UNIVERSITY OF MINNESOTA
GRADUATE MEDICAL EDUCATION

2017-2018
PROGRAM
POLICY & PROCEDURE
MANUAL

Department of
Psychiatry
Residency Program
i. Introduction/Explanation of the Manual
This 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 except as otherwise identified Fellowship Addendum.

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. 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 Institutional Manual for clarification. Please note that should information in the PPPM conflict with the Institutional Manual, the Institutional Manual takes 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 residency training program is to impart the knowledge, skills and attitudes required of a general 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. Residents are encouraged to critically examine contemporary assumptions about the causes of behavior, as well as our 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 residency 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
Psychiatry is a medical specialty focused on the prevention, diagnosis, and treatment of mental, addictive, and emotional disorders. An approved residency program in psychiatry is designed to ensure that its graduates are able to render effective professional care to psychiatric patients. The graduates will possess sound clinical judgment, requisite skills, and a high order of knowledge about the diagnosis, treatment, and prevention of all psychiatric disorders, together with other common medical and neurological disorders that relate to the practice of psychiatry. Graduates must have a keen awareness of their own strengths and limitations, and recognize the necessity for continuing their own professional development.
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Please refer to the Institution Policy Manual located on the GME website at [http://z.umn.edu/gmeim](http://z.umn.edu/gmeim) for University of Minnesota Graduate Medical Education specific policies. Should policies in the Program Manual for Fellowship Addenda conflict with the Institution Manual, the Institution Manual takes precedence.
SECTION 1 - STUDENT SERVICES

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

1.B E-Mail and Internet Access
Resident/Fellow e-mail addresses are not activated until initiation of the account with a password. This is completed at https://www.umn.edu/initiate. Computer workstations are provided in the Residency Room [F248] so that residents can access their e-mail and complete required RMS applications. It is expected that residents 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.

1.C Campus Mail & US Mail
A campus and U.S. mailbox is located in the psychiatry department.
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 55454-1495.

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 PGY1 Institutional 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 administered through ULearn modules HIPAA16 (HIPAA Training) and PJPD16 (UMN Information Security Awareness).
SECTION 2 - BENEFITS

2.A Stipends
Effective July 1, 2017, for Residents 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.myu.umn.edu/ and select my pay).

<table>
<thead>
<tr>
<th>PGY Year</th>
<th>BASE STIPEND</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGY-I</td>
<td>$53,597</td>
</tr>
<tr>
<td>PGY-II</td>
<td>$55,246</td>
</tr>
<tr>
<td>PGY-III</td>
<td>$57,147</td>
</tr>
<tr>
<td>PGY-IV</td>
<td>$59,189</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 Resident Review Committee Requirements (http://www.acgme.org/acWebsite/RRC_400/400_prIndex.asp), prior to entry into the program each resident must be notified in writing of the required length of training. This length of training for a particular resident may not be changed without mutual agreement, unless there is an extended leave of absence from the program. The length of the psychiatry residency training program is 48 months.

The Residency 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 chief resident 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 decrease reduce the length of training.

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

<table>
<thead>
<tr>
<th>Leave Allowances</th>
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<tbody>
<tr>
<td>Year</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>G1</td>
</tr>
<tr>
<td>G2</td>
</tr>
<tr>
<td>G3</td>
</tr>
<tr>
<td>G4</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 Administrator and Chief Resident. 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.
- For G1 and G2 residents, no more than 5 vacation days may be taken per session. A resident may take off 5 days of vacation at the end of one session and 5 days at the beginning of a new session. G1/G2 residents remain responsible for fulfilling assigned call requirements, despite taking vacation.
- No more than 2 consecutive weeks of vacation will be granted unless approved by Residency Director.
- Vacation and conference leave must ensure that there are at least 2 PG3 residents available to address coverage needs in the M Health Psychiatry Clinic at any given time.
- Vacation during night float blocks cannot be taken without arranging for replacement coverage.
- Residents assigned to station 20 or 22 must stagger vacations – at least one resident should always be on service on each unit. Exceptions to this rule must be approved by the program director.
- During child & adolescent psychiatry rotations, vacation requests must be coordinated with the child/adolescent fellow to ensure at least one resident or one fellow are on the treatment team at a time.
- Vacation must be approved by the Chief Resident and will be recorded by the Residency Administrator. Residents 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 chief resident.
- The Program Director and/or Chief Resident may deny/revoke vacation or conference requests if extenuating circumstances occur which would significantly impact patient care or educational objectives.

Medicine, Pediatrics, Emergency medicine and Neurology leave policies (including vacation) will apply when a resident is assigned to one of those services. No more than 5 days of vacation may be taken across 8 weeks of the neurology rotations.

For circumstances other than illness in which a trainee must miss work with less than 30 days notice (such as extreme weather, unsurmountable barriers to transportation, serious family obligations, “acts of God”, etc.) approval to miss work must be obtained from the program director and vacation days will be utilized for this purpose.

(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>
</tbody>
</table>

In the case that two or more maternity leaves are requested over the course of residency training (including the first year of the child/adol fellowship), all but the first maternity leave periods will extend residency training commensurate with duration of the entire leave, with the exception of sick and vacation days. The extension of the leave will be no greater than a total of 36 months of training for those residents who enter a Child/Adolescent Fellowship program in their 4th year, and a total of 48 months of training for those residents who complete 4 years in the adult residency program.

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 resident 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 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. Residents are not eligible to use University floating holidays, but when rotating on a University site on the University’s designated floating holiday they do honor that holiday.

(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 Chief Resident ASAP or no less than 30 days. One resident is designated to cover. Only one resident may be on vacation or conference leave off a UMMC inpatient adult geographical unit at a specific time (priority goes to earliest date submitted). 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; however, during the PGY1 and PGY2 years, up to (5) days of conference time may be used for studying and taking the USMLE Step-3 exam.

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 10 workdays per year. Sick leave is not cumulative. The minimum unit of sick leave is half-day increments. Sick leave must be used for a personal illness or
medical need of a trainee or first degree family member. For circumstances other than illness in which a trainee must miss work with less than 30 days notice (such as extreme weather, unsurmountable barriers to transportation, serious family obligations, “acts of God”, etc.) approval to miss work must be obtained from the program director and vacation days will be utilized for this purpose.

(13) Unscheduled Leave Procedures

*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 these cases, please do your best to access urgent medical care and communicate with the program regarding your status as soon as possible.

**EMAIL 1.** Include the chief resident, Jennifer Janacek, Program Administrator and your supervisor. Please let us know whether you anticipate continued survival, and whether you will be OK.

**EMAIL 2.** Please email <psychresidencysick@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

**Calling in Ill on a UMN Clinic Day (PGY2-4):**
In addition to the above steps, there is an **additional responsibility** when you call in sick from clinic. Please include the following recommendations within Email #2.

Here are those steps: (also included an attached electronic file)
1. Resident will also:
   - Review his/ her Epic schedule from home to see which patients are scheduled.
   - After reviewing schedule, resident will include recommendations for each pt.*
   - Depending of level of acuity, availability of follow-up, etc, options could include:
     - *Denote Patient by Appointment Time (Do not use names or patient initials).*
     - “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 [resident names specific time] admin slot next week”
     - “Please ask a covering resident to see 2pm Pt today”
     - “Please ask that my nurse call 3pm Pt to triage them, then call me or covering resident to discuss”
     - “3:30pm Pt can be scheduled into my [resident names specific time] emergency slot”

*In a few rare cases, a resident 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 resident, as
Resident may be aware of other pts who will likely need these slots.

2. Intake staff calls patients to cancel and communicate f/u recommendation. If the pt is not okay with f/u recommendation, Jeff passes the call to RN for triage to assess needs (#3).

3. 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 resident to make plan for pt
   - RN consults w/ faculty to make plan for pt
   - RN gets pt onto another resident’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 night float, emergency or call duties. These need to be managed in context by consulting peers, the chief or designated faculty on call.

(14) Time away from training policy:

The American Board of Psychiatry and Neurology (ABPN) requires 48 months of psychiatry residency training, several months are designated as required content. Several forms of approved paid leave are described earlier in the policy manual. Circumstances may arise where a resident requests permission from the Program Director for time away from training which falls outside of parental leave, vacation, conference days, sick leave, or witness duty. (for example, time requested to extend time away from training after having or adopting a child, unforeseen personal circumstances, or for illnesses which exceed the approved number of sick days).

With permission from the program director, Residents may request time away from training. This time is typically unpaid (although short or long-term disability benefits may apply in individual cases). Time away from training will require additional time to be made up following their expected end of training date in order to meet the requirements of the residency and ensure ABPN eligibility.

Requirements for making-up time-away from training in a given year are as follows:
- 5 or fewer days of time away from training: This is considered a ‘grace’ number of days. No formal make-up required, as it is anticipated other duties will make up for the brief time missed.
- >5 days of time away from training: Must be made up in 1-week increments, rounding up to the total number of weeks missed beyond the initial 5 days., e.g. 1-5 unpaid days missed requires no formal make-up, 6-10 unpaid days missed will necessitate that one full work week be made up, 11-15 additional days will necessitate that a full two work weeks be made up (rounding up as described above).
Note: Health insurance and other benefits continue during approved time away from training; however, the resident may be required to pay for both their portion and the employer’s portion of their health insurance premium in accordance with Human Resources policy.

2.D Policy on Effect of Leave for Satisfying Completion of Program
ACGME guidelines require 48 months of residency training in psychiatry. In addition, they stipulate that specific periods of time be spent engaged in defined clinical activities (e.g. two months full time equivalent in Consultation-Liaison Psychiatry). 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 Residents 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 residents and fellows 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 residents and 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 residency or 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 residents and 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 residents and fellows (the cost is covered by your department). In addition to the standard plan, residents and fellows have the option to purchase voluntary life insurance for themselves or their dependents at low group rates through Minnesota Life. Medical School residents and fellows are automatically eligible for Continuation of life insurance coverage 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.H Long and Short Term Group 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://shb.umn.edu/health-plans/rfi)

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
Residents and Fellows who are on-call for a service and are required to remain in the hospital are eligible to receive complimentary evening and morning meals (noon meals on weekends) in the hospital cafeterias. A swipe card will be provided to residents serving this function. In addition, residents/fellows may receive complimentary meals when special scheduling requires their presence beyond the normal duty hours, based on the following criteria:

(1) The breakfast meal, when called into the hospital after hours and remaining in the hospital overnight.
(2) Other exceptional circumstances when a program deems complimentary meals as an integral component of education and practice, upon request to UMMC.

2.N Laundry Services
Laundry service is not provided.

2.O Worker’s Compensation Program Specific Policies and Procedures
Worker’s Compensation is available through the department. The University of Minnesota UReturn 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.

Program Policy & Procedure Manual


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
Residents 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 PG year:

<table>
<thead>
<tr>
<th>PGY</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGY-1</td>
<td>$350.00</td>
</tr>
<tr>
<td>PGY-2</td>
<td>$100.00</td>
</tr>
<tr>
<td>PGY-3</td>
<td>$100.00</td>
</tr>
<tr>
<td>PGY-4</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

The cost of resident academic poster printing will be reimbursed through the University of Minnesota Foundation Eric Brown Resident Fund, if funds are available.

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 is 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 is 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 residency website.

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. Sand Creek's counselors have particular expertise in dealing with the unique needs of individuals in their residency training programs. By contacting this program, residents 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 resident-related concerns.
Sand Creek
www.sandcreekeap.com
Phone: 651-430-3383 or 1-800-632-7643

SECTION 3 - Institution Responsibilities
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 residency 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 Residency 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 three program level ranks of the residency program as well as chief residents 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 resident 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.
-Resident-resident conflicts.
-Resident-Chief resident conflicts.
-Resident-fellow conflicts.
-Resident-faculty conflicts.
-Chief resident-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

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

**PGY1**
- Primary Care, Internal Medicine UMMC, MVAHCS 2 months
- Primary Care, Pediatrics Masonic Children’s Hospital 1 month
- Emergency Medicine UMMC 1 month
- Neurology MVAHCS 2 months
- General Inpatient Psychiatry MVAHCS 1 month
- General Inpatient Psychiatry UMMC 6 months

**PGY2**
- Child-Adolescent Psychiatry (Inpatient) UMMC 2 months
- Consultation-Liaison Psychiatry MVAHCS 1 month
- Substance Use Disorders and ECT UMMC 1.1 month
- Geropsychiatry MVAHCS 1 month
- Emergency Psychiatry UMMC 1.5 months
- Night Float Call Rotations UMMC 1-2 months
- Inpatient Psychiatry UMMC 4 months
- Psychotherapy UMMC 10% time for 12 months

Program Policy & Procedure Manual
PGY3
12 months continuous outpatient with community rotation, individual, group, and family therapy components.

PGY4
Electives and forensic components.
Consultation-Liaison Psychiatry MVAHCS 1 month

Electives that require a new financial agreement will need to be approved by the PEC committee by March 1st of the prior academic year.

5.B Training Examinations
The PRITE Exam (Psychiatry Resident In-Training Examination sponsored by the American College of Psychiatry) is given each fall to all psychiatry residents and child fellows. The PRITE exam has strict a strict policy and only 1 make up exam can be given. In order to miss this exam it will need to be approved by the PEC committee. The Psychodynamic Psychotherapy Competency Test (constructed by Columbia University in New York) is provided to all residents in the spring.

5.C Didactic Schedule
Didactic coursework is offered in four 12-week blocks to each resident class. Course materials, including syllabi, slides and articles, will be updated regularly and posted on the program Google Drive.

PGY1 – THURSDAY (F263)

<table>
<thead>
<tr>
<th>Summer 2017 (12 weeks)</th>
<th>Fall 2017 (12 weeks)</th>
<th>Winter 2018 (12 weeks)</th>
<th>Spring 2018 (12 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 29th - September 14th</td>
<td>September 21st - December 14th</td>
<td>January 4th – March 22nd</td>
<td>March 29th – June 14th</td>
</tr>
<tr>
<td>1 PM – 1:50 PM Combined PGY1-2 Conference K. Nelson</td>
<td>1 – 1:50 PM Combined PGY1-2 Conference S. Miller</td>
<td>1 – 1:50 PM Combined PGY1-2 Conference Pientka</td>
<td>1 – 1:50 PM Research</td>
</tr>
</tbody>
</table>

PGY2 – THURSDAY (Washington)

<table>
<thead>
<tr>
<th>Summer 2017 (12 weeks)</th>
<th>Fall 2017 (12 weeks)</th>
<th>Winter 2018 (9 weeks)</th>
<th>Spring 2018 (12 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 29th - September 14th</td>
<td>September 21st - December 14th</td>
<td>January 4th – March 22nd</td>
<td>March 29th – June 14th</td>
</tr>
<tr>
<td>Introduction to Psychotherapy (Tue 1-3pm (July, Aug, Sep)) Moen, Nelson</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 – 1:50 PM Combined PGY1-2 Conference K. Nelson</td>
<td>1 – 1:50 PM Combined PGY1-2 Conference S. Miller</td>
<td>1 – 1:50 PM Combined PGY1-2 Conference Pientka</td>
<td>1 – 1:50 PM Cultural Psychiatry Shors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 – 3:50 PM Family/Group Therapy Moen</td>
</tr>
</tbody>
</table>
**PGY3 – TUESDAY (F263)**

<table>
<thead>
<tr>
<th></th>
<th>Summer 2017 (12 weeks) July 11th – September 26th</th>
<th>Fall 2017 (12 weeks) October 3rd – December 19th</th>
<th>Winter 2018 (12 weeks) January 2nd – March 20th</th>
<th>Spring 2018 (12 weeks) March 27th – June 12th</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Motivational Interviewing</strong> (8am-4pm)</td>
<td>3 days (9/12, 9/13, 10/4) and 1.5 hrs/month group supervision on 2nd Tuesday morning from 8:00-9:30am, November-April</td>
<td></td>
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</tr>
<tr>
<td>1 – 1:50 PM</td>
<td>Combined PGY3-4 Conference Per Schedule</td>
<td>1 – 1:50 PM Psychodynamics II (11 session)</td>
<td>1 – 1:50 pm Psychodynamics III</td>
<td>1 – 1:50 PM Combined PGY3-4 Conference Per Schedule</td>
</tr>
<tr>
<td></td>
<td>Simovic</td>
<td>Simovic</td>
<td></td>
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</tr>
<tr>
<td>2:10 – 3:00 PM</td>
<td>Intro to Outpatient (11 sessions) Bass</td>
<td>2 – 2:50 PM Cognitive Behavioral Therapy</td>
<td>2 – 2:50 PM Combined PGY3-4 Conference</td>
<td>2 – 2:50 PM History of Psychiatry &amp; Ethics</td>
</tr>
<tr>
<td></td>
<td>Zagoloff (11 sessions)</td>
<td>Zagoloff (11 sessions)</td>
<td>Per Schedule</td>
<td>Mitchell</td>
</tr>
<tr>
<td>3 – 3:50PM</td>
<td>Evidence-based Assessment of Research (11 sessions)</td>
<td>3 – 3:50 PM Combined PGY3-4 Conference Per Schedule</td>
<td>3 – 3:50 PM Public Psych Realmuto (1 field trip) (6 weeks)</td>
<td>3 – 3:50 PM Neuropsychology Roman</td>
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<td>Thuras</td>
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</table>

**PGY4 – TUESDAY (Washington)**

<table>
<thead>
<tr>
<th></th>
<th>Summer 2017 (12 weeks) July 11th – September 26th</th>
<th>Fall 2017 (12 weeks) October 3rd – December 19th</th>
<th>Winter 2018 (12 weeks) January 2nd – March 20th</th>
<th>Spring 2018 (12 weeks) March 27th – June 12th</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 1:50 PM</td>
<td>Combined PGY3-4 Conference Per Schedule</td>
<td>1 – 1:50 PM Sleep Hurwitz (11 sessions)</td>
<td>1 – 1:50 PM Self-Directed Board Review</td>
<td>1 – 1:50 PM Combined PGY3-4 Conference Per Schedule</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PGY4 Class</td>
<td></td>
</tr>
<tr>
<td>2 PM – 2:50 PM</td>
<td>Neuroscience/Neuropharm. Dean</td>
<td>2 PM – 2:50 PM Key Topics in Psychiatry</td>
<td>2 – 2:50 PM Combined PGY3-4 Conference</td>
<td>2 – 2:50 PM Self-Directed Board Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wichser (11 sessions)</td>
<td>Per Schedule</td>
<td>PGY4 Class</td>
</tr>
<tr>
<td>3 – 3:50PM</td>
<td>Professional Development Pientka</td>
<td>3 – 3:50 PM Combined PGY3-4 Conference Per Schedule</td>
<td>3 – 3:50 PM Addiction McNair</td>
<td>3:00-3:50 PM Self-Directed Board Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PGY4 Class</td>
</tr>
</tbody>
</table>

**5.D Didactic Attendance Policy**

RTC Representative (or their designee) for each class will complete a weekly written Attendance Log Form. The log will indicate date, whether class was held and status of each assigned resident (present or absent). Present will mean attendance for at least 2/3rds of the teaching activity. Attendance Log will be turned into Residency Coordinator weekly. The Residency Coordinator will reconcile Log Form with approved vacation requests and VA and FUMC psychiatry call schedules. The Residency Coordinator produces quarterly report for each course.

Grand rounds and complex case conference will also be included. This information will be generated by the department head’s office from the sign-in sheets and added in RMS.

*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 10 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 resident.*

Residents must have attended 70% of class activities that take place minus scheduled vacation days, structural duty hour absences (post assigned UMMC and MVAHS psychiatry overnight call and night float).

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 resident will be placed on academic probation with continuation of clinical and call duties. If the paper is not completed in the following quarter the deficiency will be referred to the Residency Training Committee for discussion and action.

<table>
<thead>
<tr>
<th>Months</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance Deficit</td>
<td>Make Up Delinquency</td>
<td>Probation</td>
<td>Referral to RTC</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Course Attendance less than 70% in this quarter</td>
<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>RTC discussion and action</td>
<td></td>
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<tr>
<td></td>
<td>Paper inserted in academic file, no negative action recorded if paper satisfactory</td>
<td>Clinical and call duties continue. Paper(s) due by end of three month quarter</td>
<td>Clinical and call duties continue</td>
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</tbody>
</table>
5.E Program Goals and Objectives

The clinical responsibilities for each resident will be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and availability of supervisory and support services. PGY1-2 years involve primarily inpatient activities. One month is equivalent to a 4-week session (13 sessions per academic year). The PGY3 year is ambulatory and the PGY4 year allows the resident to explore specific areas anticipating his/her transition to independent practice. Residents are expected to be knowledgeable about the level of supervision required, their scope of authority and events that entail a reporting obligation.

YEAR 1

Patient Care

- Perform a thorough assessment of patients in standardized settings. S
- With joint coroners create a hospital-based acute treatment plan for medical, neurological and psychiatric conditions. K
- Explore functional and patient preferences in developing a treatment plan. S
- Assumes responsibility for care in inpatient settings with direct supervision immediately available. S

Evidence-Based Medical Knowledge

- Use medical knowledge to analyze medical problems. K
- Develops appropriate differential diagnoses for common medical, psychiatry and neurological complaints. K
- Maintain CME and patient knowledge. K
- Understands the therapeutic use of standard psychotropic agents. S
- Recognizes the scope of authority in application of clinical care. K
- Describe the presenting symptoms of common neurological disorders. S

Practice-based Learning and Improvement

- Assumes responsibility for critical assessment of the quality of the care delivered. A
- Seeks appropriate supervision. A
- Recognizes and corrects limits of his/her knowledge of skills. A
- Designs a differential diagnosis for common acute, subacute and chronic medical conditions. K
- Generates a differential diagnosis for common psychiatric symptoms. K
- Generates a differential diagnosis for common neurological diseases. K
- Generates a differential diagnosis for common psychiatric symptoms. K

Interpersonal and Communication Skills

- Communicates findings to other health care workers. S
- Demonstrates ability to interact constructively with patients, families, colleagues, other health professionals to obtain history, and create and implement treatment plans. S
- Aware of patient and provider variables that impact communication and information gathering. K
- Generates a differential diagnosis for common psychiatric symptoms. K
- Generates a differential diagnosis for common neurological diseases. K
- Generates a differential diagnosis for common psychiatric symptoms. K

Professionalism

- Communicates findings to other health care workers. S
- Demonstrates ability to interact constructively with patients, families, colleagues, other health professionals to obtain history, and create and implement treatment plans. S
- Aware of patient and provider variables that impact communication and information gathering. K
- Generates a differential diagnosis for common psychiatric symptoms. K
- Generates a differential diagnosis for common neurological diseases. K
- Generates a differential diagnosis for common psychiatric symptoms. K

Systems-based Practice

- Communicates findings to other health care workers. S
- Demonstrates ability to interact constructively with patients, families, colleagues, other health professionals to obtain history, and create and implement treatment plans. S
- Aware of patient and provider variables that impact communication and information gathering. K
- Generates a differential diagnosis for common psychiatric symptoms. K
- Generates a differential diagnosis for common neurological diseases. K
- Generates a differential diagnosis for common psychiatric symptoms. K

A = ATTITUDE  S = SKILL  K = KNOWLEDGE

University of Minnesota Medical Center - Fairview (UMMC)

Minneapolis Veterans Affairs Health Care System (MVAHCS)

DIDACTICS

Thursday Afternoons from 1pm to 4pm. PGY1 didactics aim to provide a early practical orientation to the inpatient care environment and basic knowledge about common diagnoses and standard treatments.

ASSIGNED SUPERVISION

In addition to ongoing clinical supervision, there will be one hour of individual competency supervision a week.

ROTATIONS

Note that there are 13 four week rotations during the first year.

Primary Care – UMMC & Mpls MVAHCS (4 mths)

- Take a relevant and comprehensive medical history. S
- Conduct a complete and comprehensive physical examination. S
- Form a basic therapeutic alliance and use supportive psychotherapy methods. S
- Knows reporting obligations. K
- Performs a full mental status. K

Inpatient Neurology (2 mths) – MVAHCS

- Conduct a competent neurological examination. S
- Recognizes neurological emergencies. S
- Recognizes neurological consequences of traumatic brain injury. S

Inpatient Psychiatry (7mths) – UMMC – West Bank & Mpls MVAHCS

- Take a relevant and comprehensive psychiatric history. S
- Assesses potential for immediate self harm (act and implement appropriate protective measures. S
- Describe the presenting symptoms of common psychiatric diseases – schizophrenia, bipolar disorder, major depression, anxiety disorders, impulse control disorders, PTSD, personality disorders, delirium, dementia and the common substance related disorders. K

Program Policy & Procedure Manual
### YEAR 1 (continued)

<table>
<thead>
<tr>
<th>Call Assignments</th>
<th>Patient Care</th>
<th>Evidence-Based Practice-based Learning and Improvement</th>
<th>Interpersonal and Communication Skills</th>
<th>Professionalism</th>
<th>Systems-based Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGY1 residents do not take call independently. A PGY2 or higher is always physically present on the same campus when a PGY1 resident sees a patient. Call assignments are compliant with ACGME Duty Hour Rules.</td>
<td>Work collaboratively with hospital staff including intake workers, emergency room personnel, RNs, supervisors to address system issues in patient care.</td>
<td>Knowledge of what factors to consider in triaging a clinical problem. [K] How to grade the urgency of a clinical handoff. [K]</td>
<td>Identify areas of knowledge, skill or attitude deficiency in context of providing urgent psychiatric, medical, pediatric and neurological care.</td>
<td>Complete clinical documentation in thorough and complete manner.</td>
<td>Work collaboratively with hospital staff including intake workers, emergency room personnel, RNs, supervisors to address system issues in patient care.</td>
</tr>
</tbody>
</table>

#### Research Elective

(1 mth) UMMC or MVAHCS

A PGY1 resident may qualify for one month of research elective to advance research projects and goals well established prior to residency, as approved by the program director and residency training committee.

| Triage and prioritize clinical problems including needs of new patients and continuity of care to current patients. | Align clinical problems with the appropriate methods of clinical handoff. | Identify areas of knowledge, skill or attitude deficiency in context of providing urgent psychiatric, medical, pediatric and neurological care. | Work collaboratively with hospital staff including intake workers, emergency room personnel, RNs, supervisors to address system issues in patient care. |

| WORK SCHEDULE: \(60 \text{ hours/week} \times 4 \text{ weeks} \times 21 \text{ weeks/year} = 5040 \text{ hours/year} \) | Work collaboratively with hospital staff including intake workers, emergency room personnel, RNs, supervisors to address system issues in patient care. |

### YEAR 2

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Evidence-Based Medicine Knowledge</th>
<th>Practice-based Learning and Improvement</th>
<th>Interpersonal and Communication Skills</th>
<th>Professionalism</th>
<th>Systems-based Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Year 1.</td>
<td>See Year 1.</td>
<td>See Year 1.</td>
<td>See Year 1.</td>
<td>See Year 1.</td>
<td>See Year 1.</td>
</tr>
</tbody>
</table>

#### Year 1

- **Patient Care**
  - **Evidence-Based Medicine**
    - **Practice-based Learning and Improvement**
    - **Interpersonal and Communication Skills**
    - **Professionalism**
    - **Systems-based Practice**

#### Generic

A PGY2 assumes responsibility for diagnosis and management of patients in psychiatric and medical settings with immediate supervision available. Assessment of the appropriateness of patients for hospitalization on an inpatient psychiatry service is immediately available by phone or pager, but the level of supervision depends on the resident's need. Will provide immediate availability for supervision for PGY1 residents.

- **Assessment of the appropriateness of patients for hospitalization on an inpatient psychiatry service**
  - Supervision is immediately available by phone or pager, but the level of supervision depends on the resident's need. Will provide immediate availability for supervision for PGY1 residents.

#### Consultation-Liaison Psychiatry

(1 mth) UMMC

- **Assessment of the appropriateness of patients for hospitalization on an inpatient psychiatry service**
  - Supervision is immediately available by phone or pager, but the level of supervision depends on the resident's need. Will provide immediate availability for supervision for PGY1 residents.

#### Substance Use/ECT

(1 mth) UMMC

- **Assessment of the appropriateness of patients for hospitalization on an inpatient psychiatry service**
  - Supervision is immediately available by phone or pager, but the level of supervision depends on the resident's need. Will provide immediate availability for supervision for PGY1 residents.

#### Child Adolescent Psychiatry

(2 mths) UMMC

- **Assessment of the appropriateness of patients for hospitalization on an inpatient psychiatry service**
  - Supervision is immediately available by phone or pager, but the level of supervision depends on the resident's need. Will provide immediate availability for supervision for PGY1 residents.
<table>
<thead>
<tr>
<th>Year 3</th>
<th>Patient Care</th>
<th>Evidence-Based Medical Knowledge</th>
<th>Practice-based Learning and Improvement</th>
<th>Interpersonal and Communication Skills</th>
<th>Professionalism</th>
<th>Systems-based Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERIC</strong></td>
<td>Assume responsibility for care in ambulatory settings with immediate supervision available.S</td>
<td>Capacity to recognize and distinguish subtle presentations of medical and psychiatric conditions including those related to undetected substance use.K</td>
<td>Familiarity with and use of evidence-based treatment guidelines for familiar psychiatric syndromes.KS</td>
<td>Able to communicate effectively using a variety of modalities – face to face, phone, FAX, email, letter.S</td>
<td>Able to recognize and manage personal responses to highly disturbing situations.SAK</td>
<td>Skill in accessing and advocating for patient-care related resources.AKS</td>
</tr>
<tr>
<td></td>
<td>Ability to assess danger to self and others in an outpatient setting.S</td>
<td>Ability to create treatment options in refractory cases by researching the literature.S.KA</td>
<td>Recognizes advantages and limitations of each method of communication.K.VA</td>
<td>Ability to participate in a quality assurance/quality improvement project.A.K</td>
<td>Ability to assist others – colleagues, patients, staff, families – in their response to disturbing situations.SAK</td>
<td>Communicating and collaborating with external agencies to support patient treatment and recovery.S.K</td>
</tr>
<tr>
<td></td>
<td>Ability to formulate a safety plan for ambulatory patients.S.K</td>
<td>Knowledge of how to adjust treatment plan in light of economic and insurance variations.K</td>
<td>Aware of importance of feedback to clinical decision making.S.K</td>
<td>Able to recognize the need for a high level of professional functioning.S.K</td>
<td>Able to manage patient’s needs in a variety of settings.S.K</td>
<td></td>
</tr>
</tbody>
</table>

**Emergency (1.5 mths) UMMC**

See generic

Use electronic databases after hours to access guidance about differential diagnosis and management of acute illness.S/K

Ability to determine when and how to apply or lift an emergency hold.S/K

Knowledge of internal and external policies and procedures that control hospital admissions.K

**Night Float (1.5 mths) UMMC**

Develop a treatment plan that addresses immediate and potential risks related to the patient's medical and psychiatric conditions.S/A

Ability to manage complex psychiatric medical problems and determine when supervision is necessary.S/K

Knowledge of internal and external policies and procedures that control hospital admissions.K

**Geropsychiatry (1 mth) MAHCFS**

This is an outpatient rotation.

Complete comprehensive psychiatric history and physical exam in pts < 65 yo, including assessment of cognition, family/caregiver, medical status and function.A

Use electronic databases after hours to access guidance about differential diagnosis and management of acutely ill psychiatric patients.S/K

Ability to determine when and how to apply or lift an emergency hold.S/K

**Inpatient Psychiatry (3 mths) UMMC**

See Year 1

Use electronic databases after hours to access guidance about differential diagnosis and management of acutely ill psychiatric patients.S/K

Ability to determine when and how to apply or lift an emergency hold.S/K

**Outpatient Psychotherapy UMMC (0.5 d x 10 mths)**

Beginning competence in supportive and psychodynamic psychotherapy.S

Understands methods and indications for supportive and psychodynamic psychotherapy.K

Ability to manage complex psychiatric medical problems and determine when supervision is necessary.S/K

Knowledge of internal and external policies and procedures that control hospital admissions.K

**Call Assignments**

PGY2 residents take call with direct supervision available by means of telephone and/or electronic modalities. They may work independently and are expected to provide supervision to PGY1 residents. Call assignments are compliant with ACGME Duty Hour Rules.

Triage and prioritize clinical problems including needs of new patients and continuity of care to current patients.S

Align clinical problems with the appropriate methods of clinical handoff.S/K

Principles of prioritizing clinical problems and addressing those of greatest clinical relevance.K

Identify and formulate a safety plan for ambulatory patients.S/K

Ability to formulate a safety plan for ambulatory patients.S.K

Knowledge of how to adjust treatment plan in light of economic and insurance variations.K

**Research Elective**

A PGY2 resident may qualify for a research elective to advance research projects and goals well established prior to residency, as approved by the Program Director and Residency Training Committee.

Allow the trainees to advance research projects and scholarly inquiry already established prior to starting residency.KS/KA

Begin to plan for his/her career development.K/A/S

A faculty mentor will be assigned to enhance academic professional development.S

**YEAR 3**

**Patient Care**

Assume responsibility for care in ambulatory settings with immediate supervision available.S

Ability to assess danger to self and others in an outpatient setting.S

Ability to formulate a safety plan for ambulatory patients.S.K

Beginning to exercise independent judgment in treatment planning and implementation in representative cases.S/K

**Evidence-Based Medical Knowledge**

Capacity to recognize and distinguish subtle presentations of medical and psychiatric conditions including those related to undetected substance use.K

Knowledge of CPT codes and what documentation is appropriate for a level of service.S

Knowledge of how to adjust treatment plan in light of economic and insurance variations.K

**Practice-based Learning and Improvement**

Familiarity with and use of evidence-based treatment guidelines for familiar psychiatric syndromes.KS

Ability to create treatment plans in refractory cases by researching the literature.S.KA

**Interpersonal and Communication Skills**

Able to communicate effectively using a variety of modalities – face to face, phone, FAX, email, letter.S

Recognizes advantages and limitations of each method of communication.K.VA

**Professionalism**

Able to recognize and manage personal responses to highly disturbing situations.SAK

Able to assist others – colleagues, patients, staff, families – in their response to disturbing situations.SAK

Complete outpatient notes in the electronic medical record in an appropriate timeframe.A.S.K

**Systems-based Practice**

Skill in accessing and advocating for patient-care related resources.AKS

Communicating and collaborating with external agencies to support patient treatment and recovery.S.K

**Program Policy & Procedure Manual**

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<table>
<thead>
<tr>
<th>DUTY HOURS</th>
<th>Resident must be limited to 80 hours per week, averaged over a four-week period – inclusive of all in-house activities and both internal and external moonlighting. A duty period cannot exceed 24 hours. Residents are allowed to remain on-site for an additional four hours to accomplish effective transitions of care. There may be no additional clinical responsibilities assigned. There must be 8 hours between scheduled duty periods and there must be at least 14 hours of duty after 24 hours of in-house duty (not applicable to moonlighting). In-house call must be scheduled more frequently than every third night and there must be one day (24 continuous hours) in seven free of duty (both averaged over a four-week period).</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTPATIENT CARE – UMMC (12 mths)</td>
<td>Ability to lead a group with supervision.S Knowledge of the indications for and limitations of group therapy.K See generic See generic See generic See generic See generic</td>
</tr>
<tr>
<td>COMMUNITY MENTAL HEALTH – Community University Health Care Center or Quad Assaultive Community Treatment Services or Fairview Integrated Primary Care Clinic or Canvas Health (0.5 day x 6 mths for PGY2s)</td>
<td>Ability to engage in medication management with psychoanalytic approaches.S Manage chronically suicidal patients in an ambulatory setting.S Beginning competence in supportive, cognitive behavioral and dynamic psychotherapy.S Providing care for patients in community mental health sites – Hennepin County Mental Health Center or the Fairview Integrated Primary Care Clinic or the Community University Health Care Center or Quad ACT team.S Ability to delineate biophysical and traumatic events in immigrant and underserved populations.K Knowledge of differences in pharmacodynamics and pharmacokinetics in ethnically distinct populations being served in community mental health systems.K Taking responsibility for learning to work with underserved populations (e.g. their cultural beliefs and concerns).K/S/A Communicating effectively with persons who do not speak English.K/S/A Recognizing and accommodating the cultural practices of populations being served in the community.K/S/A Develop sensitivity and responsiveness to a diverse patient population, particularly those from non-traditional, immigrant or underserved populations.K/S/A Advocating for quality patient care in underserved patient populations.K/S/A Working with case managers and community agencies in treatment planning and delivery.K/S/A Working with health care professionals in the inpatient setting.K/S/A</td>
</tr>
<tr>
<td>FAMILY THERAPY – UMMC (2 hrs/wk x 4 mths)</td>
<td>Ability to treat families psychotherapeutically with supervision.S Knowledge of the indications for and limitations of family therapy.K See generic See generic See generic See generic See generic</td>
</tr>
<tr>
<td>RESEARCH ELECTIVE</td>
<td>Introduce the trainee to research.K/S/A Knowledge related to the medical care of a special population or treatment setting.K See generic See generic See generic See generic See generic</td>
</tr>
<tr>
<td>CLINICAL ELECTIVE (see PGY4) (0.5 day x 12 mths)</td>
<td>Introduce the resident to a special population – childhood anxiety, setting disorders, first-episode psychosis, mental health primary care integration, etc. By arrangement with supervisor and approval of program.S Knowledge related to the medical care of a special population or treatment setting.K See generic See generic See generic See generic See generic</td>
</tr>
<tr>
<td>ADMINISTRATIVE ELECTIVE (0.5 day x 12 mths)</td>
<td>Serve as a liaison for the inpatient referral process.S Serve as a liaison between clinic staff and residents. S Knowledge of clinic and administrative/regulatory practices and guidelines.K Organizes the quality assessment and improvement project.S/A Ability to intervene at either an individual or group level to address resident concerns.S/K Works closely with the clinic medical director in addressing system and individual clinical issues as pertains to residents.S/K/A Knowledge of system and administrative issues, including quality of care.K/S/A Impact of interfacing systems – clinical, financial, administrative, etc. on patient care activities.</td>
</tr>
<tr>
<td>ORGANIZATIONAL ELECTIVE (0.5 day x 12 mths)</td>
<td>Serve as a liaison for psychiatry advocacy and leadership organizations.S Knowledge of legislative and administrative regulatory practices and development.K Organizes a project to enhance psychiatry organizational involvement and advocacy.S/A Ability to intervene at either an individual or group level to address resident concerns as applies to organizational leadership.S/K Works closely with the residency program in addressing organizational and legislative issues as pertains to residents.S/K/A Knowledge of organizational and legislative issues.K/S/A Impact of interfacing systems – clinical, financial, legislative, organizational etc. on patient care, program, institutional and social activities.</td>
</tr>
<tr>
<td>YEAR 4 PATIENT CARE</td>
<td>Assume responsibility for patient care in a variety of settings at an independent level.K/S/A Knowledgeable about recent developments in the field.S/K/A Ability to independently research, organize and present a 1 hour academic lecture.S/K/A Ability to resolve complex issues using empathy and education.S/K/A Determination of professional interests and career goals.K/S/A Ability to supervise the functions of a mental health team.K/S/A</td>
</tr>
<tr>
<td>EVIDENCE-BASED MEDICAL KNOWLEDGE</td>
<td>Evidence-based practice-based learning and improvement.K/S/A</td>
</tr>
<tr>
<td>PRACTICE-BASED LEARNING AND IMPROVEMENT</td>
<td>Interpersonal and Communication Skills.K/S/A</td>
</tr>
<tr>
<td>INTERPERSONAL AND COMMUNICATION SKILLS</td>
<td>Professionalism.K/S/A</td>
</tr>
<tr>
<td>SYSTEMS-BASED PRACTICE</td>
<td>Systems-based Practice.K/S/A</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
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<tr>
<td><strong>Rotations</strong></td>
<td>Duties must be limited to 40 hours per week, averaged over a four-week period—inclusive of all in-house activities and both external and internal moonlighting. A duty period cannot exceed 24 hours. Residents are allowed to remain on-site for an additional four hours to accomplish effective transitions of care. There may be no additional clinical responsibilities assigned. There must be 8 hours between scheduled duty periods and there must be at least 14 hours free of duty after 24 hours of in-house duty (not applicable to moonlighting). In-house call must be scheduled more frequently than every third night and there must be one day (24 Continuous hours) in seven free of duty (both averaged over a four-week period).</td>
</tr>
<tr>
<td><strong>Continuity Clinic</strong></td>
<td>Develop long-term psychotherapy skills involving psychodynamic, cognitive behavioral and supportive methods. SBA. Development of ability to adjust psychopharmacologic agents to meet medical long-term patient function. SBA.</td>
</tr>
<tr>
<td><strong>Forensic Clinic—St. Peter State Hospital and/or Hennepin County Courts</strong></td>
<td>Ability to assess a patient for competence. SBA. Ability to contribute psychiatric expertise to a multidisciplinary forensic evaluation. SBA.</td>
</tr>
<tr>
<td><strong>Consultation-Liaison Psychiatry</strong></td>
<td>Adapt the psychiatric assessment to a medical setting. SBA. Understand the impact of medical illnesses on a patient's life history and mental health. SBA. Recognize the medical complications of common medical illnesses—constipation, diathesis, insomnia, pain, etc. SBA. Recognize internalization and withdrawal in the medical setting. SBA.</td>
</tr>
<tr>
<td><strong>Chief Resident</strong></td>
<td>Cross cover for junior residents during their didactics. SBA.</td>
</tr>
<tr>
<td><strong>Research Activity (%) Variations</strong></td>
<td>Adaptation of patient care to research settings and protocols. SBA.</td>
</tr>
<tr>
<td><strong>MVAHCS (%) Variations</strong></td>
<td>Special populations in ambulatory settings (PTSD, addictions, psychotherapy, primary care, mental health integration, geriatrics). SBA.</td>
</tr>
<tr>
<td><strong>UMMC Fairview Palliative Care</strong></td>
<td>Develop skill in assessment, diagnosis and treatment of patients with pain and end-of-life issues. SBA.</td>
</tr>
<tr>
<td>Community-based ambulatory psychiatry (CUHCC, Associated Clinic of Psychology, Rural community sites)</td>
<td>Learn to apply community-based treatment methods.</td>
</tr>
<tr>
<td>Perinatal Psychiatry (HCMC or Abbot Northwestern Hospital)</td>
<td>Develop the ability to assess and treat peripartum patients with co-morbid psychiatric needs.</td>
</tr>
<tr>
<td>PUBLIC and/or forensic PSYCHIATRY (Anoka Metro Regional Treatment Center, Community Based sites, St. Peter State Forensic hospital)</td>
<td>Assume responsibility for care of patients in the state hospitals and state run facilities. Display the ability to create a therapeutic alliance with the most severely ill patients.</td>
</tr>
</tbody>
</table>

Reviewed and adopted by the Residency Training Committee: June 14, 2017
**5.F Psychotherapy Training**

The University of Minnesota, Department of 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 four years of psychiatry training. Topics include supportive psychotherapy, psychodynamic theory and psychotherapy, cognitive behavioral therapy, group and family therapy, dialectical behavioral therapy, and motivational interviewing.

<table>
<thead>
<tr>
<th>Psychotherapeutic Practice</th>
<th>Psychotherapy Supervision</th>
<th>Psychotherapy Didactics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PGY1</strong></td>
<td>- Residents learn psychotherapeutic approaches to inpatient interviews which promote development of rapport, patient engagement, and advancement of hospitalization goals.</td>
<td>- Suicide assessment and acute intervention during orientation.</td>
</tr>
<tr>
<td></td>
<td>- Suicide assessment and crisis management</td>
<td>- The Prevention and Management of Disruptive Behavior course at the VAMC during orientation</td>
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<tr>
<td></td>
<td>- De-escalation and violence prevention techniques</td>
<td>- Clinical Skills Course (12 hours) including topics related to professionalism, impairment, basic psychotherapeutic skills, documentation, mentoring, use of supervision.</td>
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<tr>
<td></td>
<td>- Weekly “competency supervision” discussing the 6 ACGME competencies: Patient Care, Medical Knowledge, Practice Based Learning and Improvement, Systems Based Practice, Professionalism, Interpersonal Skills &amp; Communication</td>
<td>- Explicit skills taught include validation and reflective listening.</td>
</tr>
<tr>
<td></td>
<td>- The Prevention of Major Disorders course (12 hours) discusses indications for both medication management and psychotherapeutic modalities</td>
<td>- Treatment of Major Disorders course (12 hours) discusses indications for both medication management and psychotherapeutic modalities</td>
</tr>
<tr>
<td></td>
<td>- Human Development, Child Disorders &amp; Treatment (12 hrs) by Dr. Murray</td>
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Program Policy & Procedure Manual
**PGY2** | **Supportive psychotherapy**  
Clinic: 1-5PM Tuesday afternoons in the outpatient clinic.  

**Minimum Requirements:**  
Must maintain a minimum of two 50 minute supportive therapy patients each week. If cases go biweekly, must add a 3rd or 4th patient.  

Exception: On night float blocks, it is expected that residents see their therapy patients at least two of four weeks.  

Optional: Residents may pursue training in Dialectical Behavioral Therapy (DBT)  

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-Weekly supportive psychotherapy supervision (videotaping sessions is suggested)  

Optional: Weekly Dialectical Behavioral Therapy Study Group.  

- Supportive Psychotherapy (12 hours) by Dr. Moen.  

- Introduction to Psychotherapy (4 modules) by Dr. Nelson.  

- Psychodynamic Theory (12 hours) taught by Drs. Simovic & Setterberg  

- Family therapy (12 hours) taught by Dr. Moen.  

- Dialectical Behavioral Therapy (12 hour course) taught by Dr. Long.  

- Cultural Competency (6 hours) by Dr. Shors  

- Spirituality (3 hours) by Dr. Kroll  

PGY3 Minimum Requirements:

Psychodynamic Psychotherapy (main emphasis during PGY3 year)
- 1A. 4 total ongoing 50 minute weekly therapy sessions. 2 Psychodynamic therapy patients minimally. At least one must come weekly (ideally both)
- 1B. At least one of these patients MUST come weekly (i.e., same patient one time per week for the entire year) 2 psychodynamic psychotherapy patients minimally weekly

Cognitive Behavioral Therapy –
- Complete 1 CBT case/minimum of 8 sessions
- 8 months weekly CBT supervision
- Additional CBT case/med management with CBT focus

Group Psychotherapy –
- C. 4 month rotation in Women’s or Mixed Gender Therapy Groups serving as Dr. Moen’s co-therapist.

Family Therapy –
- 1 family beginning to end (8-10 sessions) serving as Dr. Moen’s co-therapist.
- Family meetings with med management case. Dr.Bass Requirement

Motivational Interviewing -
- 2.5 day MI Training and monthly teaching/coaching circle by Fran Lesicko, MA
- Provide one 15 minute audio or video tape to

- Weekly psychodynamic psychotherapy supervision all year.
- Weekly CBT individual supervision 8 months
- May also have CBT group supervision (requirement determined by Dr. Nelson and Dr. Moen)
- Motivational Interviewing group supervision monthly for 7-8 sessions
- Family and Group Therapy Supervision provided by Dr. Moen during the clinical rotation.

Optional: Weekly Dialectical Behavioral Therapy Study Group. IPT supervision as arranged.

- Psychodynamic Psychotherapy II & III (24 hours) by Drs. Simovic. & Setterberg
- Cognitive Behavioral Therapy (12 hours) by Dr. Zagoloff
- Motivational Interviewing (2-day training) by Fran Lesiko, MA
- Group therapy teaching and experiential learning as co-therapist with Dr. Moen.
course instructor. Can be a med management case with MI intervention or taped role-play.

Optional: Residents may pursue training in Dialectical Behavioral Therapy (DBT) or Interpersonal Therapy (IPT)

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**PGY4**

**Emphasis is on psychodynamic psychotherapy.** Continuation of Supportive, Psychodynamic, CBT, DBT, IPT and Motivational Interviewing cases. (2-6+ hours per week)

**Minimum Requirements:**
Psychodynamic Psychotherapy-
- 2-4 ongoing 50 minute weekly therapy cases.
- At least one of these patients MUST come weekly (i.e., same patient one time per week for the entire year). The other patient should also come weekly, but if they go biweekly then you must add a 3rd or 4th psychodynamic psychotherapy patient.

Additional supportive, DBT, CBT, and IPT cases are encouraged.

Complete the Family Therapy requirement if you were unable to do so during the PGY3 year.

Optional: Residents may pursue training in Dialectical Behavioral Therapy (DBT), Interpersonal Therapy (IPT), or VA psychotherapy electives

-Weekly psychodynamic psychotherapy supervision all year.

Recommended Options: Weekly Dialectical Behavioral Therapy Study Group. IPT supervision as arranged. VA psychotherapy electives can be arranged.
PSYCHOTHERAPY OPTIONAL ACTIVITIES
These are primarily 4th year electives, mostly offered at the VA:

**Interpersonal Therapy:** Individual experience supervised by Carol Peterson.

**Psychological Assessment Training Clinic:** Through this year-long group training experience, trainees conduct a range of assessments for the purpose of psychodiagnosis. Competencies emphasized include diagnostic interviewing, intellectual assessment, personality assessment using the MMPI-2, the Rorschach, and other instruments, and the provision of consultation and peer supervision. Trainees can expect to become familiar with the relevant research. Supervisors: Drs. Arbisi (ABPP) and Siegel (ABPP).

**Acceptance and Commitment Therapy (ACT):** ACT is a functional contextual therapy that views psychological problems dominantly as problems of psychological inflexibility. ACT uses acceptance and mindfulness processes, and commitment and behavior change processes, to produce greater psychological flexibility. Training includes didactic presentations, experiential exercises, and review of clinical material including audio- or videotapes in weekly small group supervision. Trainees can serve as individual ACT therapists or group therapists. Supervisor: Drs. Billig (ABPP) and Hess.

**Family Psychoeducation:** Family Psychoeducation is an evidence-based approach for working with individuals with serious mental illness (schizophrenia, bipolar disorder, recurrent depression) and their significant others. A bio-psycho-social model of mental illness guides our conceptualization of cases and treatment recommendations. Individual family and group interventions provide education about the illness, teach all participants adaptive coping skills, and provide the family unit with support and crisis intervention. Training in family psychoeducation models (Behavioral Family Therapy and Multifamily Group) is provided primarily through co-facilitation of multiple family group or individual family sessions. Trainees may also become involved with family education interventions either as a presenter at educational workshops or as a co-facilitator of an educational seminar for family members only - Support and Family Education (SAFE). Weekly meetings are held for case consultation and to discuss the relevant empirical literature. Supervisor: Dr. Nienow.

**Family Therapy Training Clinic (FTTC):** Social Constructionist therapy including Solution Focused and Narrative approaches are presented in the FTTC. This clinic provides training for staff, postdoctoral residents, and trainees in the assessment and treatment of couples and family-related concerns. The clinic format includes didactic presentations (augmented through videotapes), and experience using solution-focused, and narrative techniques. All sessions are videotaped, and supervision occurs in a group setting. Skills acquired include case conceptualization, basic techniques, and provision of peer supervision. Training is augmented by consultation with a community family therapy expert. Supervisors: Drs. Erbes and Leskela.

**The Anxiety Interventions Clinic (AIC):** AIC is a national VA award-winning training program which employs distinctive, empirically-supported approaches to treat social and simple phobias, panic disorder with and without agoraphobia, generalized anxiety disorder, and obsessive-compulsive disorder. Techniques include but are not limited to diagnostic assessment, psychoeducation, relaxation training, cognitive restructuring, exposure and response prevention. Residents can expect to develop competence in assessment and differential diagnosis of anxiety disorders using standardized forms and structured interviews, and in the application a CBT approach to specific anxiety disorders. Trainees become familiar with the empirical literature regarding the application of CBT strategies with anxiety disorders, and are encouraged to utilize process and outcome measures to track therapy progress as a part of standard care. Critical thinking and professional development are emphasized. The training setting is interdisciplinary and a peer consultation/supervision model is used. Supervisor: Dr. Olson (ABPP).
Cognitive Behavioral Social Skills Training (CBSST): This training is targeted towards individuals with serious mental illness (SMI), including schizophrenia and other psychotic disorders. The program utilizes techniques from cognitive behavioral therapy and social skills training that are implemented within a group format, which is augmented with individual sessions and consultation with other involved providers. Specific targets include modifying maladaptive thoughts, coping with persistent symptoms, identifying and monitoring warning signs of relapse, increasing problem-solving skills, promoting effective conflict management and improving communication skills. This differs from traditional supportive group therapy in that veterans' current concerns are addressed through learning and applying new skills to their everyday experiences. The intention is to improve quality of life and social functioning in our veterans with SMI, thus we work primarily within a "recovery" model. In addition, there is an emphasis on family education and involvement with the National Alliance for the Mentally Ill (NAMI). Skills acquired include case conceptualization from a CBT approach, techniques of the CBSST intervention, assessment of psychotic symptoms and other areas of patients' functioning, familiarity with relevant empirical literature, peer supervision, and multidisciplinary consultation. Supervisor: Drs. Hegeman and Hoffman-Konn.

Cognitive Processing Therapy (CPT): CPT is an evidenced-based, manualized, time-limited (12-17 weeks) treatment approach for trauma-related symptoms. Symptoms are conceptualized as developing from an inability to resolve conflicts between the traumatic event and prior beliefs about the self or others, as well as the consequent avoidance of a range of strong affects such as anger, shame, guilt, and fear. CPT treats trauma-related symptoms within the framework of a “recovery” model. The primary focus is on cognitive interventions, and treatment is structured such that skills are systematically built upon throughout the course of therapy. Treatment elements include psychoeducation, emotional processing, and cognitive interventions. Process and treatment outcome measures are used to track therapy progress as part of standard care. The CPT clinic provides training consisting of didactics, a video instruction series, bi-weekly case consultation, and participation as a CPT therapist. Opportunities are available for trainees to also serve as a group co-facilitator for both the men’s and women’s groups. Supervisors: Drs. Curry, Meyers (ABPP), and Petska.

Prolonged Exposure (PE): PE is an evidence-based, cognitive behavioral treatment for PTSD. The program consists of a course of individual therapy designed to help clients process traumatic events and thus reduce trauma-induced psychological disturbances. Twenty years of research have shown that PE significantly reduces the symptoms of PTSD, depression, anger, and general anxiety. The standard treatment program consists of nine to twelve, 90-minute sessions. Treatment components include psychoeducation, in-vivo and imaginal exposure procedures. The PE clinic provides training consisting of didactics, a video instruction series, and weekly multidisciplinary case consultation. Opportunities are available for trainees to serve as individual therapists. Supervisors: Drs. Polusny, Strom, and Voller.

Time-Limited Dynamic Psychotherapy (TLDP): Trainees participate in a group supervision model of training to learn and apply TLDP with a minimum of one patient during the course of the 6-month training clinic. Competencies acquired include case conceptualization and application of TLDP as well as peer supervision/consultation. Supervisor: Dr. Wagner.

Motivational Interviewing (MI): MI is a directive, client-centered therapeutic style for eliciting behavioral change by helping clients explore and resolve ambivalence about making changes. The therapist assesses the client's level of readiness for change and uses MI to help the client define treatment goals, time frames, and the strategies to achieve those goals. The MI training will consist of learning the basic MI goals and principles, traps to avoid, and opening strategies, eliciting self-motivational statements, handling resistance, and assessing readiness for change. The process will
include readings and discussions of didactic material, review of video and audiotapes of interactions with patients, and role-playing. Supervisor: Dr. Isenhart (ABPP).

**Dialectical Behavioral Therapy (DBT).** DBT is the empirically-supported, manualized cognitive behavioral approach to treat male and female patients who share key features with those diagnosed with Borderline Personality Disorder, specifically emotion dysregulation, distress tolerance, and interpersonal difficulties. Patients commit to weekly individual therapy and group skills training. Training includes didactic presentations and review of clinical material, including videotapes, in weekly small group supervision. Trainees can serve as individual DBT therapists, skills group co-leaders, and/or ACES group co-leaders (i.e., an advanced DBT group to assist patients with returning to work or school, establishing normative social relationships, and exiting the mental health system). They also participate in a weekly Consultation Group. Supervisors: Dr. Meyers (ABPP).

**Psychoanalytic Clinic:** This yearlong clinic is intended to give trainees experience with psychoanalytic-informed approaches to psychotherapy with individuals. Trainees participating in this clinic usually carry one to two cases, meeting once or twice weekly, for a total of two clinical hours per week. Trainees can expect to write process notes for use in a weekly group supervision meeting. Additionally, readings covering various psychoanalytic ways of thinking about and working with people are assigned and discussed in supervision. Supervisor: Dr. Walden.

5.G **Clinical Skills Evaluations (CSEs)**

Evaluation is conducted by Dr. Lidia Zylowska. This is a program requirement. This evaluation is not used for the purpose of the American Board of Psychiatry and Neurology Clinical Skills Verification (CSV), but is preparatory for this activity.

First and second year residents:
- Will be evaluated one time during the PGY1 year.
- Evaluation should be scheduled with Dr. Zylowska for 90 minutes during a mutually agreed upon by Dr. Zylowska and the G1 resident.
- The evaluation will take place on the inpatient unit.
- Residents should not know the patient.
- OK to use materials such as H&P template, write notes, etc.
- Approximately 30-40 minutes is spent with the patient, followed by a 30 minute discussion with Dr. Zylowska.

5.H **Clinical Skills Verifications (CSVs)**

In order to be eligible for ABPN certification, three clinical skills verifications must be completed. Two verifications will take place during PGY3 year, arranged and completed by Drs. Bass, Gabor, Nelson, or Zylowska. One verification will take place in the first 6 months of the G4 year, completed by Dr. Atkinson at the MVAHCS. If a resident enters the child/adol fellowship during their G4 year, the G4 verification will be completed in the context of this fellowship. All documentation will be provided to the ABPN using an approved format. Multiple attempts are allowed until three skills verifications reach the level of being satisfactory.
5.1 Goals and Objectives for Teaching Medical Students

Residents are an essential part of the teaching of medical students. It is critical that any resident 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>
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<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>
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<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>
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<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>
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<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>
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<td></td>
<td>Specific Information About the Patient and Patient’s Life Situation.</td>
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<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>
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<td></td>
<td>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 &amp; C, and Introduction to Rural Primary Care Medicine course performance at DU campus Clinical rotation performance</td>
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<td></td>
<td>Practice-Based Learning and Improvement; Systems-Based Practice</td>
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<td></td>
<td>PAS course performance at TC campus Medical Sociology and CR &amp; C course performance at DU campus Clinical rotation performance, especially the PCC Feedback from residency directors Feedback from local health plans</td>
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<td></td>
<td>Practice-Based Learning and Improvement; Systems-Based Practice</td>
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<td>10.</td>
<td>Competently evaluate and manage medical information.</td>
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<td>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</td>
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<td></td>
<td>Patient Care; Medical Knowledge; Practice-Based Learning and Improvement; Systems-Based Practice</td>
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<tr>
<td>11.</td>
<td>Uphold and demonstrate in action/practice basic precepts of the medical profession: altruism, respect, compassion, honesty, integrity and confidentiality.</td>
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<td></td>
<td>PAS course performance at TC campus Preceptorship and Cr &amp; 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</td>
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<td></td>
<td>Professionalism</td>
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<td>12.</td>
<td>Exhibit the beginning of a pattern of continuous learning and self-care through self-directed learning and systematic reflection on their experiences.</td>
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<td>PBL cases at DU campus Yr 2 Health disparities project Clinical rotation performance Participation in research</td>
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<td>Professionalism</td>
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<tr>
<td>13.</td>
<td>Demonstrate a basic understanding of the healthcare needs of society and Course performance in all years Introduction to Rural Primary Care Medicine</td>
<td></td>
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</tbody>
</table>
|   | Patient Care; Medical Knowledge; Practice-
<table>
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<tr>
<th>a commitment to contribute to society both in the medical field and in the broader contexts of society needs.</th>
<th>course project at DU campus</th>
<th>Based Learning and Improvement; Professionalism; Systems-Based Practice</th>
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<tbody>
<tr>
<td>Involvement of students in international study</td>
<td>Enrollment in RPAP, RCAM, and UCAM</td>
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<tr>
<td>Yr 2 Health disparities project</td>
<td>Feedback from residency directors</td>
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<td>Participation in volunteer service activities</td>
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</tr>
</tbody>
</table>

- 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:
**Objectives**

- **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
5J Training and Graduation Requirements

(1) Length of Program
- A complete psychiatry residency is 48 months.
- Twelve of those months may be spent in an ACGME approved Child and Adolescent psychiatry residency.
- During the four years of psychiatry training, a minimum of 2 years must be spent at one training program.
- Subspecialty fellowships (other than child training) cannot begin until a full 48 months of psychiatry training has been completed.

(2) Requirements for Graduation:
- Residents must meet all requirements of the American Board of Psychiatry and Neurology, which will allow them to sit for psychiatry boards.
- Residents must have satisfied the requirements for the adult psychiatry program as set forth by the Residency Training Committee, acting in conjunction with the University Graduate Medical Education Committee.
- The resident must be in good standing with no ethical problems or concerns about professional competency.
- The resident must have satisfactory grades in all rotations, and have performed satisfactorily in didactic courses at each level of training.

(3) Program Elements for Each Year of Training
First Year of Training PGY-1:
- Minimum four months in Internal Medicine, emergency medicine, and/or Pediatrics
- Two months in Neurology [RRC guidelines dictate there must be one month in the first or second year of training]
- Balanced program involving direct patient care, didactic teaching, and supervision.
- Skills acquired during first year should include:
  (i) Undertake the initial clinical and laboratory studies of patients presenting with a broad range of common medical and surgical disorders.
  (ii) Diagnose common medical and surgical disorders and formulate appropriate treatment plans.
  (iii) Provide continuous care of patients with medical illnesses and make appropriate referrals.
  (iv) Be especially conversant with medical disorders displaying symptoms likely to be regarded as psychiatric and with psychiatric disorders displaying symptoms likely to be regarded as medical.
  (v) Being especially cognizant of the nature of the interaction between psychiatric treatment and the medical and surgical treatments.
  (vi) Relate to patients and their families, as well as members of the health care team, with compassion, respect, and professional integrity.

Clinical Training PGY-2 - PGY-4 Years
Clinical training PGY-2 - PGY-4 years should provide sufficient experience in:
- The elements of clinical diagnosis in diverse groups, including both sexes, ethnic minorities and all age groups.
- Relating history and clinical findings to the role of biological, psychological, and social issues.
- Formulating a differential diagnosis and treatment plan.
-Major types of therapy, including short and long term individual psychotherapy, psychodynamic psychotherapy, family therapy, group therapy, cognitive behavioral therapy, crisis intervention, pharmacological and other somatic therapies, and drug and alcohol detoxification.
-Providing continuous care for a variety of patients from different age groups seen regularly for an extended period of time.
-Psychiatric consultation in a variety of medical, surgical, and community settings
-Providing care and treatment for the chronically mentally ill.
-Psychiatric administration, including leadership of inter-disciplinary teams.
-Providing psychiatric care to patients receiving treatment from non-medical therapists.
-Knowledge of the indications for and the limitations of the more common psychological tests.
-Critically appraising the professional and scientific literature.
-Ability to teach psychiatry to students in the health professions.

Specific Requirements:
-Minimum of six months inpatient psychiatric training, but no more than sixteen months.
-Outpatient training—organized, continuous supervised clinical experience of at least 12 months FTE.
-Child and adolescent psychiatry of two months full time inpatient or outpatient experience.
-Consultation/liaison - supervised consultation for a minimum of two months full time experience.
-Emergency psychiatry-supervisory responsibility on an organized 24-hour psychiatric emergency service that is responsible for evaluation, crisis management, and triage of psychiatric patients.
-Community psychiatry - supervised activities in community-based mental health program.
-Geriatric psychiatry - supervised clinical experience of diagnosis and management of geriatric patients with a variety of psychiatric disorders of at least one month in duration.
-Addiction psychiatry - supervised clinical management of alcohol and drug related problems (one month).
-Forensic psychiatry - supervised experience in evaluation of patients with forensic problems.
-Supervised clinical experience in the evaluation and treatment of couples, families, and groups.
-Techniques for evaluation and management of dangerousness in patients.
-Psychological testing - supervised experience with more common psychological test procedures, including neuropsychological assessment.
-Supervised experience in utilization review and total quality management.
-Supervised collaboration with psychologists, psychiatric nurses, social workers, and other mental health professionals.
-Clinical records must reflect the resident’s ability to:
  -Record adequate history and mental status, physical and neurological examinations.
  -Organize a comprehensive differential diagnosis.
  -Proceed with appropriate laboratory and diagnostic procedures.
  -Develop and implement an appropriate treatment plan with regular and relevant progress notes.
  -Prepare an adequate discharge summary and plan.
Logs must be maintained documenting specific cases treated by the residents and recording types of patients, diagnosis and treatment modalities. This record should be reviewed periodically with the program director or designee.

Scope of Exposure to clinical syndromes and methods

INPATIENT - Admit and manage a patient with the following syndromes
- Intellectual disability of any severity
- Major depression with and without psychosis
- Bipolar disorder – depressed
- Bipolar disorder – mixed
- Bipolar disorder - manic
- Schizophrenia – with active psychotic symptoms
- Schizoaffective disorder – with active psychotic symptoms
- Posttraumatic stress disorder
- Obsessive compulsive disorder
- Panic disorder with or without agoraphobia
- Neurocognitive disorder
- Delirium
- Alcohol Intoxication
- Alcohol withdrawal
- Alcohol Abuse/Dependence
- Opiate withdrawal
- Opiate Abuse/Dependence
- Cocaine Intoxication
- Cocaine Abuse/Dependence
- Amphetamine Intoxication
- Amphetamine Withdrawal
- Amphetamine Abuse/Dependence
- Marijuana Intoxication
- Marijuana Abuse/Dependence
- Borderline Personality Disorder
- Antisocial Personality Disorder
- Attention deficit hyperactivity disorder
- Autism
- Oppositional defiant disorder
- Conduct disorder
- Separation anxiety disorder
- Learning Disability

Evaluate and manage an inpatient with the following features
- Acute agitation
- Acute grief
- Confusion State (this is descriptive rather than DSM based) – acute and chronic
- Acute schizophrenic psychosis
- Acute manic psychosis
- Suicidal ideation and intent
- Aggression
- Medication induced movement disorders
- Non-suicidal self-injury
• Intrusive flashbacks of traumatic experiences

OUTPATIENT – evaluate and manage a patient with the following syndromes
• Intellectual disability – of any severity
• Major depression – recurrent
• Dysthymia
• Bipolar disorder – depressed symptoms
• Bipolar disorder – manic symptoms
• Schizophrenia – acute and chronic
• Schizoaffective disorder
• Acute stress disorder
• Posttraumatic stress disorder
• Obsessive compulsive disorder
• Panic disorder with or without agoraphobia
• Social phobia
• Hypochondriasis
• Bulimia nervosa
• Anorexia nervosa
• Neurocognitive disorder
• Alcohol Abuse/Dependence
• Opiate Abuse/Dependence
• Cocaine Abuse/Dependence
• Amphetamine Abuse/Dependence
• Marijuana Abuse/Dependence
• Adjustment disorder
• Borderline Personality Disorder
• Antisocial Personality Disorder
• Attention deficit hyperactivity disorder
• Pathological gambling

Evaluate and manage an outpatient with the following features
• Emergent psychosis
• Chronic suicidal ideation
• Non-suicidal self-injury
• Aggressive impulses
• Medication induced movement disorders
• Treatment non-compliance

CONSULTATION - consult on an inpatient or outpatient with the following features
• Confusion
• Movement disorder
• Pain
• Depression
• Life threatening medical illnesses
• Shortness of breath
• Substance abuse

Competent in the use (either inpatient or outpatient) of the following methods
• Supportive psychotherapy
• Cognitive behavioral therapy
• Dynamic psychotherapy
• Medication management
o Traditional antipsychotics
o Atypical antipsychotics – orally and intramuscular
o Tricyclic antidepressants
o MAOIs
o SSRIs and SNRIs
o Bupropion
o Buspirone
o Lithium
o Anticonvulsant mood stabilizers
o Stimulants
o Benzodiazepines and related sedatives

- Electroconvulsive therapy
- Group psychotherapy
- Family therapy

Work with patients with the following demographics
- Children
- Adolescents
- Adults
- Elderly (> 65-years-old)
- Developmentally delayed
- Men
- Women
- Diverse sexual orientation(s)
- Gender dysphoria
- Principal regional ethnic groups, including the special populations of Somali, American Indian, Southeast Asian.

MONITORING SOURCES
- Self-Assessment
- Inpatient Sign out Sheets
- Outpatient contact reports
- MVAHCS inpatient census

PROCEDURE
The training director will determine that the scope of exposure is satisfactory through review of the monitoring sources and discussion with the individual resident. If the scope of exposure is unsatisfactory an appropriate clinical experience will be arranged.

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

(2) There is no separate NRMP identified “research track” for participants in the psychiatry residency; however, incoming residents with a clearly established research career (PhD or masters level research, or very well developed research or quality improvement protocols, may qualify for a 4-week research elective in the PGY1 and/or PGY2 year. Interested
applicants must draft a proposal describing their prior work and how the elective time would be utilized. A faculty mentor must be identified for this elective experience. Approval of qualifications for this elective is granted by the Program Director with assistance from the RTC.

(3) PGY2 residents will prepare and present an original Grand Rounds on a suitable topic at the MVAHCS. This is an academic requirement of the program. The site director will supervise this activity.

(4) Prior to graduation, residents must complete a first-author scholarly project during residency that has local or national impact (textbook chapter, original research published in a reputable peer-reviewed journal, poster presentation at a local or national conference) prior to June 30th of the PGY4 year. The program director, with the assistance of the PEC, will determine if a project is suitable to satisfy this requirement. Residents are encouraged to complete brief reports, case reports, literary pieces and resident opinion pieces, however these types of contributions would not be considered sufficient to satisfy the scholarly work requirement.

(5) A PGY3 resident will be given four hours per week (10%) during their 12-month ambulatory care experience to a mentored research experience. A PGY3 resident is limited to one half day a week of non-clinical time.

(6) Residents are encouraged to attend Psychiatry Grand Rounds, Morbidity and Mortality Conferences, and Complex Case Conferences, which are held weekly. Attendance will be tracked and included in the didactic attendance requirement of 70% attendance.

(7) Residents are supervised in a Quality Assessment and Quality Improvement project during the PGY3 year.

(8) PGY3 residents in the outpatient setting participate in weekly teaching conferences: discussions of selected topics in psychopharmacology, and comprehensive interdisciplinary case discussions.

(9) PGY4 residents interested in research may be eligible for additional mentored research experiences in the fourth year.

5.1 Duty Hours
The Psychiatry Residency Program at the University of Minnesota is committed to insuring that all residents are compliant with the most recent [Common Program Requirements – Effective: July 1, 2011] duty hour requirements set forth by the ACGME as well as the Psychiatry Residency Review Committee. Importantly these guidelines require that external moonlighting be counted in terms of the 80 hour rule and that, effective July 1, 2011, the duty period for PGY1 residents must [present without fail] not exceed 16 hours in duration.

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. It is delineated by the Duty Hour Guidelines.

- PGY2-4 resident’s work shift, continuous duty, cannot exceed 28 consecutive hours, the last 4 hours of which cannot involve patients admitted to the system in that interval
- The start of a workday must be separated from the end of the previous required program duty period by 10 hours (with at least 14 hours free of duty after 24 hours of in-house duty)
- The aggregate duration of workdays in a four week period cannot amount to more than 80 hours per week on average
- Residents are provided at least one day in seven free of patient care responsibilities, averaged over a four-week period.

The standard workday is 8am to 5pm. Residents 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.

Residents may need to adjust arrival or departure times in order to avoid 10 hour violations when switching from evening to night float shifts or if they remain past 10pm Mon-Thur or come in to do rounds prior to 8am.

Patient contact in the Outpatient Clinic will be scheduled up to 5pm, with occasional extension in to the evening, as is the case with Family Therapy cases, which are scheduled until 6:30pm.

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). Residents may remain beyond 5pm as long as it does not incur 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 residents 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 resident will hand over care of all patients and will document the reason for remaining to care for the individual patient in RMS. If a resident 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 are during the regular duty hour review process.

All residents are required to use the Residency Management Suite [RMS] to update and approve 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 resident or fellow does not complete RMS by noon on the 4th 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 resident 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 Resident Survey generates confidential reports from residents regarding duty hour compliance. Violations identified by this process require a written response to the GMEC.
3. Monthly 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 resident’s permanent academic file.
This policy is consistent with the Institutional Policy Manual of the University of Minnesota Graduate Education Committee.

5.M Milestones Evaluation and Resident Promotion based on ACGME Competencies

The psychiatry residency program adheres to the general competencies to assess resident 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 Psychiatry Review Committee has established a set of psychiatry specific Milestones to assess individual resident’s 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 (December and May) to determine each resident’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 resident and Program Director or Associate Program Director. Throughout the academic year, the training director is available to meet individually with residents as difficulties or problems are encountered. The Milestones will be used descriptively to track resident developmental progress and serve as a vehicle for identifying resident 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 resident 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.

A PGY1 resident is expected to have foundational skills to offer sound inpatient care initially with direct supervision and transitioning to indirect with direct immediately available. At the beginning of their PGY1 year, residents are evaluated for their ability and willingness to ask for help when indicated, gather an appropriate history, ability to perform an emergent psychiatric assessment, and present patient findings and date accurately to a supervisor who has not seen the patient. PGY2 residents are evaluated at the beginning of the year for their capacity to supervise PGY1 residents. With progress and promotion, residents are given further responsibilities over the course of 48 months of training.

A PGY4 resident is expected to independently develop a sound and practical plan for managing routine clinical problems. Residents at all levels must know when they need consultation and be motivated to improve their knowledge, skills, and attitude using practice-based learning.

Areas of conditional independence are determined by the level of the trainee, the nature of the clinical problem, the supervision available and the skills of the individual trainee.
ACGME Competencies and Milestones

Resident evaluation is conceptualized as a dynamic process in which there is frequent communication between the resident and supervisor. We feel strongly that it is important for the resident to receive guidance at the time of his/her 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 resident is completed.

More specific to psychiatry, the evaluation process contains the following elements: How well the resident relates to patients and staff; whether the resident makes good use of supervision; whether the resident 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.

The Evaluation Methods Grid summarizes activities used by the educational program and its instructors to collect information about and provide formal feedback to trainees regarding achievement of the competencies outlined in the Goals and Objectives of the training program:

<table>
<thead>
<tr>
<th>#</th>
<th>Method</th>
<th>Frequency per Academic Year</th>
<th>Level</th>
<th>Patient Care</th>
<th>Medical Knowledge</th>
<th>Practice-based Learning</th>
<th>Interpersonal and Communication Skills</th>
<th>Professionalism</th>
<th>System-based Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Attending Rating (RMS)</td>
<td>13</td>
<td>ALL</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>Competency Supervisor Ratings (RMS)</td>
<td>3</td>
<td>PGY1</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>Psychotherapy supervisor Ratings (RMS)</td>
<td>3</td>
<td>PGY2-4</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>Psychotherapy Log (RMS)</td>
<td>1</td>
<td>PGY2-4</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Clinical Skills Evaluation</td>
<td>1</td>
<td>PGY1, 2, 4, 4</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>Clinical Skills Verification</td>
<td>3</td>
<td>PGY3</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>PRITE</td>
<td>1</td>
<td>ALL</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Medical Student Feedback (Evaluation)</td>
<td>8</td>
<td>ALL</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Outpatient Clinic Patient Satisfaction Surveys</td>
<td>4</td>
<td>PGY2-4</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Spontaneous Patient Comments to Program</td>
<td>Variable</td>
<td>ALL</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>QA/QI Presentation</td>
<td>1</td>
<td>PGY3</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>12</td>
<td>Grand Rounds Feedback</td>
<td>1</td>
<td>PGY4</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Resident Competency Self Assessment ALL</td>
<td>1</td>
<td>ALL</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>RMS Duty Hour Report</td>
<td>12</td>
<td>ALL</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>UMP Clinic deficiencies Report</td>
<td>Weekly</td>
<td>PGY1-2</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Moonlighting Report Form</td>
<td>Variable</td>
<td>PGY2-4</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Didactic Attendance</td>
<td>4</td>
<td>PGY1-4</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Semi Annual Meeting with Milestones Reviewed and Discussed</td>
<td>Twice</td>
<td>PGY1-4</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>19</td>
<td>Final Summative Evaluation with Milestones Reviewed and Discussed</td>
<td>Final Year</td>
<td>PGY3 or 4</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>20</td>
<td>Resident Outpatient</td>
<td>4</td>
<td>PGY2-4</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Residents will use RMS, a web-based system, to evaluate their attending physician, supervisor, their specific rotation, the site, didactics, and lecturers. Residents are notified each month via email that they have evaluations to complete. Once notified, residents 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 resident or medical student. The information will be an accumulation of comments rather than individual comments to guarantee anonymity for the residents and medical students. Residents and medical students will be able to view an evaluation on themselves completed by an attending physician once that resident or medical student has completed an evaluation on that particular attending physician.

On any resident’s departure from the program, the program director prepares a letter describing the nature and length of the rotations for which the resident has been given credit. When the resident 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.

University of Minnesota Department of Psychiatry
Adult Psychiatry Residency Clinical Competency Committee Charter

Overview and Composition:

Per ACGME requirements, the Department of Psychiatry Clinical Competency Committee has been developed to to review resident evaluations, prepare and assure the reporting of resident Milestones evaluations to the ACGME, and advise the Program Director on special issues related to resident progress, including promotion, remediation, and dismissal.

Dr. Katharine Nelson, Adult Psychiatry Residency Program Director, has appointed the following faculty members to the Clinical Competency Committee:

1. Katharine Nelson, MD (Chair)
2. Alexandra Zagoloff, PhD
3. Barry Rittberg, MD
4. Steve Olson, MD
5. Deanna Bass, MD
6. Megan Press, MD
7. Patricia Dickmann, MD
8. Richelle Moen, PhD
9. David Atkinson, MD
10. David Bond, MD
11. Quentin Gabor, MD
12. Lidia Zylowska, MD
13. Matej Bajzer, MD

Program Administrator, Jennifer Janacek, MA, will also attend all CCC meetings.
Meetings:

- The CCC will meet semi-annually in May and December of each academic year.
- Meetings will be scheduled for four hours in duration.
- Notes will be kept reflecting the content and deliberations of each meeting.
- The progress of each resident relative to the Psychiatry Milestones will be reviewed in full at each semi-annual meeting.

Responsibilities:

- The CCC will evaluate resident progress based on multiple sources of input, including written evaluations, direct observation, formal testing (e.g. PRITE) and verbal feedback from faculty, staff, and peers. Narrative comments will also be solicited from the committee regarding resident performance, strengths, and areas for growth.
- The CCC will utilize the feedback and comments described above to finalize semiannual Milestones ratings for each resident.
- Subsequent to the CCC's meetings, the Program Director will review the CCC's Milestones ratings with each resident individually at semi-annual one-on-one meetings.

Residents:

- Residents will receive their Milestones ratings and additional feedback at their semi-annual 1:1 meetings with the Program Director.
- Residents are encouraged to self-assess their own progress using Milestones criteria prior to individual meetings with the Program Director and openly discuss any areas of disagreement.

5.N Program Evaluation

As required by the ACGME, The Residency 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 Psychiatry Residency Program</td>
</tr>
<tr>
<td>VC1, VC1a1 core</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Director must appointment the PEC (required: Program Director 2 Full-time program faculty, 1 Resident/fellow).</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>VC1a2 &lt;br&gt; &lt;i&gt;core&lt;/i&gt;</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>VC1a3 &lt;br&gt; &lt;i&gt;detail&lt;/i&gt;</td>
<td>Actively participate in: The psychiatry Residency PEC members actively participate in: 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</td>
<td></td>
</tr>
<tr>
<td>VC2</td>
<td>Annual formal documentation of Annual Program Evaluation (APE)</td>
<td>The PEC develops policy changes and makes recommendations to the Residency Training Committee, which meets on a monthly basis.</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>VC2a-VC2e</td>
<td>The Program must monitor and track specific elements.</td>
<td>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>VC3 core</td>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>VC3a core</td>
<td>The action plan must be reviewed and</td>
<td>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>

The Psychiatry Program Director and PEC will use the APE report outline template developed by GME Admin in consultation with the GMEC.
approved by the teaching faculty ad documented in the meeting minutes 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.

5.0 On Call Schedules
At the University of Minnesota Medical Center (UMMC) there are two types of off-hour assignments. One is designated “on-call” because it is assigned for specific daily periods. The second is Emergency (ER) and Night Float assignments, which are formal training rotations.

The Call Schedule is constructed to provide 24-hour presence of trainees on site to admit patients to the hospital, accept crisis telephone calls from outpatients and address urgent inpatient care matters. The assignments have been designated as follows:

ER Resident (formal training rotation): Duty shift is from 5p-1am, except when transitioning from the night float rotation to allow 10 hours between shifts, Monday through Thursday. On Friday night, the ER resident call shift is from 5p-8am. Saturday and Sunday are free of duty. In the event the emergency resident is ill on Monday through Thursday the resident for that evening will serve from 5p-8am and provide supervision for the short call resident. On Friday the night float resident will take the 5pm to 8am shift.

Night Float (formal training rotation): Duty shift is from 9:00pm-8:00am on Sunday through Thursday night. No duty periods are scheduled for Friday and Saturday. In the event the night float resident is ill on Monday through Thursday the ER resident will remain until 8am (if there is a following ER shift this will begin at 6pm). If the float resident is ill on Sunday, the solo call resident assigned for Sunday will remain until 8am the following day. They will assume no new patients after 8AM and their shift will end no later than noon on the following day.

Day Float: The Day float provides back-up coverage for residents serving on the adult inpatient units who may be sick or on vacation Monday through Thursday. The Day Float resident also covers call on Sunday 8a-9pm and participates in Holiday call on a rotating basis. No other call is taken during this rotation.

PGY2 residents serving on UMMC Inpatient rotations provide in house on-call coverage in 12-24 hour shifts on Saturdays and Holidays. At least one day per week on average over the course of 4 weeks is free of call.

PGY1 residents serving on UMMC Inpatient rotations provide in house on-call coverage Mon-Thurs 5pm-9pm and on Fridays, 5pm to midnight. Residents serve concurrently with and are supervised by the ER resident [a PGY2 resident].

If the on-call resident is ill, (Day Float, PGY1s and PGY2s serving the inpatient psychiatry rotations) it is that resident’s responsibility to find his/her replacement. In most instances this would involve arranging to trade call assignments with another resident. To facilitate this process, the Residency Coordinator will create a resident contact list to be distributed by email to all residents. In the unusual circumstance that a
resident is unable to contact other residents the Chief Resident (or their designee) will facilitate this process. The Chief Resident will maintain a log of duty changes.

When possible, the PGY1 MVAHCS inpatient assignment will align with a PGY2 geropsychiatry or consult-liaison rotation, with call duties to be assigned concurrently to allow the PGY2 resident to supervise the PGY1 resident. When this is not possible, PGY1 residents on call will be supervised by the psychiatrist on duty who is a PGY2 or above in the University of Minnesota residency program. This individual is in-house during the entire call period and will directly supervise the PGY1 resident. Call assignments will comply with all ACGME regulations.

Call while serving on Pediatrics, Neurology and Internal Medicine rotations is determined by these services and must comply with ACGME regulations.

Residents in the PGY3 and 4 years 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
A private, locked call room with computer access and housekeeping services is provided for use of residents while on-call.

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

5.R Laboratory/Pathology/Radiology Services
There are in-hospital laboratory, pathology and radiology services available to residents and fellows for patient care. The lab is open 24-hours a day.

5.S Medical Records
Residents will be trained in using the Electronic Medical Record at UMMC and MVAHCS for inpatient and outpatient activities. Medical records may be accessed 24 hours a day through the electronic medical record.

5.T 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 resident’s room and call room is kept locked 24-hours a day.

The Residency 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 residents undergo safety training as part of their orientation, including techniques to de-escalate anger and aggression. All psychiatry residents’ 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 resident notifies his/her primary attending at the appropriate training site, and/or the on-call attending in case the incident happened while the resident was on-call.

(2) The primary attending works with the psychiatry resident to decide if a medical evaluation is indicated. At that time a decision is made whether the resident should continue with their duty or be discharged from their duty for the remainder of the day or call.

(3) The primary attending then notifies: the Vice Chair for Clinical Affairs, the program chief resident 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 resident’s needs following an assault (with more serious events requiring a more prompt response). The training program in collaboration with the resident 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 resident may determine whether provision of debriefing and support for all residents 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 resident.

5.U Critical Incident Postvention Procedures
Throughout the course of residency, trainees may be impacted by professional or personal circumstances, such as the death of a patient, unintended medical outcome or major life events, which prompt the need for additional support and guidance from peers and faculty members. Therefore, a group of faculty members was assembled to meet regularly to discuss resident wellness and serve as a source of support for residents if needed.

Regarding patient care related circumstances, residents are asked to bring forward information regarding a patient death or unintended outcome to their attending, chief resident or program director. The chief resident will work with the resident to select a faculty member from the postvention committee and a peer to serve on their individual support team. The chief will perform chart review to assess if additional residents were involved in patient care and provide postvention as necessary. Attendings involved in care will be contacted by program provider or appropriate attending as indicated. Nursing staff and additional support staff involved in patient care will be contacted at discretion of Chief resident. The resident guidebook contains additional information and resources, including commonly asked questions, regarding steps to take following a patient death. Presenting the case should be discussed with resident after the postvention. Cases that are deemed appropriate will be discussed in Complex Case Conference, it is encouraged that resident meet with an attending to assist with presentation. Cases that are deemed appropriate for combined conference should ideally have an attending present.

For personal life circumstances impacting resident wellbeing, a similar support team will be compiled with the permission of the resident. Resources are also available through the Resident Assistant Program (Refer to section 2.P).

5.V Moonlighting
According to RRC Guidelines the residency program should not allow activities outside the residency 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 the program needs accurate information about such activities and needs to give approval.
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. Moonlighting activities should not overlap with training activities or schedules [i.e. involve clinical responsibilities (clinical phone calls) during normal work hours (8am-5pm M-F on weekdays excluding vacations, holidays and post-call periods) and should not take the resident away from service duties during normal work hours (8am to 5pm).]

Internal moonlighting is an activity involving patient care responsibilities of any sort (research or clinical) for which you are paid that takes place at a training site of the program [MVAHCS or any UMMC/Fairview setting].

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.

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 residents are expected to be involved with residency matters during that time.

PGY-1 residents are not permitted to moonlight.

https://docs.google.com/document/d/1PoMZHGCs5trlYg-qzP6lvMtUmKYMctU3JdmTYAo88lQ/edit

5.W Supervision
Clinical Training must include adequate, regularly scheduled supervision which complies with ACGME regulations. Each Resident must have at least two hours of supervision weekly, one of which should be one on one psychotherapy or competency supervision. Supervision, authority and reporting requirements are summarized in the table below.
**Supervision, Authority, Reporting (SAR) Table.** Department of Psychiatry, University of Minnesota

**5.4 Level of Supervision Required - VI.D.3 CPR**

<table>
<thead>
<tr>
<th>Level of Supervision</th>
<th>Scope of authority - VI.D.5.a) CPR</th>
<th>Reporting Obligation - VI.D.5 CPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Able to supervise other residents post hoc or remotely</td>
<td>Event should be reported to supervising authority promptly</td>
</tr>
<tr>
<td>Indirect</td>
<td>Able to supervise if onsite</td>
<td>2. Event reported to supervising authority during same shift</td>
</tr>
<tr>
<td>Oversight</td>
<td>Able to act only with supervisor physically present</td>
<td>3. Event reported during scheduled supervision</td>
</tr>
<tr>
<td>Not applicable</td>
<td>0 Not applicable</td>
<td>4. Event need not be directly reported to supervising authority</td>
</tr>
</tbody>
</table>

**5.X Monitoring of Resident Well-Being**

It is the responsibility of the residency program to monitor resident 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 fellow residents and meets with residents on a twice yearly basis. The RMS evaluation form completed by faculty contains specific items regarding magnitude of service demands and the individual resident’s fatigue and stress level. The resident is surveyed in RMS after each rotation regarding levels of program related stress and personal stress.

**5.Y Fatigue and Work Conditions**

Residents will be educated on the negative effects of fatigue on patient care and learning, including the specific skills of alertness management and fatigue mitigation processes during the required PGY1 Institutional Orientation conducted by the University of Minnesota Graduate Medical Education Office. Educational modules are also available on the Psychiatry Residency Moodle Website. Residents are encouraged to adopt fatigue mitigation processes; specifically, strategic naps during the two hour period of...
11:00pm-1:00am for residents serving on the Night Float rotation. During this time, the ER resident will cover patient duties to accommodate sufficient rest and fatigue management. In the case of fatigue during a duty shift, or when patient care responsibilities are unusually difficult or prolonged, back-up service can be arranged by contacting the chief resident or the faculty member on-call. Additionally, the University of Minnesota Medical Center, Fairview provides reimbursement of taxi fare for residents who require transportation due to issues related to fatigue following duty shifts.

5.Z Graded Responsibility
Responsibility for patient care increases with each year of residency training. In the PGY1 year residents provide care for acutely ill patients in controlled and supervised settings. This is extended to specialty populations (e.g. consultation liaison, geriatrics, child-adolescent) that require a more specialized knowledge and skills in the PGY2 year. In the PGY3 year residents begin to take care of ambulatory patients in a less structured setting and with less moment of service supervision. The time frame of management is months and years rather than days and weeks. In the PGY4 year residents begin to function more autonomously in settings that anticipate their post-residency activities.

5.AA ACLS/BLS/PALS Certification Requirements
Required institutional and hospital certification in BLS and ACLS will be provided to PGY1 residents during orientation. If you are rotating at the Minneapolis VA Health Care System you must have a current BLS certification.

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 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 natural 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 (i.e. COMLEX) by January 1 of their PGY-2 year to be eligible for a resident contract at the PGY-3 level or beyond. Trainees are encouraged to take the appropriate licensing examination early in their training to permit adequate time to re-take the exam if more than one attempt is needed. Trainees should register for the USMLE Step 3 or
equivalent licensing examination no later than November 1st of the PGY-2 year to allow for scheduling, grading and notification of exam results by the March 1 deadline. Trainees who do not notify their program of a passing score by January 1 of their PGY-2 year forfeit their continuing position in the training program and are subject to contract non-renewal. http://www.med.umn.edu/students/usmle/

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 wellbeing 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 resident 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 resident’s ability to perform his/her duties; therefore, no resident 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 resident to discipline including, but not limited to, suspension and/or termination.

(4) When there is reasonable cause to believe that a resident may be using, selling, possessing, distributing, dispensing, transferring, or manufacturing any illegal drug, controlled substance, or alcohol, the resident may be required to undergo medical evaluation and assessment. The resident’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) Residents who are convicted of a criminal drug statute violation (including DWI, boating tickets, etc.) are required to inform the Residency Program Director or Residency Training Committee or department head of the conviction (in writing) within five (5) calendar days thereof.

(7) Other residents who have reasonable cause to believe that a colleague is using a substance that adversely impacts on the resident’s performance in the training program must report the factual basis for their concerns to the Residency Program Director.

(8) If a resident is taking a medically authorized substance which may impair his or her job performance, the resident must notify his or her supervising resident, chief resident, attending faculty, or the Residency Program Director of his or her temporary inability to perform assigned duties.
Residents are encouraged to seek assistance in addressing any problems they might have related to alcohol or substance abuse. The Resident Assistance Program is available to all residents and their families. (Please refer to Institutional Manual for contact numbers and descriptive information on these programs.)

Residents 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 residency program will monitor performance. Deficiencies will be viewed as academic, not administrative matters. Dictation of discharge summaries (unless noted) is a professional responsibility of resident physicians.

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.

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

5.FF Outpatient Note Delinquency Policy
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 Residents who have five or greater encounters that are greater than seven days old.

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

Program Policy & Procedure Manual
5.GG 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 Department of Psychiatry restrictions regarding the access of representatives to public areas that are assigned to the Department of Psychiatry.

Interactions with Industry occur in a variety of contexts, including marketing of new pharmaceutical products, medical devices, and hospital and research equipment and supplies on-site, on-site training of newly purchased devices, the development of new devices, educational support of medical students and trainees, and continuing medical education. These interactions must be ethical and cannot create conflicts of interest (COI) that could endanger patient safety, data integrity, the integrity of our education and training programs, or the reputation of either the faculty member or the institution.

Residents may not accept gifts from Industry in the context of their assigned duties. It is strongly advised that no form of personal gift from Industry be accepted under any circumstances. Individuals should be aware of other applicable policies, such as the AMA Statement on Gifts to Physicians from Industry and the Accreditation Council for Continuing Medical Education Standards for Commercial Support. Free drug samples are considered gifts under this policy and may not be accepted.

The Physician Payments Sunshine Act requires manufacturers of drugs, medical devices and biologicals that participate in U.S. federal health care programs to report certain payments and items of value given to physicians and teaching hospitals. The Centers for Medicare & Medicaid Services (CMS) has been charged with implementing the Sunshine Act and has called it the Open Payments Program. As part of this program, manufacturers now are required to submit annual data on payment and other transfers of value that they make to covered recipients. This data is publicly available.

Sales and marketing representatives are not permitted in any patient care areas except to provide in-service training on devices and other equipment and then only by appointment. During work hours, resident may only interact with industry representatives in the presence of a faculty member. Presentations will not be facilitated by the residency program.

Personal information (pager, address, cell phone) about students or residents will not be distributed to representatives.

Representatives will not be given access to the resident room (F248) or the student room (F228).

Students and residents should not take items bearing the name of a product into patient care areas (this includes notebooks, pens, clipboards, etc.).
### Psychiatry Department Telephone List (FACULTY)

#### Adult Psychiatry Faculty

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<th>LAST NAME</th>
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#### Child Psychiatry Faculty

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**Main Department Head Office**

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**ADULT PSYCHIATRY  273-9800**

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<th>OFFICE #</th>
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</thead>
<tbody>
<tr>
<td>O’Gorman</td>
<td>Office Specialist</td>
<td>Mary</td>
<td>273-9802</td>
<td><a href="mailto:ogorm014@umn.edu">ogorm014@umn.edu</a></td>
</tr>
<tr>
<td>Cabral</td>
<td>Assistant Exec. Secretary</td>
<td>Laura</td>
<td>273-9881</td>
<td><a href="mailto:cabra004@umn.edu">cabra004@umn.edu</a></td>
</tr>
<tr>
<td>Allen</td>
<td>Exec Ofc &amp; Admin Spec</td>
<td>Bonnie</td>
<td>273-9715</td>
<td><a href="mailto:baallen@umn.edu">baallen@umn.edu</a></td>
</tr>
<tr>
<td>Laitinen</td>
<td>Exec Ofc &amp; Admin Spec</td>
<td>Lois</td>
<td>273-9803</td>
<td><a href="mailto:laiti001@umn.edu">laiti001@umn.edu</a></td>
</tr>
<tr>
<td>Johansson</td>
<td>Exec Ofc &amp; Admin Spec</td>
<td>Danielle</td>
<td>626-5956</td>
<td><a href="mailto:johan003@umn.edu">johan003@umn.edu</a></td>
</tr>
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**PSYCHIATRY RESEARCH**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST</th>
<th>PHONE</th>
<th>E-MAIL</th>
<th>OFFICE #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bockenstedt</td>
<td>Executive Assistant</td>
<td>Janet</td>
<td>273-9804</td>
<td><a href="mailto:bocke001@umn.edu">bocke001@umn.edu</a></td>
</tr>
<tr>
<td>Helmerberger</td>
<td>Exec Ofc &amp; Admin Spec</td>
<td>Gregg</td>
<td>273-9714</td>
<td><a href="mailto:helmb008@umn.edu">helmb008@umn.edu</a></td>
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</table>

**CTSI SUPPORT**

<table>
<thead>
<tr>
<th>LAST NAME</th>
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<th>PHONE</th>
<th>E-MAIL</th>
<th>OFFICE #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson</td>
<td>Mahrya</td>
<td>273-9857</td>
<td><a href="mailto:mjohnso@umn.edu">mjohnso@umn.edu</a></td>
<td>F231</td>
</tr>
<tr>
<td>Carstedt</td>
<td>Tricia</td>
<td>273-9704</td>
<td><a href="mailto:triciac@umn.edu">triciac@umn.edu</a></td>
<td>F231</td>
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</table>

**EDUCATION**

<table>
<thead>
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<th>E-MAIL</th>
<th>OFFICE #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sherrer</td>
<td>Admin. Associate 1</td>
<td>Serena</td>
<td>273-9848</td>
<td><a href="mailto:ssherrel@umn.edu">ssherrel@umn.edu</a></td>
</tr>
<tr>
<td>Janacek</td>
<td>Admin. Associate 2</td>
<td>Jennifer</td>
<td>273-9824</td>
<td><a href="mailto:janacek@umn.edu">janacek@umn.edu</a></td>
</tr>
<tr>
<td>Iversen</td>
<td>Admin. Associate 1</td>
<td>Laurie</td>
<td>273-9712</td>
<td><a href="mailto:ivers047@umn.edu">ivers047@umn.edu</a></td>
</tr>
</tbody>
</table>

Psychiatry Department Telephone List (STAFF)
### Education Assistant

<table>
<thead>
<tr>
<th>Program</th>
<th>Policy &amp; Procedure Manual</th>
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</thead>
<tbody>
<tr>
<td>PSYCHIATRY CLINIC</td>
<td>273-8700</td>
</tr>
<tr>
<td>Brozak Clinic Manager</td>
<td>Kristen</td>
</tr>
<tr>
<td>Appointments</td>
<td>273-8700</td>
</tr>
<tr>
<td>Intake</td>
<td>273-8710</td>
</tr>
<tr>
<td>Fax</td>
<td>273-8727</td>
</tr>
<tr>
<td>Copy Room</td>
<td>273-9754</td>
</tr>
<tr>
<td>ARC FAX</td>
<td>626-5103</td>
</tr>
<tr>
<td>CLIN NEUROSCIENCE CTR FAX</td>
<td>626-4700</td>
</tr>
<tr>
<td>DEPARTMENT FAX</td>
<td>273-9779</td>
</tr>
<tr>
<td>DEIHLL HALL FAX</td>
<td>624-8935</td>
</tr>
<tr>
<td>F252 (Paula Clayton Conference Room)</td>
<td>273-8990</td>
</tr>
<tr>
<td>F263 (Conference Room)</td>
<td>273-9749</td>
</tr>
<tr>
<td>Library</td>
<td>273-8989</td>
</tr>
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### 6.B University of Minnesota Holidays

#### 2017-2018 University Holidays

<table>
<thead>
<tr>
<th>Date</th>
<th>Holiday</th>
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<tbody>
<tr>
<td>Tuesday, July 4, 2017</td>
<td>Independence Day</td>
</tr>
<tr>
<td>Monday, September 4</td>
<td>Labor Day</td>
</tr>
<tr>
<td>Thursday, November 23</td>
<td>Thanksgiving Day</td>
</tr>
<tr>
<td>Friday, November 24</td>
<td>Floating Holiday</td>
</tr>
<tr>
<td>Monday, December 25</td>
<td>Christmas Day</td>
</tr>
<tr>
<td>Tuesday, December 26</td>
<td>Floating Holiday</td>
</tr>
<tr>
<td>Monday, January 1, 2018</td>
<td>New Year's Day</td>
</tr>
<tr>
<td>Monday, January 15</td>
<td>Martin Luther King, Jr. Day</td>
</tr>
<tr>
<td>Friday, March 16</td>
<td>Floating Day</td>
</tr>
<tr>
<td>Monday, May 28</td>
<td>Memorial Day</td>
</tr>
<tr>
<td>Unassigned</td>
<td>(One Personal Floating Holiday)</td>
</tr>
<tr>
<td>Date</td>
<td>Holiday</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Tuesday, July 4, 2017</td>
<td>Independence Day</td>
</tr>
<tr>
<td>Monday, September 4, 2017</td>
<td>Labor Day</td>
</tr>
<tr>
<td>Monday, October 9, 2017</td>
<td>Columbus Day</td>
</tr>
<tr>
<td>Friday, November 10, 2017</td>
<td>Veterans Day</td>
</tr>
<tr>
<td>Thursday, November 23, 2017</td>
<td>Thanksgiving Day</td>
</tr>
<tr>
<td>Monday, December 25, 2017**</td>
<td>Christmas Day</td>
</tr>
<tr>
<td>Monday, January 1, 2018</td>
<td>New Year’s Day</td>
</tr>
<tr>
<td>Monday, January 15, 2018</td>
<td>Birthday of Martin Luther King, Jr.</td>
</tr>
<tr>
<td>Monday, February 19*, 2018</td>
<td>Washington’s Birthday</td>
</tr>
<tr>
<td>Monday, May 28, 2018</td>
<td>Memorial Day</td>
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