sheet is not turned in for that day ALL RESIDENTS in that PGY will be required to submit a summary of each lecture that day. Summary length and specifics will be decided by the residency training director or their designee.

Attendance sheets will be assigned to one resident each month. For PGY2 residents, the resident on research month rotation will in charge of attendance sheets for that month. There will be 2 backup residents assigned for the attendance sheet in case the assigned resident is away from didactics.

All monthly resident assignments and back up resident assignments will be made by chief residents for each class (PGY1, PGY2, PGY3, PGY4)
PGY-1: Chief resident for PGY-1
PGY-2: Chief resident for PGY-2
PGY-3: Chief resident for PGY-3
PGY-4: Executive chief resident (Chief resident for scholarly activities)
APPENDIX A

GME DUE PROCESS POLICY

Purpose:
To establish a policy for all post-graduate medical programs of SUNY Downstate Medical Center for use in addressing all actions that can result in altering the intended career path of a resident or fellow. To provide residents and fellows with fair, reasonable and readily available policies and procedures for grievance and due process through a decision-making process while minimizing conflict of interest by adjudicating parties.

Scope:
This policy applies to all programs and house officers (residents and fellows) participating in graduate medical education programs sponsored by SUNY Downstate. This policy applies to actions taken as a result of academic deficiencies or misconduct.

Definitions:
Due Process: an individual's right to be adequately notified of any changes or proceedings involving him or her, and the opportunity to be meaningfully heard with respect to those proceedings.
House Staff or House Officer: refers to all interns, residents fellows enrolled in post-graduate medical training or research program or activity
GME Program: refers to a residency or fellowship educational program
Adverse Action: disciplinary actions taken against a resident which alter the intended career development or timeframe. Such actions include the following:
   Dismissal: act of terminating a house officer participating in a GME program prior to successful completion of the course of training whether by early termination of a contract or by non-renewal of a contract.
   Non-renewal: act of not reappointing a house officer to subsequent years of training prior to fulfillment of a complete course of training.
   Non-promotion: act of not advancing a house officer to the next level of training according to the usual progression through a program
   Extension of Training: act of extending the duration of time required by a house officer to complete a course of training generally resulting from repeating unsatisfactory rotation assignments or remediating poor performance or needing additional time to demonstrate achievement of required competence in one or more domains.
   Probation: placement of a resident under close monitoring for specific performance concerns which if not successfully resolved may result in other adverse actions including dismissal. This action is reportable to state licensing authorities and health care institutions.
Policy:

Academic Matters:
The SUNY Downstate GME Academic Performance Policy affords due process to residents/fellows who are subject to adverse actions or whose intended career development is altered by an academic decision of a program. See Academic Performance Policy for delineation of specific processes provided.

Misconduct Matters:
The SUNY Downstate Resident/Fellow GME Misconduct Policy affords due process to residents/fellows who are subject to adverse actions or dismissed from a GME program in a manner that alters their intended career development. See Resident/Fellow GME Misconduct Policy for delineation of specific processes provided.

Policy revised and updated on 5/13/2011. This Policy supersedes all prior, similar and/or related versions and revisions. Revisions approved by GMEC _______. Effective immediately upon approval.
APPENDIX B

GME ACADEMIC PERFORMANCE DUE PROCESS POLICY

Purpose:
To establish a policy and procedure for all post-graduate medical programs of SUNY Downstate Medical Center to use in addressing deficiencies in the academic performance, competence or progress of a resident or fellow enrolled in a graduate medical education program. To provide fair, reasonable and readily available policies and procedures when a resident/fellow is not meeting the academic expectations of a program or fails to progress.

Scope:
This policy applies to all programs and house officers (residents and fellows) participating in graduate medical education programs sponsored by SUNY Downstate. This policy applies to actions taken as a result of academic deficiencies that may involve the knowledge, skills, attitudes or the core clinical competencies of medical knowledge, patient care, systems-based practice, practice-based learning and improvement, communications and interpersonal skills and aspects of professionalism which are not addressed by the GME Misconduct Policy. This policy describes minimum expectations providing residents with an opportunity to be notified of deficiencies and an opportunity to cure those deficiencies.

Definitions:
Due Process: an individual’s right to be adequately notified of any changes or proceedings involving him or her, and the opportunity to be meaningfully heard with respect to those proceedings.
House Staff or House Officer: refers to all interns, residents fellows enrolled in post-graduate medical training or research program or activity
GME Program: refers to a residency or fellowship educational program
Letter of Deficiency: A non-reportable warning issued to a resident/fellow when there are concerns that routine feedback is not effecting necessary improvement. Such a letter provides the house officer with formal notice and opportunity to cure any deficiencies. The Program Director can chose to alter a resident’s assignments or have a resident repeat rotation(s) or make other adjustments in the resident’s program in order to provide opportunity to cure the deficiency. It is an academic notification which is not reported to outside agencies and is not subject appeal or review. The letter should summarize deficiencies and may identify expectations for demonstrating improvement as well as the consequences of not successfully resolving the deficiencies. Copies of Letters of Deficiency, signed and dated by the Program Director, should be retained in the residents training record with copies to the GME
Department of Psychiatry
General Psychiatry Residency Program

Office. It is advisable to have the resident indicate receipt of Letters of Deficiency by signature as well or by witness or other documentation. These letters are sometimes also referred to as "Letter of Warning."

Monitored Performance: an academic function involving the heightened level of monitoring and assessment of house officer performance in the course of training program activities usually used to further assess for improvement in noted areas of deficiency often as a part of a program for remediation. This is not an adverse action, not reportable and not subject to appeal.

Adverse Action: disciplinary actions taken against a resident which alter the intended career development or timeframe. Such actions are reportable and allow a request for review and due process. Adverse actions include the following:

Dismissal: act of terminating a house officer participating in a GME program prior to successful completion of the course of training whether by early termination of a contract or by non-renewal of a contract.

Non-renewal: act of not reappointing a house officer to subsequent years of training prior to fulfillment of a complete course of training.

Non-promotion: act of not advancing a house officer to the next level of training according to the usual progression through a program.

Extension of Training: act of extending the duration of time required by a house officer to complete a course of training generally resulting from repeating unsatisfactory rotation assignments or remediating poor performance or needing additional time to demonstrate achievement of required competence in one or more domains.

Probation: placement of a resident under close monitoring for specific performance concerns which if not successfully resolved can result in further adverse actions including dismissal. This action is reportable to state licensing authorities, employers and health care institutions.

Suspension: Withdrawal of privileges for participating in clinical, didactic or research activities associated with appointment to the training program or hospital staff. This action is taken if, in the judgment of the Program Director, Department Chairperson or institutional leadership (Associate Dean, Dean, Medical Director) a resident’s or fellow’s competence or behavior is such that patients may be endangered, the educational process disrupted or other peers, staff, faculty are subjected to an adverse and unacceptable work environment. Under such circumstances, suspension may be implemented immediately pending further investigation and determination of other appropriate action. Suspension may be with salary or salary may be withheld after consultation with the labor relations department of the employing facility.

Structured Feedback: Routine feedback regarding a trainee’s performance or behavior and consistent with the educational program. Structured feedback can consist of verbal feedback, rotational and summative evaluations, spontaneous or "on-the-fly" formal evaluations, memos or letters to a resident’s record or to the
program director and shared with the resident, discussion and recommendations of a Program's Clinical Competence or Resident Performance or other similar committee.

Policy:
All programs must establish a process for evaluating residents consistent with sound andragogic practice, ACGME institutional, common program and specialty specific requirements, American Board of Medical Specialties specialty board specific requirements and those of any other agency or accrediting body. Assessment of house officer performance and competence is made based upon department, program and/or specialty-specific educational requirements and expectations.

All residents and fellows should be provided with routine structured feedback that is consistent with the educational program and its policies.

Each department should establish a committee of faculty who meet regularly, no less frequent than four times per year, to review the performance, competence and/or standing in the program and progress toward program completion for all enrolled residents. This committee which may be referred to as a Clinical Competence Committee (CCC) or Performance or Evaluation Review Committee or House Staff Affairs or Assessment Committee, for example, should provide recommendations to the Program Director regarding the status of residents in the program and their progress to advanced training levels and, ultimately, program completion. The Committee's discussions should be documented in meeting minutes. A Department can have one committee that reviews all residents and fellows in all programs in that Department. Alternatively, for Departments with multiple programs, residencies and fellowships, their may be separate and independent committees for each program. However, there must be no more than one committee with responsibility for assessing progress of all residents in a program and perspective on how all the program's residents are performing relative to one another and longitudinally in time.

Letter of Deficiency: When a resident or fellow has been identified as having deficiency, it is expected that he/she will receive routine structured feedback in order to identify and correct the issue. When the Program Director and/or CCC deems that routine feedback is not effecting necessary improvements, or if the Program Director and/or CCC determines that the deficiency is significant enough to warrant more than routine feedback, the Program Director and/or CCC may elect to issue a "Letter of Deficiency." This letter formally provides the House Officer with (a) notice of the deficiency and (b) an opportunity to cure the deficiency. "Letters of Deficiency" must be signed and dated by the Program Director and copied to the resident/fellow's record and to the GME Office. The "Letter of Deficiency" must indicate the possible outcomes of failure to fully resolve the concerns or developing deficiencies or performance problems in additional areas. The
issuance of a “Letter of Deficiency” does not trigger a report to any outside agencies. The House Staff Officer should continue to receive structured feedback addressing issues consistent with the “Letter of Deficiency.” The house officer may be subjected to a period of monitored performance to appropriately assess progress in resolving deficiencies. If the house officer satisfactorily resolves deficiencies noted in the “Letter of Deficiency,” and continues to perform acceptably thereafter, the period of unacceptable academic performance does not affect the house officer’s intended career development.

Escalation: If the Program Director and/or CCC determine that the house officer has failed to satisfactorily cure the deficiency and/or improve his/her performance to an expected and acceptable level, with consideration for what is fair and reasonable, the Program Director and/or CCC may elect to take further actions. Such actions may include but are not limited to any one or more of the following:

a) Issuance of another, new “Letter of Deficiency.” (Non-reportable, not an adverse action)

b) Placement on probation with establishment of adverse consequences for unsuccessfully meeting conditions of the probation

c) Non-promotion to the next PGY or training level and continue in the program.

d) Require repeat of training experience that in turn results in extension of required period of training

e) Extension of contract which may involve extension of the defined training period (extension of training)

f) Denial of credit for previously completed rotations/experiences

g) Non-renewal in the training program

h) Suspension from training pending further review or determination of other definitive action.

i) Dismissal from the residency or fellowship program.

For all such actions, the resident must be notified verbally, when possible, and in writing. A copy of the notification signed and dated by the Program Director with documentation that it was received by the resident (resident signed acknowledgement or witnessed or other receipt verification) must be included in the resident’s record and copied to the GME Office. Notice of adverse action or any action which can interfere with the resident’s intended career development must inform the house officer of his/her right to review and appeal of such adverse action. The house officer should be provided with or referred to applicable policies and procedures regarding due process, review and appeal. Notifications of adverse action should be done in consultation with the GME Office.

Reportable Actions: The decision not to promote a house officer to the next PGY level, to extend training, to deny credit for a period of training, suspension, probation, and/or terminating a house officer’s participation in a residency or fellowship program are each considered “reportable actions.” Such actions must be disclosed to others upon request,
including without limitation, future employers, privileging hospitals, and licensing and specialty boards. House Officers who are subject to a reportable action are permitted to request a review of the decision and seek to appeal that decision. Note that routine academic performance evaluations and assessments even when unsatisfactory are standard procedures in a training program and in and of themselves are not considered adverse actions, are not reportable actions and are not subject to appeal under this policy.

Request for Review and Appeal: A review and appeal of a Program’s decision to take a Reportable Action or any action interfering with the residents intended career development may be requested by the house officer. The request must be made in writing, addressed to the Associate Dean for GME, signed and dated, and submitted to the Director of Graduate Medical Education within 14 calendar days of the house officer learning of the Reportable Action. The request should clearly describe the reason for requesting the review and any basis upon which an appeal is being made. Upon receipt of a Request for Review and Appeal, the Associate Dean for GME will determine whether the matter is subject to review under this Policy. If so, the Associate Dean for GME will direct the Director of GME to appoint an ad hoc Review and Appeal Subcommittee of the GME Committee. This subcommittee will be composed of neutral reviewers from Departments other than the one in which the requesting house officer is appointed. The subcommittee will consist of at least two SUNY Downstate faculty members and one resident or fellow. Additional committee members may be assigned at the discretion of the Associate Dean for GME/DIO. The subcommittee may also include institutional GME Department leadership such as the Vice Dean for GME, Associate Dean for GME, the DIO or GME Office administrative officers. SUNY Counsel may serve in an advisory capacity.

The ad hoc Review and Appeal subcommittee will:

a) Conduct confidential meeting(s) open only to committee members, GME Office and GMEC staff, and any participants invited by and approved by the Committee.

b) Identify one faculty member who will serve as Chairperson of the subcommittee. The subcommittee Chairperson should be a participant on the SUNY Downstate GME Committee.

c) Arrange for an individual to take notes and document a summary of minutes of meetings held.

d) Committee meetings will be scheduled at the discretion of the committee Chair.

e) Establish a process for the review. Such process will not be rigidly prescribed and is not conducted in the manner of a legal hearing process. No legal representation will be permitted. No opportunity for cross examination or questioning is offered.

f) Review the resident/fellow complaint and request for review/appeal

g) Provide the house officer requesting the review or appeal the opportunity to appear before the committee to make a statement and/or present evidence of
relevance for rescinding the action under review. The committee may also require the house officer to respond to questions posed by the committee. As an academic review panel and not a legal hearing, when appearing before the committee, the house officer may be accompanied by an advocate who is not an attorney. Failure of an appealing house officer to appear as scheduled before the committee without just cause could result in a summary determination against the house officer.

h) If applicable, review relevant records and documentation such as the house officer’s file, program records, policies, meeting minutes, etc.

i) Consider any extenuating circumstances

j) The committee may meet with the Program Director or other program representative(s) and request presentation of evidence for upholding the proposed action.

k) The committee may request statements from or interview other house officers, faculty, staff, administrators or members of the academic or health care team in order to gather additional information.

l) The committee may consult with others, as appropriate, to assist in the decision making process.

m) Determine whether this Policy was followed, the house officer received notice and an opportunity to cure, and the decision to take the reportable action was reasonably made.

n) The subcommittee Chairperson is responsible for preparing the committee’s report summarizing findings and making recommendations to the Associate Dean for GME/DIO regarding the review and request for appeal of reportable actions.

o) The subcommittee Chairperson or designee will report the outcome of the review and appeal process to the GME Committee.

Upon receipt of the Chairperson’s report from the ad hoc Review and Appeal Subcommittee, the Associate Dean for GME shall review said findings and recommendations. The Associate Dean for GME/DIO finding the committee’s review process to have followed procedure and be fair, reasonable and appropriate shall make notification to the resident of the Review and Appeal subcommittee’s decision in writing with a copy to the Program Director, Department Chair, the employing institution, if applicable, and others as appropriate.

The decision resulting from this review is a final and binding decision. It is not subject to further formal review within the State University of New York Downstate Medical Center (Health Science Center at Brooklyn).

No Retaliation: Initial and full inquiries will be conducted with due regard for confidentiality to the extent practicable. Under no circumstances may anyone retaliate against, interfere with or discourage anyone from participating in good faith in an initial
inquiry or full inquiry conducted under this policy. A house staff officer who believes he/she may have been retaliated against in violation of this policy should immediately report it to his/her supervisor, the Director of GME, Associate Dean for GME, DIO or other any other supervisor.

Original policy completed on 5/13/2011. This Policy supersedes all prior, similar and/or related versions and revisions. Reviewed and approved by GMEC _______. Effective immediately upon approval.
APPENDIX C

- Portfolio Requirements
- Time Away Form
- CSV
- Milestones Evaluation
- Direct/Indirect Supervision Forms

Portfolio Requirements:

Minimum portfolio requirements – PGY-1
- Updated Curriculum Vitae
- Presentations done during medicine, pediatrics or neurology rotation
- Inpatient Psychiatry Case Conference
- APA membership (which is free for the first year)
- PRITE scores
- At least one additional entry (e.g. NAMI Walk, AFSP Walk, Film Forum, Brooklyn Free Clinic, presentation, publication, chairing or moderation, article review, administrative or academic committee etc.)
- Minimum 3 CSVs

Minimum portfolio requirements – PGY-2
- Updated Curriculum Vitae
- Journal Club presentation
- Biopsychosocial case formulation (Deidentified data)
- PRITE
- At least one additional entry (e.g. NAMI Walk, AFSP Walk, Film Forum, Brooklyn Free Clinic, presentation, publication, chairing or moderation, article review, administrative or academic committee etc.)
- Inpatient Psychiatry Case Conference
- Minimum 3 CSVs (Mock boards are counted as CSV)
- Research entry
- Human Subjects Research course
- Animal Care and Use in Research course
- Article review
Minimum portfolio requirements – PGY-3
- Updated Curriculum Vitae
- Didactics and OPD Journal Club presentation
- Community psychiatry entry (ACT Team)
- Psychodynamic formulation (Deidentified data)
- PRITE
- At least one additional entry (e.g. NAMI Walk, AFSP Walk, Film Forum, Brooklyn Free Clinic, presentation, publication, chairing or moderation, article review, administrative or academic committee etc.)
- Minimum 3 CSVs (Mock boards are counted as CSV)

Minimum portfolio requirements – PGY-4
- Updated Curriculum Vitae
- Didactics and OPD Journal Club presentation (with at least one biological psychiatry entry)
- Team leadership
- Teaching / supervisory (e.g. medical students or junior residents in CPEP)
- PRITE
- At least one additional entry (e.g. NAMI Walk, AFSP Walk, Film Forum, Brooklyn Free Clinic, presentation, publication, chairing or moderation, article review, administrative or academic committee etc.)
- Minimum 1 CSV (Mock boards are counted as CSV)

Before graduation:
- Minimum of one submission – Scholarly work at a regional, national or international meeting (poster, workshop, publication, presentation, letter to editor and many more...)
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**Training Office**
- Approval by
- Chief Resident
- Approval by
- Immediate Supervisor

**Educational Leave** - Requires at least 4 weeks approval and written verification of attendance upon return to service

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**Time Away Request Form**

**Departments:**
- Psychiatry
- Department of
- SUNY Downstate Medical Center

**Resident Requesting Time:**
CLINICAL SKILLS VERIFICATION

[Subject Name]
[Subject Status]
[Evaluation Dates]
[Subject Rotation]

Evaluator
[Evaluator Name]
[Evaluator Status]

CLINICAL SKILLS

Questions 1–6 reflect the evaluators OVERALL assessment of the resident's performance on the 5 major components of the CSV.

1) 1. Physician Patient Relationship
   Overall Score
   Unsatisfactory Satisfactory Superior N/A
   1 2 3 4 5 6 7 8 9 O

2) 2. Conduct of the Interview
   Overall Score
   Unsatisfactory Satisfactory Superior N/A
   1 2 3 4 5 6 7 8 9 O

3) 3. Case Presentation
   Overall Score
   Unsatisfactory Satisfactory Superior N/A
   1 2 3 4 5 6 7 8 9 O

4) 4. Case Formulation and Differential Diagnosis
   Overall Score
   Unsatisfactory Satisfactory Superior N/A
   1 2 3 4 5 6 7 8 9 O

5) 5. Treatment Planning
   Overall Score
   Unsatisfactory Satisfactory Superior N/A
   1 2 3 4 5 6 7 8 9 O

6) OVERALL COMMENTS: Did the resident perform at a level appropriate to his/her level of training?

Remaining Characters: 5,000

Questions 7–8 reflect the complexity of the patient and degree of difficulty of the interview.
7) COMPLEXITY OF THE PATIENT
LOW (rate 1): Patient presents one primary problem with clearly described symptoms.
MEDIUM (rate 3): Patient presents with one problem vaguely or inconsistently described symptoms or 2-3 problems with clear symptoms.
HIGH (rate 5): Patient presents with multiple problems with vaguely or inconsistently described symptoms.
1 2 3 4 5

8) DIFFICULTY OF THE INTERVIEW
LOW Difficulty of Interview: (rate as 1) Patient is cooperative, well organized, and cognitively intact.
MEDIUM Difficulty: (rate as 3) Patient is abrupt, uncertain, or cognitively compromised.
HIGH Difficulty: (rate 5) Patient is hostile, disorganized, or cognitively impaired.
1 2 3 4 5

Questions 9-20 reflect the evaluators detailed assessment of the 5 major components of the CSV.

9) 1. PHYSICIAN PATIENT RELATIONSHIP

1-1 RAPPORT WITH THE PATIENT
EXCELLENT (rate 7 or 8): Courteous, professional demeanor. Clear introduction to patient. Exhibits warmth and empathy.
GOOD (rate 5 or 6): Generally respectful. Adequate introduction. Adequate empathy.
FAIR (rate 3 or 4): Arrogant, disrespectful, or awkward demeanor. Inadequate introduction. Lacks empathy.
POOR (rate 1 or 2): Rude or inappropriate comments. No introduction or misrepresentation of the situation. Obvious anger or frustration.

Unsatisfactory Satisfactory Superior
1 2 3 4 5 6 7 8 9

10) 1. PHYSICIAN PATIENT RELATIONSHIP

1-2 RESPONSE TO THE PATIENT
EXCELLENT (rate 7 or 8): Responds empathically to verbal and nonverbal cues. Adjusts interview to patient's level of understanding and cultural background. Adjusts interview to new information.
GOOD (rate 5 or 6): Responds adequately to verbal and nonverbal cues. Occasional use of technical jargon. Adjusts interview to most new information.
FAIR (rate 3 or 4): Shows minimal response to sensitive information. Minimal awareness of patient's capacity to understand or cultural background. Inflexible interviewing style. Misses important verbal and nonverbal cues.
POOR (rate 1 or 2): Responds with angry, abusive, or dismissive comments. Frequently loses composure. Criticizes, deems, or condemns patient.

Unsatisfactory Satisfactory Superior
1 2 3 4 5 6 7 8 9

11) 1. PHYSICIAN PATIENT RELATIONSHIP

1-3 FOLLOW UP CUES PRESENTED BY THE PATIENT
EXCELLENT (rate 7 or 8): Responds appropriately to verbal and nonverbal information. Follows up on all pertinent information. Seeks clarification of ambiguous information.
GOOD (rate 5 or 6): Misses no major verbal or nonverbal information. Generally follows up on major issues presented by the patient.
FAIR (rate 3 or 4): Misses significant verbal and nonverbal information. Fails to ask for clarification of ambiguous information.
POOR (rate 1 or 2): Ignores or responds inappropriately to verbal or nonverbal cues. Grossly misinterprets verbal or nonverbal information.

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12)2. **CONDUCT OF THE INTERVIEW**

2-1 LISTENS TO AND FACILITATES THE PATIENT’S NARRATIVE HISTORY
EXCELLENT (rate 7 or 8): Actively listens to the patient’s story. Uses frequent, well-structured, open-ended questions to facilitate the story. Assists the patient to focus and clarify the story.
GOOD (rate 5 or 6): Passively listens to the patient’s story. Occasionally uses open-ended questions to facilitate the story. Asks occasional clarifying questions.
FAIR (rate 3 or 4): Interview consists primarily of directive, closed-ended questions. Inadequate or ineffective efforts to focus and clarify the story. Frequent interjection of assumptions or leading questions.
POOR (rate 1-2): Interview consists entirely of narrowly focused, closed-ended questions. Patient is repeatedly diverted from the narrative to check-list questions or irrelevant topics. Patient’s narrative is disregarded, contradicted, or ignored.

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13)2. **CONDUCT OF THE INTERVIEW**

2-2 OBTAINS SUFFICIENT DATA FOR DSM DIAGNOSIS
EXCELLENT (rate 7 or 8): Assists the patient in describing the full range of symptoms and history. Explores all pertinent domains of information. Gathers adequate information for DSM checklists.
GOOD (rate 5 or 6): Allows patient to describe major symptoms and history. Explores the major domains of information. Focuses interview on DSM checklists.
FAIR (rate 3 or 4): Limits interview to DSM checklists. Misses important domains of information. Shows little awareness or regard for DSM diagnoses. Fails to consider alternative diagnoses.
POOR (rate 1 or 2): Fails to gather sufficient information for major diagnosis. Misinterprets or misrepresents diagnostic information.

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14)2. **CONDUCT OF THE INTERVIEW**

2-3 OBTAINS PSYCHIATRIC, MEDICAL, SUBSTANCE ABUSE, FAMILY, AND SOCIAL HISTORIES
EXCELLENT (rate 7 or 8): Assists the patient in presenting each aspect of the history. Gathers a wide range of biopsychosocial information. Maintains focus and logical progression of interview. Appears comfortable with difficult or sensitive topics.
GOOD (rate 5 or 6): Allows the patient to present an adequate range of material. Gathers adequate biopsychosocial information. Generally redirects the patient when necessary. Somewhat uncomfortable with difficult or sensitive topics.
FAIR (rate 3 or 4): Interrupts or interferes with the patient’s story. Misses important biopsychosocial information. Fails to redirect or focus a disorganized or hyperverbal patient. Avoids difficult or sensitive topics.
POOR (rate 1 or 2): Ignores pertinent areas of the history. Asks cursory, disorganized, or irrelevant questions. Loses control of the interview. Responds inappropriately to difficult or sensitive topics.

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15)2. **CONDUCT OF THE INTERVIEW**

2-4 SCREENS FOR SUICIDALITY, HOMICIDALITY, HIGH RISK BEHAVIOR, AND TRAUMA

https://www.new-innov.com/EvaluationForms/EvaluationFormsHost.aspx?Data=1LAi7Qy93xO3Zfnu7C5VDd0aihclw4ZZUyboM8fYmThItjuJWUsu7WCCJ1Fv6SQ... 3/5
16)2. **CONDUCT OF THE INTERVIEW**

2–5 PERFORMS AN ADEQUATE MENTAL STATUS EXAMINATION

**EXCELLENT** (rate 7 or 8): All pertinent areas of the MSE were addressed. Appropriate areas of the MSE were integrated into other parts of the interview.

**GOOD** (rate 5 or 6): Most pertinent areas of the MSE were addressed. Occasional areas of the MSE were integrated into other parts of the interview.

**FAIR** (rate 3 or 4): At least one essential element of the MSE was omitted. MSE elements were inadequately performed.

**POOR** (rate 1 or 2): Multiple elements of the MSE were omitted. MSE elements were ineptly performed.

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17)3. **CASE PRESENTATION**

3–1 ORGANIZED AND ACCURATE PRESENTATION OF HISTORY

**EXCELLENT** (rate 7 or 8): HPI accurately reflects the patient's story. Presentation is logical, concise, and coherent. History integrates all-important biopsychosocial factors. Presentation includes pertinent positive and negative findings. Presentation leads to a clear understanding of the patient.

**GOOD** (rate 5 or 6): HPI generally reflects the patient's story. Presentation can be followed. History includes adequate discussion of biopsychosocial factors. Presentation includes major pertinent negative findings. Presentation leads to an adequate understanding of the patient.

**FAIR** (rate 3 or 4): HPI ignores or inaccurately represents the patient's story. Presentation is disorganized or chaotic. History misses important biopsychosocial factors. Presentation ignores some pertinent positive or negative findings. Presentation leads to a poor understanding of the patient.

**POOR** (rate 1 or 2): HPI distorts or misinterprets the patient's story. Presentation is incoherent or illogical. History shows no awareness of biopsychosocial issues. Presentation misinterprets or disregards pertinent positive or negative findings. Presentation is grossly inaccurate.

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18)3. **CASE PRESENTATION**

3–2 ORGANIZED AND ACCURATE PRESENTATION OF MENTAL STATUS FINDINGS

**EXCELLENT** (rate 7 or 8): All areas of the MSE are presented. Presentation is orderly, systematic, and easy to follow. Standard terminology and nomenclature are used. Findings are accurate and complete. Pertinent negative findings are included. An appropriate and accurate assessment of dangerousness is included.

**GOOD** (rate 5 or 6): Most areas of the MSE are presented. Presentation generally follows a standard outline. Clear and meaningful terms are used. All critical findings are included. Most important negative findings are included. An adequate assessment of dangerousness is included.

**FAIR** (rate 3 or 4): Several pertinent areas of the MSE are omitted. Presentation is disorganized and rambling. Ambiguous, inappropriate, or unclear terminology is used. Some critical findings are omitted or misrepresented. Important negative findings are omitted. Assessment of dangerousness is inadequate or only partially accurate.
POOR (rate 1 or 2): Major areas of the MSE are omitted. Presentation is incoherent and impossible to follow. Inaccurate, meaningless, or inappropriate terminology is used. Most critical findings are omitted or misrepresented. Negative findings are not included. Assessment of dangerousness is omitted or is inaccurate.

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19) 4. CASE FORMULATION AND DIFFERENTIAL DIAGNOSIS


FAIR (rate 3 or 4): Omission of at least one significant biopsychosocial factor. Limited integration of psychodynamic issues. Minimal awareness of patient's story. Too narrow or too broad differential diagnosis.

POOR (rate 1 or 2): Inaccurate or incoherent formulation. Poor awareness of biopsychosocial factors. Minimal awareness of psychodynamic issues. Misdirected or inaccurate differential diagnosis.

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20) 5. TREATMENT PLANNING

EXCELLENT (rate 7 or 8): Well-formulated, evidence-based, cost-effective treatment plan. Skillful coordination of somatic and psychosocial treatments. Full integration of patient, support system, and outpatient providers into treatment planning. Skillful development of a comprehensive safety plan.

GOOD (rate 5 or 6): General attention to evidence-based, cost-effective treatments. Awareness of available somatic and psychosocial treatments. Inclusion of patient and family preferences in treatment planning. Adequate attention to safety planning.

FAIR (rate 3 or 4): Little awareness of efficacy or cost data in treatment planning. Limited attention to integration of somatic and psychosocial treatments. Cursory attention to patient and family treatment preferences. Minimal attention to safety planning.

POOR (rate 1 or 2): Grossly inadequate or inappropriate treatment. Narrow, rigid, or one-dimensional treatment plan. Lack of attention to or awareness of patient and family treatment preferences. Absence of appropriate safety planning.

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**PC1. Psychiatric Evaluation**

A: General interview skills  
B: Collateral information gathering and use  
C: Safety assessment  
D: Use of clinician's emotional response

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<tbody>
<tr>
<td>1.1/A Obtains general medical and psychiatric history and completes a mental status examination</td>
<td>2.1/A Acquires efficient, accurate, and relevant history customized to the patient’s complaints</td>
<td>3.1/A Consistently obtains complete, accurate, and relevant history</td>
<td>4.1/A Routinely identifies subtle and unusual findings</td>
<td>5.1/A Servesc as a rule model for gathering subtle and reliable information from the patient</td>
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<tr>
<td>1.2/B Obtains relevant collateral information from secondary sources</td>
<td>2.2/A Performs a targeted examination, including neurological examination, relevant to the patient’s complaints</td>
<td>3.2/A Performs efficient interview and examination with flexibility appropriate to the clinical setting and workload demands</td>
<td>4.2/B Follows cues to identify relevant historical findings in complex clinical situations and unfamiliar circumstances</td>
<td>5.2/A, B Teaches and supervises other learners in clinical evaluation</td>
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<tr>
<td>1.3/C Screens for patient safety, including suicidal and homicidal ideation</td>
<td>2.3/B Obtains information that is sensitive and not readily offered by the patient</td>
<td>3.3/B Selects laboratory and diagnostic tests appropriate to the clinical presentation</td>
<td>4.3/D Begins to use the clinician’s emotional responses to the patient as a diagnostic tool</td>
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<tr>
<td></td>
<td>2.4/C Assesses patient safety, including suicidal and homicidal ideation</td>
<td>3.4/B Uses hypothesis-driven information gathering techniques</td>
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<td>2.5/D Recognizes that the clinician’s emotional responses have diagnostic value</td>
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Subcompetency questions are generated based on the resident’s rotation.

DPSY:PSY:INPAT-CIH (Department of Psychiatry/PSY – Psychiatry)
PC2. Psychiatric Formulation and Differential Diagnosis

A: Organizes and summarizes findings and generates differential diagnosis B: Identifies contributing factors and contextual features and creates a formulation

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<tr>
<td>1.1/A Organizes and accurately summarizes, reports, and presents to colleagues information obtained from the patient evaluation</td>
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<td>1.2/A Develops a working diagnosis based on the patient evaluation</td>
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<td>2.1/A Identifies patterns and recognizes phenomenology from the patient's presentation to generate a diagnostic hypotheses</td>
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<td>2.2/A Develops a basic differential diagnosis for common syndromes and patient presentations</td>
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<tr>
<td>2.3/B Describes patients' symptoms and problems, precipitating stressors or events, predisposing life events or stressors, perpetuating and protective factors, and prognosis</td>
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<td>3.1/A Develops a full differential diagnosis while avoiding premature closure</td>
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<td>3.2/B Organizes formulation around comprehensive models of phenomenology that take etiology into account</td>
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<td>4.1/A Incorporates subtle, unusual, or conflicting findings into hypotheses and formulations</td>
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<td>4.2/B Efficiently synthesizes all information into a concise but comprehensive formulation</td>
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<td>5.1/B Serves as a role model of efficient and accurate formulation</td>
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<td>5.2/B Teaches formulation to advanced learners</td>
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PC3. Treatment Planning and Management

A: Creates treatment plan B: Manages patient crises, recognizing need for supervision when indicated C: Monitors and revises treatment when indicated

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<tr>
<td>1.1/A Identifies potential treatment options</td>
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<td>1.2/A Recognizes patient in crisis or acute presentation</td>
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<td>2.1/A Sets treatment goals in collaboration with the patient</td>
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<td>2.2/A Incorporates a clinical practice guideline or treatment algorithm when available</td>
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<td>2.3/A Applies an understanding of psychiatric, neurologic, and medical co-</td>
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<td>3.1/A Incorporates manual-based treatment 1 when appropriate</td>
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<tr>
<td>3.2/A Applies multiple modalities and providers in comprehensive</td>
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<td>4.1/A Devises individualized treatment plan for complex presentations</td>
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<td>4.2/A Integrates emerging neurobiological and genetic knowledge</td>
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<td>5.1/A Supervises treatment planning of other learners and multidisciplinary providers</td>
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<tr>
<td>5.2/A Integrates emerging neurobiological and genetic knowledge</td>
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### PC4. Psychotherapy

Refers to 1) the practice and delivery of psychotherapies, including psychodynamic, cognitive-behavioral, and supportive therapies; 2) exposure to couples, family, and group therapies; and 3) integrating psychotherapy with psychopharmacology

A: Empathy and process
B: Boundaries
C: The alliance and provision of psychotherapies
D: Seeking and providing psychotherapy supervision

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<tbody>
<tr>
<td>1.1/A Accurately identifies patient emotions, particularly sadness, anger, and fear</td>
<td>2.1/A Identifies and reflects the core feeling and key issue for the patient during a session</td>
<td>3.1/A Identifies and reflects the core feeling, key issue, and what the issue means to the patient</td>
<td>4.1/A Links feelings, behavior, recurrent/central themes/schemas, and their meaning to the patient as they shift within and across sessions</td>
<td>5.1/C Provides psychotherapies to patients with very complicated and/or refractory disorders/problems</td>
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</tr>
<tr>
<td>1.2/B Maintains appropriate professional boundaries</td>
<td>2.2/B Maintains appropriate professional boundaries in psychotherapeutic relationships while being responsive to the patient</td>
<td>3.2/B Recognizes and avoids potential boundary violations</td>
<td>4.2/B Anticipates and appropriately manages potential boundary crossings and avoids boundary violations</td>
<td>5.2/C Personalizes treatment based on awareness of one's own skills, strengths, and limitations</td>
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</tr>
<tr>
<td>1.3/C Demonstrates a professional interest and curiosity in a patient's story</td>
<td>2.3/C Establishes and maintains a therapeutic alliance with patients with uncomplicated problems</td>
<td>3.3/C Establishes and maintains a therapeutic alliance with, and provides psychotherapies (at least supportive, psychodynamic, and cognitive-behavioral) to, patients with uncomplicated problems</td>
<td>4.3/C Provides different modalities of psychotherapy (including supportive therapy and at least one of psychodynamic or cognitive behavioral therapies) to patients with moderately complicated problems</td>
<td>5.3/D Provides psychotherapy supervision to others</td>
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</tr>
<tr>
<td>2.4/C Utilizes elements of supportive therapy in treatment of patients</td>
<td>3.4/C Manages the emotional content of, and feelings aroused during, sessions</td>
<td>3.5/C Integrates the selected psychotherapy with other treatment modalities and other treatment providers</td>
<td>4.4/C Selects a psychodynamic modality and tailors the selected psychotherapy to the patient on the basis of an appropriate</td>
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PC5. Somatic Therapies

Somatic therapies including psychopharmacology, electroconvulsive therapy (ECT), and emerging neuromodulation therapies

A: Using psychopharmacologic agents in treatment
B: Education of patient about medications
C: Monitoring of patient response to treatment and adjusting accordingly
D: Other somatic treatments

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<tbody>
<tr>
<td>1.1/A Lists commonly used psychopharmacologic agents and their indications to target specific psychiatric symptoms (e.g., depression, psychosis)</td>
<td>2.1/A Appropriately prescribes commonly used psychopharmacologic agents</td>
<td>3.1/A Manages pharmacokinetic and pharmacodynamic drug interactions when using multiple medications concurrently</td>
<td>4.1/A Initiates dosage and manages side effects of multiple medications</td>
<td>5.1/B Explains less common somatic treatment choices to patients/families in terms of proposed mechanisms of action</td>
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</tr>
<tr>
<td>1.2/B Reviews with the patient/family general indications, dosing parameters, and common side effects for commonly prescribed psychopharmacologic agents</td>
<td>2.2/B Incorporates basic knowledge of proposed mechanisms of action and metabolism of commonly prescribed psychopharmacologic agents in treatment selection, and explains rationale to patients/families</td>
<td>3.2/C Monitors relevant lab studies throughout treatment, and incorporates emerging physical and laboratory findings into somatic treatment strategy</td>
<td>4.2/C Appropriately selects evidence-based somatic treatment options (including second and third line agents and other somatic treatments) for patients whose symptoms are partially responsive or not responsive to treatment</td>
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<tr>
<td>2.3/C Obtains basic physical exam and lab studies necessary to initiate treatment with commonly prescribed medications</td>
<td>2.4/D Seeks consultation and supervision regarding potential referral for ECT</td>
<td>3.3/C Uses augmentation strategies, with supervision, when primary pharmacological interventions are only partially successful</td>
<td>5.2/C Integrates emerging studies of somatic treatments into clinical practice</td>
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Comments

Remaining Characters: 5,000
MK2. Psychopathology. Includes knowledge of diagnostic criteria, epidemiology, pathophysiology, course of illness, co-morbidities, and differential diagnosis of psychiatric disorders, including substance use disorders and presentation of psychiatric disorders across the life cycle and in diverse patient populations (e.g., different cultures, families, genders, sexual orientation, ethnicity, etc.)

A: Knowledge to identify and treat psychiatric conditions
B: Knowledge to assess risk and determine level of care
C: Knowledge at the interface of psychiatry and the rest of medicine

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<tbody>
<tr>
<td>1.1/A Identifies the major psychiatric diagnostic system (DSM)</td>
<td>2.1/A Demonstrates sufficient knowledge to identify and treat common psychiatric conditions in adults in inpatient and emergency settings (e.g., depression, mania, acute psychosis)</td>
<td>3.1/A Demonstrates sufficient knowledge to identify and treat most psychiatric conditions throughout the life cycle and in a variety of settings</td>
<td>4.1/A Demonstrates sufficient knowledge to identify and treat atypical and complex psychiatric conditions throughout the life cycle and in a range of settings (inpatient, outpatient, emergency, consultation liaison)</td>
<td>5.1/B Displays knowledge sufficient to teach assessment of risks and the appropriate level of care for patients who may represent a danger to self and/or others</td>
<td>5.2/C Shows sufficient knowledge to identify and treat uncommon psychiatric conditions in patients with medical disorders</td>
</tr>
<tr>
<td>1.2/B Lists major risk and protective factors for danger to self and others</td>
<td>2.2/B Demonstrates knowledge of, and the ability to weigh risks and protective factors for, danger to self and/or others in emergency and inpatient settings</td>
<td>3.2/B Displays knowledge of, and the ability to weigh, risk and protective factors for, danger to self and/or others across the life cycle, as well as the ability to determine the need for acute psychiatric hospitalization</td>
<td>4.2/B Displays knowledge sufficient to determine the appropriate level of care for patients expressing, or who may represent, danger to self and/or others, across the life cycle, and in a full range of treatment settings</td>
<td>5.3/C Demonstrates sufficient knowledge to identify and treat a wide range of psychiatric conditions in patients with medical disorders</td>
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<tr>
<td>1.3/C Gives examples of interactions between medical and psychiatric symptoms and disorders</td>
<td>2.3/C Shows sufficient knowledge to perform an initial medical and neurological evaluation in psychiatric inpatients</td>
<td>3.3/C Shows sufficient knowledge to identify and treat common psychiatric manifestations of medical illness (e.g., delirium, depression, steroid-induced syndromes)</td>
<td>4.3/C Shows knowledge sufficient to identify and treat a wide range of psychiatric conditions in patients with medical disorders</td>
<td>4.4/C Demonstrates sufficient knowledge to systematically screen for, evaluate, and diagnose common medical conditions in psychiatric patients, and to ensure appropriate further evaluation and treatment of these conditions in collaboration with other medical providers</td>
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<tr>
<td>2.4/C Demonstrates sufficient knowledge to identify common medical conditions (e.g., hypothyroidism, hyperlipidemia, diabetes) in psychiatric patients</td>
<td>3.4/C Demonstrates sufficient knowledge to include relevant medical and neurological conditions in the differential diagnoses of psychiatric patients</td>
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MK3. Clinical Neuroscience. Includes knowledge of neurology, neuropsychiatry, neurodiagnostic testing, and relevant neuroscience and their application in clinical settings

A: Neurodiagnostic testing B: Neuropsychological testing C: Neuropsychiatric co-morbidity D: Neurobiology E: Applied neuroscience

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<tr>
<td>1.1/A Knows commonly available neuroimaging and neurophysiologic diagnostic modalities and how to order them</td>
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<tr>
<td>1.2/B Knows how to order neuropsychological testing</td>
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<tr>
<td>2.1/A Knows indications for structural neuroimaging (cranial computed tomography [CT] and magnetic resonance imaging [MRI]) and neurophysiological testing (electroencephalography [EEG], evoked potentials, sleep studies)</td>
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<td>2.2/B Describes common neuropsychological tests and their indications</td>
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<tr>
<td>2.3/C Describes psychiatric disorders co-morbid with common neurologic disorders and neurological disorders frequently seen in psychiatric patients</td>
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<td>2.4/E Identifies the brain areas thought to be important in social and emotional behavior</td>
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<td>3.1/A Recognizes the significance of abnormal findings in routine neurodiagnostic test reports in psychiatric patients</td>
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<tr>
<td>3.2/B Knows indications for specific neuropsychological tests and understands meaning of common abnormal findings</td>
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<td>3.3/D Describes neuropsychological and genetic hypotheses of common psychiatric disorders and their limitations</td>
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<tr>
<td>4.1/A Explains the significance of routine neuroimaging, neurophysiological, and neuropsychological testing abnormalities to patients</td>
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<td>4.2/A Knows clinical indications and limitations of functional neuroimaging</td>
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<td>4.3/C Describes psychiatric co-morbidities of less common neurologic disorders and less common neurologic co-morbidities of psychiatric disorders</td>
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<tr>
<td>4.4/D Explains neurobiological hypotheses and genetic risks of common psychiatric disorders to patients</td>
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<tr>
<td>4.5/E Demonstrates sufficient knowledge to incorporate leading neuroscientific hypotheses of emotions and social behaviors into case formulation</td>
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<tr>
<td>5.1/A Integrates recent neurodiagnostic research into understanding of psychopathology</td>
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<td>5.2/B Flexibly applies knowledge of neuropsychological findings to the differential diagnoses of complex patients</td>
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<tr>
<td>5.3/D Explains neurobiological hypotheses and genetic risks of less common psychiatric disorders to patients</td>
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<tr>
<td>5.4/D Integrates knowledge of neurobiology into advocacy for psychiatric patient care and stigma reduction</td>
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MK5. Somatic Therapies. Medical Knowledge of somatic therapies, including psychopharmacology, ECT, and emerging somatic therapies, such as transcranial magnetic stimulation (TMS) and vagus nerve stimulation (VNS)

A: Knowledge of indications, metabolism and mechanism of action for medications B: Knowledge of ECT and other emerging somatic treatments C: Knowledge of lab studies and measures in monitoring treatment

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MK 4

MK4. Psychotherapy Refers to knowledge regarding: 1) individual psychotherapies, including but not limited to psychodynamic, cognitive-behavioral, and supportive therapies; 2) couples, family, and group therapies; and, 3) integrating psychotherapy and psychopharmacology.

A: Knowledge of psychotherapy; theories B: Knowledge of psychotherapy; practice C: Knowledge of psychotherapy: evidence base

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<tbody>
<tr>
<td>1.1/A Identifies psycho-dynamic, cognitive-behavioral, and supportive therapies as major psychotherapeutic modalities</td>
<td>2.1/A Describes the basic principles of each of the three core individual psychotherapy modalities</td>
<td>3.1/A Describes differences among the three core individual therapies</td>
<td>4.1/A Describes proposed mechanisms of therapeutic change</td>
<td>5.1/A Incorporates new theoretical developments into knowledge base</td>
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<tr>
<td>2.2/A Discusses common factors across psychotherapies</td>
<td>3.2/A Describes the historical and conceptual development of psychotherapeutic paradigms</td>
<td>4.2/C Discusses the evidence base for combining different psychotherapies and psychopharmacology</td>
<td>5.2/A, B Demonstrates sufficient knowledge of psychotherapy to teach others effectively</td>
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<tr>
<td>2.3/B Lists the basic indications, contraindications, benefits, and risks of supportive, psychodynamic and cognitive behavioral psychotherapies</td>
<td>3.3/B Describes the basic techniques of the three core individual therapies</td>
<td>4.3/C Critically appraises the evidence for efficacy of psychotherapies</td>
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<tr>
<td>3.4/B Describes the basic principles, indications, contraindications, benefits, and risks of couples, group, and family therapies</td>
<td>3.5/C Summarizes the evidence base for each of the three core individual therapies</td>
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### SBP2. Resource Management (may include diagnostics, medications, level of care, other treatment providers, access to community assistance)

**A: Costs of care and resource management**

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<tbody>
<tr>
<td>1.1/A Recognizes need for efficient and equitable use of resources</td>
<td>2.1/A Recognizes disparities in health care at individual and community levels</td>
<td>3.2/A Coordinates patient access to community and system resources</td>
<td>4.1/A Practices cost-effective, high-value clinical care, using evidence-based tools and information technologies to support decision making</td>
<td>5.1/A Designs measurement tools to monitor and provide feedback to providers/teams on resource consumption to facilitate improvement</td>
<td>5.2/A Advocates for improved access to and additional resources within systems of care</td>
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</table>

### SBP3. Community-Based Care

**A: Community-based programs B: Self-help groups C: Prevention D: Recovery and rehabilitation**

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<tbody>
<tr>
<td>1.1/A Gives examples of community mental health systems of care</td>
<td>2.1/A Coordinates care with community mental health agencies, including with case managers</td>
<td>3.1/B Incorporates disorder-specific support and advocacy groups in clinical care</td>
<td>4.1/B Routinely uses self-help groups, community resources, and social networks in treatment</td>
<td>5.1/A Participates in the administration of community-based treatment programs</td>
<td>5.2/A Participates in creating new community-based programs</td>
</tr>
</tbody>
</table>
SBP4. Consultation to non-psychiatric medical providers and non-medical systems (e.g., military, schools, businesses, forensic)

A: Distinguishes care provider roles related to consultation  
B: Provides care as a consultant and collaborator  
C: Specific consultative activities

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<tbody>
<tr>
<td></td>
<td>1.1/A Describes the difference between consultant and primary treatment provider</td>
<td>2.1/A Describes differences in providing consultation for the system or team versus the individual patient</td>
<td>3.1/C Assists primary treatment care team in identifying unrecognized clinical care issues</td>
<td>4.1/B Provides integrated care for psychiatric patients through collaboration with other physicians</td>
<td>5.1/B Provides psychiatric consultation to larger systems</td>
</tr>
<tr>
<td></td>
<td>2.2/B Provides consultation to other medical services</td>
<td>3.2/C Identifies system issues in clinical care and provides recommendations</td>
<td>4.2/C Manages complicated and challenging consultation requests</td>
<td>5.2/B Leads a consultation team</td>
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<tr>
<td></td>
<td>2.3/C Clarifies the consultation question</td>
<td>3.3/C Discusses methods for integrating mental health and medical care in treatment planning</td>
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<td>2.4/C Conducts and reports a basic decisional capacity evaluation</td>
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Comments

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PBL11. Development and execution of lifelong learning through constant self-evaluation, including critical evaluation of research and clinical evidence

A: Self-Assessment and self-Improvement  
B: Evidence in the clinical workflow
### Level 1

#### Not achieved

1.1/A Uses feedback from teachers, colleagues, and patients to assess own level of knowledge and expertise

1.2/A Recognizes limits of one’s knowledge and skills and seeks supervision

1.3/A Describes and ranks levels of clinical evidence

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<tbody>
<tr>
<td>2.1/A Regularly seeks and incorporates feedback to improve performance</td>
<td>3.1/A Demonstrates a balanced and accurate self-assessment of competence, using clinical outcomes to identify areas for continued improvement</td>
<td>4.1/A Demonstrates improvement in clinical practice based on continual self-assessment and evidence-based information</td>
<td>5.1/A Sustains practice of self-assessment and keeps up with relevant changes in medicine, and makes informed, evidence-based clinical decisions</td>
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</table>

#### Level 2

2.2/A Identifies self-directed learning goals and periodically reviews them with supervisory guidance

2.3/A Formulates a searchable question from a clinical question

3.2/B Selects an appropriate, evidence-based information tool to meet self-identified learning goals

3.3/B Critically appraises different types of research, including randomized controlled trials (RCTs), systematic reviews, meta-analyses, and practice guidelines

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<tbody>
<tr>
<td>4.2/A Identifies and meets self-directed learning goals with little external guidance</td>
<td>4.3/A, B Demonstrates use of a system or process for keeping up with relevant changes in medicine</td>
<td>5.2/A Teaches others techniques to efficiently incorporate evidence gathering into clinical workflow</td>
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<tr>
<th>Level 4</th>
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<tbody>
<tr>
<td>4.4/A Independently searches for and discriminates evidence relevant to clinical practice problems</td>
<td>5.3/A Independently teaches appraisal of clinical evidence</td>
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</tbody>
</table>

#### Level 5

#### N/A

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### Level 1

#### Not achieved

1.1/A Recognizes role of physician as teacher

2.1/A Assumes a role in the clinical teaching of early learners

2.2/A Communicates goals and objectives for instruction of early learners

2.3/A Evaluates and provides feedback to early learners

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<tbody>
<tr>
<td>3.1/A Participates in activities designed to develop and improve teaching skills</td>
<td>3.2/A Organizes content and methods for individual instruction for early learners</td>
<td>4.1/A Gives formal didactic presentation to groups (e.g., grand rounds, case conference, journal club)</td>
<td>5.1/A Educates broader professional community and/or public (e.g., presents at regional or national meeting)</td>
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#### Level 2

2.5/A Develops and evaluates curriculum materials

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<tr>
<td>4.2/A Effectively uses feedback on teaching to improve teaching methods and approaches</td>
<td>4.3/A, B Demonstrates use of a system or process for keeping up with relevant changes in medicine</td>
<td>5.2/A Teaches others techniques to efficiently incorporate evidence gathering into clinical workflow</td>
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<td>4.4/A Independently searches for and discriminates evidence relevant to clinical practice problems</td>
<td>5.3/A Independently teaches appraisal of clinical evidence</td>
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PROF1. Compassion, integrity, respect for others, sensitivity to diverse patient populations, adherence to ethical principles

A: Compassion, reflection, sensitivity to diversity  B: Ethics

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<tbody>
<tr>
<td>1.1/A Demonstrates behaviors that convey caring, honesty, genuine interest, and respect for patients and their families</td>
<td>2.1/A Demonstrates capacity for self-reflection, empathy, and curiosity about and openness to different beliefs and points of view, and respect for diversity</td>
<td>3.1/A Elicits beliefs, values, and diverse practices of patients and their families, and understands their potential impact on patient care</td>
<td>4.1/A Develops a mutually agreeable care plan in the context of conflicting physician and patient and/or family values and beliefs</td>
<td>5.1/A Serves as a role model and teacher of compassion, integrity, respect for others, and sensitivity to diverse patient populations</td>
<td></td>
</tr>
<tr>
<td>1.2/A Recognizes that patient diversity affects patient care</td>
<td>2.2/A Provides examples of the importance of attention to diversity in psychiatric evaluation and treatment</td>
<td>3.2/A Routinely displays sensitivity to diversity in psychiatric evaluation and treatment</td>
<td>4.2/A Discusses own cultural background and beliefs and the ways in which these affect interactions with patients</td>
<td>5.2/A Leads resident case discussions regarding ethical issues</td>
<td></td>
</tr>
<tr>
<td>1.3/B Displays familiarity with some basic ethical principles (e.g., confidentiality, informed consent, professional boundaries)</td>
<td>2.3/B Recognizes ethical conflicts in practice and seeks supervision to manage them</td>
<td>3.3/B Recognizes ethical issues in practice and is able to discuss, analyze, and manage these in common clinical situations</td>
<td>5.3/B Adapts to evolving ethical standards (i.e., can manage conflicting ethical standards and values and can apply these to practice)</td>
<td>5.4/B Systematically analyzes and manages ethical issues in complicated and challenging clinical situations</td>
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PROF2. Accountability to self, patients, colleagues, and the profession

A: Fatigue management and work balance  B: Professional behavior and participation in professional community  C: Ownership of patient care

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<tbody>
<tr>
<td>1.1/A Understands the need for sleep, and the impact of fatigue on work</td>
<td>2.1/A Notifies team and elicits back-up when fatigued or ill, so as to ensure good patient care</td>
<td>3.1/A Identifies and manages situations in which maintaining personal emotional, physical, and mental health is challenged, and seeks assistance when needed</td>
<td>4.1/A Knows how to take steps to address impairment in self and in colleagues</td>
<td>5.1/A Develops physician wellness programs or interventions</td>
<td></td>
</tr>
<tr>
<td>1.2/A Lists ways to manage fatigue, and seeks back-up as needed to ensure good patient care</td>
<td>2.2/A Follows institutional policies for physician conduct</td>
<td>3.2/A Recognizes the tension between the needs of personal/family life and professional responsibilities, and its effect on medical care</td>
<td>4.2/A Prioritizes and balances conflicting interests of self, family, and others to optimize medical care and practice of profession</td>
<td>5.2/A Develops organizational policies, programs, or curricula for maintaining professionalism</td>
<td></td>
</tr>
<tr>
<td>1.3/B Exhibits core professional behaviors</td>
<td>2.3/C Accepts the role of the patient's physician and takes responsibility (under supervision) for</td>
<td>4.3/B Prepares for obtaining and</td>
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ICS1. Relationship development and conflict management with patients, families, colleagues, and members of the health care team

A: Relationship with patients  B: Conflict management  C: Team-based care

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<tbody>
<tr>
<td>1.1/A Cultivates positive relationships with patients, families, and team members</td>
<td>2.1/A Develops a therapeutic relationship with patients in uncomplicated situations</td>
<td>3.1/A Develops therapeutic relationships in complicated situations</td>
<td>4.1/A Sustains therapeutic and working relationships during complex and challenging situations, including transitions of care</td>
<td>5.1/A Sustains relationships across systems of care and with patients during long-term follow-up</td>
<td>5.2/A, B Develops models/approaches to managing difficult communications</td>
</tr>
<tr>
<td>1.2/B Recognizes communication conflicts in work relationships</td>
<td>2.2/A Develops working relationships across specialties and systems of care in uncomplicated situations</td>
<td>3.2/B Sustains working relationships in the face of conflict</td>
<td>4.2/C Leads a multidisciplinary care team</td>
<td>5.3/B, C Manages treatment team conflicts as team leader</td>
<td>5.4/C Leads and facilitates meetings within the organization/system</td>
</tr>
<tr>
<td>1.3/C Identifies team-based care as preferred treatment approach, and collaborates as a member of the team</td>
<td>2.3/B Negotiates and manages simple patient/family-related conflicts</td>
<td>3.3/C Facilitates team-based activities in clinical and/or non-clinical situations (including on committees)</td>
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<td>2.4/C Actively participates in team-based care; supports activities of other team members, and communicates their value to the patient and family</td>
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Comments

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### ICS2. Information sharing and record keeping

A: Accurate and effective communication with healthcare team  
B: Effective communications with patients  
C: Maintaining professional boundaries in communication  
D: Knowledge of factors which compromise communication

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<tbody>
<tr>
<td>1.1/A Ensures transitions of care are accurately documented, and optimizes communication across systems and continuums of care</td>
<td>2.1/A, B Organizes both written and oral information to be shared with patient, family, team, and others</td>
<td>3.1/A, B Uses easy-to-understand language in all phases of communication, including working with interpreters</td>
<td>4.1/A, B Demonstrates effective verbal communication with patients, families, colleagues, and other healthcare providers that is appropriate, efficient, concise, and pertinent</td>
<td>5.1/A Models continuous improvement in record keeping</td>
</tr>
<tr>
<td>1.2/A Ensures that the written record (electronic medical record [EMR], personal health records [PHR], patient portal, hand-offs, discharge summaries, etc.) are accurate and timely, with attention to preventing confusion and error, consistent with institutional policies</td>
<td>2.2/B Consistently demonstrates communication strategies to ensure patient and family understanding</td>
<td>3.2/B Consistently engages patients and families in shared decision making</td>
<td>4.2/A, B Demonstrates written communication with patients, families, colleagues, and other healthcare providers that is appropriate, efficient, concise, and pertinent</td>
<td>5.2/C Participates in the development of changes in rules, policies, and procedures related to technology</td>
</tr>
<tr>
<td>1.3/B Engages in active listening, &quot;teach back,&quot; and other strategies to ensure patient and family understanding</td>
<td>2.3/B Demonstrates appropriate face-to-face interaction while using EMR</td>
<td>3.3/B Grows examples of situations in which communication can be compromised (e.g., perceptual impairment, cultural differences, transference, limitations of electronic media)</td>
<td>4.3/C Uses discretion and judgment in the inclusion of sensitive patient material in the medical record</td>
<td></td>
</tr>
<tr>
<td>1.4/C Maintains appropriate boundaries in sharing information by electronic communication</td>
<td>2.4/C Understands issues raised by the use of social media by patients and providers</td>
<td>2.5/D Lists factors that affect information sharing (e.g., intended audience, purpose, need to know)</td>
<td>4.4/C Uses discretion and judgment in electronic communication with patients, families, and colleagues</td>
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[Close Window]
OUTPATIENT GENERAL PSYCHIATRY COMBINING PSYCHOPHARM & PSYCHOTHERAPY

SUPERVISOR EVALUATION OF RESIDENT

[Subject Name]
[Subject Status]
[Evaluation Dates]
[Subject Rotation]

Evaluator
[Evaluator Name]
[Evaluator Status]

Ability to integrate psychotherapeutic and psychopharmacologic interventions in a mutually beneficial manner so that neither is neglected:

<table>
<thead>
<tr>
<th>Competent</th>
<th>Approaching Competency</th>
<th>Satisfactorily Competent</th>
<th>Highly Competent</th>
<th>Exceptionally Competent</th>
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Ability to conduct a complete medication assessment within the context of a psychotherapeutic process, while making interpretations and empathetic comments:

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Ability to appreciate the potential psychodynamic issues around the prescribing of medications (resistance, compliance, adherence, medication as a 'good object', etc):

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</table>

Ability to assess suicidality on an ongoing basis as it relates to the prescribing of potentially dangerous medications:

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PLEASE OPEN ROTATION SPECIAL GENERAL PSYCHOPHARM & PSYCHOTHERAPY SUPERVISION PATIENT CARE AND CLICK ASSESSMENT OF COMPETENCY LEVEL

Overall Comments:

Remaining Characters: 5,000

Subcompetency questions are generated based on the resident’s rotation.

DPSY:PSY:OPD-KCHC (Department of Psychiatry/PSY – Psychiatry)

PC1. Psychiatric Evaluation

A: General interview skills  B: Collateral information gathering and use  C: Safety assessment  D: Use of clinician’s emotional response

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<tbody>
<tr>
<td>1.1/A Obtains general medical and psychiatric history and completes a mental status examination</td>
<td>2.1/A Acquires efficient, accurate, and relevant history customized to the patient’s complaints</td>
<td>3.1/A Consistently obtains complete, accurate, and relevant history</td>
<td>4.1/A Routinely identifies subtle and unusual findings</td>
<td>5.1/A Serves as a role model for gathering subtle and reliable information from the patient</td>
</tr>
<tr>
<td>1.2/B Obtains relevant collateral information from secondary sources</td>
<td>2.2/B Performs a targeted examination, including neurological examination, relevant to the patient’s complaints</td>
<td>3.2/A Performs efficient interview and examination with flexibility appropriate to the clinical setting and workload demands</td>
<td>4.2/B Follows close to identify relevant historical findings in complex clinical situations and unfamiliar circumstances</td>
<td>5.2/A, B Teaches and supervises other learners in clinical evaluation</td>
</tr>
<tr>
<td>1.3/C Screens for patient safety, including suicidal</td>
<td>3.3/B Selects laboratory and</td>
<td>4.3/D Begins to use the clinician’s</td>
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PC2. Psychiatric Formulation and Differential Diagnosis

A: Organizes and summarizes findings and generates differential diagnosis B: Identifies contributing factors and contextual features and creates a formulation

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<tbody>
<tr>
<td>1.1/A Organizes and accurately summarizes, reports, and presents to colleagues information obtained from the patient evaluation</td>
<td>2.1/A Identifies patterns and recognizes phenomenology from the patient's presentation to generate a diagnostic hypothesis</td>
<td>3.1/A Develops a full differential diagnosis while avoiding premature closure</td>
<td>4.1/A Incorporates subtle, unusual, or conflicting findings into hypotheses and formulations</td>
<td>5.1/B Serves as a role model and efficient and accurate formulation</td>
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</tr>
<tr>
<td>1.2/A Develops a working diagnosis based on the patient evaluation</td>
<td>2.2/A Develops a basic differential diagnosis for common syndromes and patient presentations</td>
<td>3.2/B Organizes formulation around comprehensive models of phenomenology that take etiology into account</td>
<td>4.2/B Efficiently synthesizes all information into a concise but comprehensive formulation</td>
<td>5.2/B Teaches formulation to advanced learners</td>
<td></td>
</tr>
<tr>
<td>2.3/B Describes patients' symptoms and problems, precipitating stressors or events, predisposing life events or stressors, perpetuating and protective factors, and prognosis</td>
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PC3. Treatment Planning and Management

A: Creates treatment plan B: Manages patient crises, recognizing need for supervision when indicated C: Monitors and revises treatment when indicated

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<tbody>
<tr>
<td>1.1/A Identifies potential treatment options</td>
<td>2.1/A Sets treatment goals in collaboration with the patient</td>
<td>3.1/A Incorporates manual-based treatment plan when appropriate</td>
<td>4.1/A Devises individualized treatment plan for complex presentations</td>
<td>5.1/A Supervises treatment planning of other learners and multidisciplinary providers</td>
<td></td>
</tr>
<tr>
<td>1.2/A Recognizes patient in crisis or acute presentation</td>
<td>2.2/A Incorporates a clinical practice guideline or treatment algorithm when available</td>
<td>3.2/A Applies an understanding of psychiatric, neurologic, and medical co-morbidities to treatment selection</td>
<td>4.2/A Integrates multiple modalities and providers in comprehensive approach</td>
<td>5.2/A Integrates emerging neurobiological and genetetic knowledge into treatment plan</td>
<td></td>
</tr>
<tr>
<td>1.3/C Recognizes patient readiness for treatment</td>
<td>2.3/A Recognizes co-morbid conditions and side effects’ impact on treatment</td>
<td>3.3/A Links treatment to formulation</td>
<td>4.3/C Appropriately modifies treatment techniques and flexibly applies practice guidelines to fit patient need</td>
<td></td>
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<tr>
<td></td>
<td>2.4/B Manages patient crises with supervision</td>
<td>3.4/B Recognizes need for consultation and supervision for complicated or refractory cases</td>
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<td></td>
<td>2.5/C Monitors treatment adherence and response</td>
<td>3.5/C Re-evaluates and revises treatment approach based on new information and or response to treatment</td>
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PC4. Psychotherapy. Refers to 1) the practice and delivery of psychotherapies, including psychodynamic, cognitive–behavioral, and supportive therapies; 2) exposure to couples, family, and group therapies; and 3) integrating psychotherapy with psychopharmacology

A: Empathy and process B: Boundaries C: The alliance and provision of psychotherapies D: Seeking and providing psychotherapy supervision

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<tbody>
<tr>
<td>1.1/A Accurately identifies patient emotions, particularly sadness, anger, and fear</td>
<td>2.1/A Identifies and reflects the core feeling and key issue for the patient during a session</td>
<td>3.1/A Identifies and reflects the core feeling, key issue, and what the issue means to the patient</td>
<td>4.1/A Links feelings, behavior, recurrent/central themes, and their meaning to the patient as they shift within and across sessions</td>
<td>5.1/C Provides psychotherapies to patients with very complicated or refractory disorders/problems</td>
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</tr>
<tr>
<td>1.2/B Maintains appropriate professional boundaries</td>
<td>2.2/B Maintains appropriate professional boundaries in psychotherapeutic relationships while being responsive to the patient</td>
<td>3.2/B Recognizes and avoids potential boundary violations</td>
<td>4.2/B Anticipates and appropriately manages potential boundary crossings and avoids boundary</td>
<td>5.2/C Personalizes treatment based on awareness of one’s own skill sets, strengths, and limitations</td>
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<td>1.3/C Demonstrates a professional</td>
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<td>2.7/B</td>
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<td>Level 2</td>
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<td></td>
<td>2.8/A: Appropriately monitors adverse effects and adjusts treatment accordingly.</td>
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<td>2.8/A: Appropriately integrates psychopharmacological agents with other treatments.</td>
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<td>2.8/A: Appropriately integrates psychopharmacological agents with other treatments.</td>
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<td>Level 5</td>
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<td>2.8/A: Appropriately integrates psychopharmacological agents with other treatments.</td>
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## PCS: Somatic Therapies

Somatic therapies including psychopharmacology, electroconvulsive therapy (ECT), and emerging neuromodulation therapies.

### PCS: Psychopharmacology

- 1/A: Lists common psychopharmacological agents used to treat depression and bipolar disorder.
- 1/A: Explains the mechanisms of action, side effects, and indications for use.

### PCS: Electroconvulsive Therapy (ECT)

- 1/A: Explains the mechanisms of action, side effects, and indications for use.

### PCS: Emerging Neuromodulation Therapies

- 1/A: Lists common emerging neurostimulation devices and their mechanisms of action.
- 1/A: Explains the side effects and indications for use.

### PCS: Overall

- 1/A: Surveys the current state of somatic therapies and emerging technologies in mental health treatment.
MK1. Development through the life cycle (including the impact of psychopathology on the trajectory of development and development on the expression of psychopathology)

A: Knowledge of human development  B: Knowledge of pathological and environmental influences on development  C: Incorporation of developmental concepts in understanding

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<tr>
<td>1.1/A Describes the basic stages of normal physical, social, and cognitive development through the life cycle</td>
<td>2.1/A Describes neural development across the life cycle</td>
<td>3.1/A Explains developmental tasks and transitions throughout the life cycle, utilizing multiple conceptual models</td>
<td>4.1/B Describes the influence of acquisition and loss of specific capacities in the expression of psychopathology across the life cycle</td>
<td>5.1/A Incorporates new neuroscientific knowledge into his or her understanding of development</td>
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<tr>
<td>2.2/A Recognizes deviation from normal development, including arrest and regressions at a basic level</td>
<td>2.3/B Describes the effects of emotional and sexual abuse on the development of personality and psychiatric disorders in infancy, childhood, adolescence, and adulthood at a basic level</td>
<td>3.2/B Describes the influence of psychosocial factors (gender, ethnic, cultural, economic, general medical, and neurological illness on personality development)</td>
<td>4.2/B Gives examples of gene-environment interaction influences on development and psychopathology</td>
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<tr>
<td>2.4/C Utilizes developmental concepts in case formulation</td>
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<td>3.3/C Utilizes appropriate conceptual models of development in case formulation</td>
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MK2. Psychopathology. Includes knowledge of diagnostic criteria, epidemiology, pathophysiology, course of illness, co-morbidities, and differential diagnosis of psychiatric disorders, including
substance use disorders and presentation of psychiatric disorders across the life cycle and in diverse patient populations (e.g., different cultures, families, genders, sexual orientation, ethnicity, etc.)

A: Knowledge to identify and treat psychiatric conditions
B: Knowledge to assess risk and determine level of care
C: Knowledge at the interface of psychiatry and the rest of medicine

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<tr>
<td>1.1/A Identifies the major psychiatric diagnostic system (DSM)</td>
<td>2.1/A Demonstrates sufficient knowledge to identify and treat common psychiatric conditions in adults in inpatient and emergency settings (e.g., depression, mania, acute psychosis)</td>
<td>3.1/A Demonstrates sufficient knowledge to identify and treat most psychiatric conditions throughout the life cycle and in a variety of settings</td>
<td>4.1/A Demonstrates sufficient knowledge to identify and treat atypical and complex psychiatric conditions throughout the life cycle and in a variety of settings</td>
<td>5.1/B Displays knowledge sufficient to select appropriate level of care for patients with unusual medical disorders, recognizing the need for a multidisciplinary approach</td>
<td>5.1/B Displays knowledge sufficient to teach assessment of risks and the appropriate level of care for patients who may represent a danger to self and/or others</td>
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<tr>
<td>1.2/B Lists major risk and protective factors for danger to self and others</td>
<td>2.2/B Demonstrates knowledge of, and the ability to weigh, risk and protective factors for, danger to self and/or others across the life cycle, as well as the ability to determine the need for acute psychiatric hospitalization</td>
<td>3.2/B Displays knowledge of, and the ability to weigh, risk and protective factors for, danger to self and/or others across the life cycle, and in a variety of settings</td>
<td>4.2/B Displays knowledge sufficient to determine the appropriate level of care for patients expressing, or who may represent, danger to self and/or others, across the life cycle and in a full range of treatment settings</td>
<td>5.2/C Shows sufficient knowledge to identify and treat atypical and complex psychiatric conditions in patients with medical disorders</td>
<td>5.3/C Demonstrates knowledge of and the ability to weigh, risk and protective factors for, danger to self and/or others, across the life cycle and in a full range of treatment settings</td>
</tr>
<tr>
<td>1.3/C Gives examples of interactions between medical and psychiatric symptoms and disorders</td>
<td>2.3/C Shows sufficient knowledge to perform an initial medical and neurological evaluation in psychiatric inpatients</td>
<td>3.3/C Shows sufficient knowledge to identify and treat common psychiatric manifestations of medical illness (e.g., delirium, depression, steroid-induced syndromes)</td>
<td>4.3/C Shows knowledge sufficient to identify and treat a wide range of psychiatric conditions in patients with medical disorders</td>
<td>5.4/C Demonstrates sufficient knowledge to systematically screen for, evaluate, and diagnose common medical conditions in psychiatric patients, and to ensure appropriate further evaluation and treatment of these conditions in collaboration with other medical providers</td>
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<tr>
<td>2.4/C Demonstrates sufficient knowledge to identify common medical conditions (e.g., hypothyroidism, hyperlipidemia, diabetes) in psychiatric patients</td>
<td>3.4/C Demonstrates sufficient knowledge to include relevant medical and neurological conditions in the differential diagnoses of psychiatric patients</td>
<td>4.4/C Demonstrates sufficient knowledge to systematically screen for, evaluate, and diagnose common medical conditions in psychiatric patients, and to ensure appropriate further evaluation and treatment of these conditions in collaboration with other medical providers</td>
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MK3. Clinical Neuroscience. Includes knowledge of neurology, neuropsychiatry, neurodiagnostic testing, and relevant neuroscience and their application in clinical settings

A: Neurodiagnostic testing
B: Neuropsychological testing
C: Neuropsychiatric co-morbidity
D: Neurobiology
E: Applied neuroscience
### MK4. Psychotherapy

Refers to knowledge regarding: 1) individual psychotherapies, including but not limited to psychodynamic, cognitive–behavioral, and supportive therapies; 2) couples, family, and group therapies; and, 3) integrating psychotherapy and psychopharmacology

**A:** Knowledge of psychotherapy: theories  
**B:** Knowledge of psychotherapy: practice  
**C:** Knowledge of psychotherapy: evidence base

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<tr>
<td>1.1/A Identifies psycho–dynamic, cognitive–behavioral, and supportive therapies as major psychotherapeutic modalities</td>
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<td>2.1/A Describes the basic principles of each of the three core individual psychotherapy traditions</td>
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<td>3.1/A Describes the historical and conceptual development of psychotherapeutic paradigms</td>
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<td>4.1/A Discusses the evidence base for combining different psychotherapies and psychopharmacology</td>
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<td>5.1/A Integrates the evidence base for microtheoretical developments into the knowledge base</td>
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### MKS: Somatic Therapies

Medical Knowledge of somatic therapies, including psychopharmacology, ECT, and emerging somatic therapies, such as transcranial magnetic stimulation (TMS) and vagus nerve stimulation (VNS)

**A:** Knowledge of indications, metabolism and mechanism of action for medications

**B:** Knowledge of ECT and other emerging somatic treatments

**C:** Knowledge of lab studies and measures in monitoring treatment

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<tr>
<td>1.1/A Describes general indications and common side effects for commonly prescribed psychopharmacologic agents</td>
<td>2.1/A Describes hypothalamic mechanisms of action and metabolism for commonly prescribed psychopharmacologic agents</td>
<td>3.1/A Demonstrates an understanding of pharmacokinetic and pharmacodynamic drug interactions</td>
<td>4.1/A Describes the evidence supporting the use of multiple medications in certain treatment situations (e.g., polypharmacy and augmentation)</td>
<td>5.1/A Integrates emerging studies of somatic treatments into knowledge base</td>
<td>5.2/A Effectively teaches at a post-graduate level evidence-based or best somatic treatment practices</td>
</tr>
<tr>
<td>1.2/B Describes indications for ECT</td>
<td>2.2/A Describes indications for second- and third-line psychopharmacologic agents</td>
<td>3.2/A Demonstrates an understanding of psychotropic selection based on current practice guidelines or treatment algorithms for common psychiatric disorders</td>
<td>4.2/C Integrates knowledge of the titration and side effect management of multiple medications, monitoring the appropriate lab studies, and how emerging physical and laboratory findings impact somatic treatments</td>
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<td>2.3/A Describes less frequent but potentially serious/dangerous adverse effects for commonly prescribed psychopharmacologic agents</td>
<td>3.3/B Describes specific techniques in ECT</td>
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<td>2.4/A Describes expected time course of response for commonly prescribed classes of psychotropic agents</td>
<td>3.4/B Lists emerging neuro-modulation therapies</td>
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<td>2.5/A Describes length and frequency of ECT treatments, as well as relative contraindications</td>
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MK6. Practice of Psychiatry

A: Ethics B: Regulatory compliance C: Professional development and frameworks

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<tbody>
<tr>
<td>1.1/A Lists common ethical issues in psychiatry</td>
<td>2.1/A Lists and discusses sources of professional standards of ethical practice</td>
<td>3.1/A Discusses conflict of interest and management</td>
<td>4.1/B Describes the existence of state and regional variations regarding practice, involuntary treatment, health regulations, and psychiatric forensic evaluation</td>
<td>5.1/B Describes international variations regarding practice, involuntary treatment, and health regulations</td>
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</tr>
<tr>
<td>1.2/B Recognizes and describes institutional policies and procedures</td>
<td>2.2/A Lists situations that mandate reporting or breach of confidentiality</td>
<td>3.2/B Describes applicable regulations for billing and reimbursement</td>
<td>4.2/C Describes professional advocacy</td>
<td>5.2/C Proposes advocacy activities, policy development, or scholarly contributions related to professional standards</td>
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<tr>
<td>1.3/C Lists ACCME Competencies</td>
<td>2.3/C Describes how to keep current on regulatory and practice management issues</td>
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<td>4.3/C Describes how to seek out and integrate new information on the practice of psychiatry</td>
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SBP1. Patient Safety and the Health care Team

A: Medical errors and improvement activities B: Communication and patient safety C: Regulatory and educational activities related to patient safety

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<tbody>
<tr>
<td>1.1/A Differentiates among medical errors, near misses, and sentinel events</td>
<td>2.1/A Describes the common system causes for errors</td>
<td>3.1/A Describes systems and procedures that promote patient safety</td>
<td>4.1/A Participates in formal analysis (e.g., root-cause analysis, failure mode effects analysis) of medical errors and sentinel</td>
<td>5.1/A Leads multidisciplinary teams (e.g., human factors engineers, social scientists) to address patient</td>
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### SBP2. Resource Management (may include diagnostics, medications, level of care, other treatment providers, access to community assistance)

**A: Costs of care and resource management**

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<tr>
<td>1.1/A Recognizes need for efficient and equitable use of resources</td>
<td>2.1/A Recognizes disparities in health care at individual and community levels</td>
<td>3.1/A Coordinates patient access to community and system resources</td>
<td>4.1/A Practices cost-effective, high-value clinical care, using evidence-based tools and information technologies to support decision making</td>
<td>5.1/A Designs measurement tools to monitor and provide feedback to providers/teams on resource consumption to facilitate improvement</td>
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<tr>
<td>2.2/A Knows the relative cost of care (e.g., medication costs, diagnostic costs, level of care costs, procedure costs)</td>
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### SBP3. Community-Based Care

**A: Community-based programs B: Self-help groups C: Prevention D: Recovery and rehabilitation**

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<tr>
<td>1.1/A Gives examples of community mental health systems of</td>
<td>2.1/A Coordinates care with community mental health agencies, including</td>
<td>3.1/A Incorporates disorder-specific support and advocacy groups in</td>
<td>4.1/B Routinely uses self-help groups, community resources, and social</td>
<td>5.1/A Participates in the administration of community-based treatment programs</td>
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### SBP4. Consultation to non-psychiatric medical providers and non-medical systems (e.g., military, schools, businesses, forensic)

A: Distinguishes care provider roles related to consultation  
B: Provides care as a consultant and collaborator  
C: Specific consultative activities

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<tr>
<td>1.1/A Describes the difference between consultant and primary treatment provider</td>
<td>2.1/A Describes differences in providing consultation for the system or team versus the individual patient</td>
<td>3.1/C Assists primary treatment care team in identifying unrecognized clinical care issues</td>
<td>4.1/B Provides integrated care for psychiatric patients through collaboration with other physicians</td>
<td>5.1/B Provides psychiatric consultations to larger systems</td>
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<tr>
<td>2.1/B Provides consultation to other medical services</td>
<td>3.2/C Identifies system issues in clinical care and provides recommendations</td>
<td>4.2/C Manages complicated and challenging consultation requests</td>
<td>5.2/B Leads a consultation team</td>
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<tr>
<td>2.3/C Clarifies the consultation question</td>
<td>3.3/C Discusses methods for integrating mental health and medical care in treatment planning</td>
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<td>2.4/C Conducts and reports a basic decisional capacity evaluation</td>
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PBL11. Development and execution of lifelong learning through constant self-evaluation, including critical evaluation of research and clinical evidence

A: Self-Assessment and self-Improvement  B: Evidence in the clinical workflow

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<tr>
<td>1.1/A Uses feedback from teachers, colleagues, and patients to assess own level of knowledge and expertise</td>
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<td>1.2/A Recognizes limits of one's knowledge and skills and seeks supervision</td>
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<td>1.3/B Describes and ranks levels of clinical evidence</td>
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<tr>
<td>2.1/A Regularly seeks and incorporates feedback to improve performance</td>
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<td>2.2/A Identifies self-directed learning goals and periodically reviews them with supervisory guidance</td>
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<td>2.3/B Formulates a searchable question from a clinical question</td>
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<td>3.1/A Demonstrates a balanced and accurate self-assessment of competence, using clinical outcomes to identify areas for continued improvement</td>
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<td>3.2/B Selects an appropriate, evidence-based information tool to meet self-identified learning goals</td>
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<td>3.3/B Critically appraises different types of research, including randomized controlled trials (RCTs), systematic reviews, meta-analyses, and practice guidelines</td>
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<td>4.1/A Demonstrates improvement in clinical practice based on continual self-assessment and evidence-based information</td>
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<td>4.2/A Identifies and meets self-directed learning goals with little external guidance</td>
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<td>4.3/A, B Demonstrates use of a system or process for keeping up with relevant changes in medicine</td>
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<td>4.4/B Independently searches for and discriminates evidence relevant to clinical practice problems</td>
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<td>5.1/A, B Sustains practice of self-assessment and keeping up with relevant changes in medicine, and makes informed, evidence-based clinical decisions</td>
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<td>5.2/B Teaches others techniques to efficiently incorporate evidence gathering into clinical workflow</td>
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<td>5.3/B Independently teaches appraisal of clinical evidence</td>
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PBL12. Formal practice-based quality improvement based on established and accepted methodologies

A: Specific quality improvement project  B: Quality improvement didactic knowledge

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<tr>
<td>1.1/A Recognizes potential gaps in quality of care and system-level inefficiencies</td>
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<tr>
<td>1.2/B Discusses with supervisors possible quality gaps and problems with psychiatric care delivery</td>
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<tr>
<td>2.1/A Narrows problems within own clinical service(s) to a specific and achievable aim for a quality improvement (QI) project</td>
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<tr>
<td>2.2/A Identifies factors and causal chains contributing to quality gaps within own institution and practice</td>
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<tr>
<td>3.1/A Involves appropriate stakeholders in design of a QI project</td>
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<tr>
<td>3.2/B Lists common responses of teams and individuals to changes in clinical operations and describes strategies for managing some</td>
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<td>4.1/A Substantially contributes to a supervised project to address specific quality deficit within own clinical service(s), and measures relevant outcomes</td>
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<tr>
<td>4.2/B Describes basic methods for implementation and evaluation of clinical QI projects</td>
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<tr>
<td>5.1/A Independently proposes and leads projects to enhance patient care</td>
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<td>5.2/A Uses advanced quality measurement and &quot;dashboard&quot; tools</td>
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<tr>
<td>5.3/B Describes core concepts of advanced QI methodologies and business processes</td>
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## PBLi3. Teaching

**A: Development as a teacher B: Observable teaching skills**

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<tbody>
<tr>
<td>1.1/A Recognizes role of physician as teacher</td>
<td>2.1/A Assumes a role in the clinical teaching of early learners</td>
<td>3.1/A Participates in activities designed to develop and improve teaching skills</td>
<td>4.1/A Gives formal didactic presentation to groups (e.g., grand rounds, case conference, journal club)</td>
<td>5.1/A Educates broader professional community and/or public (e.g., presents at regional or national meeting)</td>
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</table>

| 2.2/B Communicates goals and objectives for instruction of early learners | 3.2/B Organizes content and methods for individual instruction for early learners | 4.2/B Effectively uses feedback on teaching to improve teaching methods and approaches | 5.2/B Organizes and develops curriculum materials |

| 2.3/B Evaluates and provides feedback to early learners | 4.3/B Evaluates and provides feedback to early learners | 5.3/B Evaluates and provides feedback to early learners | 6.3/B Evaluates and provides feedback to early learners |

## PROFi1. Compassion, integrity, respect for others, sensitivity to diverse patient populations, adherence to ethical principles

**A: Compassion, reflection, sensitivity to diversity B: Ethics**

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</thead>
<tbody>
<tr>
<td>1.1/A Demonstrates behaviors that convey caring, honesty, genuine interest, and respect for patients and their families</td>
<td>2.1/A Demonstrates capacity for self-reflection, empathy, and curiosity about openness to different beliefs and points of view, and respect for diversity</td>
<td>3.1/A Elicits beliefs, values, and diverse practices of patients and their families, and understands their potential impact on patient care</td>
<td>4.1/A Develops a mutually agreeable care plan in the context of conflicting physician and patient and/or family values and beliefs</td>
<td>5.1/A Serves as a role model and teacher of compassion, integrity, respect for others, and sensitivity to diverse patient populations</td>
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</tbody>
</table>

| 1.2/A Recognizes that patient diversity affects patient care | 2.2/A Provides examples of the importance of attention to diversity in psychiatric evaluation and treatment | 3.2/A Routinely displays sensitivity to diversity in psychiatric evaluation and treatment | 4.2/A Discusses own cultural background and beliefs and the ways in which these affect interactions with patients | 5.2/B Leads case discussions regarding ethical issues |

| 1.3/B Displays familiarity with some basic ethical principles (e.g., confidentiality, informed consent, professional boundaries) | 2.3/B Recognizes ethical conflicts in practice and seeks supervision to manage them | 3.3/B Recognizes ethical issues in practice and is able to discuss, analyze, and manage these in common clinical situations | 5.3/B Adapts to evolving ethical standards (i.e., can manage conflicting ethical standards and values and can apply these to practice) | 6.3/B Adapts to evolving ethical standards (i.e., can manage conflicting ethical standards and values and can apply these to practice) |
PROF2. Accountability to self, patients, colleagues, and the profession

A: Fatigue management and work balance  B: Professional behavior and participation in professional community  
C: Ownership of patient care

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</thead>
<tbody>
<tr>
<td>1.1/A Understands the need for sleep, and the impact of fatigue on work</td>
<td>2.1/A Notifies team and enlists back-up when fatigued or ill, so as to ensure good patient care</td>
<td>3.1/A Identifies and manages situations in which maintaining personal emotional, physical, and mental health is challenged, and seeks assistance when needed</td>
<td>4.1/A Knows how to take steps to address impairment in self and in colleagues</td>
<td>5.1/A/Develops physician wellness programs or interventions</td>
<td>5.2/A/Develops organizational policies, programs, or curricula for physician professionalism</td>
</tr>
<tr>
<td>1.2/A Lists ways to manage fatigue, and seeks back-up as needed to ensure good patient care</td>
<td>2.2/B Follows institutional policies for physician conduct</td>
<td>3.2/A Recognizes the tension between the needs of personal/family life and professional responsibilities, and its effect on medical care</td>
<td>4.2/A Prioritizes and balances conflicting interests of self, family, and others to optimize medical care and practice of profession</td>
<td>5.3/A/Participates in the professional community (e.g., professional societies, patient advocacy groups, community service organizations)</td>
<td>5.4/A/Serves as a role model in demonstrating responsibility for ensuring that patients receive the best possible care</td>
</tr>
<tr>
<td>1.3/B/Exhibits core professional behaviors</td>
<td>2.3/C Accepts the role of the patient’s physician and takes responsibility (under supervision) for ensuring that the patient receives the best possible care</td>
<td>3.3/B Recognizes the importance of participating in one’s professional community</td>
<td>4.3/B Prepares for obtaining and maintaining board certification</td>
<td>4.4/C/Displays increasing autonomy and leadership in taking responsibility for ensuring that patients receive the best possible care</td>
<td></td>
</tr>
<tr>
<td>1.4/A/Displays openness to feedback</td>
<td></td>
<td>3.4/C Is recognized by self, patient, patient’s family, and medical staff members as the patient’s primary psychiatric provider</td>
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<td>1.5/C/Introduces self as patient’s physician</td>
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Comments

Remaining Characters: 5,000

ICS1. Relationship development and conflict management with patients, families, colleagues, and members of the health care team

A: Relationship with patients  B: Conflict management  C: Team-based care

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<tbody>
<tr>
<td>1.1/A Cultivates positive relationships with patients, families, and team members</td>
<td>2.1/A Develops a therapeutic relationship with patients in uncomplicated situations</td>
<td>3.1/A Develops therapeutic relationships in complicated situations</td>
<td>4.1/A Sustains therapeutic and working relationships during complex and challenging situations, including transitions of care</td>
<td>5.1/A Sustains relationships across systems of care and with patients during long-term follow-up</td>
<td>5.2/A, B Develops models/approaches to managing difficult communications</td>
</tr>
<tr>
<td>1.2/B Recognizes communication conflicts in work relationships</td>
<td>2.2/A Develops working relationships across specialties and systems of care in uncomplicated situations</td>
<td>3.2/B Sustains working relationships in the face of conflict</td>
<td>4.2/C Leads a multidisciplinary care team</td>
<td>5.3/B, C Manages treatment team conflicts as team leader</td>
<td>5.4/C Leads and facilitates meetings within the organization/system</td>
</tr>
<tr>
<td>1.3/C Identifies team-based care as preferred treatment approach, and collaborates as a member of the team</td>
<td>2.3/B Negotiates and manages simple patient/family-related conflicts</td>
<td>3.3/C Facilitates team-based activities in clinical and/or non-clinical situations (including on committees)</td>
<td>4.3/C Uses discretion and technology</td>
<td>5.5/A Models continuous improvement in record keeping</td>
<td>5.6/A Models continuous improvement in record keeping</td>
</tr>
<tr>
<td>2.4/A Actively participates in team-based care; supports activities of other team members, and communicates their value to the patient and family</td>
<td>2.4/B Consistently demonstrates communication strategies to ensure patient and family understanding</td>
<td>3.4/B Consistently engages patients and families in shared decision making</td>
<td>4.4/A, B Demonstrates written communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent</td>
<td>5.7/A Models continuous improvement in record keeping</td>
<td>5.8/A Models continuous improvement in record keeping</td>
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### Remaining Characters: 5,000

**ICS2. Information sharing and record keeping**

A: Accurate and effective communication with health care team B: Effective communications with patients C: Maintaining professional boundaries in communication D: Knowledge of factors which compromise communication

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<tbody>
<tr>
<td>1.1/A Ensures transitions of care are accurately documented, and optimizes communication across systems and continuums of care</td>
<td>2.1/A, B Organizes both written and oral information to be shared with patient, family, team, and others</td>
<td>3.1/A, B Uses easy-to-understand language in all phases of communication, including working with interpreters</td>
<td>4.1/A, B Demonstrates effective verbal communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent</td>
<td>5.1/A Models continuous improvement in record keeping</td>
</tr>
<tr>
<td>1.2/A Ensures that the written record (electronic medical record [EMR], personal health records [PHR]/patient portal, hand-offs, discharge summaries, etc.) are accurate and timely, with attention to preventing confusion and error, consistent with institutional policies</td>
<td>2.2/B Consistently demonstrates communication strategies to ensure patient and family understanding</td>
<td>3.2/B Consistently engages patients and families in shared decision making</td>
<td>4.2/A, B Demonstrates written communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent</td>
<td>5.2/C Participates in the development of changes in rules, policies, and procedures related to technology</td>
</tr>
<tr>
<td>1.3/B Engages in</td>
<td>2.3/B Demonstrates appropriate face-to-face interaction while using EMR</td>
<td>3.3/D Gives examples of situations in which communication can be compromised (e.g., perceptual impairment, cultural differences, transference, limitations of electronic media)</td>
<td>4.3/C Uses discretion and technology</td>
<td>5.3/C Participates in the development of changes in rules, policies, and procedures related to technology</td>
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<tr>
<td>1.4/C Maintains appropriate boundaries in sharing information by electronic communication</td>
<td>2.5/D Lists factors that affect information sharing (e.g., intended audience, purpose, need to know)</td>
<td>Judgment in the inclusion of sensitive patient material in the medical record</td>
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<td>2.6/D Lists effects of computer use on accuracy of information gathering and recording and potential disruption of the physician/patient/family relationship</td>
<td>4.4/C Uses discretion and judgment in electronic communication with patients, families, and colleagues</td>
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Comments:

Remaining Characters: 5,000
Information Source (check all that apply)
- Resident report
- Direct observation
- Videotape
- Audiocassette
- Record review

MAINTAINS THE TREATMENT FRAME: Able to define the therapeutic contract with the patient, including time and fee.

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SUPPORTIVE PSYCHOTHERAPY

Ability to elicit, identify, and appropriately contain affect in the patient

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Ability to employ crisis intervention techniques

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Ability to utilize stress management techniques

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PSYCHODYNAMIC PSYCHOTHERAPY

Ability to recognize central dynamic issues / core conflicts

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Ability to conceptualize a psychodynamic formulation

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Ability to link patterns of thought from the patient's past, present, and in the transference.

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Ability to describe the patient's major defenses

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Ability to clarify, confront, and make interpretations at appropriate times.

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Ability to be aware of countertransference feelings and use

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Therapist's general level of activity is appropriate, i.e. reasonable balance between open ended listening and structured questioning.

COGNITIVE BEHAVIORAL THERAPY

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Ability to set a collaborative agenda for each session, manage timelines, and set goals.

Ability to identify and alter cognitive distortions in order to alleviate symptoms

Ability to help the patient recognize automatic thoughts, maladaptive assumptions, and core beliefs and schemas.

Ability to identify and alter cognitive distortions in order to alleviate symptoms.

Ability to help patients develop new, more rational responses to automatic thoughts and core beliefs.

Ability to help patients implement behavioral experiments, such as activity monitoring with reward paradigms.

Ability to implement in vivo exposure and relaxation interventions.

PLEASE COMMENT IN SUMMARY FASHION AS PRECISELY AS YOU CAN ON THE RESIDENT'S STRENGTHS AS A PSYCHOTHERAPIST, AND LIMITATIONS OR AREAS FOR IMPROVEMENT

Overall Comments:

Remaining Characters: 5,000

Subcompetency questions are generated based on the resident's rotation.

DPSY:PSY: SPECIAL GENERAL PSYCHOPHARM & PSYCHOTHER SUPERVISION PATIENT CARE (Department of Psychiatry/PSY - Psychiatry)

PC4. Psychotherapy. Refers to 1) the practice and delivery of psychotherapies, including psychodynamic, cognitive-behavioral, and supportive therapies; 2) exposure to couples, family, and group therapies; and 3) integrating psychotherapy with psychopharmacology

A: Empathy and process B: Boundaries C: The alliance and provision of psychotherapies D: Seeking and providing psychotherapy supervision
### PCS, Somatic Therapies

Somatic therapies including psychopharmacology, electroconvulsive therapy (ECT), and emerging neuromodulation therapies

A: Using psychopharmacologic agents in treatment  
B: Education of patient about medications  
C: Monitoring of patient response to treatment and adjusting accordingly  
D: Other somatic treatments

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</thead>
<tbody>
<tr>
<td>1.1/A</td>
<td>Lists commonly used psychopharmacologic agents and their indications to target specific psychiatric symptoms (e.g., depression).</td>
<td>2.1/A</td>
<td>Appropriately prescribes commonly used psychopharmacologic agents.</td>
<td>3.1/A</td>
<td>Manages pharmacokinetic and pharmacodynamic drug interactions when using multiple medications concurrently.</td>
</tr>
<tr>
<td>1.2/B</td>
<td>Maintains appropriate professional boundaries.</td>
<td>2.2/B</td>
<td>Incorporates</td>
<td>3.2/B</td>
<td>Recognizes and avoids potential boundary violations.</td>
</tr>
<tr>
<td>1.3/C</td>
<td>Demonstrates a professional interest and curiosity in a patient's story.</td>
<td>2.3/C</td>
<td>Establishes and maintains a therapeutic alliance with patients with uncomplicated problems.</td>
<td>3.3/C</td>
<td>Establishes and maintains a therapeutic alliance with patients with uncomplicated problems.</td>
</tr>
<tr>
<td>2.4/C</td>
<td>Utilizes elements of supportive therapy in treatment of patients.</td>
<td>3.4/C</td>
<td>Manages the emotional content of, and feelings aroused during, sessions.</td>
<td>4.4/C</td>
<td>Selects a psychotherapeutic modality, and tailors the selected psychotherapy to the patient.</td>
</tr>
<tr>
<td>3.5/C</td>
<td>Integrates the selected psychotherapy with other treatment modalities and other treatment providers.</td>
<td>4.5/C</td>
<td>Successfully guides the patient through the different phases of psychotherapy, including termination.</td>
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<tr>
<td>3.6/D</td>
<td>Balances autonomy with needs for consultation and supervision.</td>
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### Comments

Remaining Characters: 5,000

[https://www.new-innov.com/EvaluationForms/EvaluationFormsHost.aspx?Data=1A17Qy3xO3Zfzd7C5V0d0ubclv4ZUyboM88FyrmTihShalWUua7WCCmHVe3Q...](https://www.new-innov.com/EvaluationForms/EvaluationFormsHost.aspx?Data=1A17Qy3xO3Zfzd7C5V0d0ubclv4ZUyboM88FyrmTihShalWUua7WCCmHVe3Q...)
MK4. Psychotherapy Refers to knowledge regarding: 1) individual psychotherapies, including but not limited to psychodynamic, cognitive-behavioral, and supportive therapies; 2) couples, family, and group therapies; and, 3) integrating psychotherapy and psychopharmacology

A: Knowledge of psychotherapy: theories B: Knowledge of psychotherapy: practice C: Knowledge of psychotherapy: evidence base

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<tr>
<th>Has not achieved</th>
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</thead>
<tbody>
<tr>
<td>1.2/A Reviews with the patient/family general indications, dosing parameters, and common side effects for commonly prescribed psychopharmacologic agents</td>
<td>basic knowledge of proposed mechanisms of action and metabolism of commonly prescribed psychopharmacologic agents in treatment selection, and explains rationale to patients/families</td>
<td>3.2/C Monitors relevant lab studies throughout treatment, and incorporates emerging physical and laboratory findings into somatic treatment strategy</td>
<td>5.2/C Integrates emerging studies of somatic treatments into clinical practice</td>
<td></td>
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</tr>
<tr>
<td>2.3/C Considers consultation and supervision regarding potential referral for ECT</td>
<td>3.2/C obtains basic physical exam and lab studies necessary to initiate treatment with commonly prescribed medications</td>
<td>3.3/C Uses augmentation strategies, with supervision, when primary pharmacological interventions are only partially successful</td>
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N/A

Comments

Remaining Characters: 5,000
**MKS. Somatic Therapies. Medical Knowledge of somatic therapies, including psychopharmacology, ECT, and emerging somatic therapies, such as transcranial magnetic stimulation (TMS) and vagus nerve stimulation (VNS)**

A. Knowledge of indications, metabolism and mechanism of action for medications B. Knowledge of ECT and other emerging somatic treatments C. Knowledge of lab studies and measures in monitoring treatment

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<tr>
<td>Level 1</td>
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<tr>
<td>1.1/A Describes general indications and common side effects for commonly prescribed psychopharmacologic agents</td>
<td>2.1/A Describes hypothetical mechanisms of action and metabolism for commonly prescribed psychopharmacologic agents</td>
<td>3.1/A Demonstrates an understanding of pharmacokinetic and pharmacodynamic drug interactions</td>
<td>4.1/A Describes the evidence supporting the use of multiple medications in certain treatment situations (e.g., polypharmacy and augmentation)</td>
<td>5.1/A Integrates emerging studies of somatic treatments into knowledge base</td>
<td></td>
</tr>
<tr>
<td>1.2/B Describes indications for ECT</td>
<td>2.2/A Describes indications for second- and third-line pharmacologic agents</td>
<td>3.2/A Demonstrates an understanding of psychotropic selection based on current practice guidelines or treatment algorithms for common psychiatric disorders</td>
<td>4.2/A C Integrates knowledge of the titration and side effect management of multiple medications, monitoring the appropriate lab studies, and how emerging physical and laboratory findings impact somatic treatments</td>
<td>5.2/A Effectively teaches at a post-graduate level evidence-based or best somatic treatment practices</td>
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<tr>
<td></td>
<td>2.3/A Describes less frequent but potentially serious/dangerous adverse effects for commonly prescribed psychopharmacologic agents</td>
<td>3.3/B Describes specific techniques in ECT</td>
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<td></td>
<td>2.4/A Describes expected time course of response for commonly prescribed classes of psychotropic agents</td>
<td>3.4/B Lists emerging neuro-modulation therapies</td>
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<td></td>
<td>2.5/B Describes length and frequency of ECT treatments, as well as relative contraindications</td>
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<td></td>
<td>2.6/C Describes the physical and lab studies necessary to initiate treatment with commonly prescribed medications</td>
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© N/A

Comments:
EVALUATION FOR ELECTIVE/RESEARCH

[Subject Name]  [Evaluator Name]
[Subject Employer]  [Evaluator Employer]
[Evaluation Dates]  
[Subject Rotation]  

Strengths

Weaknesses

Special areas of concern

Remaining Characters: 5,000

Overall assessment of residents performance in the rotation

Pass  Fail

Recommendation:

Promotion  Termination  Remediation (Please include steps for remediation)

[Subject Name]
[Subject Employer]
[Subject Rotation]

Close Window
Enter the resident's score on each Quiz in the Comments box as a fraction = # correct answers/total number of questions

1) Score on QUIZ #1
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1 2 3 4 5

   Comments

   Remaining Characters: 5,000

2) Score on QUIZ #2
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1 2 3 4 5

   Comments

   Remaining Characters: 5,000

3) Score on QUIZ #3
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1 2 3 4 5

   Comments

   Remaining Characters: 5,000

4) % OF CLASSES ATTENDED
   None30%50%80%100%N/A
   1 2 3 4 5

5) LEVEL OF PARTICIPATION IN CLASS
   UnsatisfactoryMarginalSatisfactoryExcellentN/A
   1 2 3 4 5

6) OVERALL EVALUATION FOR COURSE
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1 2 3 4 5

   Pick Rotation: DPSY:PSY:SPECIAL DEVELOPMENT THROUGH THE LIFE CYCLE MK1

   Overall Comments:

   Remaining Characters: 5,000

Subcompetency questions are generated based on the resident's rotation.

DPSY:PSY:SPECIAL DEVELOPMENT THROUGH LIFE CYCLE MK1 (Department of Psychiatry/PSY - Psychiatry)
MK 1
Development through the life cycle (including the impact of psychopathology on the trajectory of development and development on the expression of psychopathology)

A. Knowledge of human development
B. Knowledge of pathological and environmental influences on development
C. Incorporation of developmental concepts in understanding

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<tr>
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<tbody>
<tr>
<td>1.1/A Describes the basic stages of normal physical, social, and cognitive development through the life cycle</td>
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<td>2.1/A Describes neural development across the life cycle</td>
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<td>3.1/A Explains developmental tasks and transitions throughout the life cycle, utilizing multiple conceptual models</td>
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<td>4.1/B Describes the influence of acquisition and loss of specific capacities in the expression of psychopathology across the life cycle</td>
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<td>5.1/A Incorporates new neuroscientific knowledge into his or her understanding of development</td>
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<td>2.2/A Recognizes deviation from normal development, including arrests and regressions at a basic level</td>
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<td>3.2/B Describes the influence of psychosocial factors (gender, ethnic, cultural, economic), general medical, and neurological illness on personality development</td>
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<td>4.2/B Gives examples of gene-environment interaction influences on development and psychopathology</td>
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<tr>
<td>2.3/B Describes the effects of emotional and sexual abuse on the development of personality and psychiatric disorders in infancy, childhood, adolescence, and adulthood at a basic level</td>
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<td>3.3/C Utilizes appropriate conceptual models of development in case formulation</td>
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Comments

Remaining Characters: 5,000
Enter the resident's score on each Quiz in the Comments box as a fraction = # correct answers/total number of questions

1) Score on QUIZ #1
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1  2  3  4  5

   Comments

   Remaining Characters: 5,000

2) Score on QUIZ #2
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1  2  3  4  5

   Comments

   Remaining Characters: 5,000

3) Score on QUIZ #3
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1  2  3  4  5

   Comments

   Remaining Characters: 5,000

4) % OF CLASSES ATTENDED
   None10%50%80%100%N/A
   0  0  0  0  0

5) LEVEL OF PARTICIPATION IN CLASS
   UnsatisfactoryMarginalSatisfactoryExcellentN/A
   0  0  0  0  0

6) OVERALL SCORE FOR COURSE
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1  2  3  4  5

   Pick Rotation: DPSY:PSY:SPECIAL PSYCHOPATHOLOGY MK2

   Overall Comments:

   Remaining Characters: 5,000

Subcompetency questions are generated based on the resident's rotation.

DPSY:PSY:SPECIAL PSYCHOPATHOLOGY MK2 (Department of Psychiatry/PSY – Psychiatry)
MK2. Psychopathology. Includes knowledge of diagnostic criteria, epidemiology, pathophysiology, course of illness, co-morbidities, and differential diagnosis of psychiatric disorders, including substance use disorders and presentation of psychiatric disorders across the life cycle and in diverse patient populations (e.g., different cultures, families, genders, sexual orientation, ethnicity, etc.).

A: Knowledge to identify and treat psychiatric conditions
B: Knowledge to assess risk and determine level of care
C: Knowledge at the interface of psychiatry and the rest of medicine

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</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>1.1/A identifies the major psychiatric diagnostic system (DSM)</td>
<td>2.1/A Demonstrates sufficient knowledge to identify and treat common psychiatric conditions in adults in inpatient and emergency settings (e.g., depression, mania, acute psychosis)</td>
<td>3.1/A Demonstrates sufficient knowledge to identify and treat most psychiatric conditions throughout the life cycle and in a variety of settings</td>
<td>4.1/A Demonstrates sufficient knowledge to identify and treat typical and complex psychiatric conditions throughout the life cycle and in a range of settings (inpatient, outpatient, emergency, consultation liaison)</td>
<td>5.1/B Displays knowledge sufficient to teach assessment of risks and the appropriate level of care for patients who may represent a danger to self and/or others</td>
</tr>
<tr>
<td></td>
<td>1.2/B Lists major risk and protective factors for danger to self and others</td>
<td>2.2/B Demonstrates knowledge of, and the ability to weigh risks and protective factors for, danger to self and/or others across the life cycle, as well as the ability to determine the need for acute psychiatric hospitalization</td>
<td>3.2/B Displays knowledge of, and the ability to weigh risks and protective factors for, danger to self and/or others across the life cycle, as well as the ability to determine the need for acute psychiatric hospitalization</td>
<td>4.2/B Displays knowledge sufficient to determine the appropriate level of care for patients expressing, or who may represent, danger to self and/or others, across the life cycle and in a full range of treatment settings</td>
<td>5.2/B Shows sufficient knowledge to identify and treat uncommon psychiatric conditions in patients with medical disorders</td>
</tr>
<tr>
<td></td>
<td>1.3/C Gives examples of interactions between medical and psychiatric symptoms and disorders</td>
<td>2.3/C Shows sufficient knowledge to perform an initial medical and neurological evaluation in psychiatric inpatients</td>
<td>3.3/C Shows sufficient knowledge to identify and treat common psychiatric manifestations of medical illness (e.g., delirium, depression, steroid-induced syndromes)</td>
<td>4.3/C Shows sufficient knowledge to identify and treat a wide range of psychiatric conditions in patients with medical disorders</td>
<td>5.3/C Demonstrates sufficient knowledge to detect and ensure appropriate treatment of uncommon medical conditions in patients with psychiatric disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.4/C Demonstrates sufficient knowledge to identify common medical conditions (e.g., hypothyroidism, hyperlipidemia, diabetes) in psychiatric patients</td>
<td>3.4/C Demonstrates sufficient knowledge to include relevant medical and neurological conditions in the differential diagnoses of psychiatric patients</td>
<td>4.4/C Demonstrates sufficient knowledge to systematically screen for, evaluate, and diagnose common medical conditions in psychiatric patients, and to ensure appropriate further evaluation and treatment of these conditions in collaboration with other medical providers</td>
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N/A

Comments

Remaining Characters: 5,000

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Enter the resident's score on each Quiz in the Comments box as a fraction = # correct answers/total number of questions

2) Score on QUIZ #2
UnsatisfactoryMarginalAverageVery GoodExceptional
1 2 3 4 5

Comments

Remaining Characters: 5,000

3) Score on QUIZ #3
UnsatisfactoryMarginalAverageVery GoodExceptional
1 2 3 4 5

Comments

Remaining Characters: 5,000

4) % OF CLASSES ATTENDED
None30%50%80%100%N/A

5) LEVEL OF PARTICIPATION IN CLASS
UnsatisfactoryMarginalAverageVery GoodExceptional

6) OVERALL SCORE FOR COURSE
UnsatisfactoryMarginalAverageVery GoodExceptional

Pick Rotation: DPSY:PSY:SPECIAL CLINICAL NEUROSCIENCE MK3

Overall Comments:

Remaining Characters: 5,000

Subcompetency questions are generated based on the resident's rotation.

DPSY:PSY:SPECIAL CLINICAL NEUROSCIENCE MK3 (Department of Psychiatry/PSY - Psychiatry)
MK4. Psychotherapy Refers to knowledge regarding: 1) individual psychotherapies, including but not limited to psychodynamic, cognitive-behavioral, and supportive therapies; 2) couples, family, and group therapies; and, 3) integrating psychotherapy and psychopharmacology

A: Knowledge of psychotherapy: theories
B: Knowledge of psychotherapy: practice
C: Knowledge of psychotherapy: evidence base

<table>
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<tr>
<th>Has not achieved Level 1</th>
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<th>Level 3</th>
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<th>Level 5</th>
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</thead>
<tbody>
<tr>
<td>1.1/A Identifies psycho-dynamic, cognitive-behavioral, and supportive therapies as major psychotherapeutic modalities</td>
<td>2.1/A Describes the basic principles of each of the three core individual psychotherapy modalities</td>
<td>3.1/A Describes differences among the three core individual therapies</td>
<td>4.1/A Describes new theoretical developments into therapeutic change</td>
<td>5.1/A Describes new theoretical developments into knowledge base</td>
<td></td>
</tr>
<tr>
<td>2.2/A Discusses common factors across psychotherapies</td>
<td>3.2/A Discusses the historical and conceptual development of psychotherapeutic paradigms</td>
<td>4.2/A Discusses the evidence base for combining different psychotherapies and psychopharmacology</td>
<td>5.2/A, B: Discusses sufficient knowledge of psychotherapy to teach others effectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3/B Lists the basic indications, contraindications, benefits, and risks of supportive, psychodynamic and cognitive behavioral psychotherapies</td>
<td>3.3/B Describes the basic techniques of the three core individual therapies</td>
<td>4.3/C Critically appraises the evidence for efficacy of psychotherapies</td>
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<tr>
<td>3.4/B Describes the basic principles, indications, contraindications, benefits, and risks of couples, group, and family therapies</td>
<td>5.3/C Summarizes the evidence base for each of the three core individual therapies</td>
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Comments

Remaining Characters: 5,800
Enter the resident's score on each Quiz in the Comments box as a fraction = # correct answers/total number of questions

1) Score on QUIZ #1
   Unsatisfactory Marginal Average Very Good Exceptional
   1  2  3  4  5
   Comments:
   Remaining Characters: 5,000

2) Score on QUIZ #2
   Unsatisfactory Marginal Average Very Good Exceptional
   1  2  3  4  5
   Comments:
   Remaining Characters: 5,000

3) Score on QUIZ #3
   Unsatisfactory Marginal Average Very Good Exceptional
   1  2  3  4  5
   Comments:
   Remaining Characters: 5,000

4) % OF CLASSES ATTENDED
   None 30% 50% 80% 100% N/A
   0  0  0  0  0

5) LEVEL OF PARTICIPATION IN CLASS
   Unsatisfactory Marginal Satisfactory Excellent N/A
   0  0  0  0  0

6) OVERALL SCORE FOR COURSE
   Unsatisfactory Marginal Average Very Good Exceptional
   1  2  3  4  5
   Overall Comments:
   Remaining Characters: 5,000

Subcompetency questions are generated based on the resident's rotation.

DPSY: PSY: SPECIAL PSYCHOTHERAPY SUPERVISION PATIENT CARE (Department of Psychiatry/PSY - Psychiatry)
PC 4. Psychotherapy. Refers to 1) the practice and delivery of psychotherapies, including psychodynamic, cognitive–behavioral, and supportive therapies; 2) exposure to couples, family, and group therapies; and 3) integrating psychotherapy with psychopharmacology

A: Empathy and process B: Boundaries C: The alliance and provision of psychotherapies D: Seeking and providing psychotherapy supervision

Has not achieved Level 1 | Level 2 | Level 3 | Level 4 | Level 5
---|---|---|---|---
1.1/A Accurately identifies patient emotions, particularly sadness, anger, and fear | 2.1/A Identifies and reflects the core feeling and key issue for the patient during a session | 3.1/A Identifies and reflects the core feeling, key issue, and what the issue means to the patient | 4.1/A Links feelings, behavior, recurrent/central themes/schemas, and their meaning to the patient as they shift within and across sessions | 5.1/C Provides psychotherapies to patients with very complicated and/or refractory disorders/problems
1.2/B Maintains appropriate professional boundaries | 2.2/B Maintains appropriate professional boundaries in psychotherapeutic relationships while being responsive to the patient | 3.2/B Recognizes and avoids potential boundary violations | 4.2/B Anticipates and appropriately manages potential boundary crossings and avoids boundary violations | 5.2/C Personalizes treatment based on awareness of one’s own skill sets, strengths, and limitations
1.3/C Demonstrates a professional interest and curiosity in a patient’s story | 2.3/C Establishes and maintains a therapeutic alliance with patients with uncomplicated problems | 3.3/C Establishes and maintains a therapeutic alliance with, and provides psychotherapies (at least supportive, psychodynamic, and cognitive–behavioral) to, patients with uncomplicated problems | 4.3/C Provides different modalities of psychotherapy (including supportive therapy and at least one of psychodynamic or cognitive behavioral therapies) to patients with moderately complicated problems | 5.3/C Provides psychotherapy supervision to others
2.4/C Utilizes elements of supportive therapy in treatment of patients | 3.4/C Manages the emotional content of, and feelings aroused during, sessions | 3.5/C Integrates the selected psychotherapy with other treatment modalities and other treatment providers | 4.4/C Selects a psychotherapeutic modality and tailors the selected psychotherapy to the patient on the basis of an appropriate case formulation
3.6/D Balances autonomy with needs for consultation and supervision | | 4.5/C Successfully guides the patient through the different phases of psychotherapy, including termination |

N/A

Remaining Characters: 5,000

MK 4. Psychotherapy Refers to knowledge regarding: 1) individual psychotherapies, including but not limited to psychodynamic, cognitive–behavioral, and supportive therapies; 2) couples, family, and group therapies; and, 3) integrating psychotherapy and psychopharmacology.
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<tr>
<td>2.1/A Describes the basic principles of each of the three core individual psychotherapy modalities</td>
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<tr>
<td>3.1/A Describes differences among the three core individual therapies</td>
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<tr>
<td>4.1/A Describes proposed mechanisms of therapeutic change</td>
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<tr>
<td>5.1/A Incorporates new theoretical developments into knowledge base</td>
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<tr>
<td>2.2/A Discusses common factors across psychotherapies</td>
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<tr>
<td>3.2/A Describes the historical and conceptual development of psychotherapeutic paradigms</td>
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<tr>
<td>4.2/C Discusses the evidence base for combining different psychotherapies and psychopharmacology</td>
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<tr>
<td>5.2/A, B Demonstrates sufficient knowledge of psychotherapy to teach others effectively</td>
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<tr>
<td>2.3/B Lists the basic indications, contraindications, benefits, and risks of supportive, psychodynamic and cognitive behavioral psychotherapies</td>
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<tr>
<td>3.3/B Describes the basic techniques of the three core individual therapies</td>
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<tr>
<td>4.3/C Critically appraises the evidence for efficacy of psychotherapies</td>
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<tr>
<td>3.4/B Describes the basic principles, indications, contraindications, benefits, and risks of couples, group, and family therapies</td>
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<tr>
<td>5.3/C Summarizes the evidence base for each of the three core individual therapies</td>
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</table>

Comments

Remaining Characters: 5,000
PSYCHOPHARMACOLOGY COURSE EVALUATION
MILESTONE MKS

Evaluator
(Evaluator Name)
(Evaluator Status)

Enter the resident's score on each Quiz in the Comments box as a fraction = # correct answers/total number of questions

1) Score on QUIZ #1
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1  2  3  4  5
   Comments
   Remaining Characters: 5,000

2) Score on QUIZ #2
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1  2  3  4  5
   Comments
   Remaining Characters: 5,000

3) Score on QUIZ #3
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1  2  3  4  5
   Comments
   Remaining Characters: 5,000

4) % OF CLASSES ATTENDED
   None30%50%80%100%N/A
   ○ ○ ○ ○ ○ ○

5) LEVEL OF PARTICIPATION IN CLASS
   UnsatisfactoryMarginalSatisfactoryExcellentN/A
   ○ ○ ○ ○ ○ ○

6) OVERALL SCORE FOR COURSE
   UnsatisfactoryMarginalAverageVery GoodExceptional
   1  2  3  4  5
   Overall Comments:
   Remaining Characters: 5,000

Subcompetency questions are generated based on the resident's rotation.

DPSY:PSY:SPECIAL SOMATIC THERAPIES MKS (Department of Psychiatry/PSY - Psychiatry)
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>1.1/A Describes general indications and common side effects for commonly prescribed psychopharmacologic agents</td>
<td>2.1/A Describes hypothesized mechanisms of action and metabolism for commonly prescribed psychopharmacologic agents</td>
<td>3.1/A Demonstrates an understanding of pharmacokinetic and pharmacodynamic drug interactions</td>
<td>4.1/A Describes the evidence supporting the use of multiple medications in certain treatment situations (e.g., polypharmacy and augmentation)</td>
<td>5.1/A Integrates emerging studies of somatic treatments into knowledge base</td>
</tr>
<tr>
<td>1.2/B Describes indications for ECT</td>
<td>2.2/A Describes indications for second- and third-line pharmacologic agents</td>
<td>3.2/A Demonstrates an understanding of psychotropic selection based on current practice guidelines or treatment algorithms for common psychiatric disorders</td>
<td>4.2/C Integrates knowledge of the titration and side effect management of multiple medications, monitoring the appropriate lab studies, and how emerging physical and laboratory findings impact somatic treatments</td>
<td>5.2/A Effectively teaches at a post-graduate level evidence-based or best somatic treatment practices</td>
</tr>
<tr>
<td>2.3/A Describes less frequent but potentially serious/dangerous adverse effects for commonly prescribed psychopharmacologic agents</td>
<td>3.3/B Describes specific techniques in ECT</td>
<td>3.4/B Lists emerging neuro-modulation therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4/A Describes expected time course of response for commonly prescribed classes of psychotropic agents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5/B Describes length and frequency of ECT treatments, as well as relative contraindications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6/C Describes the physical and lab studies necessary to initiate treatment with commonly prescribed medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N/A

Comments

Remaining Characters: 5,000

Close Window
Enter the resident's score on each Quiz in the Comments box as a fraction = # correct answers/total number of questions

Score on QUIZ #1
Unsatisfactory Marginal Average Very Good Exceptional
1 2 3 4 5
Comments

Remaining Characters: 5,000

Score on QUIZ #2
Unsatisfactory Marginal Average Very Good Exceptional
1 2 3 4 5 N/A
Comments

Remaining Characters: 5,000

% OF CLASSES ATTENDED
None 30% 50% 80% 100%

CLASS PARTICIPATION
Unsatisfactory Marginal Average Very Good Exceptional
1 2 3 4 5

OVERALL EVALUATION OF RESIDENT PERFORMANCE

Comments

Remaining Characters: 5,000

Subcompetency questions are generated based on the resident's rotation.

DPSY:PSY:SPECIAL PRACTICE OF PSYCHIATRY MK6 (Department of Psychiatry/PSY - Psychiatry)

MK6. Practice of Psychiatry

A: Ethics B: Regulatory compliance C: Professional development and frameworks

https://www.new-innov.com/EvaluationForms/EvaluationFormsHost.aspx?Data=1LA17Qy9xO3Zfd7C6sVDPdOaibclv42ZZUyboM8IfymTihShajWUsu7WCC1HVe5Q... 1/2
<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has not achieved</td>
<td>1.1/A Lists common ethical issues in psychiatry</td>
<td>2.1/A Lists and discusses sources of professional standards of ethical practice</td>
<td>3.1/A Discusses conflict of interest and management</td>
<td>4.1/B Describes the existence of state and regional variations regarding practice, involuntary treatment, health regulations, and psychiatric forensic evaluation</td>
</tr>
<tr>
<td>1.2/B Recognizes and describes institutional policies and procedures</td>
<td>2.2/A Lists situations that mandate reporting or breach of confidentiality</td>
<td>3.2/B Describes applicable regulations for billing and reimbursement</td>
<td>5.1/C Proposes advocacy activities, policy development, or scholarly contributions related to professional standards</td>
<td></td>
</tr>
<tr>
<td>1.3/C Lists ACGME Competencies</td>
<td>2.3/C Describes how to keep current on regulatory and practice management issues</td>
<td>4.2/C Describes professional advocacy</td>
<td>5.2/C Describes international variations regarding practice, involuntary treatment, and health regulations</td>
<td></td>
</tr>
</tbody>
</table>

N/A

Comments

Remaining Characters: 5,000

Close Window
PGY-1 SUPERVISION LEVEL
ASSESSMENT FORM

PGY-1 Name: ___________________________  Date: __________

Evaluator Name: ___________________________

Evaluator Status: Faculty ____ Fellow ____ Resident ____

Clinical Setting: ___________________________

Day __ Night __ Weekend __

Number of different patients seen with the resident: _____

The ACGME has defined three levels of supervision for PGY-1 residents:

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

At the beginning of residency, each PGY-1 must have Direct supervision unless there has been a prior assessment of their ability to progress to indirect supervision, based on the criteria set forth in the Duty Hours Requirements. A PGY-1 may progress to being supervised indirectly with direct supervision available only after demonstrating competence in:

a) the ability and willingness to ask for help when indicated;
b) gathering an appropriate history;
c) the ability to perform an emergent psychiatric assessment; and
d) presenting patient findings and data accurately to a supervisor who has not seen the patient.
Based on your direct observation of this PGY-1 resident, please indicate below whether or not he/she has demonstrated the following competencies (Y=yes, NY=not yet, but progressing as expected, N=no, UA=unable to assess):

<table>
<thead>
<tr>
<th>Ability and willingness to ask for help when indicated</th>
<th>Yes</th>
<th>Not Yet</th>
<th>No</th>
<th>Unable to Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y</td>
<td>NY</td>
<td>N</td>
<td>UA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gathering an appropriate history</th>
<th>Y</th>
<th>NY</th>
<th>N</th>
<th>UA</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ability to perform an emergent psychiatric assessment</th>
<th>Yes</th>
<th>NY</th>
<th>N</th>
<th>UA</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Presenting patient findings and data accurately to a supervisor who has not seen the patient</th>
<th>Y</th>
<th>NY</th>
<th>N</th>
<th>UA</th>
</tr>
</thead>
</table>

The most appropriate level of supervision for this PGY-1 resident is:

____ Direct (in-person)

____ Indirect, with Direct immediately available (i.e. in-house supervision; requires that the resident has demonstrated some of the above competencies)

____ Indirect, with Direct available (i.e. off-site supervision by phone; requires that the resident has demonstrated all of the above competencies)

**Comments and Suggestions for Improvement:**

Evaluator Signature and Date

Resident Signature and Date
Assessment of Competency of PGY 2 and 3 Residents to Serve as Supervisors

PGY 2 or 3 Name: ____________________ Date: __________

Evaluator Name: ____________________

Evaluator Status: Faculty ___ Fellow ___ Resident ___

Clinical Setting of this Assessment: __________________________________________

Day    Night    Weekend

The ACGME permits PG 2 and 3 residents in psychiatry to supervise PGY 1 residents. This is spelled out in the “Specialty-specific Duty Hour Definitions” document on the ACGME website, under “FAQ's” as follows:

**Q:** Can PGY 2 and PGY 3 provide direct or indirect supervision for more junior residents?

**A:** PGY 2 and PGY 3 residents may provide direct or indirect supervision for more junior residents as long as the following requirements are met:

--- Both the junior resident and supervising resident should inform patients of their respective roles in that patient's care; and,

--- Assignment is based on the needs of each patient and the skills (demonstrated competency in medical expertise and supervisory capability) of the individual supervising resident.

**In order to progress to this level, the following must be demonstrated:**

<table>
<thead>
<tr>
<th>SUPERVISING JUNIOR RESIDENTS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has the medical expertise necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was this assessed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Demonstrates ability to supervise appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How was this assessed?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Faculty Member Signature and Date ____________________  Resident Signature and Date ____________________