UNIVERSITY OF MINNESOTA
GRADUATE MEDICAL EDUCATION

2018-2019

POLICY & PROCEDURE MANUAL

Department of Psychiatry

Geriatric Psychiatry Fellowship Program
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I. INTRODUCTION/EXPLANATION OF THE MANUAL

This Geriatric 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 geriatric psychiatry fellows in the department’s programs.

Institution Responsibilities

Please refer to the Institution Manual for Institution Responsibilities at: http://z.umn.edu/gmeim

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 intended to be 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. Please note that should information in the PPPM conflict with the Institutional Manual, the Institutional Manual takes precedence.

II. 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 GOALS

The goal of the University of Minnesota Program in Geriatric Psychiatry (designated as the Program) is to train fellows to be effective physicians, therapists, psychiatric consultants, multidisciplinary team leaders, advocates for the elderly and experts in the mental health needs of older adults and their families.

With this goal in mind, the training of fellows is our primary focus. Service needs of the clinical teams are secondary. However, we believe the best training model involves supervising fellows while they gain clinical experience and progressively assume greater responsibility for the diagnosis and management of patients in both inpatient and outpatient settings.

Skills required by practicing geriatric psychiatrists are the ability to:

- Critically analyze complicated medical, psychiatric, functional and psychosocial presentations;
- Formulate diagnoses that lay the groundwork for therapy;
- Effectively communicate with the patient, family/caregiver, and to the primary care team as a consultant;
- Use appropriate somatic, individual and environmental therapies;
- Monitor changes in patient health and environment, alter the treatment plan to address these changes and integrate multiple systems of care;
- Stay current in evolving science and evidence based medical practice related to geriatrics; and
- Listen to patients and their families, relieve suffering and enhance function.

The Program is designed to provide exposure to a wide variety of older adults suffering from medical, psychiatric and neuropsychiatric disorders; a well-balanced clinical experience (both as primary psychiatric caregiver and consultant) including opportunities to manage elderly inpatients and ambulatory patients; an integrated curriculum covering major areas in geriatric psychiatry from a multisystem biopsychosocial perspective; and appropriate supervision for all treatment settings. During their fellowship, fellows are an essential part of our care team.

The Minneapolis Veterans Administration Health Care System’s (VAHCS) mission defines three coequal priorities:
The practice of geriatric psychiatry is essentially an interdisciplinary team effort and this is reinforced by all aspects of the Program. Team A and the Minneapolis GRECC have two interactive interdisciplinary teams of professionals who are committed to serving older persons. The teams include psychiatrists, a behavioral neurologist, internists, nurse practitioners, nurses, pharmacists, social workers, psychologists, neuropsychologists and occupational therapists. Team A maintains an active working relationship with other VAHCS services to older adults, including Consultation-Liaison and Community Living Center. The team has strong ties with the VAHCS’s highly regarded psychology graduate training program. Graduate psychologists and trainees provide neuropsychological testing, conduct support groups for patients and caregivers and provide individual, group and family psychotherapy.

Clinical rotations include those at the VAHCS; consultation to patients in the Community Living Center transitional care and hospice; outpatient geriatric psychiatry; narrative/family therapy and GRECC dementia clinic. Fellows spend time off site at the United Hospital Geriatric Psychiatry Inpatient Unit, Hennepin County Medical Center Geriatric Medicine journal club and long term care consultation team, Bethesda Hospital Geriatric Behavior Unit, and Struther’s Parkinson’s Center. Offsite rotations offer additional experience with female patients, geriatric medicine, neurology, inpatient geriatric psychiatry, behavioral dementia units, and billing/reimbursement through payer systems such as Medicare.

To increase fellow’s medical knowledge base and patient care, the clinical rotations are augmented with formal and informal didactic instruction, clinical case reviews, journal club and seminars.

Because geriatric psychiatry has a rapidly expanding field of knowledge, emphasis is placed on fellows learning the skills to access current literature and apply knowledge to critically evaluate studies and practice guidelines.

The Program promotes scholarly activities. Fellows presents monthly at the weekly reading seminar, present at Psychiatry Grand Rounds at the University of Minnesota, VAHCS and the HCMC Geriatric Grand Rounds/Journal Club, teach psychiatry residents at the University of Minnesota as part of the Geriatric Psychiatry didactic, and mentor medical students and psychiatry residents as they fulfill geriatric requirements and electives. Our faculty encourages mentoring of interested fellows in the scholarship of scientific discovery and clinical application.

Through individual supervision and modeling, our faculty promotes the attitude of lifelong learning, practice-based inquiry and provision of compassionate, state of the art care to patients.

Geriatric psychiatrists play a leadership role on the clinical teams. We are continuously involved in scholarship, comprehensive assessment, treatment planning, consultation and supervision. We teach medical, pharmacy and nursing students from the University of Minnesota and train residents from psychiatry, pharmacy, physical medicine and rehabilitation, internal medicine and neurology programs. We collaborate with the Hennepin County Medical Center Geriatric Medicine Fellowship, training geriatrician fellows for up to 6 months of the year. We provide the geriatric psychiatry experience for PGY2 psychiatry residents and elective experiences for PGY4s at the University of Minnesota. In 2005-06 we trained an international observer/research fellow who went on to establish the first geriatric psychiatry program in the Philippines. Since 2008, seven Geriatric Psychiatry Fellows have graduated from the Program. More information about our past fellows is available at: https://www.psychiatry.umn.edu/education/fellowships/geriatric-psychiatry-fellowship/our-past-fellows

The Minneapolis GRECC conducts basic and clinical research on the aging nervous system with a major focus on Alzheimer’s disease. Specific areas of interest include transgenic mice, brain imaging, biological markers, neuropsychological assessment, functional assessment, older drivers and clinical trials. The GRECC sponsors numerous educational programs in geriatrics and gerontology.

The VAHCS has a comprehensive, secure electronic medical record that allows access to remote data from within the

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system nationwide and includes links to informatics applications. Staff and fellows have access to both the VAHCS and University of Minnesota Library System which includes online journals and databases.

IV. PROGRAM OBJECTIVES

The University of Minnesota Geriatric Psychiatry Fellowship integrates the six core ACGME Competencies into its curriculum: Patient Care and Procedural Skills, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Systems-based Practice. Details of the competencies as they pertain to geriatric psychiatry, as described by the ACGME, is available at: http://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pfcatid/21/Psychiatry

Graduating fellows will have the knowledge, skills and attitudes to accomplish the following:

- Compare and contrast normal and pathological aging and the ability to differentiate between the two.
- Gather relevant information regarding older adults with a wide range of psychiatric disorders including medical, cognitive, interpersonal, social, financial, legal, environmental and functional factors, leading to a multi-level informed diagnosis and plan for treatment.
- Manage a wide range of patients from different cultures, socioeconomic backgrounds and education levels.
- Demonstrate respect, compassion and integrity in interactions with patients, family/caregivers and other team members.
- Demonstrate expertise with a broad spectrum of geriatric psychopathology with early or late onset, including neuropsychiatric disorders, psychoses, medical presentations of psychiatric disorders, iatrogenesis, and a full range of DSM-5 conditions including affective, anxiety, sleep, adjustment, substance use, sexual and personality disorders.
- Recognize comorbid medical disorders, need for psychotherapy, social service intervention and other presentations requiring consultation and effectively coordinate treatment with other providers.
- Perform a competent mental status exam, including assessments of cognition, community and environment, family and caregiver, medical status and function.
- Develop appropriate and coherent social, environmental, psychotherapeutic and somatic treatment plans for geriatric neuropsychiatric disorders.
- Implement treatment plans in a wide range of settings, including acute inpatient, hospital based outpatient, long term care and sub-acute rehabilitation.
- Provide consultation liaison activities to primary care physicians and other providers, including long term care staff.
- Work effectively as a part of a multidisciplinary evaluation and treatment team.
- Communicate effectively and in a caring, respectful manner with patients and caregivers/families.
- Apply to patient care the principles of primary and secondary prevention.
- Act as a competent teacher of professional students (psychiatry residents, pharmacists, psychologists, geriatric medicine fellows and medical students), professional colleagues in other disciplines, and caregivers and families.
- Critically assess literature, apply evidence based medicine and to generate ideas for basic research in areas of interest.
- Be a competent clinical administrator of both inpatient and outpatient evaluation and treatment teams.

GEROPSYCHIATRY OUTPATIENT CLINIC

Fellows will have a required yearlong rotation on the Older Adult Mental & Behavioral Health Team (AKA Team A), supervised by geropsychiatry faculty. This is the core rotation of the Program.

The fellows perform new and follow-up patient evaluations, formulate and implement treatment plans and present new cases at weekly Team A meetings. They see patients in the outpatient clinic, remotely via v-tel, and conduct chart reviews when e-consults are requested. Fellows receive at least two hours of individual supervision per week on
patients they have seen, including evaluation and management of cases and informal didactic material on psychotherapy and psychopharmacology.

As part of this rotation, they will observe multidisciplinary assessments, including neuropsychological testing, occupational therapy functional assessment, driving evaluation, physical therapy, recreational therapy, speech language and pathology, and sexual health. They will attend a multi-session caregiver support group and the Adult Day Health Clinic. They will interface with Home Health Care Services and may do home visits. They will participate in hospital ethics committee activities. With certified practitioners, they will perform ECT on select outpatients.

Individual psychotherapy training using evidence based approaches is integrated into the outpatient clinic rotation and includes formal individual supervision from Bridget Doane, PhD. The narrative/family psychotherapy clinic is a team supervision group with psychologists and social workers in attendance. Narrative based marital/family therapy is videotaped and supervision is obtained in a group.

Objectives

Outpatient clinic/Patient Care

The fellow is expected to:

1. Provide initial consultation and ongoing care to ambulatory veterans >70 with a wide variety of neuropsychiatric and comorbid diagnoses.
2. Develop expertise in ambulatory management of psychiatric and other health concerns experienced by veterans with varying degrees of comorbid illness, frailty, cognitive impairment, psychological distress and socio-cultural issues.
3. Actively seek collateral information from families, caregivers, and other health professionals.
4. Interact effectively and respectfully with patients and caregiver/families.
5. Obtain a comprehensive psychiatric history and mental status exam within an appropriate time frame.
7. Develop a comprehensive evaluation plan that includes adjunctive testing, as appropriate.
8. Document in the integrated medical record the comprehensive results of the evaluation.
9. Assess and manage psychiatric emergencies in geriatric patients, including indications for hospitalization.
10. Make appropriate decisions about multimodal therapies, including pharmacotherapy, psychotherapy, ECT, social and environmental interventions.
11. Demonstrate the ability to solicit and integrate treatment recommendations from the multidisciplinary mental health team and others.
12. Develop and implement bio-psycho-social treatment plans using patient information and preferences, current scientific information and clinical judgment.
13. Communicate effectively with patients and caregiver/families regarding treatment options, the treatment plan and education on diagnosis, natural history and prognosis of specific neuropsychiatric disorders.
14. Recognize caregiver burden and make appropriate referrals for caregiver/families.
15. Use social interventions that benefit patient and caregiver/family.
16. Manage pertinent ethical and legal issues.
17. Initiate and flexibly guide treatment, with ongoing monitoring of changes in mental and physical health status and medical regimens.
18. Promote to patients and their families: primary and secondary prevention, including use of OTC medications and alcohol, sleep hygiene, driving, exercise, firearms etc.
20. Know indications for and safe administration of ECT.
Outpatient clinic/Medical Knowledge

1. Demonstrate knowledge of neuropsychiatric disorders beginning in or continuing into late life.
2. Demonstrate knowledge of medical illnesses presenting with psychiatric symptoms.
3. Know the diagnostic criteria for psychiatric disorders seen in an outpatient geropsychiatry clinic.
4. Understand successful and maladaptive responses to stressors and role changes common in the elderly.
5. Know the appropriate use of psychotherapies in the elderly.
6. Attend regularly scheduled supervision with faculty for ongoing outpatient cases and have onsite supervision for clinics.
7. Read assigned journal articles, textbook chapters, and present in journal club a minimum of 10 times during the year.

Outpatient clinic/Interpersonal skills and communication

1. Establish and maintain therapeutic alliances with patients, caregivers and families.
2. Apply principles of ethical relationships to interactions in the clinic.
3. Understand interpersonal/family dynamics and apply psychotherapy techniques to each encounter with patients and families.
4. Provide useful feedback and educate families, caregivers and providers from multiple disciplines.
5. Maintain a professional, collaborative and therapeutic attitude while working with patients from all cultural backgrounds and socioeconomic strata.
6. Collaborate and work effectively with the immediate and “virtual” treatment team (referring providers, PHNs, day activity programs, social workers etc).
7. Demonstrate a proactive approach in responding to curriculum expectations and basic duties as a member of a professional team (returning calls/emails in a timely manner, consistently attending required meetings, etc.)

Outpatient clinic/Practice Based Learning

1. Know how to research evidence-based approaches to outpatient evaluation and treatment, including electronic media, journals and textbooks.
2. Know how to access evidence-based medical literature and critically evaluate medical literature as it applies to the psychiatric diagnosis and management of geriatric patients in the outpatient setting.
3. Demonstrate an attitude of open-mindedness to incorporating information in the treatment plan from family, caregivers and primary care and other mental health professionals.
4. Show willingness to identify gaps in his/her own knowledge base and professional skills and seek to remedy these gaps through means including, but not limited to, independent reading, attending didactics, seminars and conferences, and group and individual supervision.

Outpatient clinic/Professionalism

1. Integrate in case discussions knowledge of legal and ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, capacity to make informed consent decisions, competence, guardianship, advance directives, and elder abuse.
2. Accurately document assessment, mental status exam, informed consent for medications and treatment plan.
3. Effectively document collateral discussions with professionals involved in the patient’s care.
4. Maintain an attitude of professionalism and respect for patients and colleagues.
5. Maintain an attitude of cultural sensitivity in providing psychiatric outpatient care.
6. Respond to patient communications and other health professionals in a timely manner, using medical records for appropriate documentation, coordinating care with other team members and providing coverage if they are not available.
7. Demonstrate the ability to work progressively more independently.
Outpatient clinic/Systems Based Practice

1. Demonstrate knowledge of systems including family systems, hospital systems and community systems of care.
2. Work effectively as part of a therapeutic network addressing the patients’ needs, including providing consults to other VAHCS psychiatrists using the EMR and remote VAHCS facilities via v-tel.
3. Obtain pertinent clinical data from a variety of sources, including medical and/or mental health providers, family members, long-term care and community social agencies.
4. Communicate appropriate clinical information to other medical or mental health providers, families, long-term care and community social agencies.
5. Make appropriate referrals for neuropsychological, psychological, OT/PT evaluation, driving evaluation, speech and language evaluation, home safety evaluation or other evaluations as clinically indicated.
6. Collaborate effectively with patients, families, other medical and mental health providers and appropriate community agencies, while providing outpatient psychiatric care.
7. Advocate for quality patient care and assist patients and their families in dealing with system complexities, such as limitation of healthcare resources, policy and legal aspects of late-life psychiatric illness.
8. Understand how to assess the quality of patient care and to improve the system delivering care.

United Hospital Inpatient Geropsychiatry

Training in inpatient psychiatry takes place over two months at United Hospital. The fellow will be directly supervised by Dr. Sarah Kottke, a subspecialty board certified geropsychiatrist. During the rotation, the fellow assumes a primary role in providing direct care to the patients and adjunctive care to their families.

Duties during these rotations include the initial psychiatric assessment, coordination of initial treatment planning via the inpatient team, design and implementation of treatment throughout the hospitalization, and assessment for laboratory, imaging, cognitive, psychological, and/or functional testing. The fellow will act as team leader in all aspects of discharge planning, including arranging for outpatient follow up and transition to home or an appropriate care facility.

As appropriate patients are available, fellows are assigned 2-3 patients the first week. Their case load expands to 5-6 patients as fellows progressively assume greater responsibility for evaluation and management. Treatment modalities included in the psychiatric hospitalization include crisis management, initial psychiatric assessment, ECT, family intervention and psychopharmacology.

Objectives

Inpatient psychiatry/ Patient care
The fellow will demonstrate adequate knowledge, skills and attitudes to provide competent, acute inpatient psychiatric care for elderly veterans.

1. Know diagnostic criteria for psychiatric disorders for acute psychiatric hospitalization.
2. Know appropriate criteria for admission to and discharge from an inpatient psychiatric unit.
3. Know of appropriate psychiatric interventions including psychopharmacologic management, psychiatric assessment, milieu management and ECT.
4. Obtain an appropriate database for acute psychiatric assessment, from multiple historical sources and synthesizing data into a biopsychosocial formulation with a complete differential diagnosis.
5. Recognize contribution to psychiatric illness presentation of medical illness, drug interactions, treatment non-adherence, psychiatric manifestations of iatrogenic influences and polypharmacy; and treat appropriately.
6. Recognize, accurately assess and manage neuropsychiatric symptoms such as agitation, aggressiveness, wandering and changes in sleep patterns.
7. Conduct thorough discharge planning including social, medical, and legal interventions as appropriate.
8. Collaborate and cooperate with the multidisciplinary team, including psychiatric nursing service, social workers, other unit staff and appropriate consultation services.
9. Communicate treatment plans to and educate geriatric inpatients, their families and caregivers.
10. Approach inpatient psychiatry staff with an attitude of support, collaboration and supervision as appropriate.
11. Utilize knowledge gained to provide consultation to the inpatient psychiatry unit at the Minneapolis VAHCS both by attending team meetings and seeing patients as requested.

Inpatient psychiatry/ Medical knowledge

1. Know psychopathology in the acute psychiatric crisis for geriatric patients, including etiology, epidemiology, differential diagnosis, treatment and prevention of psychiatric conditions in this population.
2. Know the impact on psychiatric condition of functional impairments, medical comorbidities, polypharmacy and drug interactions.
3. Know approaches to the treatment of psychiatric disorders in the acutely hospitalized elderly patient including, but not limited to, psychotherapy, group and activity therapies and psychopharmacology.
4. Understand sociocultural factors and their impact on patients and families.
5. Obtain medical knowledge by attending didactic sessions, journal club, daily rounds, interactive teaching rounds with attendings and geropsychiatry consultants, as well as reading the appropriate textbooks, journal articles and supporting the education of other colleagues and medical students.

Inpatient psychiatry/ Interpersonal skills and communication

1. Establish therapeutic rapport with patients and families.
2. Communicate effectively with multidisciplinary treatment team members, both verbally and in writing.
3. Maintain a professional, compassionate and therapeutic attitude while working with patients from all cultural backgrounds and socioeconomic strata, as well as with their family members.
4. Skillfully conduct family/care conferences.

Inpatient psychiatry/Practice based learning

1. Demonstrate use of evidence-based approaches in inpatient psychiatric management.
2. Know how to access evidence-based medical literature and critically evaluate medical literature as it applies to the psychiatric diagnosis and management of geriatric patients in the inpatient setting.
3. Demonstrate an attitude of open-mindedness to incorporating information in the treatment plan from family, caregivers and primary care and other mental health professionals.
4. Show willingness to identify gaps in his/her own knowledge base and professional skills and seek to remedy these gaps through means including, but not limited to, independent reading, attending didactics, seminars and conferences, and group and individual supervision.

Inpatient psychiatry/Professionalism

1. Maintain patient charts and medical records, and complete all documentation in a timely manner.
2. Maintain an attitude of respect to multidisciplinary team members, colleagues, patients, and their families.
3. Maintain an attitude of cultural sensitivity in providing direct care to patients.

Inpatient psychiatry/System-based practice

1. Demonstrate knowledge of systems, including family systems, hospital and community systems and how they integrate and interface with inpatient care as well as planning care after hospitalization.
2. Demonstrate knowledge of payer systems, including Medicare, Medicaid and third party insurance.
3. Demonstrate, on patient discharge, the ability to match a patient’s level of functional needs (ADLs/IADLs) with an appropriate level of supervised environment.

**Geriatric Research Education and Clinical Center (GRECC) Dementia Clinic**

The Minneapolis VA GRECC provides comprehensive, state of the art evaluation and management of patients with neurocognitive disorders. Patients are often referred to GRECC by their primary medical providers, for concerns of cognitive loss. Physicicans working in GRECC include Howard Fink, M.D., an internist; David Atkinson M.D., a geriatric psychiatrist; John R. McCarten M.D., a behavioral neurologist; and Jamie Starks, M.D., a behavioral neurologist. They work with a multidisciplinary including pharmacy, social worker, neuropsychology, and occupational therapy, and supervise trainees ranging from medical students to fellows.

Fellows spend several months rotating in the GRECC Thursday AM clinic, and will develop skill in the following: performing an initial evaluation of a patient with cognitive loss; performing a neurologic examination; collaborating in a multidisciplinary approach to a comprehensive neurocognitive disorder workup; integrating results from neuropsychological testing, brain imaging, and occupational therapy assessment in arriving at a diagnosis; discussing diagnosis, safety concerns, support services, and longer-term care planning with patients and their families in family meetings. Fellows will also participate in Friday AM GRECC diagnosis consensus conference.

**Objectives GRECC/Patient Care**

1. Provide consultation to other health care providers regarding patients with a wide variety of dementing illnesses.
2. Become proficient in interviewing patients, family members, caregivers and other health professionals; obtaining relevant history; conducting a structured cognitive assessment and performing a focused neurological examination.
3. Demonstrate the ability to diagnose mild/major neurocognitive disorders, delirium and depression.
4. Gain experience counseling families regarding the diagnosis, natural history and prognosis for patients with specific types of neurocognitive disorders.
5. Recognize caregiver burden and make appropriate referrals for caregiver/families.
6. Work effectively with a multidisciplinary team of professionals to provide patient-focused care.

**GRECC/Medical Knowledge**

1. Learn the criteria for diagnosis and appropriate clinical presentation of mild/major neurocognitive disorders, including but not limited to: Alzheimer’s disease, Lewy Body disease, Parkinson’s disease, Frontotemporal lobar degeneration, cerebrovascular disease.
2. Recognize the potential adverse effects of medications, including polypharmacy and drug interactions, on cognitive function.
3. Learn the risk factors and protective factors for Alzheimer’s disease.
4. Learn indications for and management of cognitive enhancers such as cholinesterase inhibitors, Vitamin E, and memantine.
5. Learn how to obtain a driving assessment and when cessation of driving privileges is indicated.
6. Participate in a diagnostic consensus conference.

**GRECC/Interpersonal and Communication Skills**

1. Gain experience in counseling families regarding diagnosis, natural history and prognosis for patients with neurocognitive disorders.
2. Recognize the impact of caregiver burden and provide supportive therapy for caregivers.
3. Work collaboratively within a dementia care team to enhance patient and family satisfaction with the consultation experience.
GRECC/Professionalism

1. Appreciate and acknowledge the psychosocial effects of a neurocognitive disorder diagnosis on the patient and caregivers/family.

GRECC/Systems Based Practice

1. Know the appropriate role and resources of the GRECC clinic.
2. Know what community resources are available for patients and their families.

Community Living Center (CLC) and Hospice/Palliative Medicine Consultation

Geriatric Psychiatry fellows will have an experience, supervised by Drs. Czapiewski and Atkinson, of providing consultation to geriatric physicians and nurse practitioners for veterans >60 years old, hospitalized on the CLC wards at the VAMC. The CLC cares for patients who require rehabilitation treatment in a multidisciplinary setting for an extended period of time, and a separate hospice ward. Under supervision, the fellow evaluates and manages patients with combined medical (including neurological) and psychiatric problems. There are up to two consultation requests per week to evaluate patients with psychiatric problems, most commonly delirium, psychosis and/or depression. Rounds are conducted twice weekly, on Monday and Thursday afternoons. The fellow meets with staff for supervision on all cases and spontaneous didactic sessions are held regarding clinical problems. This rotation may provide psychotherapy candidates for ongoing treatment. The fellow may share responsibility with a geriatric medicine fellow.

Fellows will also work with the Minneapolis VAHCS Hospice and Palliative Care Unit (HPCU), a 10-bed unit housed in the Community Living Center. The HPCU provides compassionate, specialized care for veterans who have a wide spectrum of life-limiting illnesses, including cancer, severe organ failure (COPD, CHF, kidney failure, liver failure, dementia) and ALS. Palliative care services include symptom management and palliative treatments such as radiation therapy and chemotherapy. Hospice services include symptom control prior to transfer to a community setting, and direct end-of-life care for veterans expected to die in the HPCU. Hospice and Palliative Care is provided by an interdisciplinary team of health care workers including nurses, nurse practitioner, physician, social worker, chaplain, psychologist, recreation therapist, pharmacist, dietitian and volunteers.

Fellows round with the interdisciplinary team and assist in providing comprehensive medical and psychosocial care to veterans and their families, in collaboration with interdisciplinary team members, and under the supervision of the HPCU medical director, Dr. Kristopher Hartwig.

Objectives

CLC/Patient Care

1. Understand how psychiatric disorders impact the morbidity and functional incapacity from medical disorders, and use this information to improve patient outcomes.
2. Know medical disorders and pharmacotherapies that precipitate or exacerbate psychiatric disorders, and vice versa.
3. Manage agitation in elderly delirious patients using appropriate pharmacological and behavioral interventions, with understanding the limitations of restraints.
4. Collaborate and cooperate with providers requesting consultation and caring for patients.
5. Discern and effectively manage the palliative needs of complex veteran patients and their families in a long-term care setting.
6. Actively assess and care for hospice patients as a physician member of an interdisciplinary team.
7. Effectively incorporate other interdisciplinary team members’ assessments and recommendations into each
8. Proficiently facilitate patient and family care conferences around goals of care, advanced directives, prognosis and level of care transitions.
9. Take a military history and apply it to medical decision making for a veteran near the end of life.

**CLC/Medical Knowledge**

1. Demonstrate the accurate differential diagnosis and treatment of delirium, neurocognitive disorders, and depression in hospitalized patients.
2. Recognize “atypical” presentations of psychiatric illness.
3. Understand the impact of hospitalization and chronic illness on normal function of patients, integrating neurobiological, pharmacological, psychological and sociocultural aspects into a biopsychosocial formulation and treatment plan.
4. Utilize approaches to treatment of psychiatric disorders in hospitalized elderly veterans, including interpersonal, cognitive behavioral, problem solving, supportive, reminiscence therapy and pharmacotherapy.
5. Maintain academic curiosity in seeking and evaluating medical knowledge to apply in providing psychiatric consultation.
6. Demonstrate knowledge of palliative medical care regarding the evaluation and management of pain, anxiety related to dyspnea and other medical problems of patients nearing the end of life.
7. Identify the palliative needs of this patient population and their families.
8. Describe the approach to care of patients with PTSD who are facing life-threatening illnesses.
9. Describe components of family conferences to address prognosis, treatment options and care goals.

**CLC/Interpersonal Skills and Communication**

1. Demonstrate command of spoken and written English, including common colloquial usage and technical medical terminology.
2. Understand how to establish a therapeutic rapport with patients and families.
3. Understand transference and counter-transference as they apply to providing a competent psychiatric consultation.
4. Effectively communicate with primary care team members.
5. Participate in communication with formal and informal community supporters, e.g. family, caregivers, social service agencies, etc.
6. Maintain a professional, compassionate and therapeutic attitude while working with patients from all cultural backgrounds and socioeconomic strata.

**CLC/Practice based learning**

1. Know what resources are available to research evidence-based approaches to psychiatric management of hospitalized elderly veterans, including electronic media, journals and textbooks.
2. Access evidence-based medical literature and critically evaluate medical literature as it applies to the psychiatric diagnosis and management of veterans in an extended care facility.
3. Maintain an attitude of open-mindedness in evaluating new evidence-based medical literature as it applies to patients seen in consultation.
4. Exhibit competence as an educator of interdisciplinary trainees and colleagues.

**CLC/Professionalism**

1. Have working knowledge of legal and ethical principles related to clinical care issues at the end of life, confidentiality of patient information, informed consent, competence, advance directives, and required reporting of elder abuse.
2. Demonstrate the ability to progressively work more independently.
4. Maintain an attitude of professionalism in providing psychiatric consultation, including an attitude of respect for patients and colleagues.
5. Demonstrate the ability to review his/her professional conduct and remediate when appropriate
6. Demonstrate awareness of safety issues including acknowledging and remediating medical errors should they occur.
7. Respond to patient and family needs respectfully, compassionately and promptly.

**CLC/Systems based practice**

1. Demonstrate knowledge of systems, including family systems, hospital systems and community systems.
2. Understand the role of the psychiatric consultant in the context of these multiple systems.
3. Work effectively as part of an interdisciplinary team to enhance patient safety and improve palliative aspects of quality patient care in a facility setting.
4. Obtain pertinent clinical data from and communicate appropriate clinical information to a variety of sources, including the primary team, family members and community (including housing, social service and nursing services).
5. While providing psychiatric consultation, collaborate with patients, families, other medical providers, and appropriate community agencies.
6. Demonstrate knowledge of the barriers and regulations impacting care in federal facilities.
7. Utilize care resources in a cost-effective manner as appropriate to the facility setting.
8. Exhibit knowledge of the factors impacting effective transition of complex patients from an inpatient or home setting to rehabilitative or long term care setting.

**HCMC**

In the first three months of the fellowship year, fellows spend one afternoon per week at HCMC on the Outpatient Geriatric Medicine Service, participating in a geriatric grand rounds and journal club. Core readings in geriatric medicine are reviewed, including topics such as frailty, falls, urinary incontinence and polypharmacy.

For a minimum of four months, fellows spend one morning a week at the Benedictine nursing home in Minneapolis. Fellows will be assigned a case load of about 15 patients, including those with chronic psychiatric disease as well as those without psychiatric disease but with common geriatric syndromes. Fellows participate in a weekly multidisciplinary conference where staff from the nursing facility including physical therapy, occupational therapy, nursing, dietary and social work discuss patients receiving rehabilitation services. Fellows participate in seeing other patients in the nursing facility on rounds that include Dr. Roberta Meyers, board certified geriatrician; a nurse practitioner; and geriatric medicine fellows. Psychiatric evaluations will be discussed with Dr. Czapiewski or Dr. Atkinson at a separate supervision time.

**Objectives**

**HCMC/Patient Care**

1. Participate in a broad range of care issues presented by a long term care population in the context of multidisciplinary team management.
2. Manage polypharmacy, with understanding of the Beers list, the regulatory environment around medication prescribing, and off-label use of and consent issues around psychotropic medications in the nursing home.
3. Effect health maintenance and routine health care with respect to cognitive, behavioral and psychological symptoms.
4. Maintain patient functional ability and rehabilitation in long term care via secondary and tertiary preventive...
interventions.

HCMC/Medical knowledge

1. Review current scientific understanding of normal aging and disease, including impact of acute and chronic physical illness on function and issues of iatrogenesis.
2. Research evidence-based approaches to geriatric medicine and present at least one topic to the primary care group.
3. Develop expertise in management of geriatric syndromes in nursing home patients and comorbid medical issues presented by these patients; including but not limited to chronic pain, dementia and other neurodegenerative diseases.

HCMC/Practice based learning

1. Obtain and use pertinent information from long term care geriatric practice to reevaluate and modify approaches to the geriatric psychiatry patient population and to understand the contributions of medical and psychiatric illness to patient presentations.
2. Manage the side effects of long term antipsychotic medication use, including motor impairment, dystonia and tardive dyskinesia.
3. Facilitate the learning of primary care residents and geriatric medicine fellows in geriatric psychiatry evaluation and management.
4. Understand systems approach to quality management in long term care, including balancing individual autonomy and need for care.

HCMC/Interpersonal and communication skills

1. Maintain a professional, collaborative and therapeutic attitude while working with patients from all genders, cultural backgrounds, disabilities and socioeconomic strata.
2. Participate in leadership of team meetings.
3. Set realistic goals of care and coordinate goals with team members.
4. Work effectively with families and compassionately address potentially divergent goals of the care team, patient and family.
5. Work collaboratively with geriatric medicine fellows.

HCMC/Professionalism

1. Demonstrate the ability to integrate in team discussions knowledge of legal and ethical principles pertinent to care issues of the elderly.
2. Maintain an attitude of professionalism and respect for patients and colleagues.
3. Maintain an attitude of cultural sensitivity in providing geriatric care.

HCMC/Systems based practice

1. Be aware of how methods of controlling health care costs and allocating resources affect patient care, including Medicare Part A and long term nursing care funded by Medicaid or private pay.
2. Participate as a care team member within the regulatory environment of nursing homecare.
3. Become familiar with nursing home regulations including OBRA, safety/restraint reduction, polypharmacy, advanced directives, vulnerable adult reporting.
4. Understand the use of advanced directives and the use of surrogate decision makers.
5. Understand issues around the use of bedside rails and restraints.
7. Learn to work effectively in the less technically sophisticated environment of the nursing home (compared to acute hospital setting) by understanding:
   a. When a higher level of care is necessary.
   b. When a transport hold is needed to transfer someone who’s exhibiting danger to self or others.
   c. Extent of illness treated in long term care/subacute setting.
   d. Appropriate use of resources.

Bethesda Geriatric Behavior Program

For two months, the fellow will spend one day per week at the Geriatric Behavior Program at Bethesda Hospital, St. Paul. The program works to improve functional skills and independence in elderly patients with behavioral disorders stemming from Alzheimer’s disease or other neurocognitive disorders. The program goal is to safely return the person to home or another residential setting. Patient care is provided by an interdisciplinary team of professionals who assess behavioral and medical needs, develop an individualized treatment plan, monitor progress, adjust treatment as indicated and plan a safe discharge. The fellow participates in patient rounds, ECT, new patient workups and team evaluations. Supervisor is Dr. Alvin Holm, a subspecialty board-certified Geriatrician.

Objectives

Bethesda/Patient care

1. Participate in care issues present in neurocognitive disorders with complex behavioral symptoms.

Bethesda/Medical knowledge

1. Know appropriate criteria for admission to and discharge from a dementia behavior inpatient program.
2. Know indications for use of ECT in demented patients.
3. Become familiar with the use of behavioral and pharmacological treatments in inpatient dementia care.
4. Recognize neuropsychiatric symptoms in demented patients such as agitation, aggressiveness, wandering and changes in sleep patterns.

Bethesda/Practice-based learning

1. Obtain and use pertinent information from a dementia care program to evaluate and modify approaches to the geriatric psychiatry patient population.
2. Understand systems approach to dementia care management.

Bethesda/Interpersonal skills and communication

1. Communicate effectively and work collaboratively with members of the care team.
2. Maintain a professional, collaborative and therapeutic attitude while working with patients from all genders, cultural backgrounds, disabilities and socioeconomic strata.

Bethesda/Professionalism

1. Maintain an attitude of professionalism and respect for patients and colleagues.
2. Maintain an attitude of sensitivity and respect in caring for patients with cognitive and behavioral symptoms.

Bethesda/Systems based practice
1. Obtain a working knowledge of a dementia behavior program.
2. Know how to integrate multiple systems of care for demented patients who are transitioning between different care settings.
3. Learn how cost and resource allocation affect dementia patient care.

**Struther’s Parkinson’s Center**

Struther’s Parkinson’s Center is a private clinic that provides specialized multidisciplinary care for patients with complex movement disorders. The team includes neurologists, nurse clinicians, occupational therapists, physical therapists, music therapists, speech pathologists, a chaplain and an activities therapist. Under the supervision of Dr. Martha Nance, fellows participate in patient interviews and exams. Fellows observe and participate in a day program that provides day care, exercise classes and recreational therapy for patients with Parkinson’s disease and other movement disorders.

**Objectives**

**Struther’s/Patient care**

1. Participate in the evaluation and management of patients with movements disorders.

**Struther’s/Medical knowledge**

1. Recognize the cardinal clinical features of Parkinson’s disease and related disorders.
2. Distinguish among the Parkinsonian variant disorders and recognize the implications of diagnosis on therapy.
3. Understand the role of group and activity therapies in functional improvement of patients with movement disorders.
4. Know the components of a neurological examination focusing on movement disorders.

**Struther’s/Practice-based learning**

1. Obtain and use pertinent information from a movement disorders program to evaluate and modify approaches to the geriatric psychiatry patient population.
2. Understand systems approach to the support and care of patients with movement disorders.

**Struther’s/Interpersonal and communication skills**

1. Communicate effectively and work collaboratively with members of the care team.

**Struther’s/Professionalism**

1. Maintain an attitude of professionalism and respect for patients and colleagues.
2. Maintain an attitude of cultural sensitivity and respect in caring for older patients with movement disorders.

**Struther’s/Systems based practice**

1. Develop the working knowledge to bridge the multidisciplinary services and multiple services available to treat patients with movement disorders.
V. Program

Evaluation/Assessment

Competencies
The program adheres to the ACGME six core competencies to assess the fellow’s progress: Patient Care, Medical Knowledge, Practice Based Learning and Improvement, Systems Based Practice, Professionalism, Interpersonal Skills and Communication.

Ongoing informal and formal evaluation is an integral part of the program. Fellows receive direct feedback on their case presentations, diagnostic and treatment formulations during regular (2 hour weekly minimum) supervision with the program director and faculty. They receive direct feedback on their presentations and treatment plans in the weekly geriatric psychiatry team meetings. Meetings are held at least twice yearly with the fellow and members of the Graduate Resident Training Committee to discuss performance and provide feedback on areas of weakness and strength. Geriatric Psychiatry Milestones evaluations are be conducted twice yearly by the Clinical Competency Committee. There is a written semiannual evaluation. Evaluation records are be maintained as required by the RRC. The fellow performs annual written evaluations of faculty and the program. Evaluations of self-performance and knowledge are included.

Evaluation by specific competency

Patient Care

1. Multiple observations by staff of interviewing skills early in the year; observations discussed with the fellow.
2. Videotaped review of therapy sessions; group feedback
3. Observation of patient and family interactions, oral and written presentations with informal feedback by team.
4. Individual supervision and informal feedback about biopsychosocial formulation and treatment plan.
5. Faculty conduct at least twice yearly review of chart notes for completeness.

Medical Knowledge

1. Individual supervision, informal feedback.
2. RMS self-assessment of medical knowledge.

Practice Based Learning and Improvement

1. Fellows meet with program director or designated faculty at entry into the program and quarterly thereafter to conduct a self-assessment of knowledge base including geriatric psychiatry evaluation and treatment issues. Process includes being asked explicit questions that test current knowledge and fellow presentation of clinical cases. At the conclusion of this process, fellows are asked to self-identify his/her knowledge and practice deficiencies and strengths. Following self-assessment, faculty provide additional input as needed about perceived knowledge and practice deficiencies and strengths.
2. Journal club presentations are targeted to address a knowledge gap or improve a clinical skill, critically review scientific articles, conduct literature searches; CME evaluations are completed by attendees and reviewed by faculty.
3. RMS.

Interpersonal and Communication skills

1. Direct feedback by faculty and team members on evaluations, family meetings.
2. Videotaped review of family therapy sessions; group feedback.
3. RMS.

Professionalism

1. Individual supervision, informal feedback
2. RMS.

Systems Based Practice

1. Individual supervision, informal feedback
2. RMS.

SECTION 1 - STUDENT SERVICES

1.A University Pagers
Upon entering the Fellowship Program, pagers are obtained from the Coordinator after appropriate paper work is completed. All pagers must be returned to the Fellowship Coordinator’s Office when the training period has been completed.

1.B E-Mail and Internet Access
Fellows should expect to use both a VA and University of Minnesota email address. The VA email address is automatically set up for the fellow, while University email is inactivate until initiation of the account with a password. This is completed at www.umn.edu/validate. It is expected that fellows will check their VA and University e-mail accounts daily during the work week.

1.C HIPAA Training
Health Information Portability and Accountability Act (HIPAA) training is available on the central onboarding checklist with instructions to complete training prior to start date. 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.

1.D VA Credentialing
Prior to starting at the VA, the fellow will receive an application package from the program coordinator of items that need to be filled out and signed. Additionally, future fellows will need to be fingerprinted at the VA and register in the Talent Management System (TMS) to complete several online courses prior to starting. All items and fingerprints should be completed at least one month prior to the fellow’s start date and verified as being complete in the fellow’s RMS checklist.

SECTION 2 - BENEFITS

2.A Stipends
Effective June 12, 2018, 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/).

Annual Base Stipend: $62,695
Approximate Biweekly Stipend: $2,411.35
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 length of the Geriatric Psychiatry training program is 12 months.

The Fellowship Director or designee must approve all time away (e.g. leave) from the Fellowship Program in writing. The fellow should submit any leave requests to the Program Director/Coordinator 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 an ABPN requirement. Leave time may not be used to reduce the length of training.

Fellowship year leave allowances:
- Vacation, no rollover, no partial days: 20 days
- Maternity, consecutive time: 4-6 weeks
- Paternity, consecutive time: 14 days
- Sick, no rollover, 0.5 day minimum: 10 days
- Conference, 0.5 day minimum: 5 days
- Military: 15 days

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

(1) Vacation Leave

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. Fellows do not have the option of reducing the total time required for the fellowship by foregoing vacation time. No vacation is normally granted during the first or last week of the academic year. Vacation requests should be submitted at least 30 days in advance. Vacation requests submitted inside of 30 days may be denied.

- No more than two (2) consecutive weeks of vacation will be granted unless approved by Fellowship Director.
- No more than five (5) days of vacation will be granted away from a required rotation that lasts in its entirety one month.
- When more than 5 days of vacation are planned on a specific service the fellow is encouraged to consult with the attending as far in advance as possible.
- The Program Director may deny/revoke vacation or conference requests if extenuating circumstances occur which would significantly impact patient care.

Vacation must be approved by the Program Director and will be recorded and reconciled by the Fellowship Coordinator. The rotation supervisor(s) will be notified as soon as possible by the Coordinator. Although the rotation supervisor(s) does not need to approve the request unless 30 days (non UMP) or 60 days (UMP) notice is not given, fellows are encouraged to notify the attending ASAP as a courtesy. Vacation requests are prioritized according to when the written request is submitted to the Program Coordinator.

(2) Bereavement Leave
A fellow 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, maternity leave shall be granted upon request up to 4-6 weeks, depending on the nature of the birth. Compensation is provided through short-term disability benefits. Paternity leave shall be granted upon request up to fourteen (14) consecutive days. Adoption leave shall be granted upon request up is fourteen (14) consecutive days. Sick and vacation days may be used consecutively and concurrently with parental leave, compensated at the usual stipend rate. Any time away from training used to extend parental leave must be approved by the program director, will be unpaid, and residency training will be extended according to the ‘time away from training’ policy. In the case that two or more parental leaves are requested over the course residency training, all additional parental leave periods will extend residency commensurate with the amount of time away from training during subsequent occurrences. Due to the significant administrative toll associated with parental leave plan revisions, subsequent changes must be due to notable circumstances and must be discussed and approved by the program director.

(4) Medical Leave

The fellow must give notice to the program director, in writing, of intent to use medical leave 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 will serve as an intermediary for all medical and disability related issues to protect the privacy of the fellow. Time away from training not covered by sick or vacation leave will extend training in accordance with the ‘time away from training policy.’

(5) Family Medical Leave Act (FMLA)

Fellows may be eligible for Family Medical Leave Act (FMLA) protections. 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). Trainees may qualify for Short Term and Long Term Disability benefits.

(6) Holidays

When on VA and University-based rotations, the holiday schedule at that site will govern.

(7) Witness Duty

Upon request to the program director, leave is provided to fellows who are subpoenaed to testify before a court or legislative committee concerning the University, the federal or state government. No pay loss is incurred.

(8) Jury Duty

Upon request to the program director, leave is provided to 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.

(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 fellow. An emergency or personal leave of absence will extend 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 director 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. Conference time is not granted for self-study or for board prep courses unless authorized by 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.

(13) Unscheduled Leave Policy

Fellows must email <jay.stephenson@va.gov> ASAP if unable to attend non-call related program assignments during normal weekday work hours. The program coordinator’s office will contact whomever the fellow indicates in their e-mail. If fellows prefer to notify off-site contacts, they must indicate in the email that they have already notified them.

In the email subject line, the following should be entered: first name, last name and the word OUT

Example: John Doe OUT

Fellows must include the following in the body of the email:

- The problem
- When they expect to return
- Whether they will manage outpatient tasks from off site
- How to best be contacted
- Persons they want specifically contacted

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.

2.D Policy on Effect of Leave for Satisfying Completion of Program

ACGME guidelines require 12 months of fellowship training in geriatric psychiatry. In addition, they stipulate that specific periods of time be spent engaged in defined clinical activities. The duration of training can be extended to complete program requirements missed because of leave or failure for academic reasons. In practice, continuous leave
for 12 weeks or less related to maternity leave or serious personnel illness (not due to academic failure) has not extended the training period provided that all requirements are met. Continuous leave for more than 12 weeks would ordinarily extend the training period.

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. 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 (https://shb.umn.edu/health-plans/rfi).

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. 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 (https://shb.umn.edu/health-plans/rfi).

2.G Life Insurance: Minnesota Life
Fellows are automatically enrolled in a $50,000 standard life Minnesota Life insurance policy, at no cost to them. In addition to the standard plan, fellows have the option to purchase voluntary life insurance for themselves or their dependents at low group rates through Minnesota Life. 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 (https://shb.umn.edu/health-plans/rfi).

2.H Long and Short Term Disability Coverage: Guardian Life Insurance Company
Fellows are automatically enrolled in a long and short term disability insurance policy, at no cost to them. Guardian offers 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 fellow. Guardian also offers a unique Guaranteed Standard Issue Plan option. Fellows have the option to purchase long term disability coverage that continues upon completion of 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 (https://shb.umn.edu/health-plans/rfi).

2.I Flexible Spending Accounts
Fellows are eligible to participate in two types of Flexible Spending Accounts (FSAs), the U of M Health Care FSA and the Dependent Daycare FSA. Both programs allow for payment of related expenses using pre-tax dollars. This benefit is administered by the Office of Student Health Benefits (https://shb.umn.edu/residents-fellows-and-interns/fsa).

2.J 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. 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.
https://sites.google.com/a/umn.edu/medcred/

2.K Insurance Coverage Changes
The Office of Student Health Benefits manages resident and fellow benefits including insurance coverage changes
and pre-tax benefits (https://shb.umn.edu/health-plans/rfi).

2.1 Meal Tickets/Food Services
Meal Tickets/Food Service is not provided for fellows as no on-site call is taken.

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

2.N Worker’s Compensation Program Specific Policies and Procedures
Worker’s Compensation is available through the department. See the program coordinator for assistance.

2.O Parking
Fellows can park in the VA’s overflow lot after obtaining a sticker from VA police.

2.P Resident Assistance 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.

Resident and Fellow Assistance Program (RAP)
Sand Creek Group
610 North Main Street, Suite 200
Stillwater, MN 55082   Phone: 651-430-3383 or 1-800-632-7643

Websites:

Main page for health and wellness resources:
https://www.med.umn.edu/residents-fellows/current-residents-fellows/health-wellness

Resident and Fellow Assistance Program:
https://www.med.umn.edu/residents-fellows/current-residents-fellows/health-wellness/resident-and-fellow-assistance-program-rap

Mental health resources:
https://www.med.umn.edu/residents-fellows/current-residents-fellows/health-wellness/mental-health-resources

SECTION 3 - Institution Responsibilities
Please refer to the Institution Manual for Institution Responsibilities at http://z.umn.edu/gmeim

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 Geriatric Psychiatry Fellowship Program
- The committee is ad hoc, appointed by the head of the department with representation of faculty, and affiliated hospital if pertinent.
- 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
Areas of possible grievance to be resolved by the following procedures include, but are not limited to:
- Evaluation of fellow performance by the faculty.
- Assignment or definition of clinical duties.
- Interpretation and implementation of other policies and guidelines, such as those included in this document.
- Fellow-resident conflicts.
- Fellow-fellow conflicts.
- 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.

SECTION 5 – GENERAL POLICIES AND PROCEDURES

Educational Program Objectives University of Minnesota

5.A Duty Hours
The Geriatric Psychiatry Fellowship Program is committed to ensuring that all fellows are compliant with the most recent duty hour requirements set forth by the ACGME.

The standard workday is 8am to 5pm. There is no overnight or weekend call.

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.

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. Violations identified for a specific month require a written response to the GMEC explaining the violation and the measures to be taken to correct the area of non-compliance
(2) Annual ACGME Fellow Survey generates confidential reports from fellows regarding duty hour compliance. Violations identified by this process require a written response to the GMEC.
(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.B On Call Schedules
There is no call associated with this fellowship. 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 rotation period and determines the cause and solution for each violation.

5.C On Call Rooms
Not applicable. Geriatric psychiatry fellows do not provide call coverage.
5.D 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, see the VAHCS Psychiatry Training Programs Coordinator.

5.E 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.F Medical Records
Fellows will be trained in using CPRS at the Veteran’s hospital and the Electronic Medical Record at United Hospital for outpatient activities. Medical records may be accessed 24 hours a day through the electronic medical record.

5.G Security and Safety
The VA hospital has in-house police available 24/7. Each outpatient office has a panic button and a phone which can be used to dial 1-9-1-1 for emergency services.

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.

Geriatric psychiatry fellows undergo safety training as part of their orientation, including techniques to de-escalate anger and aggression. All 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 fellow notifies his/her primary attending at the appropriate training site.
2) The primary attending works with the 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.
3) The primary attending then notifies the training director.
4) The patient is assessed for ongoing dangerousness and, if appropriate, a report is filed with the Patient Behavior Committee for consideration of a behavior flag on the chart.
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 may determine whether support for all fellows in the program is indicated.
6) The training program coordinates administrative issues that may arise such as scheduling time off. The training office checks that these procedures have been followed and addressed, so that the burden is removed from the fellow.

5.H 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. Accordingly, fellows will provide accurate information about such activities and will obtain approval from the program prior to engaging in moonlighting.

A 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. 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.
External moonlighting is patient care activity for which the fellow is 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 the fellow could have been called, paged or consulted, irrespective of location (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.

University malpractice insurance does not cover moonlighting activities. The moonlighting employer must provide malpractice insurance.

5.I 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. Supervision covers not just clinical issues, but also addresses the six core competencies as well as career development. Direct supervision is also provided at each rotation site.

5.J 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 formally 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.K Fatigue and Work Conditions
The central onboarding checklist provides instructions with links on sleep deprivation and fatigue; alcohol and drug misuse; and culturally competent health care. Incoming fellows are instructed to view these materials before their start date and can access additional materials through the resident homepage: https://www.med.umn.edu/residents-fellows/current-residents-fellows

5.L Graded Responsibility
Fellows will be able to diagnose and manage patients with psychiatric disorders in hospital and outpatient settings, as well as supervise trainees (medical students, psychiatry and pharmacy residents). Proficiency and consequent increasing levels of independent responsibility/function will be determined by ongoing, informal faculty and geriatric psychiatry team review of the fellow’s verbal and written clinical presentations.

All initial patient visits during the fellowship year will be staffed in person by a faculty member, who will hear the fellow’s report, interview the patient and cosign the note. All new patients will subsequently be presented by the fellow in the inter-professional geriatric psychiatry team meetings and supervision provided as appropriate. For follow up visits, a faculty member will always be available on site and provide supervision at the fellow’s discretion. Early in the fellowship year, faculty will take a more active role in interviewing the patient and developing the assessment and plan. Over time, as the fellow’s proficiency increases, active participation by faculty will diminish; although the attending will always see new patients and the fellow will present the case in the geriatric psychiatry team meeting.

Throughout the year, the fellow will supervise trainees in clinical settings. In the spring, with greater medical knowledge and proficiency in patient care, the fellow will take an active role in teaching a psychiatry residency (PGY1) geriatric psychiatry didactic course.

5.M ACLS/BLS/PALS Certification Requirements
BLS certification is required of all VA physicians.

5.N VA HCS Dress Code Policy
All designated individuals shall wear a PIV badge issued by the Veteran’s Administration. 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. 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. 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 other. 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 fellow’s responsibility to adhere to these guidelines. It is not practical to attempt to delineate every unacceptable clothing option. Supervisors 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.

5.0 Fellow 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 Fellowship Program Director in consultation with the Psychiatry Residency Director and the Geriatric Residency Training Committee. 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 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 the Fellowship Program Director of his or her temporary inability to perform assigned duties.
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. See section 2P of this manual for contact information.

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.