i. Introduction/Explanation of the Manual
This Child and Adolescent Psychiatry Program and Procedure Manual (PPPM) is referenced in your Residency/Fellowship Agreement with the University of Minnesota. This manual describes the policies, procedures and information that apply to you in your role as a trainee. Trainees are responsible for familiarizing themselves and adhering to the policies and guidelines contained in this manual. All information outlined in this manual is subject to periodic review and change. Revisions may occur at the program, medical school, or University of Minnesota level. The information contained in this PPPM pertains to all residents and fellows in the department’s programs.

The Institutional Manual contains residency/fellowship policies, information and procedures that apply to all residents/fellows throughout the University of Minnesota Medical School. All materials are written in accordance with the Accreditation Council for Graduate Medical Education (ACGME). Please note that the Institutional Manual and the PPPM are designed to work together. Information contained in the Institutional Manual is not replicated in the PPPM, though the latter might refer to the Institutional Manual for clarification. The Institution Manual (http://hub.med.umn.edu/graduate-medical-education/policies-governance/) is designed to be an umbrella policy manual. Some programs may have policies that are more rigid than the Institution Manual in which case the program policy would be followed. Should a policy in a Program Manual conflict with the Institution Manual, the Institution Manual would take precedence.

ii. Department Mission Statement
The mission of the Department of Psychiatry is to educate University of Minnesota medical students, residents and fellows in the knowledge, skills and attitudes essential to the practice of psychiatry, to advance our understanding of the etiology, diagnosis and treatment of psychiatric disorders, and to serve residents of Minnesota through clinical expertise.

iii. Program Mission Statement
The mission of our fellowship training program is to impart the knowledge, skills and attitudes required of a child and adolescent psychiatrist to sensitively meet the needs of our patients and the various disciplines we serve. Effective psychiatric practice requires a thorough grounding in both knowledge and clinical skills. Fellows are encouraged to critically examine contemporary assumptions about the causes of behavior, as well as methods of diagnosis and treatment. The University of Minnesota offers an opportunity to study with a knowledgeable faculty dedicated to excellence in clinical psychiatry, education, and research.

As teachers, our faculty members are committed to a training program which directly links psychiatry to medicine yet emphasizes the unique features of psychiatry. Our fellowship program stresses integration of the genetic, experiential, and ecological factors relevant to all disorders. This orientation is one in which established theories and empirical studies are presented and critically reexamined in the light of new data and ideas. Throughout the training program, our central aim is to impart the knowledge, skills, and attitudes through the care and study of patients while under the close supervision of faculty.

iv. RRC Program Definition
Child and adolescent psychiatry is a medical specialty focused on the prevention, diagnosis, and treatment of disorders of thinking, feeling and behavior affecting children, adolescents and their families. The goal of residency education in child and adolescent psychiatry is to produce specialists in the delivery of skilled and comprehensive medical care of children and adolescents suffering from psychiatric disorders. The child and
adolescent psychiatrist must have a thorough understanding of the development, assessment, treatment, and prevention of psychopathology as it appears from infancy through adulthood. He or she also should have the skills to serve as an effective consultant to primary care physicians, non-psychiatrist mental health providers, schools, community agencies, and other programs serving children and adolescents.
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SECTION 1 - STUDENT SERVICES

1.A University Pagers
Upon entering the Fellowship Training Program, pagers are obtained from the Fellowship Coordinator after the appropriate paper work is completed. All pagers must be returned to the Education Office when the fellow's training period has been completed. If a fellow prefers to have pages electronically transferred to their smartphone, please discuss with the fellowship coordinator. The current fee for a lost pager is $65 plus tax.

1.B E-Mail and Internet Access
Fellow e-mail addresses are not activated until initiation of the account with a password. This is completed at www.umn.edu/validate. Computer workstations are provided for each fellow in an office space so that they can access their e-mail and complete required RMS applications. It is expected that fellows will check their University e-mail account daily during the workweek. Required notices as well as surveys and requests are distributed through the University e-mail account. Fellows are responsible for the information sent to them through their University of Minnesota email address. Failure to use their University e-mail rather than personal email addresses may result in disciplinary action as the fellow may miss critical information and correspondence.

1.C Campus Mail & US Mail
A campus and U.S. mailbox is located in the Division of Child and Adolescent Psychiatry office [F256]. Campus mail stop address: Department of Psychiatry, UMMC-Riverside, F282/2A West. US Mail address: Department of Psychiatry, F282/2A West, 2450 Riverside Avenue, Minneapolis, MN 55454.

Physical Location address (for deliveries or giving directions): University of Minnesota Medical Center, Fairview, Department of Psychiatry, 2312 South 6th St., Minneapolis, MN 55454-1495

1.D HIPAA Training
The Health Information Portability and Accountability Act (HIPAA) training occurs during orientation. Protected health information (PHI) is information that can be used to identify an individual. It is created when a person has seen a health-care professional, been treated by one, or paid for health services. It can be spoken, on paper, or electronic. It is protected wherever the information is created or received. Under the federal Health Information Portability and Accountability Act (HIPAA), only the minimum information necessary for a specific purpose should be used or disclosed. This is currently part of the GME central Onboarding Checklist.

SECTION 2 - BENEFITS

2.A Stipends
Effective July 1, 2015 for Fellows in the Department of Psychiatry, stipends are as noted below. Paychecks are biweekly. Pay statements are available on-line through the Employee/Staff self-serve website (http://www.hrss.umn.edu/).

<table>
<thead>
<tr>
<th>PGY Year</th>
<th>BASE STIPEND</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>57,745</td>
</tr>
<tr>
<td>F2</td>
<td>59,967</td>
</tr>
</tbody>
</table>

http://www.med.umn.edu/residents-fellows/current-residents-fellows/stipends-benefits

2.B Tuition and Fees
University of Minnesota Tuition and fees are waived

2.C Leave Policies
According to Fellow Review Committee Requirements

prior to entry into the program each fellow must be notified in writing of the required length of training. This length of training for a particular fellow may not be changed without mutual agreement, unless there is an extended leave of absence from the program.

The Fellowship Director or designee must approve all time away (e.g. leave) from the Residency Program in writing. The resident/fellow should submit any leave requests to the Program Director as early as possible to allow flexibility in planning. In order to ensure ABPN eligibility, the program director will determine if sufficient time has been spent in a given rotation in order to sufficiently meet a ABPN requirement. Leave time may not be used to reduce the length of training.

<table>
<thead>
<tr>
<th>Year</th>
<th>Vacation</th>
<th>No rollover Workdays</th>
<th>Sick</th>
<th>No rollover Workdays</th>
<th>Conference Workdays</th>
<th>Military Workdays</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>20</td>
<td>15</td>
<td>5</td>
<td>5</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>F2</td>
<td>20</td>
<td>15</td>
<td>5</td>
<td>5</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

http://hub.med.umn.edu/resident-fellow-administration/leave-absence

(1) Vacation Leave

- Requests for vacation should be submitted at least 30 days in advance to the Program Coordinator. Requests to block M Health Psychiatry Clinic must be submitted at least 60 days in advance.
- Vacation leave is earned each year in the amounts shown above and must be taken in the year of service (July to June). Any vacation time that is not used at the end of each academic year will be lost and will not be paid out. A resident does not have the option of reducing the total time required for the residency by foregoing vacation time.
- No vacation is normally granted during the first or last week of the academic year.
- No more than 2 consecutive weeks of vacation will be granted unless approved by Fellowship Director.
- During child adolescent psychiatry rotations, vacation requests must be coordinated with the psychiatry resident to ensure at least one resident or one fellow are on the treatment team at a time.
- Vacation must be approved by the Residency Coordinator and will be recorded by the Residency Coordinator. Fellows should notify the attending physician and other supervisors as soon as possible.
- Vacation requests are prioritized according to when the written request is submitted to the fellowship coordinator.
- The Program Director may deny/revoke vacation or conference requests if extenuating circumstances occur which would significantly impact psychiatric care.
(2) Bereavement Leave
A resident/fellow (trainee) shall be granted, upon request to the program director, up to 5 days off to attend the funeral of an immediate family member. Sick or vacation leave must be used. Immediate family include partners, children, stepchildren, parents, parents of spouse, and the stepparents, grandparents, guardian, grandchildren, brothers, sisters, or wards of the trainee.

(3) Parental Leave
In accordance with University of Minnesota Human Resources policies, parental leave shall be granted upon request as follows:

<table>
<thead>
<tr>
<th>Leave Type</th>
<th>Duration</th>
<th>Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Leave (maternity, paternity, adoption)</td>
<td>2 calendar weeks</td>
<td>Paid in full</td>
</tr>
<tr>
<td>Maternity leave (in addition to parental leave)</td>
<td>4-6 calendar weeks (depending on the nature of the birth)</td>
<td>Percentage of salary paid by short term disability</td>
</tr>
<tr>
<td>Sick and vacation days (may be used concurrently with parental leave and/or maternity leave)</td>
<td>Variable, depending on resident choice and available days</td>
<td>Paid in full</td>
</tr>
<tr>
<td>Additional time away from training</td>
<td>Variable, depending on resident choice and will extend residency according to the ‘time away from training’ policy. Requires program director approval.</td>
<td>Unpaid. Benefits continue. The resident may be required to pay both their portion and the employer’s contribution towards health insurance premiums.</td>
</tr>
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In the case that two or more maternity leaves are requested over the course of four years of residency training (including the first year of the child/adol fellowship), subsequent leave periods will extend residency training commensurate with duration of the entire leave, with the exception of sick and vacation days.

Due to the significant administrative impact associated with parental leave plan revisions, subsequent changes must be due to notable circumstances and must be discussed and approved by the program director.

In order to ensure ABPN eligibility, the program director will determine if sufficient time has been spent in a given rotation in order to sufficiently meet an ABPN requirement. Leave time may not be used to decrease the length of training.

(4) Medical Leave
The fellow must give notice, in writing, of intent to use medical leave to their program director at least four (4) weeks in advance, except under unusual circumstances. A trainee shall be granted, upon request to the program director, a leave of absence for their serious illness/injury that requires an absence of greater than 14 days. The trainee may qualify for Short Term and Long Term Disability benefits. The University of Minnesota UReturn Office (http://www.d.umn.edu/ureturn/) will serve as an intermediary for all medical and disability related issues to protect the privacy of the resident. Time away from training not covered by sick or vacation leave will extend residency training in accordance with the ‘time away from training policy’.

(5) Family Medical Leave Act (FMLA)
Residents and fellows (trainees) are eligible for the Family Medical Leave Act (FMLA) protections after serving 12 months in the program. Trainees must check with their department/program to determine if they qualify. FMLA Leave shall not exceed 12 weeks in any 12-month period. The 12-month period is based on an academic year (07/01-06/30). The trainee may qualify for Short Term and Long Term Disability benefits.

(6) Holidays
When on University (UMMC) based services, Residents and Fellows will follow the University’s holiday schedule except when covering on-call services on University of Minnesota Inpatient rotations. When assigned to other training sites [e.g. MVAHCS] the holiday schedule at that site will govern.

(7) Witness Duty
Upon request to the program director, leave is provided to residents/fellows (trainees) who are subpoenaed to testify before a court or legislative committee concerning the University or the federal or state government. No pay loss is incurred.

(8) Jury Duty
Upon request to the program director, leave is provided to residents/fellows who are called to serve on a jury. No pay loss is incurred. The training program and the trainee may write a letter to the court asking that the appointment for jury duty be deferred based on hardship to the trainee and the program. The decision for deferment is made by the court.

(9) Military Leave
Military leave shall be granted upon request up to fifteen (15) workdays per academic year. Any days beyond 15 will not be paid and the residency will be extended those extra days. If the leave happens in the PGY3 year, the ambulatory care requirements will also be extended.

(10) Personal Leave of Absence
Emergency leave or other personal leave of absences may be authorized by arrangement with the program director, should it be in the best interest of the University, the Program, and the resident/fellow. An emergency or personal leave of absence will extend residency training in accordance with the ‘time away from training’ policy.

(11) Professional and Conference Leave
All trainees accrue 5 workdays of conference leave per year, no rollover. Request should be submitted to the Fellowship Coordinator ASAP or no less than 30 days. Title of conference, location and scheduled hours will be requested. If less than 30 days’ notice, the service attending must approve. A conference is defined as an organized presentation designed to enhance professional development that lasts at least five hours in a day including travel time.

Occasionally, required or elective rotations may include off-site educational activities or conferences; for example, attendance at a prolonged exposure training as part of a PTSD clinical elective or presenting a poster at a conference as the outcome of a research elective. These types of activities may not require use of a conference day, per the discretion of the program director.

(12) Sick Leave
Sick leave shall be granted upon request for up to 15 workdays per year. Sick leave is not cumulative. The minimum unit of sick leave is half-day increments.

*Note, it is understood that circumstances may arise in which you are too ill to send an e-mail as directed in this set of procedures. In this case, please do your best to access urgent medical care and communicate with the program regarding your status as soon as possible.

13. UNSCHEDULED LEAVE POLICY

Please email umnChildpsy@umn.edu ASAP if you are unable to attend program assignments during normal weekday work hours. PLEASE NOTE THIS E-MAIL IS WIDELY DISTRIBUTED. The message will be distributed to the program coordinator’s office as well as the clinic. The clinic will notify patients and the program coordinator’s office will contact whomever the fellow indicates in their e-mail. If you prefer to notify off-site contacts, indicate in the e-mail that you have already notified them. (The program coordinator’s office will contact the appropriate attendings, peers and off-site service setting)

Please email umnChildpsy@umn.edu by 7AM.

In the title box, put the following - first name, last name and the word OUT
Sample – John Doe OUT

Include the following:
- What rotation you're on
- When you expect to return
- Whether you will manage outpatient tasks from off site
- How we can best reach you
- Persons you want us to specifically contact (attending/coverage buddy?)

In addition, if this unplanned absence falls on a clinic day please:
- Review your Epic schedule from home to see which patients are scheduled.
- After reviewing schedule, include recommendations for each pt.*
- Depending of level of acuity, availability of f/u, etc, options could include:
  - “9:30am Pt can be scheduled for my next available f/u.”
  - “10am Pt can be scheduled into my next available f/u and let them know I will call them w/in the next few days to check-in”
  - “1pm Pt can be scheduled in my [fellow names specific time] admin slot next wk”
  - “Please ask a covering fellow to see 2pm Pt today”
  - “Please ask that my nurse call 3pm Pt to triage them, then call me or covering fellow to discuss”
  - “3:30pm Pt can be scheduled into my [fellow names specific time] emergency slot”

*In a few rare cases, a fellow may be too incapacitated to do #1, in which case we move to #2

Emergency slots or admin time should not automatically be used outside of plan outlined by fellow, as fellow may be aware of other pts who will likely need these slots.
3. Intake staff calls patients to cancel and communicate f/u recommendation. If pt is not okay with f/u recommendation, Jeff passes the call to RN for triage to assess needs (#3).

4. RN calls patient and one of the following steps occurs, depending on RN evaluation
   - RN handles concern to its endpoint and has pt scheduled for f/u
   - RN consults w/covering fellow to make plan for pt
   - RN consults w/ faculty to make plan for pt
   - RN gets pt onto another fellow’s schedule that day (only if pt absolutely needs to be seen that day)
   - RN sends pt to BEC/911

This procedure is NOT for issues involving emergencies. These need to be managed in context by consulting peers, the chief or designated faculty on call.

Time away from training policy:

2.D Policy on Effect of Leave for Satisfying Completion of Program
ACGME guidelines require 24 months of fellowship training in child and adolescent psychiatry. In addition, they stipulate that specific periods of time be spent engaged in defined clinical activities (e.g. experience in child neurology). The duration of training can be extended to complete program requirements missed because of leave or failure for academic reasons.

2.E Medical Coverage: HealthPartners Fellows and Fellows Health Plan
HealthPartners provides the health plan network and claims administration services for University of Minnesota Medical School residents and fellows. HealthPartners gives members access to 650,000 healthcare providers and 6,500 hospitals across the United States. You will have a choice of two plans, Basic or Basic Plus. All trainees are required to enroll in one of the two plans for at least single coverage, or provide documentation of other comparable health benefit coverage. Medical School fellows who enroll in the University-sponsored HealthPartners plan (and enrolled dependents) are automatically eligible for Continuation of coverage through COBRA at the end of their fellowship. This benefit is administered by the Office of Student Health Benefits (http://www.shb.umn.edu/).

2.F Dental Coverage: Delta Dental
Delta Dental of MN provides dental network and claims administration services for University of Minnesota Medical School residents and fellows. Delta Dental members have access to both PPO and Premier providers. Medical School fellows who enroll in the University-sponsored Delta Dental plan (and enrolled dependents) are automatically eligible for continuation of care through COBRA at the end of their residency or fellowship. This benefit is administered by the Office of Student Health Benefits (http://www.shb.umn.edu/).

2.G Life Insurance: Minnesota Life
Medical School residents and fellows are automatically enrolled in a $50,000 standard life Minnesota Life insurance policy. Enrollment is no cost to Medical School fellows (the cost is covered by your department). In addition to the standard plan, trainees have the option to purchase voluntary life insurance for themselves or their dependents at low group rates through Minnesota Life. Medical School fellows are automatically eligible for continuation of life insurance coverage through COBRA at the end of their fellowship. This benefit is administered by the Office of Student Health Benefits (http://www.shb.umn.edu/).
2.H Long and Short Term Disability Coverage: Guardian Life Insurance Company
Medical School residents and fellows are automatically enrolled in a long and short term disability insurance policy. Short-term disability insurance provides you with income protection of 70% of your income up to $1,000 weekly benefit maximum when an injury, sickness, or pregnancy results in your continuous disability. Benefits are paid from the 15th day of a disability after a 14-day waiting period. The maximum duration of short-term disability benefits is 11 weeks. Long-term disability insurance provides you with income protection of 80% of your income up to $5,000 monthly benefit maximum if you are continuously disabled for more than 90 days. Coverage continues as long as you are certified disabled by Guardian. The maximum period that you are eligible to receive benefits is up to your Social Security normal retirement age.

2.I Optional Individual Disability Policy
The University of Minnesota offers a Guaranteed Standard Issue (GSI) plan from Foster Klima. This plan allows you to convert the group disability insurance you had as a resident or fellow to an individual disability policy, regardless of any pre-existing medical conditions. Under this plan, residents/fellows could receive benefits of up to $10,000 per month if one becomes disabled. The cost of individual coverage is guaranteed for the life of the policy. Cost of living protection can be added to your coverage (additional premium applies). Retirement assets would be protected. This individual coverage is fully portable, meaning it goes with after leaving the University. Residents/fellows may optionally enroll in the GSI plan at any time during residency or fellowship and up to six months after completion of training.

Enrollment is no cost to Medical School residents and fellows (the cost is covered by your department). Guardian offers Medical School residents and fellows up to $10,000 per month of individual coverage. In addition, Guardian offers a Student Loan Payoff benefit effective if you become disabled while you are a resident. Guardian also offers a unique Guaranteed Standard Issue Plan option. Residents and fellows have the options to purchase long term disability coverage that you can take with you upon completion of your residency/fellowship regardless of any pre-existing medical conditions—25-30 percent of residents and fellows would not otherwise qualify for this type of coverage due to pre-existing medical conditions. This benefit is administered by the Office of Student Health Benefits (http://www.shb.umn.edu/).

2.J Flexible Spending Accounts
Medical School residents and fellows are eligible to participate in two types of Flexible Spending Accounts (FSAs), the U of M Health Care Reimbursement Account and the Dependent Care Reimbursement Account. Both programs allow you to pay for related expenses using pre-tax dollars. This benefit is administered by the Office of Student Health Benefits (http://www.shb.umn.edu/).

2.K Professional Liability Coverage
Professional liability insurance is provided by the Regents of the University of Minnesota. The insurance carrier is RUMINO Limited. Coverage limits are $1,000,000 each claim/$3,000,000 each occurrence and form of insurance is claims made. “Tail” coverage is automatically provided. The policy number is RUM-1005-14. Coverage is in effect only while acting within the scope of your duties as a trainee. Claims arising out of extracurricular professional activities (i.e. internal or external moonlighting) are not covered. Coverage is not provided during unpaid leaves of absence. Professional Liability Insurance Information: https://sites.google.com/a/umn.edu/medcred/

2.L Insurance Coverage Changes
The Office of Student Health Benefits manages resident and fellow benefits including insurance coverage changes and pre-tax benefits (http://www.shb.umn.edu/).

2.M Meal Tickets/Food Services
Meal Tickets/Food Service is not provided for fellows because no on-site call is taken.

2.N Laundry Services
Laundry Service is not provided for fellows.

2.O Worker’s Compensation Program Specific Policies and Procedures
Worker’s Compensation is available through the department. The University of Minnesota U-Return Office will serve as an intermediary for all medical and disability related issues to protect the privacy of the resident. See the program coordinator for assistance.

2.P Parking
The resident/fellow will pay a $25 refundable deposit for a parking card that gives them complimentary access to the Riverside Campus Parking Ramps. Other University parking will have to be arranged with the Parking Office. The parking card may be disabled by a program representative per policy for failure to complete duty hour documentation in the RMS system or failure to complete clinical documentation in a timely manner. http:/pts.umn.edu

2.Q Education, Technology and Travel Funding
Fellows may be reimbursed for education, technology, or travel expenses incurred related to program activities. Appropriate documentation, including receipts will be required for reimbursement. The following table summarizes the amount of eligible reimbursement per fellow year:

| Fellow Yr 1 | $100 |
| Fellow Yr 2 | $100 |

Also, in thanks to the generosity of the Nissen fund to support psychiatry trainee research, psychiatry residents, fellows, psychology trainees rotating within our department, and medical students highly committed to the field of psychiatry are eligible to receive up to $1000 in grant support for academic conference participation (travel, registration fees, lodging, and/or transportation). Trainees must provide evidence they are presenting scholarly work, such as a poster, workshop, or other similar activity. There are a limited number of grants per academic year based on available funds. Travel grants are not guaranteed and will vary based on number of interested trainees, and previous grant awards. Criteria are subject to change. The Department of Psychiatry Education Council serves as the administering body of these grants and will make any necessary determinations related to the nature of the scholarly work and if a sufficient minimal threshold of eligibility is met. Grants may be requested by completing the request form available on the fellowship website (see Nissen Fund Research).

2.R Resident Assistant Program
The Metro Minnesota Council on Graduate Medical Education has contracted with an agency called the Sand Creek Group to provide the Resident Assistance Program (RAP). It is an employee assistance program designed specifically for residents and fellows. Sand Creek’s counselors have particular expertise in dealing with the unique needs of individuals in their training programs. By contacting this program, fellows will receive help in addressing issues of concern and find options for achieving resolution. RAP is for trainees and family members,
faculty, attending physicians, department heads and supervisors who need help in dealing with fellow-related concerns.

www.sandcreekeap.com
Phone: 651-430-3383 or 1-800-632-7643
SECTION 3 - Institution Responsibilities
Please refer to the Institution Manual for Institution Responsibilities at

SECTION 4 - DISCIPLINARY AND GRIEVANCE PROCEDURES

4.A Grievance Procedure and Due Process
The following is an outline of the general scheme proposed for the resolution of grievances which may arise within the fellowship program. Detail and clarification must be added as the various elements of these proposals are accepted or rejected or replaced with alternatives. These guidelines or policies are confined to the process within the Department of Psychiatry with the assumption that appeal of the final action or decision coming from the intradepartmental process will remain a viable option once the departmental grievance process has been completed.

(1) Principles
- Definition of the legitimate areas of disagreement to be covered by these procedures.
- Provision of ascending levels of recourse with potential for final resolution of the conflict at each of these levels without prejudice to any rights of the involved individuals.
- Adherence to the principles of due process, academic freedom and fairness.
- Procedures to be readily available and expeditiously executed.
- Inclusion of a system of advocacy.
- Process to be fully documented.

(2) Grievance Committee for the Psychiatry Fellowship Program
- The committee is ad hoc, appointed by the head of the department with representation of faculty, and affiliated hospital if pertinent, and one or all of program level ranks of the fellowship program as well as chief fellow(s) as appropriate.
- All actions of this committee are considered advisory to the head of the Department of Psychiatry.
- All actions of this committee are by a simple majority vote with a quorum present. A quorum consists of one-half of all the named members of the committee, plus one.

(3) Areas of Potential Grievance Covered by these Guidelines
The areas of possible grievance to be resolved by the following procedures will include, but not be limited to, the following:
- Evaluation of fellow performance by the faculty.
- Assignment or definition of house staff duties.
- Interpretation and implementation of other policies and guidelines, such as those included in this document.
- Fellow-resident fellow conflicts.
- Fellow-Chief resident conflicts.
- Fellow-resident conflicts.
- Fellow-faculty conflicts.
- Chief fellow-faculty conflicts.

(4) Potential Parties to the Process:
- Principals in the complaint.
- Mentors, as advisors and advocates.
- Grievance committee.
- Department head and/or a designee.
(5) Grievance Resolution Process
As defined here, resolution will be considered an outcome deemed acceptable to the principals to the complaint. When resolution is reached, no further steps in the process will be taken and the matter will be considered closed. This policy assumes that any single principal to the grievance retains the right to carry the process forward by denial of resolution, and to appeal the intradepartmental decision to extra-departmental grievance procedures.

Steps in the process:
(i) Review of complaint with mentor or other ad hoc advisor.
   **Outcome:** resolved OR taken to step (ii)
(ii) Informal discussion with other persons deemed appropriate by parties to the complaint.
   **Outcome:** resolved OR taken to step (iii)
(iii) Formulation of a formal written complaint.
(iv) Forwarding of complaint to the grievance committee, with copies to principals to the complaint and to the head of the department.
(v) Committee review of the complaint with consultation and written minutes, but without tape recording.
   **Outcome:** resolved with report to the head of the department OR taken to step vi
(vi) Department head reviews the grievance committee actions and recommendations and then advises the parties to the complaint of his decision as to the dispensation of the complaint action.
   **Outcome:** resolved OR taken to step (vii)
(vii) Appeal to the Medical School and the appropriate extra-departmental grievance process.
5.A Program Curriculum

(A month is defined as one 4-week session, 13 total per academic year)

First Year Fellows (F1) – Child and Adolescent Psychiatry

<table>
<thead>
<tr>
<th>Inpatient service UMMC Riverside</th>
<th>Unit 7A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient service Prairie-Care</td>
<td>Brooklyn Center</td>
</tr>
<tr>
<td>Inpatient service UMMC Riverside</td>
<td>Unit 6A</td>
</tr>
<tr>
<td>Inpatient service UMMC Masonic Children's Hospital</td>
<td>Pediatric Consultation</td>
</tr>
<tr>
<td>Partial Hospital services UMMC Riverside</td>
<td>Day treatment</td>
</tr>
</tbody>
</table>

Included in these core rotations will be time set aside for:
- Outpatient Continuity clinic (1 half-days per week)
- Didactic (with first and second-year fellows)
- Psychotherpy cases and supervision

Second Year Fellows (F2)

A variety of experiences, each having different time commitments. Some are requirements, and some are not required, but options to pursue. These experiences include continuity clinic, University specialty clinics (Anxiety, Mood, Psychosis, and ADHD), community clinic (HCMC), school consultation, research/scholarly opportunities, pediatric neurology, autism, forensics (in first or second year), and eating disorders.

Included in these core rotations will be time set aside for:

- Continuity clinic
- Didactic (with first and second-year fellows)
- Administrative Time
- Elective Time

5.B Training Examinations

The CHILD PRITE Exam (Psychiatry Fellow In-Training Examination sponsored by the American College of Psychiatry) is given each fall to child fellows. The CHILD PRITE is required of the fellowship program. Only 1 make-up exam can be given. Approval by the PEC committee would be needed to allow a fellow to miss this exam.

5.C Didactic Schedule

Didactic coursework is offered year round with the most updated schedule contained on the google drive. Access to this drive will be provided at orientation.

5.D Didactic Attendance Policy
Fellows must have attended 70% of class activities that take place minus scheduled vacation days, structural duty hour absences.

For every course where attendance is less than 70% (if retaking the course in a different year is determined by the program director NOT to be a viable option, considering among others financial and schedule issues), a typed, double-spaced, referenced 2000 word paper will be assigned on the course topic by the Program Director after consultation with the Course Director. The paper must be submitted to the Program Director no later than the end of the quarter following the deficiency. The Program Director, in consultation with the Course Director, will determine whether the paper is satisfactory.

If the paper is not turned in or is unsatisfactory, the fellow will be placed on academic probation with continuation of clinical duties. If the paper is not completed in the following quarter the deficiency will be referred to the Faculty Education Advisory Committee (FEAC) for discussion and action.

<table>
<thead>
<tr>
<th>Months</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>7</th>
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<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance Deficit</td>
<td>Course Attendance less than 70% in this quarter</td>
<td>Make Up Delinquency</td>
<td>Probation</td>
<td>Referral to RTC</td>
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<tr>
<td>Make up paper for each delinquent course due by end of three month quarter</td>
<td>Negative action recorded in academic record</td>
<td>Clinical and call duties continue. Paper(s) due by end of three month quarter</td>
<td>RTC discussion and action Clinical and call duties continue</td>
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<tr>
<td>Paper inserted in academic file, no negative action recorded if paper satisfactory</td>
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</table>

The chief fellow will complete a weekly written Attendance Log Form. The log will indicate date, whether class was held and status of each assigned fellow (present or absent). Present will mean attendance for at least 2/3rds of the teaching activity. Attendance Log will be turned into Coordinator weekly. The Coordinator will reconcile Log Form with approved vacation requests. The Coordinator will produce a quarterly report.

Ad hoc sick leave (not associated with maternity leave), conference leave, administrative leave and post-moonlighting are not approved justifications and will be considered absences. Maternity leave, extended medical leave that exceeds the 15 day yearly allotment, and Family Medical Leave are not covered by this policy. These situations will be considered on a case by case basis by the Program Director and the fellow.

**5.E Program Goals and Objectives**
The full list of Program Goals and Objectives is provided to the fellows in this manual, please see section titled: Goals and Objectives: Rotations.

**5.F Psychotherapy Training**
The University of Minnesota, Department of Psychiatry, Fellowship in Child and Adolescent Psychiatry is committed to a strong education program both in short and longer term psychotherapies. We emphasize that even the briefest medication management may reveal important dynamic issues. In this sense, all patient contacts become an important ground for learning about and applying psychotherapeutic principles.
These principles are presented in courses on the theory and practice of psychotherapy, given during the two years of child psychiatry training. Topics include supportive psychotherapy, psychodynamic theory and psychotherapy, cognitive behavioral therapy, group and family therapy, dialectical behavioral therapy, and motivational interviewing.

5.G Goals and Objectives for Teaching Medical Students
Fellows are an essential part of the teaching of medical students. The goal of our trainees is to prepare the medical student to recognize, diagnose, and care for patients with psychiatric disorders encountered in most medical practices.

Fellows are an essential part of the teaching of medical students. It is critical that any fellow who supervises or teaches medical students must be familiar with the educational objectives of the course or clerkship and be prepared for their roles in teaching and evaluation. Therefore, we’ve included in this manual the clerkship objectives for Psychiatry as well as the overall Educational Program Objectives.

Psychiatry – ADPY 7500

Description
This course is a requirement for all third year medical students. Its goal is to prepare medical students to recognize, diagnose, and care for patients with psychiatric disorders encountered in most medical practices. At the beginning of the course students will be given an outline of specific course objectives plus other orientation materials. Students will be assigned to work with interdisciplinary teams which will aid the student in meeting course objectives. Students will be assigned patients and will follow both in-hospital and outpatients. They will attend teaching rounds and a variety of teaching conferences. They will be given a series of lectures/discussions at their individual teaching sites. Each student will be required to write a brief paper concerning a patient-related problem.

Overall Goal
To prepare the medical student to recognize, diagnose, and care for patients with psychiatric disorders encountered in most medical practices.

Specific Objectives

- Using appropriate interview techniques, the student will be able to elicit a complete psychiatric history from psychiatric and medical patients and will be able to amplify or confirm the patient’s history by information from relatives and/or social agencies.
- The student will be able to perform a physical examination emphasizing aspects pertinent to the psychiatric evaluation and a mental status examination sufficiently comprehensive to detect, at a minimum, disorders of orientation, thinking, mood, and cognition.
<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>OUTCOME MEASURES</th>
<th>ACGME ESSENTIAL COMPETENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrate mastery of key concepts and principles in the basic sciences and clinical disciplines that are the basis of current and future medical practice.</td>
<td>□ USMLE Steps 1 and 2  □ Year 1 and 2 course performance, based on standardized examinations  □ Clinical rotation performance  □ Feedback from residency directors</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>2. Demonstrate mastery of key concepts and principles of other sciences and humanities that apply to current and future medical practice, including epidemiology, biostatistics, healthcare delivery and finance, ethics, human behavior, nutrition, preventive medicine, and the cultural contexts of medical care.</td>
<td>□ USMLE Steps 1 and 2  □ Course performance (esp. in Physician and Society, Nutrition, and Human Behavior at TC campus; Medical Sociology, Medical Epidemiology and biometrics, Family Medicine I, Medical Ethics, Human Behavioral Development and Problems, and Psycho-Social-Spiritual Aspects of Life-Threatening Illness at DU campus)  □ Clinical rotation performance  □ Feedback from residency directors</td>
<td>Medical Knowledge</td>
</tr>
<tr>
<td>3. Competently gather and present in oral and written form relevant patient information through the performance of a complete history and physical examination.</td>
<td>□ Yr 2 OSCE  □ Physician and Patient (PAP) course performance at TC campus, assessed by tutors using global rating forms and observed practical exams  □ Course performance at DU campus in Applied Anatomy, Clinical Rounds &amp; Clerkship (CR &amp; C), Clinical Pathology Conference, and Integrated Clinical Medicine  □ Clinical rotation performance</td>
<td>Patient Care; Interpersonal and Communication Skills</td>
</tr>
<tr>
<td>4. Competently establish a doctor-patient relationship that facilitates patients’ abilities to effectively contribute to the decision making and management of their own health maintenance and disease treatment.</td>
<td>□ Yr 2 OSCE and Primary Care Clerkship (PCC) OSCE  □ PAP course performance at TC campus, assessed by tutors using global rating forms and observed practical exams  □ Preceptorship and CR &amp; C course performance at DU campus  □ Clinical rotation performance</td>
<td>Patient Care; Interpersonal and Communication Skills</td>
</tr>
<tr>
<td>5. Competently diagnose and manage common medical problems in patients.</td>
<td>□ PCC OSCE  □ Clinical rotation performance</td>
<td>Medical Knowledge; Patient Care</td>
</tr>
<tr>
<td>6. Assist in the diagnosis and management of uncommon medical problems; and, through knowing the limits of her/his own knowledge, adequately determine the need for referral.</td>
<td>□ Clinical rotation performance  □ Documented achievement of procedural skills in the Competencies Required for Graduation</td>
<td>Medical Knowledge; Patient Care; Practice-Based Learning and Improvement</td>
</tr>
<tr>
<td>7. Begin to individualize care through integration of knowledge from the basic sciences, clinical disciplines, evidence-based medicine, and population-based medicine with</td>
<td>□ Clinical rotation performance  □ Feedback from residency directors</td>
<td>Patient Care; Medical Knowledge; Interpersonal and Communication Skills; Professionalism</td>
</tr>
<tr>
<td>8.</td>
<td>Demonstrate competence practicing in ambulatory and hospital settings, effectively working with other health professionals in a team approach toward integrative care.</td>
<td></td>
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<td>---</td>
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<td></td>
</tr>
</tbody>
</table>
| | □ Yr 2 and PCC OSCE  
□ PAP course performance at TC campus, assessed by tutors using global rating forms and observed practical exams  
□ Physician and Society (PAS) course performance at TC campus  
□ Preceptorship, CR & C, and Introduction to Rural Primary Care Medicine course performance at DU campus  
□ Clinical rotation performance |
| | Practice-Based Learning and Improvement; Systems-Based Practice |
| 9. | Demonstrate basic understanding of health systems and how physicians can work effectively in health care organizations, including:  
□ Use of electronic communication and database management for patient care.  
□ Quality assessment and improvement.  
□ Cost-effectiveness of health interventions.  
□ Assessment of patient satisfaction.  
□ Identification and alleviation of medical errors. |
| | □ PAS course performance at TC campus  
□ Medical Sociology and CR & C course performance at DU campus  
□ Clinical rotation performance, especially the PCC  
□ Feedback from residency directors  
□ Feedback from local health plans |
| | Practice-Based Learning and Improvement; Systems-Based Practice |
| 10. | Competently evaluate and manage medical information. |
| | □ Critical reading exercises in PAS and other courses at TC campus  
□ Clinical Pathology Conference performance and exercises in Problem Based Learning Cases at DU campus  
□ Year 2 Health disparities project  
□ PCC EBM project |
| | Patient Care; Medical Knowledge; Practice-Based Learning and Improvement; Systems-Based Practice |
| 11. | Uphold and demonstrate in action/practice basic precepts of the medical profession: altruism, respect, compassion, honesty, integrity and confidentiality. |
| | □ PAS course performance at TC campus  
□ Preceptorship and Cr & C course performance at DU campus  
□ Clinical rotation performance  
□ Participation in honor code and student peer assessment program  
□ Participation in anatomy memorial  
□ Participation in volunteer service activities |
| | Professionalism |
| 12. | Exhibit the beginning of a pattern of continuous learning and self-care through self-directed learning and systematic reflection on their experiences. |
| | □ PBL cases at DU campus  
□ Yr 2 Health disparities project  
□ Clinical rotation performance  
□ Participation in research |
| | Professionalism |
| 13. | Demonstrate a basic understanding of the healthcare needs of society and |
| | □ Course performance in all years  
□ Introduction to Rural Primary Care Medicine |
| | Patient Care; Medical Knowledge; Practice-
- The student will learn the applications and limitations in psychiatric practice of major diagnostic tests and procedures including laboratory tests, neuroimaging tests, psychometrics, and electroencephalography.
- The student will be able to recognize psychiatric emergencies (e.g., suicidal, violent, or delirious patients; withdrawal symptoms) and be familiar with their management. In particular, the student will develop a repertoire of questions and interpretive skills sufficient to permit estimation of the likelihood of suicide and methods of safeguarding against it.
- The student will learn the principles of giving and receiving consultation from other physicians and to cooperate with social service agencies.
- The student will learn the basic processes of judicial commitment in Minnesota and other basic forensic issues.
- The student will learn to effectively utilize the processes of patient education, reassurance, and support. The student will learn indications for, and gain some familiarity with, other psychological interventions.
- The student will be able to describe the clinical presentations, course, and prognosis of the following disorders with special emphasis on findings discriminating among them:
  - Affective disorders
  - Anxiety disorders.
  - Organic mental disorders, especially delirium and dementia.
  - Personality disorders, especially antisocial personality
  - Somatoform disorders
  - Schizophrenic disorders.
  - Substance use disorders
- The student will become familiar with somatic treatments:
  - Common pharmacologic treatments, including indications, contraindications, and side-effects of antianxiety agents, antidepressants, antipsychotics, and sedative-hypnotics.
  - Electroconvulsive treatment indications and effects.
- The student will become familiar with common psychiatric disorders in the aged.
- The student will become familiar with common psychiatric disorders first diagnosed in infancy, childhood, or adolescence.

**Educational Program Objectives**

**University of Minnesota Medical School**

Graduates of the University of Minnesota Medical School should be able to:

These objectives are written to reflect the qualities and competencies expected of our graduates. Each objective specifies the expected competency level to be attained by our students, the outcome measures used to evaluate attainment of the objective, and the essential qualities and competencies of a physician (as defined by the six ACGME Essential Competencies) addressed by the objective. The Accreditation
Council for Graduate Medical Education (ACGME) has formulated essential competencies felt to be necessary for physicians practicing in the current health care climate. They are:

**Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

**Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care

**Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

**Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals

**Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

**Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide optimal patient care

The objectives for the undergraduate curriculum can be grouped as follows:

- Objectives 1-3: Knowledge and skills addressed principally in the first two (preclinical) curricular years;
- Objectives 4-9: Knowledge and skills addressed principally in the second two (clinical) curricular years;
- Objectives 10-13: Knowledge, attitudes, and skills addressed throughout the curriculum.

The objectives, which relate to the ACGME essential competencies, are designed to be modified for use also by the graduate (GME) programs at the University of Minnesota Medical School. Residency programs can modify the competency level stated in the objectives and the outcome measures to reflect their own programs, while maintaining the overall integration of basic learning objectives across undergraduate and graduate medical education.

One of the primary outcome measures for the objectives is **clinical rotation performance**. To expand on this; clinical rotation performance is assessed by attending physicians and residents using a Web-based global rating form, evaluating the following knowledge, competencies, skills, and attitudes:

- Medical knowledge and the ability to apply knowledge in clinical situations
- Competency in patient care including communication and relationships with patients/families
- Skills in data gathering from the history, physical examination, clinical and academic sources, and diagnostic tests
- Assessment and prioritization of problems
- Management of problems, including knowledge of patient data and progress
- Appropriate decision making
- Communication in written and oral reports
- Professionalism, including: patient care and management in teams (work habits), independent learning, personal characteristics, and commitment to medicine
- Specific procedural skills (see report outlining Competencies Required for Graduation)

Ratified by Education Council 2/18/03
5.H Training and Graduation Requirements

(1) Length of Program
- A complete Child and Adolescent psychiatry fellowship is 24 months.
- The two years of full-time, specialized training in child and adolescent psychiatry may be taken in no more than two training programs, with a minimum of six months of training in one program and the remaining months of the two years in the other program.

(2) Requirements for Graduation:
- Fellows must meet all requirements of the American Board of Psychiatry and Neurology, which will allow them to sit for child and adolescent psychiatry boards.
- Applicants for certification in child and adolescent psychiatry must be certified by the Board in general psychiatry by December 31 of the year prior to the examination.
- Fellows must have satisfied the requirements for the Child and Adolescent Psychiatry program as set forth by the Faculty Education Advisory Committee, acting in conjunction with the University Graduate Medical Education Committee.
  - The fellow must be in good standing with no ethical problems or concerns about professional competency.
  - The fellow must have satisfactory grades in all rotations, and have performed satisfactorily in didactic courses at each level of training.

(3) Program Structure
- The 24 months has a minimum of 4 months of inpatient work at the University of Minnesota, with a maximum of 10 months.
  - Outpatient work has a continuity clinic throughout the two years.
  - The last year of training is devoted to consultations of various kinds listed above.
  - The didactics occur in several different seminars throughout the week.

5.J Scholarly Activity

(1) All fellows will participate in weekly self-directed learning activities scheduled during the afternoons in which fellow didactics take place. Approximately three times a year during these sessions, fellows will present a journal article or discuss a case that raises issues related to medical errors, professionalism or systems based practice. Fellows will be provided with an evaluation of the presentation by the faculty mentor.

(2) Fellows are encouraged to attend Psychiatry Grand Rounds, Morbidity and Mortality Conferences, and Complex Case Conferences, which are held weekly.

(3) Fellows interested in research are encouraged to participate in mentored research experiences in the second year of fellowship.

(4) 1st Year Fellows each present at Grand Rounds.

Fellows are supervised in a Quality Assessment and Quality Improvement project, which is presented at the yearly faculty retreat.

5.J ACGME Competencies
The psychiatry fellowship program adheres to the general competencies to assess fellow progress. Goals, objectives and observations by supervisors are organized according to the six areas of competency.
The six competencies are:
- Patient Care
- Medical Knowledge
- Practice Based Learning and Improvement
- Systems Based Practice
- Professionalism
- Interpersonal Skills and Communication
5.K Duty Hours

The Child and Adolescent Psychiatry Fellowship Program at the University of Minnesota is committed to insuring that all fellows are compliant with the most recent [Common Program Requirements – Effective: July 1, 2011; ACGME approved focused revision effective July 1, 2014]] duty hour requirements set forth by the ACGME as well as the Faculty Education Advisory Committee (FEAC). Importantly these guidelines require that external moonlighting be counted in terms of the 80 hour rule.

The duration of the workday on Psychiatry rotations at the University of Minnesota Medical Center will vary according to the year of training and service assignment. This is delineated by the Duty Hour Guidelines.

**The standard workday is 8am to 5pm.** Fellows assigned to UMMC Department of Psychiatry services are expected to be on site first responders to those services. This can be extended by call assignments, individual supervision, clinical conferences or tasks related to patient care as long as duty hour regulations are not violated. The expectation is that fellows are available during this time period by pager unless a formal request for leave has been approved.

Patient contact in the Outpatient Clinic will be scheduled up to 5pm.

The cutoff for working up new admissions on the Inpatient Services at UMMC is 4:00pm (arrival of the patient on the unit, or accessible in the Emergency Department, or behavioral Emergency Center). Fellows may remain beyond 5pm as long as it does not put them into a Duty Hour violation.

Non-emergent patient care tasks that become known during assigned didactics should be attended to either between or after didactics. They are not a sufficient reason to be absent from didactics.

In rare instances fellows may remain past their duty hours limit of their own accord to care for a single patient. Acceptable reasons to work beyond duty hours are limited to required continuity of a single severely ill or unstable patient, academic importance of events that are transpiring, or humanistic attention to the needs of a patient or family. In these situations the fellow will hand over care of all patients and will document the reason for remaining to care for the individual patient in RMS. If a fellow stays beyond their scheduled duty, they must record the justification for the extended time in the “comments” box of their duty hour entry in RMS consistent with MMCGME/RMS software protocol. The program director will review all comments during the regular duty hour review process.

All fellows are required to use the Residency Management Suite [RMS] to update their assignments and hours in the duty hours module for all training related activities, including external moonlighting, in a timely manner. **Compliance is considered a part of professional competence.**

It is the policy of the Department of Psychiatry that if a fellow does not complete RMS by noon on the 5th working day of the month his or her UMMC Campus parking card will be turned off. The department will not reimburse parking charges incurred following suspension of a parking card. The parking card will not be turned on again until RMS is completed.

Program compliance with duty hour requirements will be monitored using the following methods:
1. Annual University of Minnesota Graduate Medical Education Committee survey of duty hours.
2. Annual ACGME Fellow Survey generates confidential reports from fellows regarding duty hour compliance.
(3) RMS Duty Hour Violation Reports will be generated by the Program Coordinator for review by the Program Director. These reports with annotation by the Program Director will be maintained as a continuous log in the coordinator’s office.

Violations of these guidelines will be reported to the file and may result in a report of a negative event to the fellow’s permanent academic file.

This policy is consistent with the Institutional Policy Manual of the University of Minnesota Graduate Education Committee.

5.L Milestones Evaluation and Fellow Promotion based on ACGME Competencies
The Child and Adolescent Fellowship program adheres to the general competencies to assess fellow progress. Goals and objectives and observations by supervisors are organized according to the six areas of competency.

The six competencies are:
- Patient Care
- Medical Knowledge
- Practice Based Learning and Improvement
- Systems Based Practice
- Professionalism
- Interpersonal Skills and Communication

The Child and Adolescent Psychiatry Fellowship Review Committee has established a set of psychiatry specific Milestones to assess individual fellows’ developmental progress throughout training based on the six competencies. The Clinical Competency Committee (consisting of core faculty from the University of Minnesota and MVAHCS clinical sites) will meet twice a year to determine each fellow’s progress with respect to the Milestones. Clinical observations, informal reports, formal evaluations and other sources of performance data, as summarized in the evaluation grid will be utilized to determine specific Milestone rankings. Individual Milestone reports will be presented at the twice annual meetings of the fellow and Program Director or Associate Program Director. Throughout the academic year, the training director is available to meet individually with fellows as difficulties or problems are encountered. The Milestones will be used descriptively to track resident developmental progress and serve as a vehicle for identifying fellow strengths and growth points. There is no set numerical cut-off score or ranking required for promotion, graduation, or special privileges; however, based on the discussion of the Clinical Competency Committee, academic issues may be identified that result in remediation plans, academic probation, non-advancement, extension of residency training or termination. The Milestones will be distributed electronically through e-mail and are available in the program Google Drive for fellow and faculty reference.

The Milestones data will be deidentified and aggregated using WedAds Software and provided to the ACGME for ongoing monitoring of program quality and evidence of resident progress.

5.M Program Evaluation
As required by the ACGME, The Fellowship Program is evaluated formally on an annual basis by the Program Evaluation Committee (PEC) and a formal Annual Program Evaluation (APE) is generated by the Program Director. The Institutional requirements and charter is presented separately by the U of MN Graduate Medical Education Committee (GMEC).
PEC members and charter:

<table>
<thead>
<tr>
<th>ACGME Common Program Requirement</th>
<th>Summary</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>VC core</td>
<td>Program Evaluation and Improvement</td>
<td>The Program Director and Program Coordinator must know and be able to apply the Common Program Requirements and their Program Requirements in the Child and Adolescent Psychiatry Program.</td>
</tr>
</tbody>
</table>

**VC1, VC1a1 core**
- **Program Director must appointment the PEC (required: Program Director 2 Full-time program faculty, 1 Resident/fellow).**
  - As appointed by the Program Director, PEC members will be the Program Director, Associate Program Director, Assistant Program Director, Chief Resident, Incoming chief Resident (for the 6 months preceding their term), and the Residency Coordinator.
  - The Program director serves as chair of the committee and is responsible for assessing for a quorum, developing the agenda, bringing new or revised policies to the Residency Training Committee (RTC), and completion of the annual program evaluation report.
  - A quorum shall consist of at least three of six members, if less than three members are available, the meeting will be cancelled.
  - Members sign a statement of confidentiality.
  - The PEC meets weekly for one hour.
  - This PEC charter was developed by GME Administration in consultation with the GMEC and edited by the Psychiatry Program Director.

**VC1a2 core**
- **Develop a written description of responsibilities**
  - See VC1a3, VC2, VC2a-VC2e for list of responsibilities.
  - The PEC also responsible for responding to special reviews if GMEC determines a special review is warranted.

**VC1a3 detail**
- The psychiatry Residency PEC members actively participate in:
<table>
<thead>
<tr>
<th>Actively participate in:</th>
<th>Planning, developing, implementing, and evaluation education activities of the program. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives. Addressing areas on non-compliance with ACGME standards; and Reviewing the program annually using evaluations of faculty, residents and others The PEC develops policy changes and makes recommendations to the Residency Training Committee, which meets on a monthly basis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>VC2</td>
<td>Annual formal documentation of Annual Program Evaluation (APE) The Program Director, with assistance from the PEC will document formal, systematic evaluation of the curriculum annually, and will render a written and Annual Program Evaluation (APE) report.</td>
</tr>
<tr>
<td>VC2a-VC2e</td>
<td>The Program must monitor and track specific elements. The components of the APE will include: -Resident performance as determined by components of the Evaluation Methods Grid. -Faculty development -Graduate performance, including performance of program graduates on the ABPN certification examination -Program quality -Residents and faculty annual confidential survey evaluations. -The PEC will use results of the resident and faculty assessments of the program together with other program evaluation results to improve the program determine a set of action items on which to improve the program during the following academic year. -The APE will report on progress on the previous year’s action plans Required metrics will be developed by GME Administration in consultation with the GMEC. The PEC must use GME Admin/GMEC metrics to monitor and track program quality.</td>
</tr>
</tbody>
</table>
VC3  
**core**  
PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section VC2 as well as delineate how they will be measured and monitored

The Psychiatry Program Director and PEC will use the APE report outline template developed by GME Admin in consultation with the GMEC

VC3a  
**core**  
The action plan must be reviewed and approved by the teaching faculty ad documented in the meeting minutes

The APE report, including action plan, will be presented for approval to the RTC and documented in the meeting minutes at the August meeting (second Wednesday of the month at 12:15).

The Psychiatry Residency Program will provide the APE report (that includes an action plan) to the GMEC annually.

### 5.N Evaluation and Fellow Promotion

Systematic evaluation of knowledge, skills and professional growth of each fellow is performed twice yearly by the Clinical Competency Committee (CCC). Written summaries are generated and are the basis for promoting fellows to positions of greater responsibility. These evaluations are provided to the fellow in a timely manner and they are discussed in twice yearly meetings with the program director. During this meeting, the fellow's strengths and weaknesses are discussed, and an attempt is made to explore ways that the fellow can more effectively participate in the training process. Throughout the academic year, the training director is available to meet individually with fellows as difficulties or problems are encountered.

The program assesses the knowledge of each fellow annually through administration of an in training examination (Child PRITE) constructed and scored by the American College of Psychiatrists.

Fellows are observed and evaluated in their clinical performance during at least three Clinical Skills Verification exercises during the PGY4 or 5 year in accordance with the American Board of Psychiatry and Neurology guidelines. The Child and Adolescent fellowship requires that you use the ABPN’s form 1 (8-page document) which can be obtained from the program coordinator or downloaded from the ABPN site. There must be 2 of 3 age groups involved in the ABPN examinations. Fellows must competently complete three such verifications with at least two different ABPN boarded examiners. Fellows are observed and evaluated on each rotation in an evaluation of clinical skills covering the core competencies set forth by ACGME.

On any fellow’s departure from the program, the program director prepares a letter describing the nature and length of the rotations for which the fellow has been given credit. When the fellow leaves the program (including by graduation), the program director affirms in the record that there is no documented evidence of unethical behavior or unprofessional behavior or a serious question of clinical competence.
Fellow evaluation is conceptualized as a dynamic process in which there is frequent communication between the fellow and supervisor. We feel strongly that it is important for the fellow to receive guidance at the time of their clinical or didactics experience, rather than being entirely dependent upon a formal review process at the end of a rotation cycle. At the conclusion of each rotation or formal didactic experience a supervisor evaluation of the fellow is completed.

More specific to psychiatry, the evaluation process contains the following elements: How well the fellow relates to patients and staff; whether the fellow makes good use of supervision; whether the fellow works independently; has good diagnostic skills; makes appropriate use of labs, psychological tests, and other diagnostic procedures; uses psychopharmacologic agents effectively; maintains adequate records; is able to handle a reasonable patient load; is knowledgeable about psychiatric literature; understands psychodynamic issues; provides appropriate supportive therapy; recognizes countertransference issues; and understands uses of cognitive/behavioral therapies.

Ongoing evaluation of the fellow is completed within the setting of the Clinical Competency Committee. Twice a year during these meetings a comprehensive review is made of fellow's progress. At that point, a final recommendation is made regarding the fellow's continuing academic progress. Fellows will use RMS, a web-based system, to evaluate their attending physician, supervisor, their specific rotation, the site, didactics, and lecturers.

Fellows are notified each month via email that they have evaluations to complete. Once notified, fellows can access computers at each hospital site or from home and can log onto the Internet to complete their evaluations.

Attending physicians will be able to view information on themselves after three or more evaluations have been completed by a fellow or medical student. The information will be an accumulation of comments rather than individual comments to guarantee anonymity for the fellows and medical students. Fellows and medical students will be able to view an evaluation on themselves completed by an attending physician once that fellow or medical student has completed an evaluation on that particular attending physician.

5.O On Call Schedules
Fellows do not provide call coverage. Internal and external moonlighting must be approved by the Program Director and logged on RMS. Moonlighting commitments cannot lead to duty hour violations or interfere with training activities. The Program Director receives a comprehensive written report of all duty hour violations for each 4-week rotation period and determines the cause and solution for each violation.

5.P On Call Rooms
Child & Adolescent Fellows do not provide call coverage so there is no on-call room for them.

5.Q Support Services
There are no dedicated secretarial services available to fellows. There are computers available with software to support most needs. For projects that may require additional support, please see the Psychiatry Fellowship Coordinator.

5.R Laboratory/Pathology/Radiology Services
There are in-hospital laboratory, pathology and radiology services available for patient care. The lab is open 24-hours a day.
5.5 Medical Records
Fellows will be trained in using the Electronic Medical Record at UMMC for inpatient and outpatient activities. Medical records may be accessed 24 hours a day through the electronic medical record.

5.7 Security and Safety
UMMC has an in-house security staff. Campus Courtesy phones located throughout the campus can be used to report emergencies or to request assistance. Dial 9-1-1- or 888 for security. To reach Campus Police dial-6000. Escort service is also available 24-hours a day on the Riverside Campus by dialing 612-273-4544.

The Fellowship Program acknowledges the utmost importance of promoting a safe and healthy training environment with the goals of minimizing the risk of injury in training, providing procedures to report unsafe training conditions, and providing mechanisms to take corrective action.

Psychiatry fellows undergo safety training as part of their orientation, including techniques to de-escalate anger and aggression. All psychiatry fellows’ experiences of verbal threats, physical intimidation, and physical assault by patients are monitored and reported to the Training Office. In case of an assault:

1) The psychiatry fellow notifies their primary attending at the appropriate training site.
2) The primary attending works with the psychiatry fellow to decide if a medical evaluation is indicated. At that time a decision is made whether the fellow should continue with their duties or be discharged for the remainder of the day or call.
3) The primary attending then notifies: the Vice Chair for Clinical Affairs, the program chief fellow and the training director.
4) The chief of clinical service considers an alternative disposition and/or provider for the patient who initiated the threat or assault. The patient is assessed for continuous dangerousness.
5) The training program immediately assesses the fellow’s needs following an assault (with more serious events requiring a more prompt response). The training program in collaboration with the fellow will assess whether ongoing supervision with a chosen supervisor or a referral for psychiatric evaluation and/or care is indicated. In addition, the training director with the chief fellow may determine whether provision of debriefing and support for all fellows in the program is indicated.
6) The training program coordinates administrative issues that may arise such as scheduling time off or changing the call schedule. The training office checks that these procedures have been followed and addressed, so that the burden is removed from the fellow.

5.U Critical Incident Post-vention Procedures
These procedures were developed with the intent of providing a supportive response to patient suicide, however similar procedures will be utilized in response to other critical incidents as determined by the Program faculty.

1) Fellow learns of patient death
2) Fellow contacts responsible attending – supervisor and Dr. Anjum.
3) Fellow contacts Chief Fellow
4) Chief Fellow will:
   a. Notify training director of event
   b. Meet 1:1 with the affected Fellow to provide support and guidance
   c. Assist affected Fellow in selecting a supervisor from the Fellow Support Team to provide support and answer questions, if so desired by Fellow
   d. Facilitate discussion with affected Fellow’s class (or a subset) in consultation with Fellow Support Team leadership, if so desired by Fellow
5) Contact patient family after some reflection and discussion with your supervisor
   a. Should be brief (10 minutes) where the Fellow tells the family they are sorry for their loss
b. Consider sending condolence letter with support materials from the American Foundation for Suicide Prevention, http://www.afsp.org

6) Optional: Contact Fellow attorney Keith Dunder: dunde001@umn.edu, (612) 626-3700 or VA Regional Counsel, 612-467-5900

7) Optional: Contact county medical examiner (they may contact you, no ROI needed)
   a. Ramsey Co Medical Examiner 651-266-1700
   b. Hennepin Co Medical Examiner 612-215-6300

8) M&M by Fellow, faculty member, or Chief. Ideally within 1-3 months of incident.

9) Consider taking a day off to reflect

5.V Moonlighting
According to RRC Guidelines the fellowship program should not allow activities outside the program that interfere with education, clinical performance, or clinical patient care responsibilities related to training. Such activities would include all moonlighting [both internal and external, whether on site or home call] commitments and accordingly, fellows will provide accurate information about such activities and will obtain approval from the program prior to engaging in moonlighting.

A Moonlighting form must be completed and approved prior to initiation of a moonlighting activity and should be resubmitted if the maximal number of hours per 4 week period changes. One form should be submitted for each moonlighting site. (link below)

https://docs.google.com/document/d/1PoMZHGCs5triYg-qzP6lvMtUmKYMctU3JdmTYA088lQ/edit

Moonlighting activities should not overlap with training activities or schedules [i.e. involve clinical responsibilities (clinical phone calls) during normal work hours]. They should not take the fellow away from service duties during normal work hours. Normal work hours are defined as 8am – 5pm Monday through Friday excluding vacations and holidays.

Internal moonlighting is an activity involving patient care responsibilities of any sort (research or clinical) for which trainees are paid that takes place at a training site of the program [such as UMMC- Fairview, PrairieCare –].

External moonlighting is patient care activity for which you are paid at a non-training site for this program. All moonlighting, internal and external, in-house or home call must be reported in RMS. Home call has two RMS codes: (1) time when you could have been called, paged or consulted, irrespective of where you are (home, hotel) and (2) actual time spent in-house. Time in transit is not counted as time in-house.

All moonlighting activities count towards the 80 hour work week limit averaged over a four week period.

Moonlighting is not allowed on weekdays between 8:00 a.m. and 5:00 p.m. as Fellows are expected to be involved with residency matters during that time.

University malpractice insurance does not cover moonlighting activities. The moonlighting employer must provide malpractice insurance. Moonlighting is not allowed on weekdays between 8:00 a.m. and 5:00 p.m. as Fellows are expected to be involved with fellowship matters during that time.
5.W Supervision
Clinical training must include adequate, regularly scheduled supervision which complies with ACGME regulations. Each Fellow must have at least two hours of supervision weekly, one with their psychotherapy supervisor and one with their psychopharmacology/competency supervisor. Time spent in a group on service does not fulfill this requirement as defined by the ACGME.

5.X Monitoring of Fellow Well-Being
It is the responsibility of the fellowship program to monitor fellow well-being. This is done through graded responsibility and face-to-face supervision. The program director receives feedback from supervisors, course directors, hospital and clinic staff and meets with fellows on a twice yearly basis. The RMS evaluation form completed by faculty contains specific items regarding magnitude of service demands and the individual fellow’s fatigue and stress level. The fellow is surveyed in RMS after each rotation regarding levels of program related stress and personal stress.

5.Y Fatigue and Work Conditions
Fellows will be educated about the negative effects of fatigue on patient care and learning, including the specific skills of alertness management and fatigue mitigation processes during the required Institutional Orientation conducted by the University of Minnesota Graduate Medical Education Office. Educational modules are also available on the Psychiatry Moodle Website. Fellows are encouraged to adopt fatigue mitigation processes when necessary. In the case of fatigue during a duty shift, or when patient care responsibilities are unusually difficult or prolonged, back-up service may be arranged by contacting the chief fellow or the faculty member on-call. Additionally, the University of Minnesota Medical Center, Fairview provides reimbursement of taxi fare for fellows who require transportation due to issues related to fatigue following duty shifts.

5.Z Graded Responsibility
The F1 year, for the most part, have on-site supervision available. The F2 year leads to independent practice in settings such as school consultation and community sites such as Hennepin County Medical Center. The PGY5 Fellow learns the role of team leader and managing the dynamics of systems in off-campus clinical settings.

5.AA ACLS/BLS/PALS Certification Requirements
If there is required institutional and hospital certification in BLS and ACLS it will be provided to fellows during orientation.

5.BB University of Minnesota Medical Center Hospital Dress Code Policy
All designated individuals shall wear a photo identification badge issued by the medical center. The photo identification is to be worn above the waist, with the photograph visible, and with no alteration to the photo or information on the badge. It is to be worn at all times except when removal is necessary for safety during Behavioral Control procedures. Good personal hygiene is required. Footwear and stockings will be worn at all times on inpatient units. Stockings are optional in outpatient programs. Clothing must be consistent with a professional image appropriate to a health care setting. Clothing is to be neat, pressed, clean, non-transparent and will comfortably allow full range of motion. Scrubs are acceptable but should be distinct from the type given to our patients. Clothing that exposes midriff, hips, lower back, buttocks, breasts, chest, cleavage, and underwear of all types are unacceptable in the workplace. In addition the following items are not to be worn: halter tops, tank tops, sweat pants, shorts, workout clothes, shirts with pictures, symbols or writing beyond brand identification and clothing that is un-hemmed, torn, frayed, ripped or in disrepair. Tattoos which have disturbing, violent, provocative, or frightening content are not to be visible. Jewelry including piercings must be limited for safety and must
present a professional image to our patients, families, and others. Artificial fingernails, enhancements or extenders are prohibited for direct physical caregivers. Anything applied to nails other than polish is considered an enhancement. This includes, but not limited to artificial nails, tips, wraps, appliqués, acrylics, gels and any additional items applied to the nail surface. Gloves are not an acceptable alternative. It is each employee’s responsibility to adhere to these guidelines. It is not practical to attempt to delineate every unacceptable clothing option. Managers will intervene when they have a concern that the goals of safety, infection prevention, professionalism and healing environment are being compromised by dress choices of questionable taste or appropriateness. Intervention may include counseling, corrective action or requiring the employee to change into scrubs.

5.CC Step 3 Requirement
All trainees must pass the USMLE Step 3 or an equivalent licensing examination before entering the fellowship.

5/DD House Staff Substance Use/Abuse Policy
It is the policy of the University of Minnesota that University personnel will be free of controlled substances. Chemical abuse affects the health, safety and well being of all members of the University community and restricts the ability of the University to carry out its mission. Similarly, the Department of Psychiatry recognizes that chemical/substance abuse or dependency may adversely affect the physician-in-training’s ability to perform efficiently, effectively and in a professional manner. The department believes that early detection and intervention in these cases constitutes the best means for dealing with this social problem and creates the best environment for providing improved patient care. Accordingly, the following policy has been adopted.

(1) No fellow shall report for assigned duties under the influence of alcohol, marijuana, controlled substances, or other drugs including those prescribed by a physician that affect his/her alertness, coordination, reaction, response, judgment, decision-making abilities, or adversely impact his/her ability to properly care for patients.

(2) Engaging in the use, sale, possession, distribution, dispensation, transfer or manufacture of illegal drugs or controlled substances may have a negative impact on fellow’s ability to perform his/her duties; therefore, no fellow shall use, sell, possess, distribute, dispense, transfer or manufacture any illegal drug, including marijuana, nor any prescription drug (except as medically prescribed and directed) during working hours, while on rotation at any hospital or institution participating in the training program.

(3) Any violation of this policy may subject the fellow to discipline including, but not limited to, suspension and/or termination.

(4) When there is reasonable cause to believe that a fellow may be using, selling, possessing, distributing, dispensing, transferring, or manufacturing any illegal drug, controlled substance, or alcohol, the fellow may be required to undergo medical evaluation and assessment. The fellow’s ability to continue participation in the program will be determined by the Residency Program Director in consultation with attending faculty or the Residency Training Committee and the chairperson on the department. Actions may include, but are not limited to, recommendation for treatment and return to duty, suspension from duty with pay, suspension from duty without pay, and/or termination.

(5) Depending upon the circumstances, the department may notify appropriate law enforcement agencies and/or medical licensing boards of any violation of this policy.

(6) Fellows who are convicted of a criminal drug statute violation (including DWI, boating tickets, etc.) are required to inform the Fellowship Program Director or Fellowship Training Committee or department head of the conviction (in writing) within five (5) calendar days thereof.

(7) Other fellows who have reasonable cause to believe that a colleague is using a substance that adversely impacts on the fellow’s performance in the training program must report the factual basis for their concerns to the Fellowship Program Director.
(8) If a fellow is taking a medically authorized substance which may impair his or her job performance, the fellow must notify his or her supervising fellow, chief fellow, attending faculty, or the Fellowship Program Director of his or her temporary inability to perform assigned duties.

(9) Fellows are encouraged to seek assistance in addressing any problems they might have related to alcohol or substance abuse. The Fellow Assistance Program is available to all fellows and their families. (Please refer to Institutional Manual for contact numbers and descriptive information on these programs.)

(10) Fellows must be aware that there are significant criminal penalties, under state and federal law, for the unlawful possession or distribution of alcohol and illicit drugs. Penalties include prison terms, property forfeiture, and fines.

5.EE Policy on Completion of Discharge Summaries
Timely completion of Hospital Discharge Summaries is a core competency objective of the general psychiatry residency program. Accordingly training in these activities will be provided and UMMC Health Information Management (HIM) and the fellowship program will monitor performance. Deficiencies will be viewed as academic, not administrative matters.

UMMC Hospital Policy and Procedure states:
Discharge summaries must be completed within 24 hours of discharge. An abbreviated summary is acceptable for patients hospitalized less than 48 hours with problems of a minor or uncomplicated nature.

In general the weekly Deficiency List from HIM will assess timeliness of completion. Ordinarily disputes about the accuracy of the Deficiency List must be resolved with HIM by the fellow. If a Deficiency List indicates any summaries over 30 days old the fellow will be (under ordinary circumstances) considered out of compliance with this policy.

Responsibility for the discharge summary devolves as follows.

If a team fellow has been responsible for the patient in the context of regular, weekday (non-holiday) attending rounds then that fellow is responsible for the discharge summary whenever the patient is discharged (weekday, holiday, weekend). If more than one fellow has seen the patient in this context it is the last fellow to have done so (even if this is a single encounter). As a matter of collegiality, a fellow who knows the patient best may volunteer to do the summary.

On weekends and holidays—if a patient has not been seen by a team attending as part of regular, weekday (non-holiday rounds)-the discharge summary is the responsibility of the person who writes the discharge orders.
If a team attending sees a patient on regular, weekday (non-holiday rounds) and a team assigned fellow has never rounded on the patient-fellow(s) assigned to that team is (are) not on duty (vacation, illness, PRITE exam etc) or there is no fellow assigned to that team (i.e. an uncovered service)-the discharge summary is the responsibility of the last team attending to do regular, weekday (non holiday) rounds on that patient whenever that patient is discharged.

Consequences of delinquent (>30 days records) Discharge Summaries

<table>
<thead>
<tr>
<th>Status</th>
<th>Definition</th>
<th>Requirements</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written Advisory</td>
<td>First occasion of record(s) over 30 days old.</td>
<td>*Meet with chief fellow to review knowledge and skills related to medical documentation.</td>
<td>*Advisory from Program Director- would typically be written on dictation log demonstrating delinquent records.</td>
</tr>
<tr>
<td></td>
<td>This episode continues and moves forward through the various stages as long as any record is 30 days or over. The record that prompted an advisory must be completed and</td>
<td></td>
<td>*No academic consequences</td>
</tr>
</tbody>
</table>

Program Policy & Procedure Manual
<table>
<thead>
<tr>
<th>Status</th>
<th>Event Description</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written Warning</td>
<td>Written Advisory status not resolved in 30 days.</td>
<td>* Completion of delinquent record(s) within 3 weeks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Advisory does not go to academic file.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Fellow continues all duty activities.</td>
</tr>
<tr>
<td>Official Warning</td>
<td>Failure to resolve Written Warning</td>
<td>* Meet with faculty designated by program director to determine source of deficiencies and devise a remediation plan.</td>
</tr>
<tr>
<td></td>
<td>Or</td>
<td>* Completion of delinquent record(s) within 3 weeks.</td>
</tr>
<tr>
<td></td>
<td>If there have been three previously unresolved Written Advisories a further written advisory will become an Official Warning</td>
<td>* Written warning from Program Director.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* No academic consequences.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Warning does not go to academic file.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Fellow continues all duty activities.</td>
</tr>
<tr>
<td>Probationary Status</td>
<td>Failure to resolve Official Warning</td>
<td>* Meet with program director.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Completion of delinquent record(s) within 3 weeks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Official note of Probationary Status placed in academic file.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Fellow may or may not be allowed to continue other duty activities.</td>
</tr>
<tr>
<td>Failure of rotation</td>
<td>Failure to resolve Probationary Status</td>
<td>* Meet with program director.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Completion of delinquent record(s) within 3 weeks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Fellow fails the rotation(s) during which the deficiencies occurred and must repeat them, thereby extending the fellowship</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Record of this in the academic file.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Fellow may or may not be allowed to continue other duty activities.</td>
</tr>
<tr>
<td>Dismissal</td>
<td>Failure to resolve Failure of Rotation Status</td>
<td>* Due process for dismissal is implemented.</td>
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<tr>
<td></td>
<td></td>
<td>* Fellow is relieved of all duty assignments.</td>
</tr>
</tbody>
</table>
5.FF Outpatient Note Delinquency Policy
Outpatient EMR notes are required to be ready for attending signature by the end of 7 calendar days for evaluations and by the end of 3 calendar days for other notes. Compliance is considered aspects of Professionalism and Patient Care. Noncompliance will typically be ascertained by UMP billing operation and reported to Program Director. Depending on circumstances, failure to remediate deficiencies can lead to a negative report to the academic file, withdrawal of approval for moonlighting activities, probation, non-credit for rotation and/or dismissal.

Outpatient EMR notes are required to be ready for attending signature by end of 48 hours for evaluations and progress notes. Compliance is considered aspects of Professionalism and Patient Care. Depending on circumstances, failure to remediate deficiencies can lead to a negative report to the academic file, withdrawal of approval for moonlighting activities, probation, non-credit for rotation and dismissal.

Parking cards will be shut off for Fellows who have five or greater encounters that are greater than seven days old.

1) The administrative Fellow will review the clinic managers weekly list of open encounters.
2) If a general adult Fellow has five or more open encounters that are greater than a week old, the administrative Fellow will identify the encounter and verify whether the Fellow has completed all necessary components. Fellows will not be penalized if an encounter remains open because faculty has not signed the note (this will not be counted to the five or greater threshold).
3) The administrative Fellow will send a page to Fellows who do not meet this expectation and alert them that their parking card will be turned off.
4) Fellows can resolve open encounters through Tuesday morning. If encounters have not been routed to attending physicians by Tuesday morning, the administrative Fellow will turn off parking cards.
5) To turn parking cards back on, Fellows will need to alert me by email, page, or in person that the open encounters have been resolved.

5.GG Rules and Guidelines for Medical Students, Residents and Fellows on Interactions with Industry Representatives
The Medical School, Graduate Medical Education Committee, Department of Psychiatry and the University of Minnesota do not have specific policies regarding interaction with industry representatives (hereafter representatives). The University of Minnesota Medical Center and the Minneapolis VA Medical Center do have policies.

There are no restrictions regarding the access of representatives to public areas that are assigned to the Department of Psychiatry.

Trainee – representative interactions are not specifically monitored. The program expects the fellows to regulate their interactions with attention to the following rules and guidelines.

Personal information (pager, address, cell phone) about students or fellows should not be distributed to representatives.
Representatives should not be given access to the fellow’s offices.
Students and fellows should not take paraphernalia bearing the name of a product into patient care areas (this includes notebooks, pens, clipboards, etc.).
Students and fellows should not personally solicit or accept gifts or monetary support from industry sources.
Support for educational materials/activities obtained from industry sources should be negotiated on behalf of all fellows (or a specific class) by the Chief Fellow (in consultation with the Program Director) and will be distributed by the program coordinator. Industry representatives are advised that acceptance of such support does not constitute an agreement for fellows to meet face to face with representatives (i.e. hand them the book, etc).

No discussion with representatives should violate patient confidentiality.

Educational activities intended for fellows (outside speakers, videoconferences, etc) conducted on campus that are organized and supported by representatives must be arranged through the Chief Fellow. At the discretion of the Chief Fellow a faculty member or member of the UMMC pharmacy staff may be invited to participate as well.

5.HH Rules and Guidelines for Medical Students and Residents on Interactions with Industry Representatives

The Medical School, Graduate Medical Education Committee, Department of Psychiatry and the University of Minnesota do not have specific policies regarding interaction with industry representatives (hereafter representatives). The University of Minnesota Medical Center and the Minneapolis VA Medical Center do have policies.

There are no restrictions regarding the access of representatives to public areas that are assigned to the Department of Psychiatry.

Student or resident – representative interactions are not specifically monitored. The program expects the residents to regulate their interactions with attention to the following rules and guidelines.

- Personal information (pager, address, cell phone) about students or residents should not be distributed to representatives.
- Representatives should not be given access to the resident room (F248) or the student room (F228).
- Students and residents should not take paraphernalia bearing the name of a product into patient care areas (this includes notebooks, pens, clipboards, etc.).
- Students and residents should not personally solicit or accept gifts or monetary support from industry sources.
- Support for educational materials/activities obtained from industry sources should be negotiated on behalf of all residents (or a specific class) by the Chief Resident (in consultation with the Program Director) and will be distributed by the program coordinator. Industry representatives are advised that acceptance of such support does not constitute an agreement for residents to meet face to face with representatives (i.e. hand them the book, etc).
- No discussion with representatives should violate patient confidentiality.
- Educational activities intended for residents (outside speakers, videoconferences, etc) conducted on campus that are organized and supported by representatives must be arranged through the Chief Resident. At the discretion of the Chief Resident a faculty member or member of the UMMC pharmacy staff may be invited to participate as well.

5.II Visa Sponsorship

The J-1 alien physician visa sponsored by ECFMG is the preferred visa status for foreign national trainees in all UMN graduate medical education programs; therefore, the Department of Psychiatry sponsors only J-1 visas. We do not sponsor H-1B visas.

More information on the J-1 visa can be found on the UMN-GME webpage:

http://hub.med.umn.edu/resident-fellow-administration/international-medical-graduates-visas
## 6. A Department and Program Administrative Contact Lists

### Psychiatry Department Telephone List (FACULTY)

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST</th>
<th>PHONE</th>
<th>PAGER</th>
<th>E-MAIL</th>
<th>OFFICE #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Badgaiyan, M.D.</td>
<td>Rajendra</td>
<td>625-6115</td>
<td></td>
<td><a href="mailto:rdb@umn.edu">rdb@umn.edu</a></td>
<td>Diehl Hall</td>
</tr>
<tr>
<td>Bass, M.D.</td>
<td>Deanna</td>
<td>273-8700</td>
<td>612-538-1539</td>
<td><a href="mailto:bassx003@umn.edu">bassx003@umn.edu</a></td>
<td>F275</td>
</tr>
<tr>
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</table>

### Child Psychiatry Faculty

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST</th>
<th>PHONE</th>
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</table>

**Psychiatry Department Telephone List (STAFF)**

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Becker Wesley Research Accountant</td>
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<tr>
<td>Goenner Asst. Dir. of Operations</td>
</tr>
<tr>
<td>Gross Finance Manager</td>
</tr>
<tr>
<td>Marshall Admin. Center Director</td>
</tr>
<tr>
<td>Melander HR Manager</td>
</tr>
<tr>
<td>Olson Accountant II</td>
</tr>
<tr>
<td>Overgaard Accountant I</td>
</tr>
<tr>
<td>Peterson Research Accountant</td>
</tr>
<tr>
<td>Cote HR Representative</td>
</tr>
<tr>
<td>Sidla Research Accountant</td>
</tr>
<tr>
<td>Stork HR Specialist</td>
</tr>
</tbody>
</table>

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| 273-9820 |

**ADULT PSYCHIATRY  273-9800**

| 273-9711 |

**EDUCATION**

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<td>TOBACCO RESEARCH FAX</td>
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### 6.B University of Minnesota Holidays

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<td>Monday, July 4</td>
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<td>Monday, September 5</td>
<td>Labor Day</td>
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<td>Thursday, November 24</td>
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<td>Friday, December 23</td>
<td>Floating Holiday</td>
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<tr>
<td>Monday, December 26</td>
<td>Christmas Day Holiday</td>
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<tr>
<td>Monday, January 2, 2017</td>
<td>New Year's Day Holiday</td>
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<tr>
<td>Monday, January 16</td>
<td>Martin Luther King, Jr. Day</td>
</tr>
<tr>
<td>Friday, March 17</td>
<td>Floating Day</td>
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<tr>
<td>Monday, May 29</td>
<td>Memorial Day (One Personal Floating Holiday)</td>
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</tbody>
</table>

Program Policy & Procedure Manual
GOALS AND OBJECTIVES:

ROTATIONS
LEARNING OBJECTIVES FOR: Inpatient Acute Child and Adolescent Psychiatry

The six core competencies are:

1. **Patient Care:** Care of acutely, seriously ill patients from early childhood through adolescence is the primary goal. Being able to understand extremely complex differential diagnoses, interactions of biology and family events, and coping strategies and defense mechanisms (of both children and families) are an inherent part of this learning experience. Not only direct care of the residents’ patients, but also the residents’ supervision, overview, and oversight of other students (such as medical students) allow them to develop their skills in caring for these extremely disturbed patients.

2. **Medical Knowledge:** The capacity to adapt those ideas, treatment interventions, and management styles that they have learned in lectures and reading is a part of their growing medical knowledge. In their lectures and in their daily discussions, specific articles are discussed and the application of that information to the problem at hand is oftentimes the subject of a 2-5 minute discussion with the entire team. Being able to see side effects (such as Parkinsonism, akathisia, and sedation) provides real life knowledge about the presentation of medication side effects; the effect of these medications on comorbid conditions is a practical outcome of this experience.

3. **Practice-Based Learning:** Each of the fellows has an opportunity over a 10-week period to follow a patient from the beginning, through the middle, and to the end of the patient’s hospital stay. Hospital stays can be as short as less than 24 hours and as long as 5-6 weeks. Thus, they are able to understand how each decision made at the time of the family meeting and the gathering of data affect the care of the patient. We are able to look over each day the effects of our decision-making over the previous days or weeks to see how well these principles meet the needs of the patient. Interactions with families also provide a unique learning environment where the effect of the family’s response to the information about the improvement in their child’s behavior and to their planning for the welfare of their child is seen as part of the overall clinical decision-making skills that are being developed.

4. **Interpersonal and Communication Skills:** The fellows learn to improve and expand their interviewing techniques. By having a wide variety of ages, cultures, and diagnostic conditions, they are able to learn more about how to assess this information and to encourage the children to talk. Many times, the children are oppositional and afraid, issues that limit communication initially. Being able to develop a relationship and a therapeutic alliance becomes one of the skills that is enhanced greatly during this rotation. Similarly, the fellow is able to perceive the family’s response to the crisis. The families may have drawn from sources of strength and the family difficulties may also become evident during the interview. Being able to respond to this, to encourage their discussion, and to work through issues with the families are major parts of being able to understand how the illness presents in the family. Being able to facilitate this through a therapeutic alliance is again a skill that
grows significantly with the many interactions with families.

5. **Professionalism:** The fellow becomes much more capable of responding flexibly, empathetically, and knowledgeably to the questions and the cares of the different patients and their families. This growing sense of being a responsible person who can communicate the facts of medicine and the understanding of disease process to the families helps them determine even more their sense of responsibility and their compassion.

6. **Systems-Based Practice:** The inpatient unit is ideal for understanding different systems. This is because the inpatient wards and staff are hired and run by the Fairview Health System. The students, on the other hand, come from various schools, including, for the most part, the University of Minnesota. The understanding of how decisions made for both our team and also the hospitalists (i.e., how coverage is provided, for instance, on weekends) allows the residents to learn how decisions made by the administration affect how patients are cared for. It also helps them to understand in an insightful way their own motivations and how they may be more mature in understanding how decisions for patient care become affected by factors beyond what the physician and nursing staff decide together.
LEARNING OBJECTIVES
Child and Adolescent Anxiety and Mood Disorders Clinic

The six core competencies are:

1. **Patient Care**: Providing evidence-based, compassionate outpatient care of children and adolescents with anxiety and mood disorders is the primary goal. This is a subspecialty clinic and many of the children who are referred have been assessed and/or treated elsewhere. We provide a comprehensive evaluation that involves integrating multiple sources of information including outside records; interviews from parents and child together, child alone, and parents alone; testing results; and laboratory tests, if indicated. The fellow integrates the information to arrive at a differential diagnosis and a biopsychosocial formulation. Being able to understand complex differential diagnoses and interactions of biology and environment is an inherent part of this learning experience. The fellow facilitates the recommendations from the evaluation, whether this means gathering more information (e.g., from teachers or daycare providers), making a referral for additional consults (e.g., neuropsychological testing), providing psychoeducation about the child’s diagnoses, or initiation of treatment.

2. **Medical Knowledge**: The fellow uses medical knowledge in arriving at the differential diagnosis, case formulation, and recommendations for treatment. Fellows are encouraged to go to the medical literature to obtain more information about the patients’ presenting symptoms and diagnoses. Some of the cases seen in the Child and Adolescent Anxiety and Mood Disorders Clinics are rare and require special expertise [e.g., Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)]. Dr. Bernstein provides articles to the fellows about these psychiatric conditions.

3. **Practice-Based Learning and Improvement**: Working in the Child and Adolescent Anxiety and Mood Disorders Clinic allows the trainee to see a variety of cases that would likely be seen in an outpatient clinic setting. The trainee learns to independently and professionally evaluate the child or adolescent under the supervision of Dr. Bernstein. After observing Dr. Bernstein provide feedback and recommendations to the family for a couple of cases, the fellow will take on the responsibility of providing this information to the family with Dr. Bernstein observing. The fellow learns to be efficient and confident in obtaining information, and fluent in providing feedback to families, answering their questions, and arranging follow-up. As noted under Medical Knowledge, fellows are encouraged to find articles related to their patients’ diagnoses.

4. **Interpersonal and Communication Skills**: The fellows learn to improve and expand their interviewing techniques. By evaluating patients of different ages and from different cultural backgrounds, they are able to learn more about how to assess this information. Advancing interviewing techniques and forming of a strong therapeutic alliance with their patients are goals of this rotation. Trainees learn to encourage children and adolescents to “open up” and share information. Evaluation reports are required to be timely, well-written, and concise. Feedback is provided by Dr. Bernstein about interviewing style and report writing. Oral case presentations are given by fellows at the weekly Anxiety Round Table seminar.
5. **Professionalism:** Fellows are expected to maintain professional dress and appearance and to interact with patients and their families in a professional and empathic manner. Fellows are encouraged to independently manage the evaluations and follow-up appointments with their patients under Dr. Bernstein's supervision. They learn to provide comprehensive assessment and evidence-based treatments. Issues related to confidentiality, decision making, billing, documentation, and risk assessment are emphasized. This growing sense of being a responsible physician who can understand and communicate knowledge of psychopathology and treatment interventions to families helps him/her develop a sense of responsibility and compassion.

6. **Systems-Based Practice:** Within the Clinic, the fellow interacts with other mental health professionals, including intake workers and nurses. After the evaluations are completed, releases of information are obtained to acquire additional information from outside sources such as school personnel, primary care physicians, and therapists and to send reports to primary care physicians, therapists, and school personnel, as indicated. Referrals are made to other disciplines for consultation, as needed.
Child Psychiatry Consultation Rotation

Learning Objectives

In accordance with ACGME guidelines, the educational objectives are designed around the six core competencies:

1. **Patient Care** - Emphasis is on the interaction of physical and mental illness, and their joint presentation. Medication interactions in patients with complex regimens, disease coping, and effects of childhood illness on family structures.

2. **Medical Knowledge** - Linked with the above, expected areas where the knowledge base will improve are medication metabolism and side effects, prevalence and presentation of comorbidities, and broader familiarity with pediatric illness.

3. **Practice-based learning** - As each patient will present unique challenges, there will be ample opportunity (and need) to visit the literature, and synthesize the available information to best address the needs of the patient. In all likelihood, very few articles will adequately address all aspects of a patient’s case, and so the trainee will need to balance all the information gathered and arrive at a meaningful synthesis for the individual patient.

4. **Interpersonal and Communication Skills** - This is a major component of consultation-liaison psychiatry. In addition to building on existing skills in communicating with patients, the trainee will focus on timely, efficient communication with the inpatient pediatrics team and with primary care pediatricians. This will include not only providing advice on clinical management, but listening to concerns and assisting pediatrics residents in framing their questions. Communication with patient families at times of high stress is also a key skill, coupled with the need to assess when the timing for certain communication is right.

5. **Professionalism** - The performance of all of the above functions leads to appropriate professionalism. The patients seen in consultation can require a challenging negotiation between the care team, the patient, and the family. At times, even determining our most appropriate role can be difficult.

6. **Systems-based practice** - The scarcity of child and adolescent psychiatry resources provides the main learning opportunity in systems-based practice. All patients seen in consultation should have an aftercare plan, and the development of this plan should start the day they are seen.
Goals and Objectives for Psychosis clinic rotation

In keeping with the ACGME guidelines, the educational goals and objectives for the psychosis clinic are designed to incorporate the six core competencies.

Patient care

The goal is to deliver compassionate, appropriate, and timely care for a diagnostically challenging patient population, keeping in mind that various medical illnesses and developmental delays can mimic early onset psychotic disorder. Various aspects of patient care, including medications, family support, family psychoeducation, academic supports, will have to be addressed as integral part of treatment.

Medical Knowledge

Psychotic disorders are a heterogeneous group of disorders with widely varying etiopathogenesis. Trainees will have to develop an understanding of the symptomatology using appropriate developmental and psychodynamic framework. This will also include various investigations to rule out medical basis for psychotic illnesses. The trainee has a challenging task to tease apart various diagnosis that can mimic psychosis in on a psychiatric diagnosis following thorough clinical exam and testing. In addition, this will be accomplished with literature search, consultation with colleagues, and case discussions. Trainees will gain skills and knowledge to manage medications with full awareness of their side effect profile and develop strategies to prevent and manage adverse effects.

Practice Based learning

Trainees will learn as they treat the individual patients the unique presentations and the precipitating and perpetuating factors for the individual’s illness. Monitoring the patients for their unique adverse effect profiles and warning signs for decompensations and understanding how their environment contributes to their stability will be another skill acquired by the end of the rotation. Fellows will also focus on evidence-based practice guidelines and use them in their treatment plans.

Interpersonal and communication skills.

Trainees will have to develop unique communication skills with this subset of population. In addition to maintaining empathy, they will have to acquire the trust of the patient in order to successfully implement any treatment strategy. Trainees will have to keep an eye on the expressed emotionality and address how it impacts and perpetuates the illness. They will also have to deal with the school and county to advocate for appropriate accommodations and resources for the patient. During this rotation, fellows will learn to provide family psychoeducation and also be in consultation with the patients’ providers to highlight their other medical needs. They will also acquire skills to convey the overall impact of the illness and prognosis using objective data from the literature as they optimize the services negotiating with various agencies.

Professional Competency
The various above approaches the fellow has to incorporate will steer the trainee towards competency and high professional standards. While dealing with various agencies the trainees will learn to uphold and advocate for high standards of care as stated above. He will in addition learn to communicate with various agencies in timely and professional manner.

System Based Practice

The university setting provides a unique opportunity for the trainee to interact with the system at various levels. This will not only give the fellow an opportunity to understand the hierarchy at managerial and administrative level but also at clinical level help the fellow discern the various levels of care that are uniquely geared to address the severity of the illness and the needs of the patient. The fellow will be able to help colleagues manage his patient in various setting and develop unique perspective on the needs of his patient. The system based practice will also create an awareness about cost effective care. The fellow will develop appreciation for the unique role of the various specialists like the pharmacist, social worker and various therapists who will partner in patient’s care. Therapy, supports groups, case management meetings will provide a unique perspective for the administrative policies and cost effective patient oriented care, utilizing various system resources.
GOALS AND OBJECTIVES FOR CHILD PSYCHIATRY ROTATION
HENNEPIN COUNTY MEDICAL CENTER (HCMC)

The HCMC outpatient Child Psychiatry rotation exposes the fellow to children and adolescents with a broad variety of psychopathology primarily from Northeast Minneapolis. The population of the clinic is drawn from families that are typically dealing with moderate to severe psychosocial stresses including problems such as social isolation, poverty, parental substance abuse, parental psychopathology, childhood neglect and abuse, and witnessing domestic and community violence. A full range of treatment modalities is used to treat patients that frequently have co-morbid conditions, including pharmacotherapy and a variety of psychotherapies. The fellow will have an opportunity to work parallel to child psychology trainees. Fellows will be expected to develop more advanced interviewing and diagnostic formulation skills and to be able to access community resources to develop a comprehensive treatment plan.

Patient Care

Goal:
The fellow will further develop his/her understanding and knowledge concerning the medical, cultural, legal, and ethical aspects of community psychiatric treatment for pediatric patients.

Objectives:
• Demonstrate an ability to obtain thorough histories from patients and their families, teachers and other allied health professionals.
• Formulate a differential diagnosis and gather appropriate information to narrow the differential.
• Demonstrate an ability to accurately diagnose childhood psychiatric disorders and make judgments as to the appropriate setting for initiation of treatment (i.e., outpatient vs. day hospital vs. inpatient).
• Develop a biopsychosocial treatment plan.
• Demonstrate safe prescription of psychotropic medications in children and adolescents based on age and weight.
• Demonstrate an awareness of appropriate evidence-based psychotherapeutic techniques for common problems affecting children and adolescents and how these treatments should be appropriately sequenced with medications.
• Demonstrate the ability to coordinate thorough follow-up plans for patients after completion of a diagnostic evaluation.
• Present cases succinctly and accurately.
• Understand the importance of proper documentation in the clinical record.
• Gain skills as a teacher.

Medical Knowledge Goal:
The fellow must demonstrate knowledge of the administration of established FDA approved psychotropic medications and the judicious use of off-label medications for the care of children and adolescents with psychiatric disorders.
Goals and Objectives for Psychiatry Rotation

Professionalism Goal:
The Fellow must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Fellows are expected to:

Objectives:
• Demonstrate sensitivity to patients’ ethnicity, gender, age and disabilities.
• Demonstrate a commitment to ethical principles such as confidentiality and informed consent.
• Demonstrate respect, compassion and integrity in carrying out patient care duties.
• Complete documentation of patient encounters in a timely fashion.

Systems-Based Practice Goal:
The fellow must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Objectives:
• Effectively coordinate patient care with a multidisciplinary team.
• Understand the appropriate use of day hospital, residential care and inpatient services.

Evaluations

The objectives will be measured by attendance and by formal evaluation of the fellow’s participation and knowledge. Evaluations will be completed by the supervising physician at the end of the rotation.
LEARNING OBJECTIVES FOR PHP PROGRAM

The six core competencies are:

1. *Patient Care:* Care of partially stabilized, seriously ill patients from early childhood through adolescence on a step-down unit is the primary goal. Being able to understand extremely complex differential diagnoses, interactions of biology and family events, and coping strategies and defense mechanisms (of both children and families) are an inherent part of this learning experience. Not only direct care of the residents’ patients, but also the residents’ supervision, overview, and oversight of other students (such as medical students) allow them to develop their skills in caring for these extremely disturbed patients.

2. *Medical Knowledge:* The capacity to adapt those ideas, treatment interventions, and management styles that they have learned in lectures and reading is a part of their growing medical knowledge. In their lectures and in their daily discussions, specific articles are discussed and the application of that information to the problem at hand is frequently the subject of a 2-5 minute discussion with the entire team. Being able to recognize common medication side effects (such as Parkinsonism, akathisia, and sedation) provides real life knowledge about the presentation of medication side effects; the effect of these medications on comorbid conditions is a practical outcome of this experience.

3. *Practice-Based Learning:* Each of the fellows has an opportunity over a 10-week period to follow a patient from the beginning, through the middle, and to the end of the patient’s PHP stay. Treatment in the PHP program can be as short as 24 hours and as long as 8 weeks. Thus, they are able to understand how each decision made at the time of the family meeting and the gathering of data affect the care of the patient. We are able to look over each day the effects of our decision-making over the previous days or weeks to see how well these principles meet the needs of the patient. Interactions with families also provide a unique learning environment where the effect of the family’s response to the information about the improvement in their child’s behavior and to their planning for the welfare of their child is seen as part of the overall clinical decision-making skills that are being developed.

4. *Interpersonal and Communication Skills:* The fellows learn to improve and expand their interviewing techniques. By having a wide variety of ages, cultures, and diagnostic conditions, they are able to learn more about how to assess this information and to encourage the children to talk. Many times, the children are oppositional and afraid, issues that limit communication initially. Being able to develop a relationship and a therapeutic alliance becomes one of the skills that is enhanced greatly during this rotation. Similarly, the fellow is able to perceive the family’s response to the crisis. The families may have drawn from sources of strength and the family difficulties may also become evident during the interview. Being able to respond to this, to encourage their discussion, and to work through issues with the families are major parts of being able to understand how the illness presents in the family. Being able to facilitate this through a therapeutic alliance is again a skill that grows significantly with the many interactions with families.

5. *Professionalism:* The fellows become much more capable of responding flexibly, empathetically, and knowledgeably to the questions and the cares of the different patients and their families. This growing sense of being a responsible person who can communicate the facts of medicine and the understanding of disease process to the families helps them determine even more their sense of responsibility and their compassion.
6. **Systems-Based Practice:** The PHP program is ideal for understanding different systems. This is because the step-down units are hired and run by the Fairview Health System. The students, on the other hand, come from various schools, including, for the most part, the University of Minnesota. The understanding of how decisions are made for both our team and also the hospitalists allows the residents to learn how these decisions made by the administration do affect how patients are cared for. It also helps them to understand in an insightful way their own motivations and how they may be more mature in understanding how decisions for patient care become affected by factors that are other than what the physician and nursing staff decide together.
LEARNING OBJECTIVES
Child and Adolescent Mood Disorders Clinic

The six core competencies are:

1. Patient Care: The primary goal is to develop expertise in the assessment and development of a plan of care for children and adolescents with mood disorders. Fellows will learn to utilize the results of some psychological measurements to help guide their assessment and plan formulation. Fellows will take special care to understand the risk and protective factors for each child and family, and how these played a role in the development of mood disorders in each child’s lifetime. Fellows generally follow these children for medication management after the assessment, and occasionally take them on for therapy patients, providing the opportunity to continue to revise their case formulations and to provide ongoing care to these patients and their families.

2. Medical Knowledge: The capacity to adapt those ideas, treatment interventions, and management styles that they have learned in lectures and reading is a part of their growing medical knowledge. In the discussions of each case during the staffing, fellows are given the opportunity to demonstrate their knowledge via case presentations, to ask questions both general and particular to each case, and to receive feedback.

3. Practice-Based Learning: Over the course of the rotation, fellows evaluate one child or adolescent per week, and then to provide follow-up care as indicated. Prior to staffing, fellows generally share their impressions with the family, and then when the faculty joins for the final discussion after having discussed the case with the family, additional questions are asked and the formulation is fine-tuned. Thus the fellows have an opportunity to develop a formulation and plan of care on their own which is then worked through with the faculty. Additionally, the follow-up care provides the opportunity for fellows to continually revise their formulation. Follow-up visits are conducted without faculty so that fellows have substantial independence in their decision-making.

4. Interpersonal and Communication Skills: The fellows learn to improve and expand their interviewing techniques. They learn to gather sensitive information from children, adolescents and parents and develop a trusting relationship right from the beginning, during the evaluation. Additional assessment and ongoing care often requires collaboration with outside providers such as therapists, social workers, teachers, pediatricians, etc. Fellows learn to establish clearly with patients and families procedures related to confidentiality, which is important both in assessment and ongoing care.

5. Professionalism: The fellow becomes much more capable of responding flexibly, empathetically, and knowledgeably to the questions and the cares of the different patients and their families. This growing sense of being a responsible person who can communicate the facts of medicine and the understanding of disease process to the families helps them determine even more their sense of responsibility and their compassion.

6. Systems-Based Practice: In the process of assessment, fellows determine what level of services the family is currently receiving, and make a determination of what is needed. Frequently, additional services are recommended, which requires the fellow to learn how to help families implement these. In the process, fellows learn how to assess level of care, what resources are available in the community, and how to navigate systems to best advocate for their patients.
Goals and Objectives for Child and Adolescent Psychiatry Rotation in Outpatient Clinic at the University of Minnesota Medical Center (UMMC)

The UMMC outpatient clinic rotation exposes the fellow in both first and second years to a wide range of patients presenting with a wide range of psychopathologies. [please list the demographics]

The clinic attracts referrals from community physicians from the Twin Cities, suburbs, and the surrounding areas. The University's Amplatz Children's Hospital refers a majority of our patients from various pediatric specialties. This clinic also serves as a continuity of care for a majority of the patients transferred from the inpatient units and different day treatment facilities.

The unique setting provides the fellow with ample opportunity to use a wide range of treatment modalities, including pharmacotherapy and psychotherapy. The fellow will collaborate with primary care providers, school staff, and county/state services.

The fellow also uses this rotation to perform individual and family psychotherapy for their patients. The fellow is supervised by Board-certified psychiatrists and psychotherapists on a regular basis who provide regular evaluations and feedback both to the fellow and the program.

1. **Patient Care:** The fellow will demonstrate ability to obtain thorough histories, examine the patient, and develop biopsychosocial formulation to present interactions of biological and psychosocial underpinnings of psychiatric illnesses. Based on the formulations, they are expected to develop differential diagnosis and comprehensive treatment recommendations addressing the identified needs of the patients. The fellow will also assist with follow-up care in the appropriate setting as needed as they continue to provide support and care in the continuity clinic.

2. **Medical Knowledge:** The fellow will enhance their knowledge in diagnosing and treating various pediatric illnesses as they relate to mental health concerns and coexisting comorbidities. They will familiarize themselves with the DSM-IV criteria for various mental health diagnoses. They will also improve their knowledge about various psychopharmacologic agents, their indications, benefits, and side effect profiles and metabolism as it relates to pediatric patients. They will judiciously use various medications for FDA-approved indications and also familiarize themselves with the off-label uses of other medications in children and adolescents. They will assess patients and monitor for side-effects as recommended.
3. Practice-Based Learning: The fellow will keep abreast of the advancing science and reviewing existent literature regularly, seeking supervision consistently and discussing cases with colleagues and attending conferences regularly.

4. Interpersonal Communication Skills: The fellow is expected to demonstrate nuanced communication skills while dealing with the patient’s various developmental levels, families with differing strengths, and various other agencies involved in the patient’s care. The fellow will serve as the patient’s advocate, effectively communicating about the patient’s needs, educating various agencies, and helping customize the patient’s accommodations at school. The fellow will also be in communication with referring physicians and help manage the patient in various settings during this rotation. Fellow will demonstrate empathic listening skills and develop rapport with families and help them through crisis situations.

5. Professionalism: The fellow will demonstrate adherence to the highest professional and ethical standards while caring for the patient by being sensitive to patient’s gender, cultural values, and disability-specific needs. The fellow will respect patient privacy and confidentiality. The fellow will also complete documentation in a timely fashion and communicate the appropriate information to the referring providers. The fellow will also nurture and model for medical students and residents and delegate appropriate roles and responsibilities for them.

6. Systems-Based Practice: The fellow will demonstrate the ability to work with various systems and optimize care. He/she will also demonstrate the skills to recognize and refer patients to appropriate levels of care/settings, depending upon the severity of their illnesses. The fellows will also learn and demonstrate cost-effective care delivery as they manage their patients. A multi-level care setting like UMMC provides the fellow several opportunities to coordinate care in various settings.
LEARNING OBJECTIVES FOR PRAIRIECARE INPATIENT ROTATION

The six core competencies are:

1. **Patient Care**: Care of acutely, seriously ill patients from early childhood through adolescence is the primary goal. Being able to understand extremely complex differential diagnoses, interactions of biology and family events, and coping strategies and defense mechanisms (of both children and families) are an inherent part of this learning experience. Not only direct care of the residents’ patients, but also the residents’ supervision, overview, and oversight of other students (such as medical students) allow them to develop their skills in caring for these extremely disturbed patients.

2. **Medical Knowledge**: The capacity to adapt those ideas, treatment interventions, and management styles that they have learned in lectures and reading is a part of their growing medical knowledge. In their lectures and in their daily discussions, specific articles are discussed and the application of that information to the problem at hand is oftentimes the subject of a 2-5 minute discussion with the entire team. Being able to see side effects (such as Parkinsonism, akathisia, and sedation) provides real life knowledge about the presentation of medication side effects; the effect of these medications on comorbid conditions is a practical outcome of this experience.

3. **Practice-Based Learning**: Each of the fellows has an opportunity over a 10-week period to follow a patient from the beginning, through the middle, and to the end of the patient’s hospital stay. Hospital stays can be as short as less than 24 hours and as long as 5-6 weeks. We are able to look over each day the effects of our decision-making over the previous days or weeks to see how well these principles meet the needs of the patient. Interactions with families also provide a unique learning environment where the effect of the family’s response to the information about the improvement in their child’s behavior and to their planning for the welfare of their child is seen as part of the overall clinical decision-making skills that are being developed.

4. **Interpersonal and Communication Skills**: The fellows learn to improve and expand their interviewing techniques. By having a wide variety of ages, cultures, and diagnostic conditions, they are able to learn more about how to assess this information and to encourage the children to talk. Many times, the children are oppositional and afraid, issues that limit communication initially. Being able to develop a relationship and a therapeutic alliance becomes one of the skills that is enhanced greatly during this rotation. Similarly, the fellow is able to perceive the family’s response to the crisis. The families may have drawn from sources of strength and the family difficulties may also become evident during the interview. Being able to respond to this, to encourage their discussion, and to work through issues with the families are major parts of being able to understand how the illness presents in the family. Being able to facilitate this through a therapeutic alliance is again a skill that grows significantly with the many interactions with families.

5. **Professionalism**: The fellow becomes much more capable of responding flexibly, empathetically, and knowledgeably to the questions and the cares of the different patients and their families. This growing sense of being a responsible person who can communicate the facts of medicine and the understanding of disease process to the families helps them determine even more their sense of responsibility and their compassion.
6. **Systems-Based Practice:** The inpatient unit is ideal for learning how a truly interdisciplinary treatment system is organized and functions. Fellows learn to interact with a variety of other professionals and learn how to incorporate a variety of opinions into a cohesive treatment plan.
LEARNING OBJECTIVES
Pediatric Neurology—Gillette Children’s Specialty Healthcare

The six core competencies are:

1. **Patient Care**: The primary goal is to develop an understanding of pediatric neurologic disorders. The fellow demonstrates compassion and develops a caring interaction with the patient and their family. The fellow builds rapport with the patient and the family, formulating neurologic assessments by taking history, physical findings, and psychosocial factors into account.

2. **Medical Knowledge**: The fellow applies advanced knowledge of pediatric neurologic disorders, obtained through literature review and supervision, to their medical knowledge base. The fellow has opportunity to discuss each case with a board certified pediatric neurologist, thus providing and opportunity to demonstrate their knowledge, and also to ask pertinent questions and request feedback. The fellow will have the opportunity to learn and practice the pediatric neurologic examination.

3. **Practice-Based Learning**: Over the course of the rotation, under the direct supervision of board certified pediatric neurologists, the fellow will learn appropriate management of an array of pediatric neurologic disorders. This experience is current conducted on an outpatient setting, with occasional opportunity to observe inpatient consultation and diagnostic testing, such as EEG (electroencephalogram). Depending on scheduling, the fellow will have the opportunity to see patients over time and follow up on diagnostic testing. The neurologist will routinely review brain imaging, such as MRI, with the fellow, further integrating the formulation of the treatment plan. The fellow also will develop an understanding of appropriate referral to pediatric neurology and/or neurologic diagnostic testing.

4. **Interpersonal and Communication Skills**: The fellow expands their patient interaction skills, with specific goal to improve interaction with children with neurologic disorders and their families. Also this rotation improves the fellow’s ability and comfort discussing cases with pediatric neurologist collaborators.

5. **Professionalism**: The fellow improves their capability in empathetically and knowledgeable providing information and recommendations to the patients and their families. This growing sense of being a responsible person who can communicate the facts of pediatric neurology and the understanding of disease process to the families helps them determine even more their sense of responsibility and their compassion.

6. **Systems-Based Practice**: In the process of assessment, fellows determine what level of services the family is currently receiving, and make a determination of appropriate follow up. The fellow will learn appropriate referrals and consultation specific to a pediatric neurologic setting, including physical and occupational therapy, psychosocial interventions, and diagnostic testing.
Research Competencies

1. Patient care.

In participating in research or in doing scholarly review of information, the resident receives a much better understanding of alternatives in designing patient care. With a comprehensive understanding of at least one part of the spectrum of psychopathology in child and adolescent psychiatry, they are able to more knowledgeably think about, formulate, and treat patients with psychiatric disorders.

2. Medical Knowledge

Of course doing a careful literature review, organizing ones thoughts, and being able to make a presentation, makes the medical knowledge much more consolidated and much more likely to be remembered by the resident. Similarly performing research projects involves a mastery of the available literature and an in-depth knowledge of the understanding of a research question, and results in a much better ability to read published work. Because of an increased knowledge of the research process, the fellow becomes much more capable of critically reading the literature.

3. Practice-based learning and improvement.

Residents will have the chance to apply these data that are learned from either giving a scientific talk or from performing scientific investigation. These skills allow them to evaluate their own patient care and to then design hypothetical questions for themselves that will help them to review how effective they really are in performing care.

4. Interpersonal and communication skills.

The resident develops a better and more extensive set of skills by being able to give a speech or to interact with the research mentor, and the patients in a protocol. By understanding the scales that are used to measure improvement and by understanding assessment techniques that are part of protocols, the fellow is much more knowledgeable and therefore better able to direct their investigation and their questions. This fosters much better communication because the interview is more guided by the physician’s understanding of the questions and how they relate to the condition. This develops more confidence in explaining to patients what the diagnosis is and the origin of evidence for the decisions that are made.

5. Professionalism.

The essential part of being a physician is understanding the basis of medical theory and knowledge. In understanding these percepts, the physician develops more confident understanding of the process of delivering care and their role as an expert and a professional who can communicate this at the level of the patient’s ability to understand.

The fellow develops a much better understanding of the research and academic systems that are involved in universities. Being able to understand the requirements, the conflicts, and systems that are set in place to govern research is critical to understanding how this affects patient care. That is, there are a variety of checks and balances in a research system including human subjects protection. How these are employed and how information then is formed will affect how patients are eventually cared for. Being understanding of this arm of the academic center is to be able to much more correctly interpret how information can be applied to patient care situations.
Learning Objectives for School Consultation.

The six core competencies are:

1. Patient care. The children in these school experiences are those who have failed the "regular" schools. There are a number of reasons for failure to learn and reasons why they have not been able to prosper. These include family situations that are chaotic and non-supportive, chemical and alcohol abuse, mental illness and involvement in juvenile crime. The interactions of all these conditions and how they have affected the child's ability to learn is the primary task of the fellow working with the school team. This patient care that will allow children to learn and to be able to function normally in the social setting of a school is founded in an understanding of the child's development and history. In the normal course of evaluations on outpatient or inpatient or day hospital, the component of school is included. However, there is nothing like the experience of being in the school building, working with the teachers, the administrators, and the support staff to see what the child's behavior is and how it responds to various interventions, whether they be pharmacological, behavior management, involvement with families and support systems, or working with the juvenile justice system.

2. Medical knowledge. The medical education that the fellows have is a very important part of their being able to communicate their style of thinking to the school. School personnel do not have medical training and therefore do not have the medical thinking patterning that has been taught to the fellows through their 4 years of medical school and their 4 or 5 years of residency training. The capacity to formulate a differential diagnosis, to include pertinent data in support of their formulation, and to then evolve a plan of treatment is not a common part of school teachers' experience and understanding of behavior. All of the lectures, psychopharmacology techniques, and medical knowledge obtained from inpatient and outpatient rotations in both general and child & adolescent psychiatry can be brought to bear in a practical way in a school setting. This ability to bring information to the school in a highly articulated, problem solving technique is the fellow's special skill. This experience expands their medical knowledge by helping them understand the practical application of theories and ideas in a system which requires children to have attention, concentration, patience, and good social behavior.

3. Practice-based learning. Each of the fellows will find themselves in a team setting with a group that is acting together to provide good care. They learn to understand how they communicate and what they communicate. They experience its effect on the child and this becomes a part of the knowledge of what is possible and what is most effective. The suggestions that they have for schools will be enhanced by this practical onsite application of their ideas and their encouragement of different team members collaborating to solve the problems that these children face.
4. Interpersonal and communication skills. Not only do the fellows interact with children who come from different subsets of culture such as African American, Latino, and world-wide immigrants, but they also are communicating with professionals who have been trained in completely other ways of thinking. That is, the social work theories and ideas along with psychological training of the psychologists will enhance their ability to talk in common terms that are understood by all. Similarly, working with principals and school personnel, the systems language of those areas will need to be integrated carefully with the language that is common in medical circles. Thus instead of working with nursing personnel and others who have worked in hospital and clinical settings, they must expand their capacity to work with these professionals from different disciplines. Similarly, the families that they may have found in inpatient or clinic setting may be very different from the ones who present at these schools. Poverty, resentment against systems, unstable home situations, and involvement in criminal systems are much more common and therefore the intervention with families and the communication with families will be new and different. There will be learning in the skill set of being able to communicate with these families.

5. Professionalism. In this setting the role of the doctor stands out. In the medical setting where there are faculty, other physicians who are hospitalists, and other residents and medical students, the professionalism may be easy to emulate. However, when the fellow is present as the only physician in the room, they are given more responsibility and more demand is made upon how they frame their ideas than in other settings. That is, they become an important member of the community, one who is looked to for wisdom and for advice, and for consultations. This will sharpen their awareness of their role.

6. Systems based practice. A natural outcome of working in a school system is that the fellows will learn how the school system, the administration of the schools, and the importance of leadership manifest in a school system. That is, the personality and ideas that flow from the principal will affect the entire school. Similarly, how school systems delegate funds, and how they approach the physical and practical needs of their students will become very apparent.
GOALS AND OBJECTIVES: CHILDREN’S HOSPITAL ROTATION – MINNEAPOLIS

Provided below are the Program’s educational goals and objectives for this rotation(s) and/or a link to Program’s website where the goals and objectives may be accessed.

In keeping with the ACGME guidelines the educational goals and objectives for the Children’s Hospital rotation are designed to incorporate the six core competencies.

Patient Care
The resident will demonstrate the ability to:
Complete an in-depth assessment to determine the diagnosis of an eating disordered patient including:

- A Psychiatric history
- A Social and educational history
- A Family history
- A Substance abuse history
- A Medical history and review of systems
- A Physical and neurological examination, as deemed necessary
- A Developmental history

Mental status examination including assessment of cognitive functioning
Laboratory, radiologic, and ECG studies
Understand and have knowledge of the techniques used in the evaluation of children and adolescents with eating disorders, especially as it relates to denial of the illness, and be able to determine the best treatment for each patient
Identify the associated medical complications of eating disorders, as well as other co-morbid psychiatric diagnoses.
Understand why a multimodal treatment team approach is necessary for the treatment of many patients with eating disorders
Incorporate the various treatments used in the treatment of the resident’s individual patient with an eating disorder and the family of that patient

Medical Knowledge
Be familiar with the standardized rating scales and evaluation tools including the Eating Disorders Evaluation used in evaluation of eating disordered patients.
Knowledge of the associated medical complications of eating disorders, as well as other co-morbid psychiatric diagnoses
Knowledge of the roles the multimodal treatment team plays in the treatment of many patients with eating disorders.
Understand and be familiar with the literature and current research related to their effectiveness in treating eating disordered patients
Be familiar with the manualized family-based treatment as well as cognitive-behavioral treatment for patients with eating disorders and their families
Interpersonal and Communication Skills
The resident will develop skills during this time to:
Educate patients and families regarding eating disorders including the risk of morbidity and mortality, and treatment options
Collaborate effectively with other members of the team, primary care physicians and other therapists
Maintain a therapeutic relationship with the patient and their parents/primary caregivers
Learn to work collaboratively with supervisors and other care providers.
Respect the privacy and confidentiality of the patient, while learning how to make sure that important information is not left out of family treatment.
Residents will demonstrate the ability to communicate effectively with allied healthcare professionals

Professional Competency
The residents will demonstrate a collaborative and nonjudgmental attitude characterized by empathy, respect, curiosity, and openness. Residents will also demonstrate the ability to tolerate ambiguity and show confidence in the efficacy of supportive therapy.
Residents will be sensitive to the sociocultural, socioeconomic, and educational issues that arise within the therapeutic relationship as demonstrated by:

Respect for the patient’s and the family’s stress during evaluation and treatment
Willingness to seek supervision for all treatments, especially those which engender strong countertransference responses
Respect for the members of the treatment team and their differing roles

Practice-based Learning and Improvement
The resident will learn how to educate families with eating disordered children and teenagers.
The resident will receive feedback from the supervising attending, and incorporate suggestions in the clinical care of patients.
The resident will identify their own strengths and weaknesses in dealing with this clinical population, and work with the clinic supervisor to develop a plan of care to work on these issues.

Systems-Based Practice
Each resident must recognize and accept limitations in his/her knowledge base and clinical skills, and understand the need for life-long learning.

Residents will possess research appropriate skills and demonstrate the ability to obtain current scientific research and clinical practice guidelines to assist in promoting high quality patient care. This will include, but not be limited to:
use of medical libraries
use of information technology, including Internet-based searches and research databases (e.g., MedLine)
use of drug information databases

Residents will understand how their patient care affects and is affected by other health care providers. Residents will understand the regulation of outpatient psychiatric treatment including patient confidentiality, HIPAA, state regulations regarding drug prescription and scheduled medications.
GOALS AND OBJECTIVES: FRASER:

The goals of “Fellows in Child and Adolescent Psychiatry at Fraser” will be to complement the educational experience of UMN fellowship program focus on childhood psychiatric and neurodevelopmental disorders, including experience with developmental delays, Autism Spectrum Disorder (ASD), and its co-morbidities. Participating in case conference presentations, reading modules and lectures will prepare the resident for observation, case formulation and developing medical and psychiatric consultation skills at Fraser. The design of the rotation includes frequent intervals over a period of months, so fellows will be able to observe assessment and treatment of individuals over time as well as larger numbers in group settings in order to make peer comparisons with typical and atypically developing children.

Patient Care: Outline a plan for further evaluation and follow-up of a toddler, child, adolescent and adult with suspected ASD including high functioning ASD; which specialists can best assist the child psychiatrist in determining whether a child meets DSM 5 criteria for ASD? Given the gap in knowledge about adults with ASD, child psychiatrists may be consulted given their general and adult psychiatry training and developmental perspective.

Medical Knowledge: Know the prevalence of ASD according to current CDC data and how to keep up with changes in epidemiological data nationally and locally. Ascertain the range of common co-existing comorbidities including childhood psychiatric disorders or symptoms such as anxiety, depression as well intellectual disability, risk for epilepsy and learning disorders. Be able to discuss risk for ASD with families in clinical and educational settings.

Describe DSM 5 criteria for ASD and define the key concepts of joint attention and social-emotional reciprocity. Know how this has been modified from DSM-IVR criteria, and how to identify children and siblings with closely related deficits and developmental delays.

Know current recommendations regarding appropriate medical workup for a child with recently diagnosed ASD. Understand this history of “complex” or “syndromic” autism as compared with “essential” or “idiopathic” autism. Describe the recommendations for genetics work up. Know potential value of conventional neuroimaging (CT, MRI) for children with suspected ASD. When might diagnostic tools and referrals be appropriate.

Practice Based Learning: Early childhood learning educational objectives at Fraser: Observe typical and atypically developing children in the Fraser nursery and preschools. Review developmental milestones. Identify atypical trajectories including speech, language variation. Describe alternative methods of communication and resources such as visual tools and assisted speech technology.

Describe measurements for assessing an individual’s developmental level and level of functioning at home, school and the community. Know who can administer standardized tools for assessment, diagnosis or progress and practice using some of these tools.

Practice identifying the patient’s strengths and acknowledging weaknesses in order integrate them into therapeutic strategies. Know how to assess and incorporate family preferences, cultural values, abilities and challenges in treatment plan formulation.

Interpersonal Communication Skills: The fellow is expected to demonstrate nuanced communication skills while dealing with the patient’s various developmental levels, families with differing strengths, and various other agencies involved in the patient’s care. The fellow will serve as the patient’s advocate, effectively communicating about the patient’s needs, educating various agencies, and helping customize the patient’s accommodations at school. The fellow will also be in communication with referring physicians and help
manage the patient in various settings during this rotation. Fellow will demonstrate empathic listening skills and develop rapport with families and help them through crisis situations.

**Professionalism:** The fellow will demonstrate adherence to the highest professional and ethical standards while caring for the patient by being sensitive to patient’s gender, cultural values, and disability-specific needs. The fellow will respect patient privacy and confidentiality. The fellow will also complete documentation in a timely fashion and communicate the appropriate information to the referring providers. The fellow will also nurture and model for medical students and residents and delegate appropriate roles and responsibilities for them.

**Systems Based Practice:** Describe currently available Intensive Behavioral Interventions, Early Childhood Special Education, Speech Therapy, Occupational Therapy and services families request. Describe alternative therapies available to the community and strategies for discussions with families about their options. Outline the process of referral to school-based services, educational evaluation and the provisions of an IEP. Cite current research regarding long-term prognosis for children with ASD and at least several major factors influencing prognosis. Practice identifying the patient’s strengths and acknowledging weaknesses in order integrate them into therapeutic strategies. Know how to assess and incorporate family preferences, cultural values, abilities and challenges in treatment plan formulation.

**Child Psychiatry Consultation Rotation**

**Learning Objectives**

In accordance with ACGME guidelines, the educational objectives are designed around the six core competencies:

1. **Patient Care** - Emphasis is on the interaction of physical and mental illness, and their joint presentation. Medication interactions in patients with complex regimens, disease coping, and effects of childhood illness on family structures.

2. **Medical Knowledge** - Linked with the above, expected areas where the knowledge base will improve are medication metabolism and side effects, prevalence and presentation of comorbidities, and broader familiarity with pediatric illness.

3. **Practice-based learning** - As each patient will present unique challenges, there will be ample opportunity (and need) to visit the literature, and synthesize the available information to best address the needs of the patient. In all likelihood, very few articles will adequately address all aspects of a patient’s case, and so the trainee will need to balance all the information gathered and arrive at a meaningful synthesis for the individual patient.

4. **Interpersonal and Communication Skills** - This is a major component of consultation-liaison psychiatry. In addition to building on existing skills in communicating with patients, the trainee will focus on timely, efficient communication with the inpatient pediatrics team and with primary care pediatricians. This will include not only providing advice on clinical management, but listening to concerns and assisting pediatrics residents in framing their questions. Communication with patient families at times of high stress is also a key skill, coupled with the need to assess when the timing for certain communication is right.

5. **Professionalism** - The performance of all of the above functions leads to appropriate professionalism. The patients seen in consultation can require a challenging negotiation between the care team, the patient, and the family. At times, even determining our most appropriate role can be difficult.

6. **Systems-based practice** - The scarcity of child and adolescent psychiatry resources provides the main learning opportunity in systems-based practice. All patients seen in consultation should have an aftercare plan, and the development of this plan should start the day they are seen.
Confirmation of Receipt of your Program Policy Manual for Academic Year 2016-20167

By signing this document you are confirming that you have received and reviewed your Program Policy Manual for this academic year. This policy manual contains policies and procedures pertinent to your training program. This receipt will be kept in your personnel file.

Resident Name (Please print) _________________________________________________

Resident Signature ________________________________________________________

Date __________________

Coordinator Initials ________________

Date __________________

Date __________________