SMA HEALTHCARE

PSYCHIATRY RESIDENCY PROGRAM MANUAL

Training Year 2025-2026

Table of Contents

Residents are required to familiarize themselves with:

1. The SMA Healthcare Graduate Medical Education (GME) Institutional Policies and Procedures Manual.
2. The SMA Healthcare Human Resources (HR) Policies and Procedures Manual and the SMA Healthcare Employee Handbook.
3. The ACGME Requirements, Policies, and Procedures.
4. The American Medical Association (AMA) Principles of Medical Ethics

All italicized numbers in parenthesis reference the ACGME Program Requirements for Graduate Medical Education in Psychiatry.
Disclaimer: Information outlined in this manual are subject to amendments and adjustments by SMA Healthcare, as appropriate.

Introduction

Dear residents,

Thank you for your interest in SMA Healthcare's Psychiatry Residency Program. We value your decision to pursue the unique specialty of psychiatry through our training program. During the next four years, you will hone skills in the diagnosis, treatment, and prevention of a wide range of emotional, mental, and behavioral health conditions.

SMA Healthcare is committed to improving access to healthcare and provides service to a high volume of patients across multiple Florida counties. We offer a comprehensive range of services, including primary care, psychiatric services, crisis intervention, justice services, outpatient treatment, residential care, and substance abuse treatment. In collaboration with SMA Healthcare, the program has created a curriculum that follows the ACGME requirements and Core Competencies. The program is designed to prepare residents for the examination to obtain initial board certification by the American Board of Psychiatry and Neurology (ABPN), meet ACGME Psychiatry Milestones, and to serve diverse communities in various fields of psychiatry.

Our residents train in a safe, supervised clinical and educational environment that fosters both professional and personal growth. Clinical experiences are structured to provide opportunities to conduct initial psychiatric evaluations, participate in the subsequent diagnostic processes, and to follow patients during treatment phases, including crisis, stability, and recovery of psychiatric conditions.

This manual is distributed to all residents and will be updated yearly. To obtain an additional copy of the manual, residents access it in the "SMAResidents" share folder or contact the Program Coordinator. We encourage you to reach out with any questions or concerns. We are eager to provide you with support during each step of your residency training and preparation for the independent practice of psychiatry.

Tarek Aly, MD
Psychiatry
Residency
Program Director

Vickki-Ann Samuel, MD
Associate Psychiatry
Residency
Program Director

Graduate Medical Education Structure

Program Structure

SMA Healthcare's Primary Clinical Training Sites:

- SMA Chet Bell Crisis Center (CBCC)
  1150 Red John Drive
  Daytona Beach, FL 32124
- SMA Crisis Stabilization Unit (CSU) Marion
  5664 SW 60th Avenue
  Ocala, FL 34474

Participating Sites:

- Mosaic Psychiatry
  1. 208 Booth Road
  Ormond Beach, FL 32174

  2. 3500 West ISB
  Daytona Beach, FL 32127
- HCA Florida Ocala Hospital
  1431 SW 1st Avenue
  Ocala, FL 34471
- FL Health Institute
  145 Cypress Point Parkway
  Palm Coast, FL 32164

1. SMA Healthcare's Psychiatry Residency Program is accredited by the Accreditation Council for Graduate Medical Education (ACGME). The program is designed to train residents pursuing psychiatry to meet the ACGME Core Competencies, achieve each Psychiatry Milestone, and ensure eligibility for the American Board of Psychiatry and Neurology (ABPN).

2. Residents must manage a sufficient number of patients to develop competency in treating acute and chronic psychiatric illnesses. Residents are provided with comprehensive clinical experiences to conduct initial psychiatric evaluations, participate in subsequent diagnostic processes, and follow patients through treatment and/or evolution of their psychiatric disorders/conditions.

3. The program has organized lectures, conferences, workshops, and other educational activities, guaranteeing one day per week that is protected for didactics (typically Wednesdays). Clinical responsibilities are structured to align with educational requirements without disrupting the non-patient care aspects of the program.

4. Each resident should participate in a minimum of 70% of regularly scheduled didactic sessions. Residents and faculty members should participate in journal clubs, research, conferences, and/or other activities that address critical appraisal of the literature and understanding of the research process. Upon effective completion of the program, each resident will be provided with a final evaluation and a certificate that guarantees the resident's successful completion of the program's requirements and readiness for the independent practice.

Guide to All Systems

New Innovations	"SMAResidents" Share Folder	SMA Intranet	Datis
Logging Work Hours	Didactics, Journal Club, ISBAR	All SMA Policy and Procedure Manuals, All Forms	Requesting Leaves of Absence
Logging Procedures	DEA Information		
Evaluations	Committees	Townhall	To Enroll in Benefits
Anonymous Feedback Reporting	GME and SMA Contacts	All SMA Locations	
Announcements	AMA Principles	Resolver (Occurrence Entry)	W2/W4
Assignments, Rotation, Conference Schedules	Apartment Suggestions		
	Budget Worksheet		Paystubs
Milestone Reviews	Access to Medical Literature	FMLA Request Forms	
Employee Handbook, HR Policy Manual	Employee Handbook, HR Policy Manual	HR Employee Handbook, HR Policy Manual	Attendance
	Work Order Instructions	Work Order Instructions	Credentials
Self-Care Review, Self-Assessment Review Forms (Well-being)	Self-Care Review, Self-Assessment Review Forms (Well-being)	Link-Relias (HR Assigned Trainings)	Link-Relias (HR Assigned Trainings)
Benefits information	Benefits information	Benefits information	Benefits Information
Dispute Resolution Form	Dispute Resolution Form	Dispute Resolution Form	
Mileage/Travel Reimbursement Form	Mileage/Travel Reimbursement Form	Mileage/ Travel Reimbursement Form	
Check Request Form (Wellness Stipend)	Check Request Form (Wellness Stipend)	Check Request Form (Wellness Stipend)	
Purchase and Training Request Forms	Purchase and Training Request Forms	Purchase and Training Request Forms	
SMA Program Manual and SMA GME Policies and Procedure Manual	SMA Program Manual and SMA GME Policies and Procedure Manual		
ACGME Resources	ACGME Resources		
Interim Coverage	Interim Coverage		
Rotation Addresses	Rotation Addresses		

- **EMR- Avatar, Credible, NextGen (Launch Date TBD)**
- **Contact numbers of all employees- Ring Central**
- **Updated Call, Rotation, Holiday, and Mentor Schedules- "ResidentSchedule2025-2026" Share Folder**

Committees

Graduate Medical Education Committee (GMEC)

The GMEC directs and supervises SMA Healthcare's Psychiatry Residency Program, guaranteeing the highest quality education is being provided. The GMEC ensures that the program and the institution operate in compliance with the ACGME requirements and, in collaboration with the Designated Institutional Official (DIO), holds authority and responsibility for the oversight and administration of SMA Healthcare's residency program.

The GMEC meets, at a minimum, once per quarter. Detailed minutes are taken every meeting that document the execution of the GMEC's functions and responsibilities for oversight, review, and approval. For a detailed list of the GMEC's functions and responsibilities, please see SMA Healthcare's GME Institutional Manual of Policies and Procedures: "Graduate Medical Education Committee (GMEC)".

GMEC Voting Members:

- Chair of the GMEC: Yusef Canaan, MD
- Vice Chair of the GMEC: Tarek Aly, MD
- Associate Program Director: Vickki-Ann Samuel, MD
- Core faculty member of the program: Ramon Martinez, MD
- Quality Improvement/Patient Safety designee: Jessica Nelson, VP of Quality Assurance
- Minimum of two peer-selected residents: Gurninderjeet Singh Sathi, MD; Karan B. Assudani, MD
- Governing body representative: Sarah Burman, Chief Administrative Officer
- Members actively involved in GME but outside the residency program: Patrick Miley, VP of Development; Andrea Schweizer, Chief Financial Officer
- Institutional Coordinator: Elizabeth McQueen, Director of Clinical Excellence

GMEC Subcommittees

The GMEC subcommittees report directly to the GMEC and carry out GMEC responsibilities. These subcommittees include:

1. Clinical Learning Environment Review (CLER) Program Subcommittee

    a. Membership:
        - Tarek Aly, MD
        - Vickki-Ann Samuel, MD
        - April Ferguson, MD
        - Ramon Martinez, MD
        - Sarah Burman
        - Elizabeth McQueen
        - Mashall Zaheer, MD

b. The CLER Subcommittee monitors that the program is following the CLER focus areas, including patient safety, healthcare quality, professionalism, and supervision. The subcommittee recommends strategies to engage the residents in learning to provide safe, high-quality patient care. The subcommittee monitors that the program provides residents with opportunities to learn and participate in quality improvement and patient safety efforts that align with the needs of the clinical learning environments. The subcommittee guarantees that resident clinical performance data is regularly distributed to the residents, as well as the provision of patient safety reports to residents and faculty.
c. During ACGME CLER inspections, the subcommittee supports the GMEC by preparing all data on the program and institutional attributes that have a valuable result on the quality and safety in the learning and working environment. For more information on the ACGME CLER Program, please see SMA Healthcare's GME Institutional Manual of Policies and Procedures: "Clinical Learning Environment Review (CLER) Program".

2. Wellness Subcommittee

a. Membership:
   - Bailey Rerko
   - Tarek Aly, MD
   - Anne Harley
   - Elizabeth McQueen
   - Rachel Jett
   - Rosibel Scafidi
   - Jeremiah Alberico
   - Jemimah Okonjo, MD
   - Apoorva Polavarapu, MD

b. The GMEC, through the Wellness Subcommittee, oversees the program's implementation of well-being initiatives, such as wellness activities, education on fatigue mitigation strategies, and support for residents' mental, emotional, and physical health.
c. This subcommittee reviews Work Hour reports and ensures compliance with work hour requirements.

3. Institutional Review (IR) Subcommittee

a. Membership:
   - Tarek Aly, MD
   - Vickki-Ann Samuel, MD
   - Yusef Canaan, MD
   - Elizabeth McQueen
   - Sarah Burman

- Mallory Garfield, MD

b. The GMEC supervises the institution's accreditation status through the Annual Institutional Review (AIR). The IR Subcommittee is responsible for conducting the AIR and developing/monitoring resulting action plans.
c. The period of review for each AIR is the previous training year (July-June)
d. For more information on the Annual Institutional Review, please see SMA Healthcare's GME Institutional Manual of Policies and Procedures: "Annual Institutional Review (AIR)".

4. Special Review (SR) Subcommittee

a. Membership:
   - Dr. Yusef Canaan
   - Elizabeth McQueen
   - Jessica Nelson
   - Faculty outside the program
   - Peer-selected resident

b. The GMEC ensures the oversight of underperformance in the program through a Special Review Process. The SR Subcommittee will conduct a special review through the assessment of materials, data, and other important information provided by the program and through interviews with identified individuals.
c. For more information on special reviews and criteria for a special review to be conducted, please see SMA Healthcare's GME Institutional Manual of Policies and Procedures: "Special Review".

Program Evaluation Committee (PEC)

The Program Evaluation Committee (PEC) of each program conducts and documents the Annual Program Evaluation (APE) as part of the program's continuous improvement plan. The Program Director is responsible for assigning the PEC. *(5.5)* The PEC meets in the winter to conduct an internal APE, and in the spring/summer to conduct an APE to submit to the ACGME.

PEC Membership:

- Yusef Canaan, MD
- Tarek Aly, MD
- Vickki-Ann Samuel, MD
- Jessica Nelson
- Jennifer Stephenson
- Jeremiah Alberico
- Ramon Martinez, MD

- Robin Lanier
- Mallory Garfield, MD

1. PEC Responsibilities
    a. Conducts program planning, development, implementation, and evaluation of the educational activities of the program.
    b. Acts as an advisor to the Program Director through program oversight.
    c. Reviews and makes recommendations for meeting competency-based curriculum and self-determined goals and objectives of the program. *(5.5.b)*
    d. Addresses areas of non-compliance, in accordance with ACGME standards.
    e. Guides ongoing program improvement, including development of new goals, based upon outcomes. *(5.5.c)*
    f. Reviews the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. *(5.5.d)*
    g. At least annually, documents a formal, systematic evaluation of the curriculum.
    h. Submits the APE to the GMEC Office for review.
    i. APE parameters that are to be monitored, tracked, and incorporated into the APE include the following:
        i. Program goals and objectives;
        ii. Non-identifying resident performance information;
        iii. Faculty development;
        iv. Graduate performance, including performance on certification examination;
        v. Program quality, as assessed by residents' annual evaluations of the program, faculty evaluations of the program, and previous APE outcomes/action plans; *(5.5.e)*
        vi. If applicable, Special Review reports and corrective action plans.

2. PEC Documentation: The written work product of the PEC includes the following:
    a. APE report (New Innovations);
    b. Documented PEC Minutes; and,
    c. Documentation of faculty/resident review of action plan. The PEC minutes and action plan should be reviewed and approved by the teaching faculty and documented in faculty meeting minutes.

3. The APE, including the action plan, is distributed to and discussed with the faculty members, residents, and appropriate staff. The report must be submitted to the

DIO. The outcomes of the documented APEs will be integrated into the Institution's 10-year Self-Study process. *(5.5.g, 5.5.h)*

Clinical Competency Committee (CCC)

The Clinical Competency Committee (CCC) provides input from several individuals to assist the Program Director in making evaluative decisions regarding the abilities of residents. Semiannually, the CCC reviews all resident evaluations of performance and assessment, as well as prepare and ensure reporting of Milestone evaluations on each resident to the ACGME. The CCC advises the Program Director regarding resident progress, including promotion, remediation, and dismissal. All Milestone evaluations of resident performance are compiled by the CCC. The CCC acts as a disciplinary panel, as needed.

CCC Membership: *(5.3-.b)*

- Yusef Canaan, MD
- Tarek Aly, MD
- Vickki-Ann Samuel, MD
- Antonio Canaan, MD
- April Ferguson, MD
- Sarah Burman
- Kelly Mellichampe

1. CCC Responsibilities
    a. Monitor each resident's progress by reviewing evaluations and performance assessments, including Milestone assessments, and provide recommendations to the Program Director. Identify gaps in resident assessment by analyzing evaluation methods and processes, using the Milestones as a guide, to enhance performance reviews, ensure comprehensive evaluation, improve evaluation tools, and better the program as a whole. *(5.3.c,5.3.d)*
    b. Review patient panel data (patient encounters as required by the Program Requirements)
    c. Support the preparation of individualized learning plans for residents with requirements for successful remediation of a sub-competency or Milestone, as determined by the individual program.
    d. Guarantee the submission of Milestone evaluations for each resident to the ACGME through the ADS system, prior to each deadline.
    e. Aggregate data, which is non-identifiable, regarding resident performance evaluations is sent to the Program Evaluation Committee (PEC) to include in the annual review process.
    f. Acts as a disciplinary panel, as needed.

2. CCC Meetings *(5.3.e)*
    a. The CCC must meet at least semiannually, prior to the residents' semiannual evaluations.
    b. Ad hoc meetings may be called to address pressing resident issues that may include, but are not limited to the following:
        i. Recommendations by the Program Director for any reason;
        ii. Constantly low or unsatisfactory evaluation scores;
        iii. Reliable lack of adherence to program requirements; and,
        iv. A specific egregious incident for possible probation or dismissal.

3. Due Process
    a. Should a resident disagree with the recommendation of the CCC, the resident may request to meet and address the CCC.
    b. The CCC shall follow the Due Process Procedures as indicated in SMA's HR Policies and Procedures: "Dispute Resolution Policy HR005".
    c. The DIO shall receive notification of the action of the resident filing a grievance and exercising due process.

Resources

To advance their education and clinical opportunities, residents have full access to a variety of healthcare delivery systems and resources at all primary training and participating sites. The following resources are offered by the institution:

1. Access to computers, IT (Help Desk), and EMRs at clinical sites, as well as assigned laptops and Ring Central accounts.

2. Computerized Physician Order Entry.

3. Web-based clinical resources and digital access to medical literature journals, including The Journal of the American Medical Association (JAMA), JAMA Psychiatry, American Journal of Psychiatry (AJP).

4. Personal hard copies of DSM5TR books and reference guides.

5. Appropriate clinical and educational workspaces, lactation rooms, resting areas, food while on duty, and transportation reimbursement for residents who are too fatigued to drive after their shift.

6. Access to appropriate exam/interview rooms, faculty offices, family meetings spaces, lab and imaging services, and opportunities for continuity of care, transitions of care, and transfers to other services, such as recommendations to other specialties, psychiatric subspecialty services, and referrals to social services, rehabilitation, and community agencies.

7. An educational stipend of $800 and a wellness stipend of $200 (see the Program Coordinator for more information on how to access stipends).

8. ACLS/BLS and PALS courses.

9. Support for the state medical license and Step 3 exam.

10. Personalized lab coats.

11. Access to medical care 24 hours a day, seven days a week, provided through SMA Healthcare's Employee Assistance Program (EAP).

Program Personnel

Residents

Resident Responsibilities

1. Achieve the requirements designed by the ACGME and the ABPN.
2. Follow the policies and procedures of SMA Healthcare and the program.
3. Achieve the ACGME Core Competencies and Psychiatry Milestones.
4. Demonstrate high standards of professionalism and ethical principles.
5. Work efficiently as a member or leader of the healthcare interprofessional team.
6. Under faculty supervision, provide safe, competent, and compassionate patient care.
7. Report and demonstrate responsibility to faculty members for the care of patients.
8. Participate in didactic sessions, clinical teaching rounds, rotations, continuity clinics, research, assigned meetings, and other activities organized by the program.
9. Achieve at least one research project and a QI project before graduation.
10. Participate in each annual In-Service Examination (PRITE).
11. Become certified in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), and provide proof of certification to the GME administration.
12. Maintain an active state medical license in good standing.
13. Provide evaluations of the faculty and program, at least annually.
14. Maintain appropriate medical records and clinical logs.
15. Log accurate work hours by Friday of each week.
16. Attend continuity clinics and didactic sessions.
17. Demonstrate teaching skills through the education of lower-level residents and medical students.
18. Participate in meetings assigned by the program, including QI, committees, Resident Forum meetings, and other activities, as required.

Program Director *(2.1)*

Program Director Qualifications

1. The Program Director must possess specialty experience and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the ACGME Psychiatry Review Committee, current certification in the specialty by the American Board of Psychiatry and Neurology (ABPN) or by the American Osteopathic Board of Neurology and Psychiatry, or specialty qualifications that are acceptable to the Review Committee.
2. Current medical licensure and appropriate medical staff appointment.
3. Ongoing clinical activity.

Program Director Responsibilities

1. Design and conduct the program in a manner consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission and aims of the program.
2. Administer and maintain a learning environment satisfactory to educating the residents in each of the ACGME Competencies and Psychiatry Milestones.
3. Oversee the process to evaluate faculty members prior to approval for participation in the program and at least annually subsequently.
4. Guarantee that faculty members effectively role model the ACGME Core Competencies.
5. Demonstrate responsibility to approve and remove program faculty members from participation in the residency program education at all sites.
6. Use the protected time to develop the program curriculum, develop the program's aims, improve supervisory and administrative duties, and monitor the didactic program.
7. Submit accurate information required and requested by the DIO, GMEC, and ACGME.
8. Provide information to applicants, including important data about the program, benefits, and information concerning eligibility for the specialty board examination.
9. Supervise that the program activities are developed within a learning and working environment in which residents may increase their concerns and provide feedback in a confidential manner, as appropriate, without fear of intimidation or retaliation.
10. Supervise the program's compliance with the Sponsoring Institution's policies and procedures, including but not limited to those related to grievances and due process, disciplinary actions, supervision, work hours, fatigue mitigation, and well-being.

11. Guarantee the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of the resident.

12. Guarantee the program's compliance with the Sponsoring Institution's policies related to the selection and appointment of residents, employment, diversity, and non-discrimination.

13. Guarantee the policy of non-competition or restrictive covenant.

14. Supervise the residents' clinical logs and validate their accuracy when they are transmitted to the Review Committee, in accordance with the format and deadlines.

15. Ensure appropriate distribution of cases among the residents and guarantee that service commitments do not compromise educational goals and objectives.

16. Meet with residents through a semiannual assessment, so they can develop their individualized learning plans of improvement with set identified goals, strengths, and weaknesses.

17. Provide confirmation of an individual resident's completion upon the resident request, within 30 days; obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements, and outlined in the ACGME Program Director's Guide to the Common Program Requirements.

Faculty *(2.8)*

Faculty Qualifications:

1. Certification in the specialty (ABPN) or holding qualifications judged acceptable to the Specialty Review Committee.

2. Keep the maintenance of certification (MOC).

3. Hold current and active state medical licensure and appropriate medical staff appointment.

4. The non-physician faculty will have appropriate qualifications, as per institutional appointments.

Faculty Responsibilities:

1. Educate residents to be skilled in providing safe and high-quality patient care.

2. Maintain a role model of professionalism and core competencies.

3. Demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care.

4. Ensure that patients receive the level of care expected from a specialist in the field of psychiatry.

5. Demonstrate a strong interest in education, supervision, and evaluation of residents.

6. Devote time to the educational program, fulfilling their teaching responsibilities.

7. Administer and maintain an educational environment conducive to educating residents, so they can achieve the goals and objectives of the program.

8. Participate in organized didactic activities, such as clinical discussions, rounds, journal clubs, seminars, and conferences.

9. At least annually, pursue faculty development designed to enhance their skills as an educator and evaluator.

10. Foster personal and resident well-being.

11. Participate in PBLI efforts and contribute to an inclusive environment.

12. Evaluate residents throughout the duration of their rotation, providing a written evaluation at the end of the rotation or every three months.

13. Dedicate satisfactory time to develop the educational program, achieving supervisory and teaching responsibilities, and becoming available for consultation and teaching.

14. Provide residents with graded supervision according to the resident educational level/skills.

15. Provide psychiatry residents with two hours supervision weekly, one of which must be individual.

16. Establish and maintain an environment of inquiry and scholarships.

17. Mentor and support residents' scholarly activities and projects.

18. Oversee and cosign resident's documentation on records.

19. Provide evaluation of the program, at least annually.

20. Core faculty members must complete the annual ACGME Faculty Survey.

Program Coordinator *(2.12)*

1. The program coordinator is a member of the leadership, acting as an active factor to achieve the accomplishment of the program, assisting the program director in

accreditation efforts, educational programming, and supporting the resident's daily requirements.

2. SMA Healthcare and its program will ensure the accessibility of professional, technical, and clerical personnel for efficient operation and administration of the program.

3. The program, in partnership with SMA Healthcare, will support the professional development of the program coordinator.

4. The program coordinator contributes to the establishment and implementation of the program's activities, handling GME procedures, and serving as a connection with residents, faculty, and other members of the team, as well as the ACGME.

Faculty Roster

Physician Faculty		
Name	**Position**	**Contact**
Edmundo Rivera, MD *General Psychiatry* *ABPN*	Core Faculty	akashrink@aol.com (386) 956-6444
Antonio Canaan, MD *General Psychiatry*	Faculty	acanaan7@gmail.com 386-507-9312
Ramon Martinez, MD *General Psychiatry* *ABPN*	Core Faculty	rmartinez@gopafl.com (407) 222-7641
Fernando Sylvestre, MD *General Psychiatry* *ABPN*	Core Faculty *Didactics*	(407) 262-2220
Guy Czaykowsky, MD *General Psychiatry* *ABPN*	Faculty	gczaykow@smahealthcare.org (386) 236-3167
John G Symeonides, MD *FM Addiction Medicine* *ABFM*	Core Faculty	johnsymeonides.fsam@gmail.com (386) 569-5592
Nisha Sinha, MD *Neurology* *ABPN*	Core Faculty (Neuro)	nisha424@gmail.com (352) 208-2544
Glenn I. Kolluri, MD *Neurology* *ABPN*	Core Faculty *Didactics*	gkolluri@yahoo.com (386) 793-7588
April M. Ferguson, DO *Family Medicine/Primary Care* *AOA*	Core Faculty	aferguson@smahealthcare.org (386) 254-1148

Non-Physician Faculty		
Name	**Faculty**	**Contact**
Jeremiah Alberico, LMHC	Faculty	jalberico@smahealthcare.org (352) 565-7198
Sarah Burman, LCSW, CAP	Faculty-CAO	sburman@smahealthcare.org (386) 236-1667
Melissa J. Eugley, LMHC	Faculty	meugley@smahealthcare.org (386) 236-1799
Ivan Fleishman, Psy.D	Faculty	ifleishman@aol.com (386) 736-8337
Karen M. Duncan, APRN, MSN, MBA	Faculty-CNO	kduncan@smahealthcare.org (386) 236-1772

Administration		
Tarek Aly, MD *General Psychiatry, Child and Adolescent Psychiatry* *ABPN*	Program Director (Core Faculty)	tarekalymd@gmail.com 3863146026
Vickki-Ann Samuel, MD *General Psychiatry, Forensic Psychiatry* *ABPN*	Associate Program Director (Core Faculty)	vsamuel@smahealthcare.org (352) 565-7211
Yusef Canaan, MD *General Psychiatry* *ABPN*	DIO/CMO (Core faculty)	ycanaan@smahealthcare.org (386) 254-1251
Elizabeth McQueen, LMHC, MDiv	Institutional Coordinator-Clinical Excellence Director	emcqueen@smahealthcare.org (386) 236-1673
Bailey Rerko	Program Coordinator	brerko@smahealthcare.org (386) 236-3183
Karli Sparks	Manager-Primary Care (Willis)	ksparks@smahealthcare.org (386) 236-1654
Deborah Postell	Case Manager-CBCC	dpostell@smahealthcare.org (386) 383-4914

Mission and Aims of the Program

The Psychiatry Residency Program's Mission

The mission of SMA Healthcare's Psychiatry Residency Program is to address the nationwide healthcare workforce shortage by training skilled, knowledgeable, and compassionate psychiatrists. Graduates of our program will be equipped to provide high-quality mental health care in diverse clinical settings and make meaningful contributions to the field of psychiatry as expert clinicians, researchers, educators, and healthcare leaders, as well as meet ACGME Core Competencies and ABPN requirements.

This mission aligns with SMA Healthcare's mission in transforming lives through exceptional substance abuse, mental health, and primary care services. Residents will be provided training through team-based collaboration across all clinical settings and participating sites, under expert guidance of our experienced faculty, administration, and Graduate Medical Education Committee.

The Psychiatry Residency Program's Aims

1. Provide a four-year residency program that satisfies the community's needs and residents' professional goals, aligned with the ACGME requirements, evidence-based medicine, scientific literature, and current Psychiatry Guidelines.

2. Train residents on the medical, biological, and psychosocial factors contributing to mental illness, behavioral issues, and global functional impairment.

3. Prepare residents to become board-certified psychiatrists that are able to pursue subspecialty training or careers in clinical psychiatry, research, or academia, with an emphasis on the importance of lifelong learning, quality improvement, patient safety, professionalism, and scholarship in their future practice.

4. Develop the program's aims consistently with the SMA Healthcare's mission, the distinctive capabilities of our residents, and the needs of the community.

Goals and Objectives of the Program

The Psychiatry Residency Program's Goals

1. Provide a comprehensive postgraduate educational program that prepares residents to achieve ACGME competency-based goals and objectives in each educational setting, at each educational level, and to acquire prerequisite knowledge, clinical skills, and attitudes set forth by the ACGME and the American Board of Psychiatry and Neurology (ABPN).

2. Graduate psychiatrists for the independent, competent, and effective practice of the specialty that will make emphasis on the excellence of patient care and evidence-based medicine. Educate residents to become leaders in quality improvement, research, clinical care, and administration.

3. Provide residents with varied electives, career opportunities, and guidance on options to continue education in psychiatry subspecialties.

The Psychiatry Residency Program's Objectives

1. Shadow SMA Healthcare's GME policies, as well as the policies and procedures enclosed in this manual.

2. Provide residents with the appropriate level of clinical and educational experience, as well as a sufficient number of patients to demonstrate their competence to manage acute and chronic psychiatric illnesses.

3. Provide residents with a variety of clinical settings, cases, and activities through didactics, research projects, and rotations that promote the improvement of their clinical skills and knowledge required for the independent practice of the specialty, including supporting their scholarly activity, practice management, and education in mental health administration.

4. Measure the residents' progress and accomplishment of the ACGME requirements, Core Competencies, and Psychiatry Milestones through regular evaluation and assessment.

5. Prepare residents to formulate an appropriate diagnosis and to deliver safe treatment plans, maintaining continuity of care and prevention of mental health issues, acute exacerbations of the illness, and hospitalizations.

6. Assure a working and educational environment free of excessive reliance on non-physician duties, and that is favorable to teamwork, supporting the healthcare industry's commitment to adhere to professional principles, and business practices.

7. Focus the educational program on evidence-based medicine, continuing education, and guidelines of care, while preparing residents to expand their teaching skills and supervisory roles.

Program Curriculum

Length of the Program *(4.1)*

The program is 48 months in length.

Educational Components *(4.2)*

1. At each educational level, competency-based goals and objectives for each educational experience are designed to promote progress on a trajectory to autonomous practice. These goals and objectives will be routinely reviewed, distributed, and available to residents and faculty members. The Milestone evaluations will document the trajectory to autonomous practice and are considered formative. They can be used to develop individualized learning plans by identifying the residents' learning needs.

2. Resident responsibilities for patient care, including a progressive responsibility for patient management with graded supervision, are based on the resident's training level and Milestone progress, as determined by the Clinical Competency Committee.

3. The program's curriculum is organized to improve the program's educational experiences, the length of these experiences, and supervisory continuity. Curriculum design is structured around the program's aims, and demonstrates a systematic approach, with attention to evidence-based principles and scientific literature, standards of the psychiatric profession, and developmental appropriateness for learners.

Patient Logs

The resident shall maintain a record of their psychiatric cases seen in the continuity clinic, documenting this info in a way that does not identify the name of patients, but demonstrating each resident's clinical experience and ensuring that this educational requirement is met. Residents must be exposed to an adequate variety and number of patients, gender, diagnosis, ethnicity, socioeconomic status, and treatment modality. This data will be reviewed during the residents' semi-annual evaluations and will be reviewed periodically with the program director or a faculty designee. Residents should log all procedures in New Innovations.

Teaching Skills

Residents are required to demonstrate behaviors rooted in life-long learning, quality improvement, and progressive teaching skills. PGY-1 residents will be supervised by attending physicians. Evaluation methods include monthly evaluations, patient evaluations, peer evaluations, and direct observation. Senior level residents will be responsible for guiding junior level residents, as applicable.

ACGME Rotation Requirements for Psychiatry (4.11)

1. **Primary Care Rotation:** A minimum of four months in a clinical setting that provides comprehensive clinical care, met in a primary care specialty setting. This must be completed in the first year. *(4.11.d)*

2. **Neurology Rotation**: Resident experience in neurology must include two months FTE of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. At least one month of this experience should occur in the first of second year of the program. *(4.11.e)*

3. **Inpatient Psychiatry Rotation:** Inpatient psychiatry must include a minimum of six months (no more than sixteen months FTE) of significant responsibility for the assessment, diagnosis, and treatment of general psychiatric patients who are admitted to traditional psychiatry units. *(4.11.f.)*

4. **Outpatient Psychiatry Rotation:** Outpatient psychiatry must include twelve months of FTE of organized, continuous, and supervised clinical experience. Each resident must have significant experience treating outpatients longitudinally for at least one year, to include: *(4.11.g)*
    a. initial evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly;
    b. participation in multiple treatment modalities that emphasize developmental, biological, psychological, and social approaches to outpatient treatment;
    c. application of psychosocial rehabilitation techniques for the evaluation and treatment of differing disorders in a chronically ill patient population; and,
    d. no more than 20 percent children and adolescent patients.

5. **Child and Adolescent Psychiatry Rotation**: Child and adolescent psychiatry must include two months of FTE of organized clinical experience. Supervising faculty members must have current ABPN certification in child and adolescent psychiatry. Residents must participate in assessing, evaluating, and treating a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities. *(4.11.h)*

6. **Geriatric Psychiatry Rotation**: Geriatric psychiatry must include one month FTE of organized experience focused on areas unique to the care of the elderly. Each experience must include: *(4.11.i)*
    a. the diagnosis and management of mental disorders in geriatric patients with coexistent medical disorders;
    b. diagnosis and management, including management of the cognitive component, of degenerative disorders,
    c. basic neuropsychological testing of cognitive functioning in the elderly; and,
    d. management of drug interactions.

7. **Addiction Psychiatry Rotation**: Addiction psychiatry must include one month FTE of organized experience focused on the evaluation and clinical management of patients with substance use disorder/dependence problems, including dual diagnosis. Residents must have treatment modalities that include: *(4.11.j)*
    a. detoxification, overdose management, and maintenance pharmacotherapy;
    b. the use of therapeutic techniques that address the psychological and social consequences of substance use disorder, to include confronting and intervening in chronic addiction rehabilitation used in recovery stages from pre-contemplation to maintenance; and,
    c. self-help groups.

8. **Consultation-liaison Psychiatry Rotation:** Consultation-liaison psychiatry must include two months FTE in which residents consult, under supervision, on other medical and surgical services. (*4.11.k)*

9. **Forensic Psychiatry Rotation:** Forensic psychiatry must include experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency. *(4.11.l)*

10. **Emergency Psychiatry Rotation:** Emergency psychiatry must be conducted in an organized, supervised psychiatric emergency service. This experience must not be counted as part of the twelve-month outpatient requirement. Resident experiences must include crisis evaluation and management, and triage of psychiatric patients. On-call experiences alone must not fulfill the requirement for resident experience in emergency psychiatry*. (4.11.m)*

11. **Community Psychiatry Rotation:** Community psychiatry must provide residents with a cohort of persistently and chronically ill patients in the public sector, such as in community mental health center, public hospitals and agencies, and other community-based settings. This experience must include learning about and using community resources and services in planning patient care, as well as consulting and working collaboratively with case managers, crisis teams, and other mental health professionals. (*4.11.n)*

12. **Electives:** Electives must have written curriculum with goals and objectives, and learning experiences that lead to specified learning outcomes. The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor. *(4.11.o)*

13. **Supervision:** Residents at all levels must be provided with at least two hours of faculty supervision weekly, one hour of which must be individual. (*4.11.p)*

14. **Administration:** Psychiatric administration includes leadership of interdisciplinary teams, experience in utilization review, quality assurance, and performance improvement. *(4.11.q)*

15. **Didactic Sessions**: Each resident should participate in a minimum of 70 percent of regularly scheduled didactic sessions. Residents and faculty members should participate in journal clubs, research conferences, didactics and/or other activities that address critical appraisal of the literature and understanding of the research process. Didactic instruction should include regularly scheduled lectures, seminars, and assigned readings that are coordinated with concurrent clinical experiences and are specific to each resident's level of education. *(4.11.s)*

16. **Pain Management**: The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. *(4.12)*

Resident Goals and Objectives at Each Educational Level

The program has designed goals residents must meet and objectives to achieve those goals. The goals and objectives are listed by postgraduate year.

PGY-1 Goals

1. Demonstrate initial working knowledge about general principles related to psychiatry, neurology, and primary care.

2. Prove basic psychiatric acquaintance through didactics and clinical settings.

3. Accomplish the appropriate level of the ACGME Milestones to meet Core Comptencies for PGY-1.

4. Work successfully in various healthcare delivery settings and systems, continuously learning and educating patients, families, and other healthcare professionals.

PGY-1 Objectives

1. Demonstrate basic knowledge about laboratories, workups, investigations, indications, techniques, risks, benefits, and procedures used in psychiatry.

2. Improve management skills of mental health in patients and perform psychiatric assessments of patients with co-morbid medical conditions.

3. Under appropriate supervision, perform the appropriate level of psychiatric interviews, manage psychiatric emergencies, and crisis interventions.

4. Learn the program curriculum, GME policies, and all educational schedules.

5. Acquire basic knowledge concerning DSM-5 criteria, psychiatric diagnosis, and treatment modalities.

6. Demonstrate basic knowledge related to risk assessments and management of aggressive and suicidal patients.

7. Create a semiannual plan of improvement that will include extra learning activities, individual study, and approaches to achieve the goals. Participate in mentorship sessions and annual ACGME surveys.

8. Develop skills to formulate a differential diagnosis, appropriate for PGY-1 residents.

9. Obtain knowledge concerning professionalism.

10. Improve knowledge of psychiatric treatment modalities, psychological, pharmacological, physical, recovery and psychosocial rehabilitation.

PGY-2 Goals

1. Demonstrate working knowledge about principles related to psychiatry, geriatric psychiatry, consultation liaison, addiction, and child and adolescent psychiatry.

2. Improve the level of teaching and supervisory roles toward lower-level residents and education to the staff, patients, and families.

3. Accomplish the appropriate level of the Psychiatry Milestones to meet Core Comptencies expected for PGY-2.

4. Improve specialty knowledge, clinical skills, and professional attitudes, working successfully in various healthcare delivery settings and systems, continuously learning and educating patients, families, and other healthcare professionals.

PGY-2 Objectives

1. Improve personal knowledge concerning laboratories, workups, psychological investigations, and those indications, techniques, risks, benefits, and procedures used in psychiatry.

2. Improve personal knowledge related to the psychiatric methods of care, the DSM-5 diagnostic criteria, developmental life periods, research, and quality improvement.

3. Improve the results of the in-service exams and level of participation in didactic activities.

4. Improve clinical skills to manage patients, based on the bio-psychosocial perspective.

5. Perform complete psychiatric assessments, taking care of primary co-morbid medical conditions.

6. Improve skills to be able to manage psychiatric emergencies, crisis interventions, risk assessment, and management of suicidal patients.

7. Advance knowledge concerning professionalism and the civil commitment of psychiatry patients.

8. Improve knowledge related to professionalism.

9. Analyze his/her own medical practice, using quality improvement methods, and applying changes with the goal to realize practice improvement.

10. Progress values of autonomy in the assessment and treatment of psychiatric patients, expanding psychotherapy skills and psychopharmacology knowledge.

11. Improve the knowledge concerning the program curriculum and assigned educational and clinical schedules.

12. Integrate personal knowledge acquired from independent reading and study.

PGY-3 Goals

1. Improve Core Competencies, medical knowledge and skills learned in the prior years, and demonstrate a superior level to assess and manage challenging cases, resistant-refractory disorders, special populations, and patients with complex psychiatric and behavioral conditions.

2. Provide care to a panel of patients in the outpatient psychiatry setting, including the delivery of continuity of care, while maintaining a therapeutic alliance and professional relationships with patients and families.

3. Accomplish the appropriate level of the Psychiatry Milestones expected for PGY-3.

4. Improve specialty knowledge, clinical skills, and professional attitudes, working successfully in various healthcare delivery settings and systems, continuously learning and educating patients, families, and other healthcare professionals.

PGY-3 Objectives

1. Participate in the outpatient psychiatry setting during the twelve months of PGY-3.

2. Advance knowledge about laboratories, workups, and psychological investigations, as well as the indications, techniques, risks, benefits, and procedures used in psychiatry.

3. Be able to manage patients based on a bio-psychosocial perspective, and to perform complete psychiatric assessments with the care of primary co-morbid medical conditions.

4. Develop personal understanding of pharmacological and physical treatments involved in the care of the acutely and seriously mentally ill.

5. Manage complex psychiatric disorders with both biological and psychotherapeutic modalities.

6. Advance skills to manage severe and chronic persistent mental illness in the community; advance skills of risk assessment and management of suicidal and aggressive patients.

7. Advance medical knowledge and skills to function more independently, with faculty supervision, and values of responsibility and independence.

8. Improve personal skills in the assessment and treatment of patients, psychotherapy skills and knowledge in psychopharmacology, pathophysiology, and alternative treatment options.

9. Develop skills to assimilate and assess the scientific/medical literature.

10. Improve personal knowledge related to the DSM-5 criteria, incorporating this knowledge into case presentations and clinical practice.

11. Advance knowledge concerning professionalism and the civil commitment of psychiatry patients, improving the doctor-patient relationship and psychoeducation to patients and families.

12. Analyze his/her own medical practice, using quality improvement methods, and apply changes with the goal to realize practice improvement.

PGY-4 Goals

1. Achieve all requisites for training in psychiatry, being ready for post-residency career and independent clinical practice.

2. Develop personal experiences in psychiatric subspecialties through electives.

3. Improve knowledge related to psychiatric administration, academics, practice management, quality improvement, and research endeavors.

4. Demonstrate improvement of the results concerning the in-service exam and board reviews.

5. Accomplish the requirements of interview skills assessments for eligibility for ABPN examination.

6. Accomplish the appropriate level of the Psychiatry Milestones to meet Core Comptencies expected for PGY-4.

PGY-4 Objectives

1. Complete patients' logs, ABPN requisites, CMEs, and any pending requirement.

2. Be well versed in knowledge related to the DSM-5 criteria, incorporating this knowledge into case presentations and clinical practice

3. Advance knowledge about laboratories, workups, and psychological investigations, as well as the indications, techniques, risks, benefits, and procedures used in psychiatry.

4. Advance skills to manage patients based on a bio-psychosocial perspective, and to perform complete psychiatric assessments taking care of primary co-morbid medical conditions.

5. Improve personal medical knowledge and skills to function more independently and advance knowledge in risk assessment and management of suicidal or homicidal patients.

6. Show advanced knowledge related to psychological, pharmacological, and physical treatments involved in the care of the seriously mentally ill patient and advance skills to manage severe, acute, and chronic persistent mental illness.

7. Demonstrate high standards of supervisory duties and teaching skills.

8. Demonstrate effective leadership roles during didactic activities.

9. Present the QI and Research projects in an assigned didactic session.

10. Advance knowledge concerning professionalism and the civil commitment of psychiatry patients, improving the doctor-patient relationship and psychoeducation to patients and families.

11. Analyze his/her own medical practice, using quality improvement methods, and applying changes with the goal to realize practice improvement.

12. Progress values of autonomy in the assessment and treatment of psychiatric patients, expanding psychotherapy skills and psychopharmacology knowledge.

13. Understand the changing health-care environment and competencies for success in clinical practice and in other professional leadership roles, appreciating the rational approaches to administrative decisions.

14. Assume advanced responsibility for the psychiatry service and supervise lower-level residents.

15. Demonstrate well-established ethical, judgmental, and clinical skills for the independent practice of psychiatry.

ACGME Core Competencies

- **Professionalism**
- **Patient Care and Procedural Skills**
- **Medical Knowledge**
- **Intercommunications Skills**
- **Systems-based Practice**
- **Practice-based Learning and Improvement**

Professionalism: Residents must demonstrate a commitment to professionalism and an adherence to ethical principles**.** *(4.3)*

Demonstrate responsibility to:

1. Respond properly to communications from patients and health professionals in a timely manner.

2. Communicate back-up arrangements and seek emergent care when necessary.

3. Use medical records to keep documentation of the course of illness and its treatment.

4. Provide coverage if unavailable, such as when out of town or on vacation.

5. Provide continuity of care, including appropriate consultation, transfer, or referral if necessary.

6. Demonstrate ethical behaviors, integrity, honesty, compassion, and confidentiality, including matters of informed consent, professional conduct, patient privacy, and conflict of interests.

7. Respect patients, families, colleagues, ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religion, political leanings, and sexual orientation.

8. Demonstrate sensitivity to end-of-life care and to the provision of care.

9. Review individual professional conduct and remediate, if appropriate.

10. Participate in the review of the professional conduct of their peers.

11. Appropriately disclose and address conflict or duality of interest.

Patient Care and Procedural Skills: Residents must be able to provide patient care that is patient- and family centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. *(4.4)*

Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. *(4.5)*

1. Assess, treat, and form therapeutic alliance with patients and patients' families of a varied range of age, gender, and from a variety of ethnic, racial, sociocultural, and economic backgrounds.

2. Understand and document clear and accurate patient history.

3. Provide psychiatric consultation in a variety of medical settings, including providing psychiatric care to patients receiving treatment from non-medical therapists and coordinating such treatment.

4. Complete a systematic recording of findings in the medical record.

5. Formulate diagnosis and differential diagnosis, through patient interviews and examination, and develop treatment plans.

6. Formulate an understanding of each patient's biological, psychological, behavioral, and sociocultural issues associated with etiology and treatment.

7. Appropriately treat chronically-mentally ill patients through psychopharmacologic, psychotherapeutic, and social rehabilitative interventions.

8. Manage and treat patients using pharmacological regimens, including use of medications and psychotherapy concurrently, using both brief and long-term supportive psychotherapies.

9. Assess and document patient's potential for safety, self-harm or harm to others, assessment of risks, involuntary treatment standards and procedures, and provide interventions to minimize risks. Implement prevention methods against self-harm and harm to others.

10. Recognize and respond appropriately to family violence and its effect on both victims and perpetrators.

11. Formulate the etiology of psychiatric disorders and rule out organic or neurologic diseases.

Medical Knowledge: Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific

inquiry, as well as the application of this knowledge to patient care. *(4.6)*

1. Demonstrate knowledge of major theoretical approaches to understanding patient-doctor relationships.

2. Understand influence of medical conditions, consideration of age, gender, race, and ethnicity, based on the literature and standards of practice, epidemiology, etiology, including medical, genetic, and sociocultural factors, phenomenology, influence of physical illness on the patient's functioning, experience, meaning, and explanation of the illness for the patient and family, including the effect of cultural factors and culture-bound syndromes, treatment plans, course, and prognosis.

3. Understand the history of psychiatry and its relationship to the evolution of medicine.

4. Demonstrate knowledge of behavioral science and social psychiatry, including:
    a. Learning theories.
    b. Theories of family organization, dynamics, and communication
    c. Theories of group dynamics and process, anthropology, sociology, and theology as they pertain to clinical psychiatry.
    d. Transcultural psychiatry.
    e. Community mental health.
    f. Epidemiology.
    g. Research methodology.
    h. Statistics.
    i. Psychodynamic theory.

5. Demonstrate knowledge of patient evaluation, treatment, diagnostic, and therapeutic studies, including:
    a. Diagnostic interviewing.
    b. Mental Status Examination.
    c. Psychological and educational testing.
    d. Laboratory testing.
    e. Imaging studies.
    f. Treatment comparison and selection.

6. Demonstrate knowledge of various treatments, including:
    a. Psychotherapies, including brief, cognitive behavioral, interpersonal, psychodynamic, and supportive therapy.
    b. Delivery systems of psychotherapies-individual, group, family
    c. Recognition and treatment of psychosexual dysfunctions.
    d. Somatic treatments, including pharmacotherapy-antidepressants, antipsychotics, anxiolytics, mood stabilizers, hypnotics, stimulants, pharmacologic actions, indications, side effects, drug interactions, over-the counter, herbal, and alternative medications, toxicities, prescribing practices.

e. Use of electroconvulsive and neuromodulation therapies.

7. Demonstrate knowledge relating to emergency psychiatry, suicide, homicide, violent behaviors, child, domestic abuse, elder abuse, crisis intervention, differential diagnoses, and treatment methods.

8. Substances of abuse, pharmacologic actions, toxicity, withdrawal, toxicity and withdrawal, epidemiology, sociocultural factors, prevention, and treatment.

9. Psychiatric subspecialties and other areas of psychiatric activities:
    a. Addiction psychiatry.
    b. Child and adolescent psychiatry.
    c. Clinical neurophysiology.
    d. Forensic psychiatry.
    e. Geriatric psychiatry.
    f. Pain medicine.
    g. Psychosomatic medicine.
    h. Sleep medicine.
    i. End-of-life/palliative care.

10. Psychopathology, epidemiology, diagnostic criteria, and clinical courses for common psychiatric disorders and diseases across the lifespan, including treatment, for the following:
    a. Disorders that are usually first diagnosed in infancy, childhood, or adolescence.
    b. Delirium, dementia, amnestic, and other cognitive disorders.
    c. Mental disorders due to general medical conditions.
    d. Substance-related disorders.
    e. Schizophrenic and other psychotic disorders.
    f. Mood disorders.
    g. Anxiety disorders.
    h. Somatoform disorders.
    i. Factitious disorders.
    j. Dissociative disorders.
    k. Sexual and gender identity disorders.
    l. Eating disorders.
    m. Sleep disorders.
    n. Impulse control disorders not elsewhere classified.
    o. Adjustment disorders.
    p. Paranoid personality disorder.
    q. Schizoid personality disorder.
    r. Schizotypal personality disorder.
    s. Antisocial personality disorder.
    t. Borderline personality disorder.
    u. Histrionic personality disorder.

v. Narcissistic personality disorder.
w. Avoidant personality disorder.
x. Dependent personality disorder.
y. Obsessive-compulsive personality disorder.
z. Personality disorder not otherwise specified.
aa. Mental retardation (Intellectual Disability).
bb. Drug dependence and substance abuse.
cc. Interplay between psychosomatic and neurologic manifestations, somatization, and conversion.
dd. Recognize diverse clinical presentations in child and adult victims of abuse.
ee. Manage uncomplicated psychiatric disorders and indications for consultation.

11. Neurology: Pathophysiology, epidemiology, diagnostic criteria, and clinical course of neurologic disorders including:
    a. Movement disorders, stroke, dementia, and seizure disorders.
    b. Neurologic manifestations/complications of common psychiatric disorders.
    c. Psychiatric manifestations of neurologic disorders. Major medications, such as, anticonvulsants, antiparkinsonian agents and its side effects.
    d. Neurologic complications of somatic therapy.

12. Demonstrate knowledge of the principles of QI used in psychiatry.

13. Demonstrate knowledge of legal aspects of psychiatric practice.

Practice-based Learning and Improvement: Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. *(4.7)*

1. Recognize any gaps and limitations in personal knowledge and clinical skills.

2. Demonstrate advanced skills for obtaining and evaluating up-to-date information from scientific and practice literature and other foundations to assist in the quality care of patients, including the use of medical libraries, information technology, Internet-based search and literature databases, drug information databases and participation, as appropriate, in educational courses, conferences, and other activities.

3. Assess caseload and practice experience in a systematic manner. This may include:
    a. Case-based learning.
    b. Use of best practices through practice guidelines or clinical pathways.
    c. Review of patient records.
    d. Obtaining evaluations from patients, e.g., outcomes and patient satisfaction.
    e. Practice the values of quality improvement in practice.
    f. Attain appropriate supervision and consultation.
    g. Maintain a system for examining errors and initiating improvement.

h. Critically assess the medical literature, including knowledge of common methodologies employed in psychiatric research, examining, and summarizing a particular problem that derives from their own caseloads.

4. Review the scientific literature to determine how quality of care can be improved in relation to personal practice.

5. Demonstrate competence in incorporating feedback and formative evaluation into daily practice.

6. Develop and follow remediation strategies based on critical review of scientific literature.

Interpersonal and Communication Skills: Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. *(4.8)*

1. Listen to and understand patients, and nonverbal and electronic communications, communicate effectively with patients using verbal, nonverbal, and written skills as appropriate, develop a therapeutic cooperation, partner with patients to develop a health care management plan, convey information in a clear and meaningful fashion, work collaboratively with other health care teams, educate patients, families, and professionals and protect patient confidentiality principles.

2. Understand the impact of the psychiatrist's own feelings and behavior so that it does not interfere with treatment

3. Acquire, interpret, and evaluate consultations from other medical specialties.
    a. Referral for consultation and sensitivity to assess the need for consultation.
    b. Formulate and clearly communicate the consultation question.
    c. Discuss the consultation findings with the consultant.
    d. Discuss the consultation findings with the patient and family.

4. Serve as consultants to other medical or mental health specialists and agencies. Respect the knowledge and expertise of the requested professionals.

5. Educate and communicate effectively with patients and their families across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, by:
    a. Matching communications to educational and intellectual levels of patients and families.
    b. Demonstrating sociocultural competence to patients and their families.
    c. Providing explanations of psychiatric disorders and treatment that are jargon free and matched to the educational/intellectual levels of patients and their families.
    d. Providing preventive education that is understandable and practical.

e. Respecting patients' cultural, ethnic, religious, and economic backgrounds.
f. Developing rapport and a working alliance with patients and their families.
g. Ensuring that the patient and/or family have understood the communication.
h. Responding promptly to electronic communications when used as a communication method agreed upon by psychiatrists and their patients and patients' families.

6. Maintain up-to-date medical records and write legible prescriptions.

7. Work efficiently within a multidisciplinary treatment team, listen effectively, elicit information, integrate information, manage conflict, communicate an integrated treatment plan.

8. Communicate appropriately with patients and families, respect confidentiality, compassion for the patient in providing accurate medical information and prognosis, risks and benefits, proposed treatment plan, and complications of non-pharmacologic treatments, alternatives options, education of disorders, prognosis, and prevention of mental illnesses.

Systems-based Practice: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. *(4.9)*

1. Demonstrate knowledge of the systems involved in treating patients of all ages and understand how to use the systems as part of a comprehensive system of care in general and as part of a comprehensive, customized treatment plan. This shall include the evaluation and implementation of practice guidelines, the ability to access community, national, and health professionals that may enhance the quality of life of patients with psychiatric and neurologic illnesses, and the ability to lead, work, and coordinate patient care across the health care continuum and beyond within health care teams.

2. Demonstrate appropriate skills for the practice of ambulatory care.

3. Use consultation and referrals for the optimal clinical management of patients.

4. Demonstrate responsiveness of the importance of adequate cross-coverage.

5. Use medical data in communication with and effective management of patients.

6. Distinguish limitations of health care resources and act as an advocate for patients within their sociocultural and financial constraints, know the legal aspects of psychiatric diseases and demonstrate an understanding of risk management.

7. Improve personal knowledge concerning diverse health care systems, maximize cost-effective use of resources, ensuring quality, allocating resources, and participate in utilization review communications, support quality patient care, and educate patients and the community.

8. Authenticate acquaintance in community systems of care and assist patients to access care and support services, including knowledge of treatment settings in the community, which may include ambulatory, consulting, acute care, partial hospital, skilled care, rehabilitation, nursing homes and home care facilities, substance abuse facilities, and hospice organizations.

9. Demonstrate personal knowledge related to providing high quality patient care and the ability to integrate the care of patients across diverse settings, understanding safety issues, system complexities, and the recognition/remediation of any medical errors.

10. Demonstrate competence in advocating for the promotion of mental health and the prevention of mental disorders.

ACGME Psychiatry Residency Milestones

The Milestones are designed to evaluate each resident's progress and participation in the program. The Milestones provide a framework for assessing the development of the skills needed for physician competence in a specialty or subspecialty. They neither represent the entirety of the six domains of physician competence, nor are they designed to be relevant in any other context. The Clinical Competency Committee (CCC) conducts the Milestone reports twice a year, which are then reviewed with the resident semiannually.

The Psychiatry Milestones include the following components:

- Knowledge
- Skills
- Attitudes
- Attributes for each of the ACGME Competencies, organized in a developmental framework

The Milestones are prearranged in five levels and are synonymous to moving from novice to expert resident in psychiatry. For each reporting period, the Clinical Competency Committee will review the completed evaluations to select the levels that best describe each learner's current performance, abilities, and attributes for each sub-competency.

These levels do not directly correspond with the post-graduate year of training. Depending on previous experience, a junior resident may achieve higher levels early in his/her educational program just as a senior resident may be at a lower level later in his/her educational program. There is no predetermined timing for a resident to attain any level.

Residents may also retreat in achievement of their Milestones for many reasons, such as over scoring in a previous review, a rambling experience in a particular procedure, or a significant act by the resident. Making decisions about readiness for graduation and unsupervised practice is falls under the responsibility of the Program Director.

Patient Care (PC)

<u>PC1. Psychiatric Evaluation</u>

- Gather and organize findings from the patient interview and mental status examination.
- Gather and organize data from collateral sources.
- Screen for risk and integrate risk assessment into the patient evaluation.

1. LEVEL 1
    a. Collect general medical and psychiatric history and complete a mental status examination.
    b. Collect relevant information from collateral sources.
    c. Screen for risk of harm to self, to others, or by others.

2. LEVEL 2

a. Efficiently acquire an accurate and relevant history and perform a targeted examination customized to the patient's presentation.
b. Select appropriate laboratory and diagnostic tests.
c. Engage in basic risk assessment and basic safety planning.

3. LEVEL 3
    a. Use hypothesis-driven information gathering to obtain complete, accurate, and relevant history.
    b. Interpret collateral information and test results to determine necessary additional steps.
    c. Incorporate risk and protective factors into the assessment of imminent, short, and long-term patient safety and the safety of others.

4. LEVEL 4
    a. Elicit and observe subtle and unusual findings.
    b. Interprets collateral information and test results to determine necessary additional steps in the evaluation of complex conditions.
    c. Incorporate risk and protective factors into the assessment of complex patient presentations, including eliciting information not readily offered by the patient.

5. LEVEL 5
    a. Serve as role model for gathering subtle and accurate findings from the patient and collateral sources.
    b. Serve as a role model for risk assessment.

<u>PC2. Psychiatric Formulation and Differential Diagnosis</u>

- Organize and summarize findings and generate differential diagnosis.
- Identify contributing factors and contextual features and create a formulation.
- Use the emotional responses of clinicians and patients as diagnostic information.

1. LEVEL 1
    a. Organize and precisely summarize information obtained from the patient evaluation to develop a clinical impression.
    b. Recognize that biological, psychosocial, and developmental/life cycle issues play a role in a patient’s presentation.
    c. Recognizes that clinicians have emotional responses to patients.

2. LEVEL 2
    a. Integrate information from the most relevant sources to develop a basic differential diagnosis for common patient presentations.
    b. Identify the biological, psychosocial, and developmental/life cycle factors that contribute to a patient’s presentation.
    c. Recognize that clinicians’ emotional responses have a diagnostic value.

3. LEVEL 3
    a. Develop a prioritized differential diagnosis while avoiding premature closure for a range of patient presentations.

b. Synthesize all information into a concise but comprehensive formulation, taking into account biological, psychosocial, and developmental/life cycle factors.
c. Begins to use the clinician's emotional responses to the patient to aid formulation.

4. LEVEL 4
    a. Develops the differential diagnoses in complex cases and incorporates subtle, unusual, or conflicting findings.
    b. Develops formulations based on multiple conceptual models.
    c. Integrate clinician's and patient's emotional responses into the diagnosis and formulation.

5. LEVEL 5
    a. Serve as a role model to develop accurate and complete differential diagnoses.

PC3. Treatment Planning and Management

- Create treatment plans
- Monitor and revise treatment when indicated
- Incorporate the use of community resources

1. LEVEL 1
    a. Identify potential biopsychosocial treatment options.
    b. Recognize that acuity impacts the level of care and treatment monitoring.
    c. Give examples of the multiple community resources.

2. LEVEL 2
    a. Engage the patient in the selection of evidence-based biopsychosocial treatment, recognizing that comorbid conditions and side effects impact treatment.
    b. Select the most appropriate level of care based on acuity and monitors treatment, adherence, and response.
    c. Coordinate care with community resources.

3. LEVEL 3
    a. Apply an understanding of psychiatric, neurologic, and medical comorbidities in the management of common presentations.
    b. Select the most appropriate interventions, treatments, and adjustments in treatment in common presentations based on consideration of patient factors and acuity.
    c. Integrate support and advocacy groups in treatment planning.

4. LEVEL 4
    a. Devise individualized treatment plan for complex presentations; integrates multiple modalities and providers in a comprehensive approach.
    b. Select the most appropriate interventions, treatments, and adjustments in treatment in complex presentations based on consideration of patient factors and acuity.

c. Locate and connect patients to community resources in complex and difficult situations

5. LEVEL 5
    a. Supervise treatment planning for other learners and multidisciplinary providers.
    b. Participate in the creation or administration of community-based programs.

PC4. Psychotherapy

- Establish therapeutic alliance and manage boundaries.
- Select, set goals, provide psychotherapies such as supportive, psychodynamic, and cognitive-behavioral.
- Manage therapeutic process.

1. LEVEL 1
    a. Establish a working association with patients demonstrating interest and empathy.
    b. List the three core psychotherapies.
    c. Accurately identify patient emotions, particularly sadness, anger, and fear.

2. LEVEL 2
    a. Establish a bounded therapeutic alliance with patients with uncomplicated problems.
    b. Use the common factors of psychotherapy in providing supportive therapy to patients.
    c. Identify and reflect the core feelings and key issues for the patient during the session.

3. LEVEL 3
    a. Establish and maintain a therapeutic alliance with patients with uncomplicated problems and recognizes and avoids boundary violations.
    b. Provide selected psychotherapies (including supportive, psychodynamic, and cognitive-behavioral), sets goals, and integrates therapy with other treatment modalities.
    c. Identify and reflect the core feelings, key issues and what the issues mean to the patient during the session, while managing the emotional content and feelings elicited.

4. LEVEL 4
    a. Establish and maintain a therapeutic alliance with patients with complicated problems; anticipates and appropriately manages boundary violations.
    b. Select appropriate psychotherapeutic modality based on case formulation, tailors the therapy to the patient, and provides psychotherapy (at least supportive and one of psychodynamic or cognitive-behavioral) to complex patients.
    c. Identify and reflect core feelings, key issues, and what the issues mean to the patient within and across sessions.

5. LEVEL 5

a. Assess and help to repair alliances and/or boundary difficulties between junior residents and patients.
b. Tailor psychotherapeutic treatment based on awareness of personal skill sets, strengths, and limitations.
c. Connect feelings, recurrent, central themes/schemas and their meaning to the patient as they change within and across sessions.

PC5. Somatic Therapies. Psychopharmacology, Electroconvulsive Therapy (ECT), and Neuromodulation therapies

- Understand the mechanisms of action, indications, and evidence base for somatic therapies and appropriately applies them to patient care.
- Educate patients about somatic therapies including access to accurate psychoeducational resources.
- Appropriately screen patient's response to treatment.

1. LEVEL 1
    a. List commonly used somatic therapies and their indications to target specific psychiatric symptoms.
    b. Review with the patient general indications and common adverse effects for commonly prescribed drugs and other somatic treatments.
    c. List key baseline assessments necessary before initiating somatic treatments to ensure patient safety.

2. LEVEL 2
    a. Appropriately prescribe commonly used somatic therapies and understands their mechanism of action.
    b. Appropriately use educational and other resources to support the patient and optimize understanding and adherence.
    c. Obtain baseline assessments necessary before initiating treatment with commonly used somatic therapies.

3. LEVEL 3
    a. Research, cite, and apply evidence-based info when developing treatment plans that include somatic therapies.
    b. Explain the mechanisms of action and the body's response to commonly prescribed drugs and other somatic treatments (including drug metabolism) to patients/families.
    c. Monitor relevant assessments and adverse effects throughout treatment and incorporates findings from the literature into treatment strategy.

4. LEVEL 4
    a. Consistently apply the evidence base when developing treatment plans that include somatic therapies, including with complex or treatment-refractory cases.
    b. Explain less common somatic treatment choices to patients/families in terms of proposed mechanisms of action, potential risks and benefits, and the evidence base.

c. Manage adverse effects and safety concerns in complex or treatment refractory cases.

5. LEVEL 5
    a. Manage complex combinations of somatic therapies and consider novel approaches.
    b. Lead the development of novel patient educational processes or materials.
    c. Incorporate new developments in the evidence base into treatment to optimize safety, minimize adverse effects, and improve response.

PC6. Clinical Consultation

1. LEVEL 1
    a. Respectfully request a consultation.
    b. Respectfully receive a consultation request.

2. LEVEL 2
    a. Clearly and concisely request a consultation.
    b. Clearly and concisely respond to a consultation request.
    c. Demonstrate understanding of the consultation model, including liaison function.

3. LEVEL 3
    a. Apply consultant recommendations judiciously to patient care.
    b. Assist the consulting team in identifying unrecognized clinical care issues and provides relevant recommendations, checking for understanding.
    c. Understand models of integrated multidisciplinary mental health and primary care.

4. LEVEL 4
    a. Critically appraise and integrate recommendations.
    b. Manage complicated and challenging consultation requests.
    c. Collaborate skillfully with practitioners from other disciplines in medical settings.

5. LEVEL 5
    a. Contribute to identifying and rectifying flaws of consultation system.
    b. Lead consultation-liaison psychiatry teams.
    c. Serve as a leader of integrated care teams or implementation projects.

Milestone: Medical Knowledge (MK)

MK1. Development through the Life Cycle (Impact of Psychopathology on the Trajectory of Development and Development on the Expression of Psychopathology)

- Knowledge of human development
- Knowledge of pathological and environmental influences on development

1. LEVEL 1

a. Conceptualize the development stages throughout the life cycle
b. Identify major deviations from typical development

2. LEVEL 2
    a. Describe the basic stages of typical biological, sociocultural, sexual, and cognitive development throughout the life cycle.
    b. Give examples of biological, psychological, sociocultural, cognitive, and sexual factors that contribute to a shift towards an atypical developmental trajectory.

3. LEVEL 3
    a. Explain developmental tasks and transitions throughout the life cycle, using multiple conceptual models.
    b. Describe the influence of biological, psychological, sociocultural, cognitive, and sexual factors on atypical personality development and psychopathology.

4. LEVEL 4
    a. Articulate an integrated understanding of typical development.
    b. Describe how acquiring and losing specific capacities can influence the expression of psychopathology.

5. LEVEL 5
    a. Incorporate new knowledge into one's own understanding of typical and atypical development.

<u>MK2. Psychopathology (Knowledge of Diagnostic Criteria, Epidemiology, Pathophysiology, Course of Illness, Comorbidities, and Differential Diagnosis of Psychiatric Disorders, including substance use disorders and Presentation of Psychiatric Disorders across the Life Cycle and in Diverse Patient Populations)</u>

- Knowledge to identify and treat psychiatric conditions
- Knowledge at the interface of psychiatry and the rest of medicine

1. LEVEL 1
    a. Identify the major psychiatric diagnostic categories.
    b. Gives examples of interactions between medical and psychiatric symptoms and disorders.

2. LEVEL 2
    a. Demonstrate adequate knowledge to identify and assess common psychiatric conditions.
    b. Demonstrate knowledge to identify medical conditions in psychiatric patients.

3. LEVEL 3
    a. Demonstrate satisfactory knowledge to identify and treat common psychiatric conditions throughout the life cycle.
    b. Apply knowledge to recognize and treat psychiatric symptoms due to other medical illnesses.

4. LEVEL 4
    a. Demonstrate knowledge to categorize and treat atypical and complex psychiatric conditions throughout the life cycle.
    b. Apply knowledge to identify and treat psychiatric conditions in patients with comorbid medical disorders and ensure treatment of medical conditions in psychiatric patients is addressed.

5. LEVEL 5
    a. Apply knowledge to identify and manage uncommon conditions at the interface of psychiatry and medicine.

MK3. Clinical Neuroscience (Knowledge of Neurology, Neuropsychiatry, Neurodiagnostic Testing, and Relevant Neuroscience and their Application in Clinical Settings)

- Neurodiagnostic and neuropsychological testing
- Neuropsychiatric comorbidity
- Application of neuroscientific findings in psychiatry

1. LEVEL 1
    a. List commonly available neuroimaging, neurophysiologic, and neuropsychological tests.
    b. Describe basic components and functions of the nervous system.
    c. Describe basic features of common neurologic disorders.

2. LEVEL 2
    a. Describe indications for neuroimaging, neurophysiologic, and neuropsychological tests.
    b. Describe major neurobiological processes underlying common psychiatric illness.
    c. Define the interplay between psychiatric and neurologic disorders.

3. LEVEL 3
    a. Identify findings in neuroimaging, neurophysiologic, and neuropsychological tests.
    b. Explain how neurobiological processes are included in case formulation.
    c. Identify common comorbidities in psychiatric and neurologic disorders.

4. LEVEL 4
    a. Correlate the significance of neuroimaging, neurophysiological, and neuropsychological testing results to case formulation and treatment planning.
    b. Relate neurobiological processes into case formulation and treatment planning.
    c. Synthesize knowledge of psychiatric/neurologic comorbidities for case formulation.

5. LEVEL 5
    a. Integrate recent neuroimaging, neurophysiologic, and neuropsychological tests research into understanding of psychopathology.
    b. Engage in scholarly activity related to neuroscience and psychiatric disorders.

c. Integrate research into understanding the interface between neurology and psychiatry.

MK4. Psychotherapy

- Fundamentals
- Practice and modalities
- Evidence base

1. LEVEL 1
    a. Identify psychotherapy as an effective modality of treatment.
    b. Describe the basic framework of a psychotherapeutic experience.
    c. List the three core psychotherapy modalities.

2. LEVEL 2
    a. Describe the common elements across psychotherapeutic modalities.
    b. List the basic indications and benefits of using psychotherapy.
    c. Describe the evidence for one core psychotherapy modality.

3. LEVEL 3
    a. Classify the central theoretical principles across the three core psychotherapeutic modalities: supportive, psychodynamic, cognitive-behavioral.
    b. Identifies the techniques of the three core individual psychotherapies.
    c. Summarize the evidence base for the three core individual psychotherapies.

4. LEVEL 4
    a. Explain the theoretical mechanisms of therapeutic change in each of the three core modalities.
    b. Compare the selection criteria and potential risks, and benefits of core individual psychotherapies.
    c. Analyze the evidence base for combining psychotherapy and pharmacotherapy.

5. LEVEL 5
    a. Incorporate new theoretical developments into a knowledge base.
    b. Demonstrate satisfactory evidence-based knowledge of core individual therapy.

Milestone: Interpersonal and Communication Skills (ICS)

ICS 1. Patient-Family-Centered Communication

1. LEVEL 1
    a. Use language and nonverbal communication to demonstrate empathic curiosity, respect, and to establish rapport
    b. Identify common barriers to effective communication; accurately communicates own role within the health care system
    c. Recognize that communication strategies may need to be adjusted based on clinical context

2. LEVEL 2
    a. Establish a therapeutic relationship in straightforward encounters using active listening and clear language
    b. Identify complex barriers to effective communication
    c. Organize and initiate communication with patient/family by clarifying expectations and verifying understanding of the clinical process.

3. LEVEL 3
    a. Establish a therapeutic relationship with challenging patients; use nonverbal communication skills effectively
    b. When prompted, reflect and identify personal biases that may contribute to communication barriers
    c. With guidance, sensitively and compassionately delivers medical information, elicits patient/family values, goals and preferences; acknowledges uncertainty and conflict

4. LEVEL 4
    a. Effectively establish and sustain therapeutic relationships with patient/family with awareness of their concerns and context, regardless of complexity.
    b. Independently recognize personal biases and attempts to proactively minimize their contribution to communication barriers.
    c. Independently, use shared decision making to align patient/family values, goals, and preferences with treatment options to make a personalized care plan.

5. LEVEL 5
    a. Mentor others in situational awareness and critical self-reflection to consistently develop positive therapeutic relationships.
    b. Role model self-awareness practice while identifying and teaching a contextual approach to minimize communication barriers.
    c. Role model shared decision making in patient/family communication including those with a high degree of uncertainty/conflict.

<u>ICS 2. Interprofessional and Team Communication.</u>

1. LEVEL 1
    a. Use language that values all members of the health care team.
    b. Recognize the need for ongoing feedback with the health care team.

2. LEVEL 2
    a. Communicate information effectively with all health care team members.
    b. Solicit feedback on performance while operating as a member of the health care team.

3. LEVEL 3
    a. Use active listening to adapt communication style to fit team needs.
    b. Communicates concerns and provides feedback to peers and learners.

4. LEVEL 4

a. Coordinate recommendations from different members of the health care team to optimize patient care.
b. Respectfully communicate feedback and constructive criticism to superiors.

5. LEVEL 5
    a. Demonstrate to be role models of flexible communication strategies that value input from all health care team members, resolving conflict when needed.
    b. Facilitate the regular health care team-based feedback in complex situations.

IC3. Communication within Health Care Systems

1. LEVEL1
    a. Accurately record information in the patient record.
    b. Safeguard patient personal health information as required by HIPAA.
    c. Communicate administrative issues as required by institutional policies.

2. LEVEL 2
    a. Demonstrate organized diagnostic and therapeutic reasoning through documentation in the patient record.
    b. Use documentation shortcuts accurately and appropriately to enhance efficiency of communication.
    c. Respectfully communicate concerns about the system to the program director.

3. LEVEL 3
    a. Accurately report diagnostic and therapeutic reasoning in the patient record.
    b. Appropriately select forms of communication based on context and document.
    c. Use appropriate channels to offer clear and constructive suggestions.

4. LEVEL 4
    a. Communicate in an organized written form, seeking guidance from attending when needed.
    b. Achieve written or verbal communication that serves as an example for others to follow.
    c. Initiate difficult conversations with appropriate institutional staff to improve the system of care.

5. LEVEL 5
    a. Contribute to departmental or organizational initiatives to improve communication systems.
    b. Facilitate dialogue regarding systems issues among larger community stakeholders.

Milestone: Practice-Based Learning and Improvement (PBLI)

PBLI 1. Evidence-Based and Informed Practice.

1. LEVEL 1

a. Demonstrate how to access and summarize available evidence of routine mental conditions;

2. LEVEL 2
    a. Articulate clinical questions and initiates literature searches to provide evidence-based care;

3. LEVEL 3
    a. Locate and apply the best available evidence-based practices to the care of patients addressing a hierarchy of need.

4. LEVEL 4
    a. Critically appraise and apply best practices even in the face of uncertainty and conflicting evidence regarding care, so to tailor the treatment to the individual patient

5. LEVEL 5
    a. Coach others to critically appraise and apply evidence-based practices for complex patients; and where indicated participate in the development of care guidelines.

<u>PBLI 2. Reflective Practice and Commitment to Personal Growth.</u>

1. LEVEL 1
    a. Accept responsibility for personal and professional development by establishing goals
    b. Identifies the factors which contribute to gap(s) between expected and actual performance
    c. Actively seeks opportunities to improve.

2. LEVEL 2
    a. Demonstrate openness to performance data (faculty feedback and other sources of date) in order to inform goals
    b. Analyze and reflect on the factors which contribute to gap(s) between expected and actual performance
    c. Design and implement a learning plan, with prompted and approved by program director.

3. LEVEL 3
    a. Seek performance data episodically, with openness and humility
    b. Analyze, reflect on, and practice in compliance with institutional change(s) to narrow the gap(s) between expected and actual performance
    c. Independently create and implement a learning plan

4. LEVEL 4
    a. Seek performance data with openness and modesty
    b. Challenge personal assumptions and consider alternatives to narrow the gap(s) between expected and actual performance

c. Use performance data to measure the effectiveness of the learning plan and necessary improvement. Amend the learning plan as directed by faculty.

5. LEVEL 5
    a. Role model the consistent seeking of performance data showing openness and humility.
    b. Coach others on reflective practice.
    c. Facilitate the design and implementation of learning plans for others.

Milestone Systems-Based Practice (SBP)

SBP1: Patient Safety and Quality Improvement

- Analyze patient safety events
- Appropriately disclose patient safety events
- Participate in quality improvement initiatives

1. LEVEL 1
    a. Demonstrate knowledge of common patient safety events.
    b. Demonstrate knowledge of how to report patient safety events.
    c. Demonstrate knowledge of basic quality improvement methodologies and metrics.

2. LEVEL 2
    a. Identify system factors that lead to patient safety events.
    b. Report on patient safety events through institutional reporting system
    c. Identify quality improvement initiatives (e.g., reduced restraint rates, falls risk, suicide rates)

3. LEVEL 3
    a. Participate in analysis of patient safety events (simulated or actual)
    b. Participate in disclosure of patient safety events to patients and families (simulated or actual)
    c. Participate in local quality improvement initiatives.

4. LEVEL 4
    a. Conduct analysis of patient safety events and offers error prevention strategies
    b. Disclose patient safety events to patients and families
    c. Demonstrate skills to identify, develop, implement, and analyze quality improvement projects.

5. LEVEL 5
    a. Actively engage the clinical team and identify processes to improve systems to prevent patient safety events.
    b. Role model or mentor others in the disclosure of patient safety events.
    c. Create, implement, and access quality improvement corrective action plans

SBP2. System Navigation for Patient-Centered Care

- Coordinate patient care
- Safely transition to appropriate level of care
- Consider population and community health needs

1. LEVEL 1
    a. Demonstrate knowledge of care coordination.
    b. Identify key elements for safe and effective transitions of care and hand-offs.
    c. Demonstrate knowledge of population and community health needs and disparities.

2. LEVEL 2
    a. Coordinate the care of patients with the interprofessional teams.
    b. Perform safe and effective transitions of care/hand-offs in routine clinical situations.
    c. Identify population and community health needs as well as inequities for the local population.

3. LEVEL 3
    a. Coordinate the care of patients in complex clinical situations effectively using the input of the interprofessional teams.
    b. Perform safe and effective transitions of care/hand-offs in complex clinical situations.
    c. Use local resources effectively to meet the needs of a patient population and community.

4. LEVEL 4
    a. Role model coordination of patient-centered care among different disciplines and specialties.
    b. Role model and serves as a patient advocate for safe and effective transitions of care/hand-offs within and across health care delivery systems including outpatient settings.
    c. Participate in changing and adapting practices to provide for the needs of specific populations.

5. LEVEL 5
    a. Analyze the process of care coordination and lead in the design and implementation of improvements.
    b. Improve quality of transitions of care to optimize patient outcomes.
    c. Lead innovations and advocate for populations and communities with health care inequities.

SBP 3. Physician's Role in Health Care Systems

- Understanding and working within the health care system
- Health care financing and advocacy

- Transition to practice

1. LEVEL 1
    a. Identify key components of the complex health care system.
    b. Describe practice models and basic mental health payment systems.
    c. Identify basic knowledge domains for effective transition to residency.

2. LEVEL 2
    a. Describe components of complex health care system and how this impacts patient care.
    b. Identify barriers to care in different health care systems.
    c. Demonstrate the use of information technology and documentation required for medical practice.

3. LEVEL 3
    a. Discuss how individual practice affects the broader system.
    b. Engage with patients in shared decision making and advocate for appropriate care and including mental health parity.
    c. Describe core administrative knowledge needed for transition to practice.

4. LEVEL 4
    a. Manage various components of the complex health care system to provide high-value, efficient, and effective patient care and transition of care.
    b. Advocate for patient care needs including mobilizing community resources.
    c. Analyze individual practice patterns and professional requirements in preparation for practice.

5. LEVEL 5
    a. Advocate systems change that enhances efficient patient care and transition of care.
    b. Participate in advocacy activities for access to care in mental health and reimbursement.
    c. Educate others to prepare them for transition to practice.

Milestone Professionalism

<u>1: Professional Behavior and Ethical Principles.</u>

1. LEVEL 1
    a. Identify and describe core professional behavior.
    b. Recognize that one's behavior in professional settings affects others.
    c. Demonstrate knowledge of core ethical principles.

2. LEVEL 2
    a. Demonstrate professional behavior in routine situations.
    b. Take responsibility for own professionalism lapses and respond appropriately.
    c. Analyze straightforward situations using ethical principles.

3. LEVEL 3
    a. Demonstrate professional behavior during complex or stressful situations.
    b. Describe when and how to appropriately report professionalism lapses in others, including strategies for addressing common barriers to reporting.
    c. Examine complex situations using ethical principles.

4. LEVEL 4
    a. Distinguish situations that may trigger professionalism lapses and intervenes to prevent lapses in self and others.
    b. Respond appropriately to professionalism lapses of colleagues.
    c. Recognize and use appropriate resources for managing and resolving ethical dilemmas as needed. (Ethics consultations, literature review, risk management/legal consultation)

5. LEVEL 5
    a. Demonstrate and role model professional behaviors and ethical principles.
    b. Address system-level factors that exacerbate ethical problems.

<u>Milestone Professionalism 2: Accountability and Conscientiousness</u>

1. LEVEL 1
    a. Take responsibility to complete expected tasks and identify potential contributing factors in failure to complete tasks and describe strategies for ensuring timely task completion in the future.
    b. Introduce yourself to patients as resident physician.

2. LEVEL 2
    a. Perform tasks and responsibilities with appropriate attention to detail
    b. Accept the role of the patient's physician and take responsibility (under supervision) for ensuring that the patient receives the best possible care.

3. LEVEL 3
    a. Perform tasks and responsibilities in a timely manner with appropriate attention to detail in complex or stressful situations.
    b. Recognize personal, patient, family, and medical staff as in collaboration with the primary psychiatric provider.

4. LEVEL 4
    a. Recognize when others are unable to complete tasks and responsibilities in a timely manner and assist in problem solving.
    b. Display increasing autonomy and leadership while ensuring the patients receive the best care.

5. LEVEL 5
    a. Take ownership of system outcomes.
    b. Serve as a role model of responsibility for ensuring that patients receive the best possible care.

Milestone Professionalism 3: Well-Being

1. LEVEL 1
    a. Recognize the importance of maintaining personal and professional well-being.

2. LEVEL 2
    a. List available resources for personal and professional well-being
    b. Describe institutional resources designed to promote well-being

3. LEVEL 3
    a. With assistance, propose a plan to promote personal and professional well-being
    b. Recognize which institutional factors affect well-being

4. LEVEL 4
    a. Independently develop a plan to promote personal and professional well-being
    b. Describe institutional factors that positively and/or negatively affect well-being

5. LEVEL 5
    a. Create institutional level interventions that promote resident well-being
    b. Describe institutional programs designed to examine systemic contributors to burn out.

Didactics

Didactics: Training Year 2025-2026

- PGY-1 Orientation. Electronic Medical Record and Documentation Training
- Review of the GME Policies
- Review of the ACGME Requirements, Competencies and Milestones
- Professionalism and Cultural Competencies

Daily

- Morning Report Inpatient Unit-Junior Level
- Transitions of Care/Hands Off Meetings-Junior Level
- Clinical Teaching Rounds Inpatient Unit -Junior Level

Weekly (During weekly Protected Didactic Day)

- Core Psychiatry Lectures (Wednesdays at CBCC, Building B and virtually via Life Size in the Board Room Building 1, CSU Marion)
- Psychiatry In Service Exam (PRITE and Ninja Guide) Review
- Psychotherapy and Neurodevelopment lectures
- Neurology Lectures (Weekly through rotations at participating site)
- Primary Care Lectures (Weekly through rotation at participating site)

Other

- Journal Club (Monthly)
- Research / QI Lecture/Workshops (Monthly)
- M&M Conference (Bi-monthly)
- Grand Round (Monthly)
- Teaching Skills and Leadership Lectures (Quarterly)
- Professionalism and Practice Management (Annually)

Morning Report

Morning Report will create time for a short didactic window, patient hand-off, and event reporting. It is a requirement of all residents except those on specialized electives or primary care.

Journal Club and Grand Rounds

Residents are required to attend Grand Rounds and Journal Club once a month. Journal Club requires one resident each month to present a journal article to the rest of the program and to a supervising physician. This is to facilitate discussion and create a sense of community.

Didactic Goals Per Post Graduate Year

PGY-1 Didactic Goals

- PGY-1 residents are excused from clinical responsibilities to attend their Didactics.
- PGY-1 will successfully complete orientations, health screenings, EMR and Documentation training, and will provide proof of medical license registration.
- Understand the GME and the psychiatry program's policies and procedures.
- Understand the fundamentals of the Core Competencies and Milestones for training in Psychiatry.
- Acquire basic Core Competencies, attitudes, and funds of knowledge.
- Progressively acquire an elementary understanding and skills related to Psychiatry, Interview Skills, Primary Care, and Neurology.
- Obtain overall knowledge and skills related to specialty-specific series and In-service exam topics.
- Demonstrate knowledge related to research literacy and Quality Improvement.
- Start planning with faculty mentor on research and QI projects.

PGY-2 Didactic Goals

- Attend protected Didactic Sessions.
- Be familiar with the GME institutional updates and the program's policies and procedures.
- Improve Competencies, attitudes, and knowledge crucial to training in Psychiatry, as expected for PGY-2.
- Improve knowledge related to Child Psychiatry, Consultation Liaison, Geriatrics, Addiction Psychiatry, Emergency Psychiatry, Elective, and Continuity Clinical Skills/case logs.
- Demonstrate advanced knowledge related to research and Quality Improvement.
- Continue working with the Faculty Mentor on their Research and QI projects, including a timeline to accomplish these projects.

PGY-3 Didactic Goals

- PGY-3 residents are excused from clinical responsibilities to attend their protected didactic sessions. They will adopt supervisory and leadership roles at didactic conferences.
- Through all didactic sessions, PGY-3 residents are expected to demonstrate a progressive knowledge regarding the institutional and program policies and procedures, and improved level of the Core Competencies and Milestones expected for PGY-3.
- Demonstrate a superior level of knowledge, professional attitudes, and clinical skills.
- Demonstrate advanced knowledge concerning outpatient psychiatry clinics, community delivery systems and resources, continuity of care, psychotherapy skills, interview skills, forensics, administration, and electives.
- Advance knowledge related to research literacy and Quality Improvement. Complete and present their research and QI projects, serving as role models for lower years residents.

- Demonstrate advanced supervisory roles and teaching skills.
- Demonstrate prerequisite knowledge, clinical skills, and attitudes set forth by the ACGME and the ABPN, superior clinical judgment, and wide base of knowledge.

PGY-4 Didactic Goals

- PGY-4 residents are excused from clinical responsibilities to attend their protected Didactic Conferences. They will assume leadership roles through didactic sessions.
- Through all didactic sessions, PGY-4 residents are expected to demonstrate an advanced knowledge regarding institutional and the program's policies and procedures and an advanced level of the Core Competencies and Milestones expected for PGY-4.
- Demonstrate a high level of knowledge and clinical skills.
- Demonstrate advanced knowledge concerning community psychiatry, interview skills, forensics, administration, electives, and transition to the independent practice.
- Act as coordinator and leader of Grand Rounds and Journal Club.
- Advance knowledge related to research literacy and Quality Improvement. Complete and present their research and QI projects, serving as role models for lower years residents.
- Demonstrate advanced supervisory roles and teaching skills.
- Demonstrate prerequisite knowledge, clinical skills, and attitudes set forth by the ACGME and the ABPN, superior clinical judgment, and wide base of knowledge.

Rotation Descriptions

Prior to the start of each rotation, residents meet with faculty to review the goals and objectives of the rotation. Faculty provide residents with the appropriate teaching, supervision, and feedback throughout the rotation, as well as a written evaluation every three months and at the end of the rotation. Residents will discuss their formative evaluations during their semiannual meeting with the program director.

Elective rotations are supervised by the resident's faculty mentor, supervising attending, and at the approval of the program director. The "Elective Request" form at the end of the manual is required to be completed before starting an elective.

1. Inpatient Psychiatry Rotation

Residents acquire significant responsibility for the assessment, diagnosis, and treatment of psychiatric patients who are admitted to the inpatient psychiatric unit. Residents conduct psychiatric interviews and assessments, perform physical and mental examinations, and develop treatment plans to diagnose and manage psychiatric conditions. PGY-1 and PGY-2 residents will perform initial admissions and follow-ups, with supervision provided by the PGY-4 residents (if applicable) and attending physicians. Patient cases are evaluated upon admission, discussed during the morning report, and followed daily until transfer of care or discharge.

Residents gather patient histories, formulate psychiatric diagnoses, identify comorbidities, differential diagnoses, and conduct mental and neurological status examinations. They utilize workups, labs, psychological tests, and scales, as appropriate. They design treatment plans based on the newest guidelines of psychopharmacological and psychological guidelines. Residents must request collateral information when necessary, integrating ethical and legal principles into care, and ensuring informed consents and advanced directives are provided to patients.

Residents participate in teaching rounds, transitions of care/hand off meetings, and discharge planning. Residents collaborate with attending physicians and case managers to ensure continuity of care following discharge.

The psychiatric inpatient units that residents rotate through are located at SMA Healthcare's two primary GME sites, SMA Crisis Stabilization Unit (Marion County) and Chet Bell Crisis Center (Volusia County). The units both serve a diverse adult population of both genders, encompassing a broad range of socioeconomic and cultural backgrounds. Patients are admitted with a variety of behavioral and psychiatric conditions, including acute anxiety and panic disorders, agitation, emotional and behavioral disorders, aggression, substance use issues, mood disorders, major depression disorders, suicidality, somatic disorders, disruptive disorders, acute trauma stress disorders, psychotic spectrum disorders, dissociative disorders, neuropsychiatric manifestations of neurocognitive disorders, and somatoform disorders. Stays typically range from two to fourteen days, with an average of five to seven days.

Residents are typically assigned to four to six patients, depending on the demand of the unit and complexity of cases. Residents attend the weekly protected didactic day (Wednesdays) and participate in weekly individual supervision. Vacation is allowed, following approval by the Program Coordinator and Program Director.

2. Primary Care Rotation

The objective of this rotation is to provide primary care training to PGY-1 psychiatry residents, helping them develop clinical judgement and skills in patient assessment, as well as in the use and interpretation of laboratory tests, diagnostic workups, and imaging studies. During this rotation, residents improve their clinical skills, including gathering medical history, physical examination, formulation of diagnosis and differentials, and identification of appropriate diagnostic procedures, labs, and imaging. Residents also improve their knowledge in treatment planning and medication management.

Residents complete their primary care rotation at SMA's outpatient clinics in Bunnell and Daytona Beach; at the participating sites, the FL Health Institute in Palm Coast and HCA FL Ocala Hospital; and at Chet Bell Crisis Center. Clinical population for this rotation includes individuals of diverse socioeconomic statuses, encompassing both genders, various age groups, ethnicities, and cultures. A wide range of medical diagnosis and treatment options are covered in the primary care setting.

Residents manage an average daily caseload of approximately five to six patients that present with a wide range of chronic and acute medical conditions or diseases, such as electrolyte imbalances, allergies, infections, cardiovascular and respiratory diseases, medical disorders concerning gastroenterology, endocrinology, and nephrology, as well as conditions from other medical specialties.

Attendance at either primary care or psychiatry didactics is mandatory.

No vacation requests will be permitted during this block.

3. Neurology Rotation

During the neurology rotation, PGY-1 residents train in a structured clinical environment, designed to build foundational skills in neurological evaluation, diagnosis, and management within a hospital-based setting (HCA FL Ocala Hospital). Residents actively participate in initial neurological assessments, diagnostic reasoning, and collaborative treatment planning under direct faculty supervision.

During the rotation, residents engage in inpatient neurology consultations supporting various clinical services, caring for a diverse patient population of varying ages, socioeconomic backgrounds, and genders. Patients present with a broad spectrum of primary neurological disorders and neurological complications of systemic illnesses. Common cases include headaches, neuropathic pain, movement disorders, neurocognitive disorders, epilepsy/seizures, behavioral neurology, spinal cord disorders, pain management, stroke, and neurodevelopmental disorders.
Residents are expected to obtain comprehensive neurological histories and perform detailed neurological examinations. Residents learn to localize neurological lesions and formulate diagnosis, differential diagnoses, and treatment plans. Residents order and interpret appropriate diagnostic tests including laboratory studies, EEGs, neuroimaging (CT, MRI, nuclear medicine), and lumbar punctures. Residents should be able to recognize common neuromuscular, neurodegenerative, cerebrovascular,

neuroinflammatory, neuroinfectious, neurogenetic, and neoplastic neurological conditions at the end of the rotation.

Residents will participate in daily clinical rounds and interdisciplinary discussions, enhancing communication skills and clinical decision-making. Patient care responsibilities will generally involve managing four to five patients daily, depending on census and case complexity, always under faculty supervision to ensure patient safety and resident learning.

Residents attend the weekly protected didactic day (Wednesdays) and participate in weekly individual supervision.

No vacation requests will be permitted during this block.

4. Emergency Psychiatry Rotation

Residents triage patients needing urgent or emergency psychiatric care, performing crisis evaluations, interventions, and management. Residents are exposed to cases of patients with exacerbation of psychiatric symptoms, emotional or behavioral instability, substance use disorders, psychiatric symptoms related to acute medical or neuropsychiatric conditions, and other mental illnesses. Residents collect history and obtain collateral information, as appropriate. Residents perform mental status examinations, as well as order and monitor laboratory tests and screenings.

Regular responsibilities will include safety evaluations, consultations, coordination and transition of care, admissions, and medication management, as needed. The rotation aids residents in accomplishing their ACGME Core Competencies, clinical skills, and knowledge in managing psychiatric emergencies. They will also participate in case presentations, teaching rounds, emergency drills, and other educational activities.

Residents complete their emergency psychiatry rotations at SMA Healthcare's two primary GME sites, SMA Crisis Stabilization Unit (Marion County) and Chet Bell Crisis Center (Volusia County). The setting includes a diverse adult population of different ages, genders, socioeconomic statuses, and cultural backgrounds. Some patients and families may not have insurance and produce low incomes. Examples of common diagnoses include acute psychiatric conditions, behavioral disturbances, aggression, suicidality, substance use issues, crisis interventions, interpersonal life crisis, and cases requiring referrals for acute or court-ordered evaluation/admission.

Under faculty supervision and based on the resident's training level, skills, census, and the patient's needs, the resident is responsible to provide care to approximately an average of five to eight patients throughout the shift.

Residents attend the weekly protected didactic day (Wednesdays) and participate in weekly individual supervision.

No vacation requests will be permitted during this block.

5. Child and Adolescent Psychiatry

Residents provide supervised care for children and adolescents, encountering a broad range of mental health conditions typical of this population. They engage in daily meetings, morning reports, clinical rounds, and family meetings, gaining exposure to psychodynamic principles, play therapy, and psychotherapy. This experience fosters interdisciplinary collaboration with psychologists, social workers, and case managers. Patient care emphasizes team collaboration, evidence-based practices, and the development of competencies essential for effective treatment and prevention of mental illness.

The clinical population includes preschool, latency-age children, and adolescents from a diverse ethnic background and even gender distribution. Common diagnoses include affective disorders (depression, bipolar spectrum), behavioral disturbances, conduct disorders, oppositional defiant disorders, ADHD, psychotic disorders, neurodevelopmental and trauma-related disorders. Adolescents frequently present with comorbid substance use, anxiety, depression, and school-related challenges. Treatment modalities include psychopharmacology (stimulants, antidepressants, mood stabilizers, antipsychotics), individual psychotherapy, and family therapy.

This rotation ensures PGY-1 and PGY-2 residents develop essential clinical competencies in child and adolescent psychiatry, aligned with ACGME and ABPN requirements. Each resident manages a caseload of four to five patients appropriate to their training level, with direct supervision by attending faculty.

Protected didactic time includes one weekly session focused on core educational topics.

6. Addiction Psychiatry Rotation

The addiction psychiatry rotation provides PGY-1 and PGY-2 psychiatry residents with supervised training in the evaluation and management of patients with substance use disorders and co-occurring psychiatric conditions. Residents care for adult patients of diverse backgrounds presenting with a range of substance-related disorders such as alcohol, opioids, stimulants, nicotine, cannabis, sedatives, and others, managing cases from admission through discharge.

Clinical skills developed include diagnosing using DSM-5 criteria, performing mental status exams, ordering and interpreting labs and drug screenings, utilizing neuropsychological testing, and treating patients with psychopharmacology alongside supportive psychotherapy and social interventions. Treatment modalities also include individual and group therapy, 12-step programs, motivational interviewing, crisis intervention, detoxification, dual-diagnosis care, and linkage to social services such as housing and vocational rehabilitation.

Residents handle caseloads of approximately four to five patients depending on complexity and census, and all care is delivered in accordance with ethical and legal standards, including informed consent. This experience meets all ABPN and ACGME requirements for resident education in addiction psychiatry.

Faculty and ancillary staff provide direct supervision, and residents attend the weekly protected didactic day (Wednesdays) and participate in weekly individual supervision.

7. Consultation Liaison Rotation

Under faculty supervision, PGY-2 residents conduct psychiatric consultations across varied clinical settings. Patient care is delivered within a therapeutic, multidisciplinary framework, supported by consulting liaison relationships.

Residents follow current psychopharmacology guidelines under attending guidance, prioritizing patient safety and quality of care. Residents actively participate in teaching rounds, grand rounds, morbidity and mortality conferences, multidisciplinary meetings, transition of care discussions, and other educational activities.

Residents provide comprehensive care to adult patients of diverse genders, races, ethnicities, socioeconomic statuses, and cultural backgrounds presenting with a wide range of psychiatric conditions. Common consultations include evaluation of emotional and behavioral disturbances, altered mental status, delirium, agitation, and psychotropic medication management. Residents also assess decisional capacity for treatment and medical decisions, including instances of treatment refusal, evaluate risk factors such as suicidality, violence, and dementia, and contribute to discharge planning, placement, and long-term care needs.

This training ensures PGY-2 residents develop competencies in clinical assessment, differential diagnosis, psychopharmacology, interdisciplinary collaboration, and patient-centered care aligned with ACGME and ABPN standards. Residents are typically responsible for four to five patients.

Residents attend the weekly protected didactic day (Wednesdays) and participate in weekly individual supervision.

8. Outpatient Psychiatry Rotation

During PGY-3, residents will be assigned to one of the outpatient psychiatry affiliated sites, where they will follow a panel of patients for twelve consecutive months. Patient care is delivered through a team-oriented approach focused on mental health promotion, prevention, and allocation of community resources. Under faculty supervision, residents act as the primary psychiatrists for their patient panels, developing essential clinical skills and medical knowledge to manage patients in a public outpatient psychiatry setting. Resident responsibilities include initial evaluations, follow-ups, medication management and refills, psychotherapy, and coordination with social support services.

Therapy cases are staffed on-site and reviewed in detail during individual supervision, which supports the development of both psychotherapy and psychopharmacology skills. Faculty provide teaching, direct daily supervision, and ongoing formative evaluations with feedback. Residents create individualized learning and improvement plans to integrate new skills into clinical care.

The patient population is diverse across gender, ethnicity, culture, and socioeconomic backgrounds, presenting with a broad spectrum of psychiatric disorders including depression, anxiety, panic disorder, psychotic and mood disorders, behavioral disturbances, personality disorders, somatic and neurodevelopmental disorders, trauma and stressor-related conditions, dissociative and neurocognitive disorders, substance abuse, and social and cultural challenges. Residents typically manage a caseload of five to six patients daily, adjusted for case complexity and clinical demands.

In addition to daily supervision, residents attend weekly longitudinal didactic sessions and individual supervision but do not have separate continuity clinics during this year-long outpatient experience.

9. Geriatric Psychiatry Rotation

The Geriatric Psychiatry team is composed of PGY-2 and PGY-4 (if applicable) psychiatry residents, medical students, mental health technicians, psychologists, social workers, case managers, nurses, psychotherapists, security personnel, chaplains, and other team members, delivering patient care through a therapeutic, team-based approach that emphasizes liaison relationships and community resource coordination. Cases are regularly reviewed with faculty, and residents participate in case presentations.

Under attending psychiatrist supervision, residents provide comprehensive psychiatric care to geriatric patients, conducting admission assessments and daily follow-ups until discharge. They develop competencies in diagnosis, differential diagnosis, mental status and neurological examinations, laboratory assessments, and use of neuropsychological testing and cognitive screening tools. Treatment involves psychopharmacology integrated with counseling, psychotherapy, social support reinforcement, and discharge planning, with collateral information gathered as appropriate while adhering to ethical and legal standards including evaluation of mental capacity, advanced directives, and informed consent.

The clinical population is diverse in gender, ethnicity, socioeconomic status, and culture, with lengths of stay averaging six days. Common diagnoses include delirium, altered mental status, depression, neurocognitive and mood disorders, acute psychosis, anxiety, and behavioral issues such as suicidality, aggression, neglect, and post-discharge social or housing challenges. Residents manage caseloads of up to five patients, adjusted for patient complexity and census.

Direct supervision is provided by attending faculty, and residents attend both didactic sessions and individual supervision, as well as maintain their continuity clinic throughout the rotation.

10. Forensic Psychiatry Rotation

Patient care is delivered within a therapeutic milieu through a team-oriented approach involving attendings, residents, psychiatrists, social workers, case managers, nurses, security personnel, and other multidisciplinary team members. The forensic psychiatry experience offers residents training in core forensic skills within general psychiatry and inpatient settings, including assessing risk to self and others, decisional capacity, conservatorship eligibility, commitment to locked facilities, and treatment against a patient's will. Residents provide psychiatric care to patients involved with legal, correctional, detention, or court-mandated programs, as well as those with ethical or forensic issues. They also serve patients in criminal justice and inmate programs who have serious mental illness or co-occurring substance use disorders, providing community-based treatment and support. When appropriate, residents may accompany attendings to court and gain experience writing forensic reports and providing courtroom testimony.

Throughout the rotation, residents develop competencies and clinical skills while gaining knowledge of relevant legal and ethical principles. Residents conduct thorough histories, mental status exams, DSM-5-based diagnoses, order labs and imaging, and manage treatment with evidence-based psychopharmacology combined with counseling and social supports.

The clinical population includes adults of all genders and diverse racial, ethnic, socioeconomic, and cultural backgrounds, presenting with a broad range of psychiatric and behavioral disorders such as psychotic, mood, anxiety, personality, neurocognitive, paraphilic, impulse control, and substance-related disorders, as well as malingering and evaluations of mental capacity.

Residents manage caseloads of approximately three to four patients daily, adjusted for census, staffing, and case complexity. They attend protected didactic sessions and individual supervision throughout the rotation.

11. Community Psychiatry Rotation

Patient care in the community outpatient setting emphasizes promotion, prevention, psychoeducation, a team-based approach, and utilization of community resources. PGY-4 residents develop improvement plans to incorporate new skills into daily practice. The community psychiatry service focuses on preventing and treating ambulatory psychiatric conditions, psychosocial rehabilitation, ACT teams, targeted case management, and care for underserved and uninsured populations.

Under faculty supervision, residents provide psychiatric care and psychoeducation to adults, advancing medical knowledge, clinical skills, psychopharmacology management, system-based practice, evidence-based medicine, quality improvement, and practice-based learning. They demonstrate professionalism and effective communication while collaborating with staff, peers, patients, and families. Residents refine individual and group psychotherapy skills, coordinate community resource allocation, and consult with case managers, crisis teams, and other mental health professionals.

The clinical population includes adults of both genders and diverse racial, ethnic, cultural, and socioeconomic backgrounds presenting with diagnoses such as chronic psychiatric disorders, mood and anxiety disorders, psychotic disorders including schizophrenia, bipolar disorder, major depression, trauma-related and dissociative disorders, neurocognitive and neurodevelopmental disorders, intellectual disability, autism spectrum disorders, substance use disorders, and comorbid medical conditions. Residents manage an average caseload of six patients daily, adjusted for clinical demands and complexity, with daily direct and indirect supervision by faculty.

Residents attend protected didactic sessions and individual supervision throughout the rotation.

12. Administrative Psychiatry Rotation

PGY-4 residents train in the management, organizational, and leadership aspects of psychiatric care systems and health care delivery during this rotation. The rotation aims to enhance understanding of how psychiatric services are structured, coordinated, and delivered within clinical and institutional settings. Residents gain understanding on administrative issues related to the practice of psychiatry and reflect on postgraduate career options.

Residents gain experience in working with multidisciplinary teams, including care managers, primary care providers, social workers, legal or medial professionals, emphasizing communication and coordination for patient care. Residents learn the legal, ethical, and procedural aspects of admission procedures, crisis management, and institutional policies relevant to psychiatric care and administration.

PGY-1 Goals and Objectives Per Rotation

1. Inpatient Psychiatry Rotation

Inpatient Psychiatry Rotation Goals

Residents will develop responsibility, under appropriate supervision, in the assessment, diagnosis, and treatment of a diverse range of patients admitted to the psychiatric unit with acute mental health and behavioral conditions. They will perform psychiatric interviews and evaluations, formulate diagnoses and differentials, establish treatment plans, and coordinate post-discharge continuity of care. Residents must achieve the ACGME Competencies and meet psychiatry-specific Milestones for PGY-1.

Inpatient Psychiatry Rotation Objectives

1. Patient Care and Procedural Skills
    a. Provide compassionate, patient-centered care to stabilize acute psychiatric conditions and improve their patients' mental wellbeing, focusing on safety, evidence-based medicine, quality improvement, and continuity of care.
    b. Acquire elementary skills to perform psychiatric evaluations, and to provide treatment plans to patients with diverse ethnic, racial, sociocultural, and economic backgrounds.
    c. Understand basic knowledge and clinical skills to professionally and safely conduct mental status and neurological exams of patients, including the gathering of history, accurate documentation, mental status exams, and neurological exams, as well as incorporate an understanding of patients' risks, triggering factors, comorbid medical disorders, personal history, mental status/decisional capacity, and safety.
    d. Order and monitor workups, labs, imaging studies, and other diagnostic tools.
    e. Acquire the basic skills to formulate the diagnosis and the differential diagnosis, following psychiatric guidelines and the DSM-5 criteria.
    f. Acquire clinical skills to organize safe treatment plans, including alternative options, risks, benefits, and continuity of care after discharge.
    g. Provide informed consent and psychoeducation to patients and families.
    h. Treat patients following psychopharmacological guidelines, combining treatment plans with psychotherapy, ancillary systems, psychosocial support, and rehabilitative interventions.
    i. Assess patient's risks, manage aggressive behaviors, and understand guidelines concerning ethical matters, legal matters, and crisis intervention.
    j. Manage patients with acute behavioral disturbances in a safe and effective manner.
    k. Demonstrate basic skills to present cases and perform appropriate transitions of care.
    l. Learn the inpatient psychiatric unit's procedures, including the incorporation of important features such as patient's consents, mental capacity, legal guardian, second opinions, refusal of treatment, transfer of care, criteria for discharge, placement, and discharge planning.

2. Medical Knowledge

a. Understand the influence of the patient's biological, psychological, behavioral, and sociocultural factors in mental health.
b. Recognize theoretical approaches of the patient-doctor association, and aspects related to biological, genetic, psychological, sociocultural, economic, ethnic, gender, religious, spiritual, sexual orientation, and family factors which may impact physical and psychological factors.
c. Recognize and differentiate common psychiatric disorders, their epidemiology, diagnostic criteria, treatment, and prevention.
d. Understand basic principles of current psychiatric guidelines, tailoring them to the patient's functioning, care, and clinical setting.
e. Improve medical knowledge regarding reliability and validity of diagnostic tests.
f. Acquire elementary knowledge regarding indications of laboratory testing, screenings, imaging, neurophysiologic and neuropsychological testing.
g. Understand legal and ethical standards in psychiatric practice, including consent and discharge criteria.
h. Acquire the essential knowledge concerning integrated medical decisions, including comprehensive clinical findings, evidence-based data, and adequate professionalism and clinical judgment.
i. Understand indications, side effects, drug interactions, and effectiveness of non-pharmacological alternative options while following prescriber guidelines.

3. Interpersonal and Communication Skills
    a. Develop skills to actively listen and effectively exchange information with patients, their families, and health professionals through non-verbal, verbal, and written communication.
    b. Develop basic skills to perform patient interviews, under faculty guidance.
    c. Maintain empathetic, appropriate professional boundaries and therapeutic rapport.
    d. Educate patients, families, colleagues, and other health professionals, as appropriate.
    e. Discuss the goals of the rotation with faculty.

4. Professionalism
    a. Demonstrate professional responsibility and adherence to ethical principles.
    a. Become familiar with ethical principles, following SMA Healthcare's GME Policies and Procedures, as well as the ACGME Requirements and Competencies.
    b. Understand the AMA Principles of Ethics.
    c. Respect patient's privacy and autonomy, maintaining professional boundaries, demonstrate honesty, reliability, and punctuality, and responsiveness to patient needs that supersede self-interests.
    d. Demonstrate compassion and responsiveness to a diverse patient population, respecting gender, age, culture, race, religion, disabilities, and sexual orientation.
    e. Demonstrate ethical values pertaining to the provision or withholding of clinical care, confidentiality, informed consent, business practice and ongoing self-development.
    f. Develop the plan for personal and professional well-being.
    g. Appropriately disclose and address conflict or duality of interests.

5. Systems-based Practice

a. Demonstrate appropriate knowledge related to practice and delivery of systems, and to basic legal issues involved in the inpatient psychiatric care scenery.
b. Obtain skills to evaluate risks, benefits, limitations, and costs of available resources, improving system of care integrating the practice within the larger health system.
c. Advance the responsiveness to the system of health care, and the ability to call effectively on other resources in the system to provide optimal health care.
d. Work with the health care delivery systems related to psychiatry practice.
e. Coordinate effective and safe patient care, incorporating considerations of cost awareness and risk-benefit analysis.
f. Acquire skills to provide quality patient care, while working with inter-professional teams.
g. Participate in classifying system errors and implementing potential systems solutions.
h. Support the promotion of mental health and the prevention of mental and behavioral disorders.
i. Improve personal skills to assist patients in dealing with the health care system complexities, agencies, and disparities of mental health care resources.

6. Practice-Based Learning and Improvement
    a. Incorporate educational resources for self-directed learning.
    b. Acquire skills to investigate and assess patients, appraise, and assimilate scientific evidence.
    c. Improve patient care based on continuous self-evaluation and the development of life-long learning methods.
    d. Recognize strengths, deficiencies, and limits in knowledge and expertise, setting an individual plan of improvement, identifying appropriate learning activities and strategies to achieve the goals, which will be incorporated into patient care.
    e. Analyze personal clinical practice using quality improve faculty evaluations feedback into the individual patient care, demonstrating awareness to locate, appraise, and assimilate the evidence from scientific studies.
    f. Use information technology to improve learning and coaching or teaching skills.
    g. Provide psychoeducation to patients and families.
    Integrate the faculty feedback from formative and semiannual evaluations into patient care.

2. Primary Care Rotation

Primary Care Rotation Goals

Residents will refine their clinical judgment and patient-assessment skills, including the appropriate utilization, selection, and interpretation of overall patient management, laboratory, and diagnostic studies. They will further develop history-taking techniques, physical-examination proficiency, diagnostic formulation and differential diagnosis, and the use and interpretation of diagnostic procedures, laboratory tests, and imaging studies. The Primary Care rotation will ultimately enable the residents to craft comprehensive treatment plans and optimize medication management.

Primary Care Rotation Objectives

1. Patient Care
    a. Provide patient care that is compassionate, timely, safe, based on prevention, and effective to relieve patient's medical problems. Care must be designed to improve population health, while reducing per capita costs.
    b. Gather an accurate history, obtain appropriate and prioritized data from secondary sources (e.g., family, records, pharmacy) as appropriate, and obtain relevant historical information to clarify diagnosis and treatment moving forward.
    c. Perform physical examinations targeted to the patient's medical complaints.
    d. Classify unusual physical findings that may influence clinical decision making.
    e. Establish differential diagnoses, evidence-based diagnosis, and therapeutic plans.
    f. Under supervision, distinguish disease presentations that may diverge from common patterns and that require complex decision-making skills.
    g. Order and monitor medical/diagnostic workups and procedures considered essential for the area of practice, providing the appropriate informed consent.
    h. Develop clinical decisions based on the results diagnostic testing, including routine blood chemistries, hematologic studies, coagulations tests, ABG, ECG, chest radiographs, pulmonary function tests, urinalysis, and other body fluids.
    i. Under direct faculty supervision, understand and report situations needing urgent or emergent medical care, and life-threatening conditions.

2. Medical Knowledge
    a. Understand the pathophysiology and basic science for common medical conditions.
    b. Demonstrate the appropriate level of medical knowledge to diagnose and treat common, comorbid, and complex medical conditions.
    c. Evaluate, diagnose, and treat undifferentiated, emergent, and other medical conditions that will require more intensive care.
    d. Improve knowledge to provide education on the promotion of health.
    e. Understand aspects of pathophysiology and basic sciences for uncommon or complex medical conditions, improving the level of knowledge about medication management.

3. Interpersonal and Communication Skills
    a. Improve verbal and written communication skills to build effective, empathetic therapeutic relationships with patients and families.
    b. Advance skills for making decisions in difficult, ambiguous, or controversial scenarios.
    c. Provide informed consents and counsel to patients about the risks and benefits of treatment, medications, tests, and procedures, highlighting cost awareness and resource allocation.
    d. Learn from the faculty role model and communication skills in challenging situations.
    e. Understand patient differences and feelings on respectful communication.
    f. Communicate with caregivers to maintain continuity during transitions of care.
    g. Communicate plans of care and discharge to members of the health care team.
    h. Communicate efficiently the resident role as consultants, under faculty supervision.
    i. Communicate timely consultative recommendations to the team in a precise manner.

j. Maintain legible, accurate, complete, and timely written communication that is consistent with medical standards, ensuring concise, relevant, and patient-specific written documentation.
k. Discuss the goals of the rotation with faculty.

4. Professionalism
    a. Follow professional responsibilities, ethical values, and demonstrate respect, compassion, integrity, and responsiveness to the needs of patients and society that supersedes self-interest, respect for patient's privacy, autonomy, and responsibility to patients, society, and the profession.
    b. Accomplish ethical principles related to the provision of clinical care.
    c. Establish sensitivity and receptiveness to diverse patients' culture, age, gender, race, religion, disabilities, economic status, and sexual orientation.
    d. Plan for personal well-being and ongoing professional development for oneself.

5. Systems-based Practice
    a. Demonstrate awareness of and responsiveness to the context and system of healthcare.
    b. Demonstrate the ability to call on system resources to provide care that is of optimal value to the patient.
    c. Practice cost-effective healthcare and resource allocation.
    d. Promote quality patient care and assist patients in dealing with system complexities.
    e. Coordinate patient care beyond the resident's clinical specialty.
    f. Work with interprofessional teams to enhance patient safety and quality of care.
    g. Incorporate considerations of value, cost awareness, and risk-benefit analysis, as well as identify system errors and implement potential system solutions.
    h. Understand health care finances and its influence on individual patients' health decisions.
    i. Advocate for patients to achieve the patient's and family's care goals.

6. Practice-based Learning and Improvement
    a. Recognize gaps and limitations in personal knowledge and clinical skills, understanding the need for lifelong learning.
    b. Advance skills for obtaining and evaluating up-to-date information from scientific and practice literature, as well as other foundations to assist in the quality care of patients. This includes the use of medical libraries, information technology, Internet-based research and literature databases, drug information databases and participation, in educational courses, conferences, and other organized educational activities at both local and national levels.
    c. Assess caseload experiences in a systematic manner.
    d. Attain appropriate supervision and consultation.
    e. Maintain a system for examining errors and initiating improvement.
    f. Assess medical literature.
    g. Integrate the faculty feedback from formative and semiannual evaluations into patient care.

3. Neurology Rotation

Neurology Rotation Goals

1. Provide residents with an opportunity to evaluate and treat patients with neurological disorders while gaining a foundational understanding of pathophysiology, epidemiology, diagnostic criteria, and clinical course of common neurologic conditions.
2. Introduce residents to neurological complications of psychiatric disorders and somatic therapies, including relevant aspects of neuropharmacology.
3. Facilitate the residents in conducting comprehensive neurological evaluations, diagnosis, and management of disorders
4. Provide exposure to complex and common neurological conditions, teaching residents to recognize when to manage independently and when to consult neurology specialists.

Neurology Rotation Objectives

1. Patient Care
   a. Provide patient care that is compassionate, safe, and effective in the treatment of neurological conditions, demonstrating caring and respectful behaviors.
   b. Deliver safe, efficient, timely, patient-centered, and equitable care that is designed to improve population health, while reducing per capita costs.
   c. Gather complete patient history and perform the physical exams on patients from diverse backgrounds.
   d. Recognize when symptoms are neurological in origin, distinguishing between central, peripheral, and non-neurological causes.
   e. Apply diagnostic reasoning, including formulation of differential diagnoses, interpretation of laboratory and neurodiagnostic studies, and development of evidence-based treatment plans.
   f. Make informed decisions regarding diagnostic and therapeutic interventions in collaboration with patients and their families, scientific evidence, and sound clinical judgement.
   g. Utilize information technology to support clinical decision-making and patient education.

2. Medical Knowledge
   a. Demonstrate knowledge concerning the biological foundation of neurological illnesses and apply this knowledge to patient care.
   b. Understand the pathophysiology, epidemiology, diagnostic criteria, and clinical courses for common neurological disorders, including:
      - Dementia/NCD
      - Epilepsy and related disorders
      - Neuromuscular and demyelinating disorders
      - Cerebrovascular diseases
      - Central nervous system diseases and tumors
      - Traumatic brain and spinal cord injury
      - Toxic and metabolic disorders of the central nervous system
      - Acute and chronic pain
      - Coma and brain death
      - Headache and facial pain
      - Sleep and Movement disorders.
      - Neurological manifestations/complications of common psychiatric disorders.
      - Psychiatric manifestations of neurological illness, and vice versa

c. Understand and manage neuropharmacology, including commonly used medications (anticonvulsant, antiparkinsonian agents, etc.), their side effects, interactions, and complications.
d. Decide appropriate treatment options, based on patient history, physical findings, localization, differential diagnoses, and risk-benefit analysis of potential therapies.

3. Interpersonal and Communication Skills
    a. Improve communication skills with patients, families, and the healthcare team.
    b. Establish therapeutic and ethically sound relationships with patients, demonstrating empathy while maintaining appropriate professional boundaries.
    c. Show active listening skills in interactions with patients, families, and health care providers.
    d. Communicate difficult information to patients and their families in a respectful, empathetic manner.
    e. Work efficiently within a multidisciplinary team.
    f. Discuss the goals of the rotation with faculty.

4. Professionalism
    a. Demonstrate respect, compassion, and integrity in all interactions with patients, families, and other health care providers.
    b. Exhibit responsibility to patients, health care providers, faculty, and the medical profession that supersedes self-interest.
    c. Commit to excellence and ongoing professional development.
    d. Display compassion and responsiveness to each patient, regardless of age, gender, culture, ethnicity, religion, and disabilities.

5. Systems-based Practice
    a. Understand the context of the mental health care system and use system resources to provide optimal patient care.
    b. Understand how health care providers, the health care organization, and the health care system affect patient care.
    c. Distinguish how different types of medical practice and delivery systems differ from one another to control health care costs and allocation of resources.
    d. Practice cost-effective health care that does not compromise quality.
    e. Advocate for quality patient care and assist patients in navigating the healthcare system.

6. Practice-Based Learning and Improvement
    a. Embrace lifelong learning and recognize limitations in personal knowledge and clinical skills.
    a. Assess scientific literature, medical libraries, and technology to advance knowledge and quality improvement in personal practice.
    b. Engage in case-based learning and quality improvement.
    c. Seek appropriate supervision and consultation.
    d. Maintain a system for examining errors and initiating improvement.
    e. Integrate the faculty feedback from formative and semiannual evaluations into patient care.

4. Emergency Psychiatry Rotation

Emergency Psychiatry Rotation Goals

1. Acquire the appropriate level of medical knowledge and clinical skills to identify and manage psychiatric emergencies, triage, diagnosis, treatment, and disposition.
2. Manage mental illness based on the patient's biological, psychological, and socio-cultural factors, as well as improve skills in gathering patient histories, formulate diagnoses, and implement treatment plans, focusing on acute stabilization with aftercare strategies.
3. Assess patients for safety and risks to determine an appropriate, safe disposition and subsequent continuity of care.
4. Participate in psychosocial interventions, including family meetings and staff discussions.
5. Achieve the goals of the rotation, and the ACGME Competencies.
6. PGY-2 Residents hold supervisory roles to PGY-1 residents.

Emergency Psychiatry Rotation Objectives

1. Patient Care

    a. Provide patient care that is compassionate, safe, appropriate, and effective for the treatment of patients with acute or severe mental illness, crisis, or emergency.
    b. Formulate treatment plans and implement them appropriately, focusing on safety and acute stabilization with subsequent plans of continuity of care.
    c. Perform bio-psychosocial assessments, including genetic predisposition, developmental issues, co-morbid medical conditions, comorbid substance use, influencing ethnic, cultural, spiritual, and economic factors, relationships, psychosocial stressors, and mental status.
    d. Order appropriate interventions to protect the safety of the patients, and asses risk of violence and self-harm.
    e. Improve skills to perform informed decisions about diagnostic and therapeutic interventions based on patient preferences, up-to-date scientific evidence, and good clinical judgment.
    f. Use psychotherapeutic strategies during crisis, including psychopharmacologic interventions, supportive techniques, crisis interventions, and risk reduction strategies.
    g. Manage behavioral emergencies under appropriate supervision.
    h. Work comprehensively with other mental health professionals, focusing on safe patient care.
    i. For PGY-2 residents, demonstrate an advanced level of medical knowledge related to the emergency psychiatry setting, to master above-mentioned objectives in a supervisory role.

2. Medical Knowledge

    a. Acquire specialized medical knowledge based on the patient's biological and psychological factors that may contribute to an acute crisis and apply this knowledge to patient care, focusing on the etiology, risks, history, prevalence, diagnosis, treatment, psychoeducation, and future prevention of the psychiatric conditions seen in patients.

b. Diagnose patients through the current DSM-5 criteria, formulating differential diagnoses and assessment of collateral information, history, risks, and comorbidities.
c. Understand the variety of psychopharmacological treatments for acute psychiatric and behavioral presentations, including treatment algorithms, treatment-resistant illnesses, augmentation strategies, and combination therapies.
d. Improve knowledge regarding the laws governing emergency medicine services.
e. Understand investigatory and analytic approaches to clinical situations.

3. Interpersonal and Communication Skills

a. Effectively communicate with all healthcare professionals and staff, using language that values all members of the healthcare team.
b. Communicate effectively with patients and families, providing counsel when needed.
c. Create and maintain therapeutic and ethical relationships with patients and families.
d. Practice listening skills and provide information through non-verbal and verbal statements, appropriate questioning, and documentation.
e. Effectively communicate in urgent situations.
f. Develop strong skills in relaying difficult information to patients and their families.
g. Keep comprehensive, timely, and legible medical records.
h. Act in a consultative role to other physicians and health professionals.
i. Discuss the goals of the rotation with faculty.

4. Professionalism

a. Practice professionalism pertaining to the provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
b. Demonstrate respect, compassion, and integrity in all interactions with patients, families, and other health care providers.
c. Exhibit care to patients, health care providers, faculty, and the medical profession that supersedes self-interest.
d. Commit to excellence and ongoing professional development.
e. Display compassion and responsiveness to each patient, regardless of age, gender, culture, ethnicity, religion, and disabilities.

5. Systems-based Practice

a. Understand the context of the mental health care system and use system resources to provide optimal patient care.
b. Understand regulations of emergencies, federal rules, seclusion, restraints; psychiatric commitment and guardianship issues; confidentiality and HIPAA; COBRA, EMTALA.
c. Practice cost-effective health care that does not compromise quality.
d. Advocate for quality patient care and assist patients in navigating the healthcare system.
e. Work with interprofessional teams to enhance patient safety and quality.
f. Distinguish how different types of medical practice and delivery systems differ from one another to control health care costs and allocation of resources.
g. Identifies key elements for safe and effective transitions of care and hand-offs.

6. Practice-based Learning and Improvement
    a. Evaluate patient care in the emergency setting by locating, appraising, and assimilating scientific evidence, as well as progressing the patient care practice experience.
    b. Identify strengths and limitations in one's knowledge and expertise.
    c. Incorporate the faculty feedback to improve individual experience.
    d. Use information technology, study designs, and evidence-based medicine.
    e. Thoroughly analyze practice outcomes using quality improvement methods.
    f. Integrate the faculty feedback from formative and semiannual evaluations into patient care.

5. Child and Adolescent Psychiatry Rotation

Child and Adolescent Psychiatry Rotation Goals

1. Assess and manage psychiatric problems presented in childhood and adolescence.
2. Act as a consultant to other physicians, departments, and agencies.
3. Generate referrals to other sub-specialties, professionals, and community agencies.
4. Incorporate feedback from the faculty in advancing patient care and clinical improvement.

Child and Adolescent Psychiatry Rotation Objectives

1. Patient Care

    a. Provide patient care that is compassionate, appropriate, safe, efficient, timely, patient-centered, equitable, and designed to improve population health.
    b. Advance skills in the evaluation and treatment of children and adolescents of different genders, culturally diverse, and from a variety of ethnic, racial, sociocultural, and economic backgrounds, establishing a therapeutic alliance with patients.
    c. Educate parents on informed consent, alternative treatments, and potential benefits.
    d. Formulate the diagnosis based on the DSM-5 criteria, patient interviews, history gathering, physical and mental status exams, diagnostic studies, making a systematic medical record by formulating an understanding of the biological, psychological, behavioral, and sociocultural issues.
    e. Develop a differential diagnosis and treatment plan appropriate for child psychiatry.
    f. Under faculty supervision, treat children and adolescents with psychiatric disorders using updated pharmacological treatments, alternative treatment options, psychotherapy, and strengthening parent involvement in the treatment, education, and community supportive systems.
    g. Identify and evaluate patient safety and respond appropriately in case of complexities such as domestic violence, child abuse, conduct disorder and other conditions involving where legal issues may arise.

2. Medical knowledge

a. Understand biomedical, clinical, evolving sciences and the application of this knowledge to patient care.
b. Residents will be able to demonstrate knowledge of the following elements:
    - Human development through the cycle of life.
    - Psychopathology in children and adolescents vs. normal development.
    - Diagnosis of psychiatric illnesses seen in children and adolescents, as outlined in the latest edition of the DSM-5.
    - Understand and deliver the basic bio-psychosocial evaluation and methods for multi-system physical exams.
    - Understand the potential side effects, interactions, and risks of common treatments used in children.
    - Understand the indications for clinical and laboratory studies, neuropsychological tests, and scales.
    - Know the risks factor assessment for suicidal and aggressive behaviors. Know the contraindications, side effects, doses, and potential interactions of the psychotropic medications most prescribed for children and adolescents.
    - Know the Medical-legal issues involved with treating minors.

3. Interpersonal and Communication Skills

    a. Demonstrate effective interpersonal and communication skills that result in information exchange and teaming with patients, the patient's families, and professional associates.
    b. Create and maintain therapeutic and ethical relationships with patients and families.
    c. Work as a member of a health care team.
    d. Communicate effectively with patients, families, and the public.
    e. Understand that personal experiences, demeanors, and wording may impact the perceptions in a physician's relationships with patients.
    f. Communicate with uncooperative patients and family members in respectful manner.
    g. Maintain comprehensive, timely, and legible medical records and documentation.
    h. Educate patients, families, students, residents, and other health professionals regarding care.
    i. Act as a consultant to other physicians and health professionals.
    j. Discuss the goals of the rotation with faculty.

4. Professionalism

    a. Demonstrate respect, compassion, and integrity for others, responsiveness to the needs of patients and society, respect for patient privacy and autonomy, and accountability to patients, society, and the profession.
    b. Establish adherence to ethics pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
    c. Validate sensitivity and responsiveness to diverse patients' culture, age, gender, race, religion, disabilities, and sexual orientation.
    d. Identify a plan for personal well-being. Address conflicts and duality of interests.
    e. Establish and maintain appropriate professional boundaries.

5. Systems-based Practice

a. Demonstrate responsiveness to the context and system of health care as well as the ability to call on system resources to provide care that is of optimal value to the patient.
b. Practice cost-effective healthcare and resource allocation.
c. Advocate for quality patient care.
d. Participate in classifying system errors and implementing potential system solutions.
e. Organize patient care across the health care continuum.
f. Work with interprofessional teams.
g. Incorporate considerations of value, costs, delivery, payment, and risk-benefit analysis.
h. Recognize health care cost and its impact on patients' health decisions.
i. Advocate for patients within the health care system in order to achieve the patient's and family's care goals.

6. Practice-based Learning and Improvement
    a. Recognize gaps and limitations in personal knowledge and clinical skills.
    b. Comprehend and address the need for lifelong learning.
    c. Advance skills for evaluating information from scientific and practice literature.
    d. Assess caseload and practice experience in a systematic manner, including case-based learning, use practice guidelines and clinical pathways, faculty evaluations, from patients' outcomes and satisfaction surveys
    e. Critically assess the medical and scientific literature to improve knowledge base.
    f. Integrate the faculty feedback from formative and semiannual evaluations into patient care.

6. Addiction Psychiatry Rotation

Addiction Psychiatry Rotation Goals

Residents will acquire competencies to diagnose and treat individuals presenting with conditions related to the use of substances, and those with co-occurring psychiatric disorders. Residents will be able to recognize factors that impact the patients comfort within the addiction setting. Residents will achieve the objectives of the rotation and incorporate them into their patient care. Residents will be required to demonstrate advanced clinical skills, medical knowledge, competencies, teaching skills, and high standards of professionalism.

Addiction Psychiatry Rotation Objectives

1. Patient Care
    a. Provide patient care that is compassionate, appropriate, and effective for the treatment of patients with addictive diseases.
    b. Provide quality patient care that is safe, efficient, timely, patient-centered, equitable, and designed to improve patient health while reducing per capita costs.
    c. Perform medical diagnostic work up for this area of practice.
    d. Manage and treat acute intoxications, overdoses, and withdrawal treatment.
    e. Perform a complete evaluation and treat patients with substance use disorders.

f. Conduct interviews, gather history, perform a physical, neurological, and mental status examination needed to formulate a diagnosis, develop a treatment plan, and track findings in the medical record.
g. Provide consultation to a diversity of settings and to patients who are receiving treatment from non-medical providers or therapists.
h. Recognize, evaluate for safety, responding accurately in complex cases.
i. Make use of pharmacological regimens, psychotherapy, and community supportive programs as indicated.
j. Order and practice psycho-therapeutic techniques, including motivational interviewing, psychoeducation, relapse prevention, supportive therapy, cognitive behavioral therapy, psychodynamic therapy, as well as psychotherapy for couples, families, and groups.

2. Medical Knowledge

a. Advance knowledge concerning established and evolving biomedical sciences and make application of this knowledge to patient care.
b. Diagnose substance use disorders, based on the DSM 5 criteria.
c. Advance knowledge concerning treatment modalities, including promotion, prevention, detoxification, overdose, intoxication, treatment maintenance, pharmacotherapy, therapeutic techniques that address the psychological and social consequences of addiction.
d. Establish knowledge of disorders including intoxication and withdrawal from non-substance-related disorders.
e. Manage appropriate treatment plans, including withdrawal treatment.

3. Interpersonal and Communication Skills

a. Establish effective interpersonal communication skills for information exchange and teaming with patients, the patient's families, and professional associates.
b. Generate and sustain a therapeutic and ethical relationship with patients and families.
c. Interconnect as a member the health care team or professional groups.
d. Communicate effectively with patients, families, and the public.
e. Comprehend how personal experiences, demeanor, and words can affect perceptions in a physician's relationships with patients, families, and professionals.
f. Always maintain a professional attitude with patients and families.
g. Communicate with uncooperative patients and family members in respectful manner.
h. Maintain comprehensive, timely, and legible medical records.
i. Educate patients, families, students, residents, and other health professionals.
j. Act in a consultative role to other healthcare professionals.
k. Discuss the goals of the rotation with faculty.

4. Professionalism

a. Demonstrate a commitment and adherence to ethical principles.
b. Demonstrate respect, compassion, integrity, and respect for patient privacy and autonomy.
c. Establish adherence to ethical principles pertaining to provision or withholding of clinical care and medical practices.
d. Show sensitivity and responsiveness to the diversity of individuals and populations.

e. Recognize and develop a plan for one's own personal and professional well-being.
f. Establish and maintain appropriate professional boundaries.

5. Systems-based Practice

   a. Demonstrate awareness and responsiveness to system resources to provide care that is of optimal value to the patient.
   b. Practice cost-effective care and resources allocation.
   c. Advocate for quality patient care and assist patients in dealing with healthcare system complexities.
   d. Participate in identifying system errors and the implementation of system solutions.
   e. Coordinate patient care across the health care continuum.
   f. Work in interprofessional teams to enhance patient safety and improve patient care quality.
   g. Assist patients in achieving the patient's and family's care goals.

6. Practice-based Learning and Improvement

   a. Recognize gaps and limitations in personal knowledge and clinical skills.
   b. Comprehend and address the need for lifelong learning.
   c. Advance skills for obtaining and evaluating up-to-date information from scientific and practice literature and other foundations to assist in the quality care of patients., including the use of medical libraries, information technology, Internet-based searches and as appropriate participation in educational courses, conferences, and other organized educational activities at both local and national levels.
   d. Assess caseload and practice experience in a systematic manner, including case-based learning, use of best practices following practice guidelines and clinical pathways, review of patient records, and from patients' outcomes.
   e. Attain appropriate supervision and consultation.
   f. Maintain a system for examining errors and initiating improvement.
   g. Integrate the faculty feedback from formative and semiannual evaluations into patient care.

Quality Improvement

- Research curriculum includes education concerning the basic principles of research, such as how research is directed, assessed, explained to patients, and integrated into patient care. SMA Healthcare, in partnership with the program, ensures the distribution of educational resources to support research and scholarship. Residents are required to attend sessions concerning research and evidence-based medicine. The subjects include HIPAA principles, informed consent, investigative work reviews, analysis of the current medical literature, statistics, access to institutional resources, the IRB Process from study design to protocol revisions, and the selection of appropriate outcome measures and scientific literature.
- Residents are required to participate in one QI project before graduation.
- Residents must demonstrate their ability to analyze and improve practice and patient care, increase patient safety, and avoid wasting limited resources.
- The project has a collaborative and interdisciplinary approach in nature.
- The project activity is mentored, supervised, and evaluated by an assigned faculty member/advisor or mentor.

QI Project – Steps to Planning, Implementation, Evaluation and Presentation

1. Identify the topic and title of your project, which should be related to healthcare/mental healthcare and have a meaningful impact.

2. Present your project plan and timeline to a faculty member/mentor for approval. This presentation should include the steps and duties that will be taken to complete the project, an “Aims” or “Goals” statement, the implementation process, and the project’s deadline.

3. Plan frequent meetings with the faculty member/mentor to discuss the significance of the project, information or quality metrics collected, sources of investigation, and progress status.

4. Understand the principles of QI and Quality Metrics, including a comprehensive review of the topic, the making of a root cause analysis, investigation of medical errors or deficient procedures, patient safety issues, plan-do-study-act cycles, teamwork and communication, achievement of screenings, policies and standards of care, recommended treatment plan approaches, the measurement of patient and system outcomes, and the planning of the implementation of the significant change in clinical practice.

5. At the end of the project, the resident should be able to measure the results of the positive change and apply the benefits and recommendations from this change into future patient care and education.

6. Complete a final report and final meeting with the faculty member/mentor.

7. Residents must present their projects during the final year of training as role models for junior residents. Presentation will be completed during designated didactic sessions

and include posters, PowerPoint, and oral formats. The goal is to use this project at future symposiums and for publication.

8. This project is expected to make a significant difference in the safety and quality of care of current and future patients.

9. These projects will be supervised and evaluated by the faculty. In addition, the resident's accomplishment of their QI project will be assessed during the semiannual and annual meetings with the program director.

10. Successful completion of the QI project is a requirement for graduation.

Criteria for Graduation

The Graduate Medical Education Committee (GMEC) and the Clinical Competency Committee (CCC) work with the Program Director to determine resident promotions.

The criteria for graduation will include, but are not limited to:

1. Satisfactory completion of rotations, continuity clinics, patients' clinical logs, CMEs, QI and research, evaluations, inservice exams, and achievement of the responsibilities assigned by the program.

2. Follow the ACGME's requirements and SMA Healthcare's policies and procedures.

3. Demonstrate consistent attendance at didactic seminars and conferences.

4. Adequate breadth and depth of clinical patient experience, as documented by patient logs.

5. Reliable participation in required individual supervision sessions.

6. Satisfactory passing of the USMLE/COMLEX Step 3.

7. Satisfactory completion of the program's goals and objectives, as outlined in the ACGME Common and Psychiatry-specific Program Requirements for Graduate Medical Education in Psychiatry and as enclosed within this manual.

8. Meet the ACGME Core Competencies and Psychiatry Milestones.

9. Meet the ABPN requirements and clinical skills for board eligibility examination.

10. Demonstrate absence of any serious errors in clinical judgment, or in the case of such errors, successful completion of any corrective remedial training.

11. Demonstrate absence of unethical/unprofessional behavior or any serious question of clinical competence.

12. Exhibit adequate knowledge and clinical skills of a clinician, ability to use current literature, and ability to negotiate a general psychiatric practice.

Board Review Series

ABPN Dimension 1

- Developmental processes and development through the life cycle 2-4%
- Disorders of infancy, childhood, or adolescence (Neurodevelopmental disorders) 3-5%
- Substance-related and addictive disorders 7-11%
- Depressive disorders 8-12%
- Bipolar and related disorders 4-6%
- Obsessive-compulsive and related disorders 2-4%
- Trauma-and stressor-related disorders 4-6%
- Somatic symptoms and related disorders 2-4%
- Eating disorders 2-4%
- Sleep-wake disorders 3-5%
- Sexual dysfunctions 1-3%
- Disruptive, impulse-control, and conduct disorders 1-3%
- Personality disorder 5-7%
- Other conditions that may be a focus of clinical attention 1-3%
- Neurocognitive disorders 6-8%
- Neurologic disorders 4-6%
- Dimension 2 Topics without a corresponding Dimension 1 topic 4-6%

ABPN Dimension 2

- Neuroscience and mechanisms of disease 17-23%
- Behavioral and social sciences 4-6%
- Clinical aspects of psychiatric and neuropsychiatric disorders 17-23%
- Diagnostic procedures 8-12%
- Treatment 25-35%
- Interpersonal and communication skills 2-4%
- Professionalism, ethics, and the law 3-5%
- Practice-based learning and improvement 3-5%
- Systems-based practice 2-4%

Recommended Bibliography

- American Psychiatric Association (APA) DSM-5: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS.
- Kaplan and Sadock's. Synopsis of Psychiatry. Newest Edition.
- Kaplan & Sadock's Study Guide and Self-Examination Review in Psychiatry (STUDY GUIDE/SELF EXAM REV/ SYNOPSIS OF PSYCHIATRY (KAPLANS)) Ninth Edition.
- Behavioral Sciences/Clinical Psychiatry latest edition.
- Stahl's Essential Psychopharmacology.
- Prescriber's Guide: Stahl's Essential Psychopharmacology 5th Edition.
- The Psychiatric Interview by Daniel J. Carlat.
- The Massachusetts General Hospital/McLean Hospital Residency Handbook of Psychiatry
- Kaufman's Clinical Neurology for Psychiatrists
- Psychiatry Board Review: Pearls of Wisdom

American Board of Psychiatry and Neurology (ABPN)
Board Reviews

- Board Vitals. https://www.boardvitals.com/psychiatry-moc-recertification-prep
- Beat the Boards: https://www.beattheboards.com/psychiatry-board-review-certification
- True Learn Psychiatry
- Clinical Neurology & Psychiatry for Psychiatrists. Board Review by David M. Kaufman

Online Resources

- American College of Psychiatrists
  - https://www.acpsych.org/prite/purchase-old-prites
- The Psychiatrists In-Practice Examination (PIPE)
  - https://www.acpsych.org/education
- American Board of Psychiatry and Neurology
  - https://www.abpn.com/
  - https://www.abpn.com/become-certified/general-requirements/
  - https://www.abpn.com/maintain-certification/abpn-approved-products-list/

- Ninja guide to PRITE / Loma Linda University Department of Psychiatry
  - http://www.llupsychresidency.com/ninja/

- Neuroscience Education Institute (NEI) Stahl Online.
  https://stahlonline.cambridge.org/about_nei.jsf

- Psychiatry Online
- https://libraryguides.umassmed.edu/psychiatry/for_residents#s-lg-box-10568757

- Medscape
  - https://reference.medscape.com/drug-interactionchecker

- Epocrates
  - https://online.epocrates.com/
  - https://online.epocrates.com/interaction-check

- PubMed
  - https://apps.apple.com/us/app/pubmed-on-tap/id301316540

RESIDENTS ARE REQUIRED

TO READ THE

INSTITUTIONAL MANUAL

OF POLICIES

THE FOLLOWING ARE POLICIES

SPECIFIC FOR THE

PSYCHIATRY

RESIDENCY PROGRAM

Supervision Policy

Policy Name: Psychiatry Resident Supervision 001
Area: The ACGME-accredited Psychiatry Residency Program, sponsored by SMA Healthcare
Regulatory Standard for: ACGME Program Requirements for GME in Psychiatry
Effective Date: 9/12/2023
Date Last Revised: 6/26/2025

Policy: Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. *(6.5)*

The Psychiatry Resident Supervision Policy ensures that patient care is provided by clinicians who are qualified to deliver quality and safe patient care, that this care is documented appropriately in the medical record, and guarantees procedures to report inadequate supervision, free from reprisal.

1. The SMA Psychiatry Residency Program implements this policy consistently with the institution's Supervision Policy and with the Psychiatry Review Committee requirements.

2. The Program Director of the Psychiatry Residency Program is responsible for implementing this Supervision Policy. The Program Director supervises that the appropriate level of supervision is granted to the residents. The Program Director must evaluate each resident's abilities based on specific criteria, guided by the CCC'S Milestone reports.

3. The program must maintain guidelines for circumstances and events in which the residents must communicate with the supervising faculty members.

4. Although the attending physician is ultimately responsible for the care of the patient, every physician share responsibility and accountability for their efforts in the delivery of patient care. The goal is that each resident develops the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine.

5. Faculty supervision assignments should be of sufficient duration to evaluate the knowledge and skills of residents and to delegate them the appropriate level of patient care, authority, and accountability. The supervising physicians should

delegate portions of patient care to residents based on the patient's needs and resident's achievement of ACGME Competencies.

6. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.

7. Residents at all levels must be provided with at least two hours of faculty supervision weekly, one hour of which must be individual. *(4.11.p)* Residents will receive weekly mentorship from an assigned faculty member.

8. Responsibilities of the Supervising Attending Physician
    a. To deliver appropriate, high-quality patient care. To provide residents with education, supervision, constructive feedback, and written evaluation after assignment.
    b. To guarantee that the learning environment is adequate to grant-graded autonomy and responsibility.
    c. To provide a safe and collaborative learning setting that is free from intimidation or discrimination.
    d. To provide residents with supervision based on their level of training, knowledge, and skills.
    e. To supervise all clinical decisions, be accessible for the performance of procedures, and to guarantee patient safety and a quality educational experience.
    f. To inform the patient that residents may be involved in patient care.
    g. To carry out any/all of the following in ambulatory clinical settings:
        i. Discuss the patient's presentation, findings, and their significance;
        ii. Discuss patient management and involve the resident in major decisions;
        iii. Involve the resident in the planning and performance of procedures, including direct supervision when required to ensure patient safety or when requested by the trainee;
        iv. Identify aspects of the case affording educational importance; and,
        v. Guide the residents to develop administrative responsibilities related to patient care.
    h. Typically, to be present, in person, when providing supervision for a resident on call, where the physician would usually be outside of the hospital. If not present in person, the supervisor must always be readily/immediately available, by phone or pager, when a resident is

involved in direct patient care.

9. Responsibilities of the Resident
    a. To evaluate patients and discuss the patients' cases with the attending physician. To formulate diagnosis, workup, development of the treatment plan, and participation in the bedside procedures.
    b. To inform the patient (or family) that they are a resident in training, that they are in a teaching facility or being seen in a teaching clinic, and that patient care is provided through a team approach under the supervising physician (provide name of supervisor). *In all situations, the attending is responsible for all patient care decisions.*
    c. To complete, in a timely manner, accurate documentation in medical records.
    d. Each resident is responsible for communicating significant patient care issues to the responsible attending physician. In certain circumstances, more senior-level residents will be responsible for supervising junior-level residents. This situation may occur in both the inpatient and outpatient setting. The more senior-level resident in this situation will be involved with both clinical supervision and didactic education. Ultimate responsibility still resides with the attending physician.

10. Levels of Supervision: The program must use the following classification of supervision to promote appropriate supervision, ensuring graded authority and responsibility.
    a. Direct Supervision *(6.7)*
        i. The supervising physician is physically present with the resident and patient during the key portions of patient interaction.
        ii. PGY-1 residents must initially be supervised directly.
        iii. PGY-1 residents should progress to being supervised indirectly with direct supervision available only after demonstrating competence in:
            a) the ability and willingness to ask for help when indicated;
            b) gathering an appropriate history;
            c) the ability to perform an emergent psychiatric assessment; and,
            d) presenting patient findings and data accurately to a supervisor who has not seen the patient.
        iv. When the supervising physician is not physically present with the resident and is concurrently monitoring the patient care through appropriate telecommunication technology.
        v. When a resident requiring direct supervision provides remote care, the supervising physician must be physically present with the resident.

b. Indirect Supervision: The supervising physician is available at all times to provide direct supervision to the resident, if needed, but is not physically present.
c. Oversight: The supervising physician provides feedback to the resident and is available for the review of procedures post-care.

11. The program defines when the physical presence of a supervising physician is required. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the Program Director and the program faculty members. *(6.9)*

12. Any urgent patient situation should be discussed immediately with the supervising physician. There will be circumstances in which the residents, regardless of their level of training and experience, must verbally communicate with the faculty and when the physical presence of the supervising physician is required, including but not limited to:
    a. A hospital/emergency admission
    b. A patient discharged against medical advice (AMA) or not formally discharged
    d. The unexpected deterioration of a patient's medical condition
    e. Patients needing intubation or ventilatory support
    f. Patient experiences an adverse outcome regardless of cause
    g. Family, legal, or systems issues
    h. End of life decisions or DNR orders
    i. Transfer of patient to a higher level of care (example: floor to ICU)
    j. Rapid Response, Code Blue Team activation
    k. A patient death
    l. A clinical problem requiring an invasive procedure or surgery
    m. When requesting a consultation not previously discussed
    n. If a resident has any uncertainty about the patient's care plans or goals or feels uncomfortable/is unsure of their ability to perform a procedure or patient care activity with the level of supervision provided
    o. Situations in which they feel their safety is threatened
    p. Situations in which they personally feel impaired or witness others working while impaired.
    q. When the resident perceives that patient safety is at risk
    r. Suicidal or homicidal patient/patient was physically aggressive with staff or others

s. In case of a sentinel event or medication/treatment error requiring intervention.

13. In the ambulatory clinical setting, the attending is usually present during the clinical setting hours. However, the resident should immediately notify the supervising physician of the following:
    a. A patient's medical condition deteriorates.
    b. Patient needs to transfer to a higher level of care.
    c. Emergencies and patient adverse events/errors.
    d. To perform certain procedures.
    e. If a patient expresses concern about the standard of care, he/she is receiving from the resident.
    f. If a member of the health care team is concerned about the standard of care being provided by the resident.

14. Procedures to Report Insufficient Supervision
    a. Residents can report inadequate supervision in a manner that is free from reprisal.
    b. Residents may report at any time, any supervision issue, to the GME leadership or GME office. The Program Coordinator will assist the resident and report the issue to the Program Director and DIO, who will notify the GMEC.
    c. Residents can make anonymous complaints in New Innovations. Please see the "Evaluations" section of this manual for more information on how to complete and anonymous concern or feedback report.
    d. The DIO, Program Director, and the GMEC are responsible for the monitoring of the process of resident supervision and for the active investigation of any report related to inadequate supervision that does not follow the requirements of the ACGME and the GME Policy of Supervision.
    e. After the appropriate investigation, corrective actions will be taken, and the resident will be informed of the determined solution.

Well-being Policy

Policy Name: Well-being 002
Area: The ACGME-accredited Psychiatry Residency Program, sponsored by SMA Healthcare
Regulatory Standard for: ACGME Program Requirements for GME in Psychiatry
Effective Date: 9/12/2023
Date Last Revised: 6/26/2025

Policy: The Psychiatry Residency Program supports the well-being of residents and faculty members, in compliance with the ACGME Requirements, and addresses areas of non-compliance in a timely manner.

1. It is the responsibility of the program, in partnership with SMA Healthcare, to: *(6.13)*
    a. Pay attention to scheduling, work intensity, and work compression that impacts the well-being of the residents;
    b. Evaluate workplace safety data and address the safety of residents and faculty members;
    c. Have policies and programs in place to encourage optimal resident and faculty well-being;
    d. Allow residents the opportunity to attend appointments, including those scheduled during working hours; and,
    e. Educate residents and faculty members in symptoms of burnout, depression, substance abuse, suicidal ideation, potential for violence, and how to recognize these symptoms in themselves, self-screening, and how to seek appropriate care.

2. Residents and faculty share the responsibility to alert the Program Director, DIO, or other designated GME personnel when they are concerned that another resident or faculty member may be showing signs of burnout, depression, substance abuse, or potential for self-harm or aggressive behavior.

3. The program, in partnership with SMA Healthcare, provides residents with access to appropriate tools for self-screening, as well as resources to encourage and promote healthy lifestyle and foster resilience, such as UHC health risk and well-being assessments, improvement and wellness programs, wellness stipends, mindfulness and health coaching, and nutritional support.

4. Access to medical care 24 hours a day, seven days a week, will be provided through SMA Healthcare's Employee Assistance Program (EAP).

5. The program, in partnership with SMA Healthcare, supports faculty in their protected time for teaching and supervision, as well as adequate clinical/academic schedules.

6. Residents are able to report any issue and any time anonymously through New Innovations. Please see the “Evaluations” section of this manual for more information on how to complete and anonymous concern or feedback report.

7. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Residents will be provided up to six weeks of 100% paid leave for a qualifying reason that is consistent with FMLA, such as parental leave (maternity, paternity, or adoption of a child), caregiver leave (to care for a spouse, son, daughter, or parent that has a “serious health condition”), or medical leave (resident has own “serious health condition”). Residents will be eligible starting the first day they are required to report.

8. Residents will have access to resting rooms and transportation reimbursement if they are too fatigued to drive. Residents will also have access to nutritious food and break areas at sites they are rotating through.

9. Residents will have the opportunity to meet in an organized forum and have the opportunity to conduct these meetings without administration, faculty, or GME leadership. Round Table/Wellness groups will be included into preserved Wednesday didactic days monthly.

   For more information on the Resident Forum, please see the GME Institutional Manual of Policies and Procedures “Resident Forum”.

10. The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care.

11. These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.

    For more information on institutional wellness resources, please see the GME Institutional Manual of Policies and Procedures “Well-being”.

Work Hours Policy

Policy Name: Psychiatry Resident Supervision 003
Area: The ACGME-accredited Psychiatry Residency Program, sponsored by SMA Healthcare
Regulatory Standard for: ACGME Program Requirements for GME in Psychiatry
Effective Date: 9/12/2023
Date Last Revised: 6/20/2025

Policy: The program will ensure that the residents are provided with appropriate schedules and workloads that can be accomplished during the scheduled work hours. This includes ensuring that a resident's allocated direct patient load is manageable, that residents have appropriate support from teaching clinical teams, and that residents are not overburdened with clerical work and/or other non-physician tasks.

It is the responsibility of the resident to log their work hours weekly in New Innovations.

1. Maximum Hours of Clinical and Educational Work per Week *(6.20)*
    a. 80 hours/week: Clinical and educational work hours must be limited to no more than 80 hours per week, averaging over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.
    b. Residents and programs utilizing any flexibility of work hours will be required to adjust the work schedules to achieve the 80-hour maximum weekly limit, when averaged over a four-week period. Residents and programs will not violate the 80-hour requirement.
    c. The ACGME Review Committees will monitor and enforce compliance with the 80-hour requirement. When any violations of the 80-hour requirement are identified, the program will be subject to institutional actions, citations, and at risk for an adverse accreditation action.
    d. Work from home must be counted toward the 80-hour maximum weekly limit, however the expectation remains that scheduling should be structured so that residents are able to complete most work on site during scheduled clinical work hours if needed, without requiring them to take work home. Residents are required to track and report to the program the time they spend on clinical work from home. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident.

2. Mandatory Time Free of Clinical Work and Education *(6.21)*

a. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
b. Residents shall be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home calls cannot be assigned on these free days.
c. Residents should have eight hours off between scheduled clinical work and education periods. There may be some circumstances when residents select to stay to care for specific patients or return to the hospital or facility with fewer than eight hours free of clinical experience and education. This shall happen within the context of the 80-hour and the one day-off-in-seven days requirements.

The program is encouraged to distribute days off in a fashion that optimizes resident well-being, educational, and personal goals. A “day off” is defined in the ACGME Glossary of Terms as “one continuous 24-hour period free from all administrative, clinical, and educational activities.”

3. Maximum Clinical Work and Educational Period Length *(6.22)*
    a. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
    b. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. This shall occur within the context of 80-hour weekly limit, averaged over four weeks.

4. Clinical and Educational Work Hour Exceptions (6.23)
    a. In uncommon circumstances, after transitioning into all other responsibilities, a resident, on their own incentive, may choose to remain up to four hours at the clinical site in the following circumstances:
        i. To provide care to a single acutely ill or unstable patient, or to continue assisting an emergency;
        ii. To provide human-centered attention to the needs of a patient or family; or,
        iii. To attend an important and unique educational event.
    b. The procedures for residents to remain beyond their scheduled hours are as follows:
        i. The resident will notify the Program Director, who will discuss the conditions that require the resident to remain at the facility, assess the situation, and provide appropriate feedback.

ii. The program will ensure that the decision was initiated by the resident, and that this time is counted within the 80-hour maximum weekly limit.
iii. The Program Director will review and track each incident of additional service hours that have been counted within the maximum 80-hour weekly limit.
iv. The resident will notify the Program Director, who will discuss the conditions that required the resident to remain at the facility, assess the situation, and provide appropriate feedback.

c. The Review Committee for Psychiatry will not consider requests for exceptions to the 80-hour limit to the residents' work week.

5. Maximum In-House On-Call Frequency *(6.27)*
    a. Residents must be scheduled for in-house calls no more frequently than every third night (when averaged over a four-week period). Residents on psychiatry rotations will be scheduled for in-house calls no more frequently than every fourth night (when averaged over a four-week period).

6. In-House Night Float *(6.26)*
    a. Night float shall occur within the setting of the 80-hour and one-day-off-in-seven requirements. (Residents will not be scheduled for more than four consecutive weeks or a total of eight weeks of night float during the required one-year, full-time outpatient psychiatry experience.)

7. At-Home Call *(6.28)*
    a. Time spent on patient care activities by residents on at-home calls shall count toward the 80-hour maximum weekly limit. The frequency of at-home calls is not subject to the every-third night limitation but shall achieve the requirement for one-day-in-seven free of clinical work and education, when averaged over four weeks.
    b. At-home calls shall not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
    c. Residents are permitted to return to the inpatient unit while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be within the 80-hour maximum weekly.

Moonlighting Policy

Policy Name: Moonlighting 004
Area: The ACGME-accredited Psychiatry Residency Program, sponsored by SMA Healthcare
Regulatory Standard for: ACGME Program Requirements for GME in Psychiatry
Effective Date: 9/12/2023
Date Last Revised: 6/26/2025

---

1. Moonlighting is an independent clinical activity as an independent physician. The resident must be credentialed by the specific site. The moonlighting activity is not covered by SMA Healthcare's GME liability insurance, as these activities are outside the scope of the training program. Moonlighting activities are not counted toward meeting training requirements of the program.

2. Moonlighting activities must not interfere with the resident's ability to achieve the goals and objectives of the program and must not interfere with the resident's fitness for work nor compromise patient safety. *(6.25)*

3. Residents are not required to engage in moonlighting and will need written permission from their Program Director to moonlight. Under no circumstances are PGY-1 residents permitted to moonlight.

4. Time spent by residents in internal and external moonlighting will be counted toward the 80-hour maximum weekly limit.

5. For more information on procedures relating to moonlighting, please SMA Healthcare's GME Institutional Manual of Policies and Procedures, "Moonlighting".

Evaluations

- Resident Evaluation of Program
- Faculty Evaluation of Program
- Resident Evaluation of Faculty
- Faculty Evaluation of Resident (Formative Evaluation)
- Resident Self-Evaluation
- Resident Peer-Evaluation
- Patient Evaluation of Resident
- Nursing or Clinical Staff Evaluation of Resident
- Resident Semiannual Evaluation
- Resident Annual Evaluation
- Annual ABPN Clinical Skills Evaluation
- Resident Final /Summative Evaluation

Residents: Samples of all evaluations are available on the "SMAResidents" share drive.
Faculty: Samples of all evaluations are available on the "GME" share drive.

Anonymous Report, Concern, or Feedback

The "Anonymous Report or Feedback" evaluation is a way for residents to report concerns or feedback in a **100% confidential and anonymous manner**. It can be accessed on the left side of the home page after logging into New Innovations. "Create an Evaluation" -> Choose the name or rotation the feedback or concern pertains to. If you do not wish to provide this information or the feedback/concern does not apply to any names or rotations listed, choose "Aly, Tarek".

Reports made will be reviewed by administration. The evaluation is available to the residents at any time and is completely optional.

ABPN Clinical Skills Evaluations

An annual evaluation of each resident's clinical skills is required for all residents. Residents may only advance to the next level of education after demonstrating competence at their current level. In addition to the annual evaluation of clinical skills, the program must also document that each resident has passed three CSV exams using ABPN-approved forms. The program may elect to administer the CSV exams annually, including PGY-1 residents. If done annually, the CSV exams could also satisfy the annual clinical skills examination requirement for all program years. While the ACGME Review Committee does not review the results of these exams, the ABPN will require evidence demonstrating that the exams are administered (frequency, skills assessed, types of assessors, evaluation forms used). Additional information can be found on the ABPN website. The American Board of Psychiatry and Neurology (ABPN) requires the achievement of the following indicators:

1. Physician-patient relationship.
2. Psychiatric interview, including mental status examination.
3. Case presentation.

These components will be assessed in the setting of a patient evaluation that is directed in the presence of a board-certified psychiatrist. The interview may be videotaped, simulated/standardized patients, or live video streaming cannot be used as the basis for the evaluation. The three evaluations will have three different patients.

The training program may assign additional evaluations, if applicable, or assess supplementary competency indicators. Evaluations must be completed on ABPN-approved forms (Psych CSV v1 and Psych CSV v2) available at the ABPN website.

The Psychiatry Residency Program may enhance further competencies for their purposes, e.g., differential diagnosis and treatment planning. Before approval of an application for certification, the ABPN requires confirmation of completion of the clinical skills evaluations from the residency program director of an ACGME-accredited psychiatry program. Documentation will include a statement that the physician performed adequately on three clinical skills evaluations and must contain the full name of the ABPN- certified evaluators and the exact dates of the evaluations. It is recommended that the program retain the evaluation forms as part of a resident's training file. The ABPN reserves the right to audit the evaluation process. The evaluations of residents are valid for seven years following completion of residency training. The evaluations of other psychiatrists are valid for seven years following completion of the final evaluation. The third clinical skills evaluation must be completed within five years of the first evaluation. Documentation for psychiatry candidates must be received from the program director of an ACGME-accredited psychiatry residency program. Documentation of evaluations of physicians no longer in training must be in the same manner as that of current residents. All documentation must be received in the ABPN office by July 31 of the year of the examination.

For more information, please consult the ABPN website.
www.ABPN.com

Definitions

ACGME: Accreditation Council for Graduate Medical Education (accreditation body of residency and fellowship programs in the USA).

Clinical Experience and Educational Work Hours: Refers to clinical and academic activities of the program, such as patient care, administrative responsibilities related to patient care, transfer of patient care, time spent in-house during call activities, and attendance at academic activities and conferences. Duty hours include all hours spent on moonlighting activities. Duty hours do not include reading and preparation time that is spent away from the duty site.

Clinical Learning Environment Review (CLER) Program: An ACGME program designed to provide U.S. teaching hospitals, medical centers, health systems, and other clinical settings affiliated with ACGME-accredited Sponsoring Institutions with periodic feedback in "Focus Areas" specific to the safety of the clinical learning environment.

Clinical Responsibilities: The resident clinical responsibilities are based on the PGY level, patient safety, resident ability, severity and difficulty of patient illness/condition, and available support services. (ACGME Specialty Review Committees may additionally specify optimum clinical workload).

Core Competencies: Specific knowledge, skills, behaviors, and attitudes in the following domains: patient care; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and system-based practice.

Designated Institutional Official (DIO): Individual who, in collaboration with a Graduate Medical Education Committee (GMEC), has authority and responsibility for the oversight and administration of each of the Sponsoring Institution's ACGME-accredited program(s).

Discrimination: An act or omission based on race, religious beliefs, color, gender, family status, income, sexual orientation, or political beliefs when that act or omission results in loss or limit on opportunities to work or fully participate in campus life, or which offends the dignity of the person.

Faculty: Individuals who meet the qualifications and have received a formal assignment to teach resident/fellow physicians.

Fellows: Physician in training enrolled in a subspecialty fellowship program at the Sponsoring Institution.

GME / Graduate Medical Education: Period of the physician postgraduate training in a specialty (residency) or subspecialty (fellowship), accredited by the ACGME.

Governing Body: Single entity that maintains authority over and responsibility for the Sponsoring Institution and its ACGME-accredited program(s), as well as for ensuring

compliance with the ACGME Institutional, Common, and specialty-/subspecialty-specific Program Requirements.

Hand-over: The transfer of essential information and the responsibility of care from one provider to another. Satisfactory transition/handover procedures include the transmission of accurate patient information between staff members or teams in transferring responsibility for patient care in the healthcare setting.

Milestones: Description of performance levels residents and fellows are expected to demonstrate for skills, knowledge, and behaviors in the six Core Competency domains.

Moonlighting: Services that licensed residents perform outside the scope of the GME program, either occurring within the Sponsoring Institution (internal moonlighting) or outside the Sponsoring Institution (external moonlighting).

Patient Safety (PS): Absence of preventable harm to a patient during the process of health care and the decrease of risk or unnecessary harm associated with health care to an acceptable minimum, which refers to the collective notions of given current knowledge, resources available, and the context in which care was delivered, considered against the risk of non-treatment or other treatments.

Patient Safety Practices: Habits and routines that reduce the risk of adverse events related to exposure to medical care across a range of diagnoses or conditions.

PGY: Postgraduate Training Year.

Quality: The degree to which health care services for individuals and populations surges the probability of desired outcomes, consistent with current professional knowledge.

Quality Improvement (QI): Systematic and continuous actions to measure development of the health services and the health status of patient groups. Quality improvement is a clinical, academic, and financial component to a safe health care delivery system. The QI practice is intended to deliver quality, safe, patient-centered care, and to advance scholarships related to QI and patient safety. The GME curriculum includes QI in order to prepare physicians to improve their values of quality, patient safety, and comprehensive patient care concepts in their current and future clinical care practices.

Residency Program: Residency is a dynamic dimension of the transformation from a medical student into an independent medical practitioner. The satisfactory completion of the program may result in eligibility for examination to obtain board certification. The residency program will establish its residency manual in compliance with the ACGME requirements.

Residents: Physician in training enrolled in a post-graduate medical education residency program at the Sponsoring Institution.

Retaliation: Retaliation, or “revenge”, may occur when the employee leadership disciplines an employee engaging in legally protected activities related to the workplace rights, discrimination, or harassment.

Sponsoring Institution: An organization (SMA Healthcare) that takes the ultimate financial and academic responsibility to develop GME program(s), accredited by the ACGME. This will be the primary training site for the residents to receive teaching, supervision, and evaluation by the faculty. The Sponsoring Institution must be in significant compliance with the ACGME Institutional Requirements and shall guarantee that its ACGME-accredited program(s) operate(s) in substantial compliance with the ACGME Institutional, Common, and specialty-/subspecialty-specific Program Requirements.

Supervision: Refers to the dual responsibility that an attending physician or faculty must enhance the knowledge of the resident and ensure the quality of care delivered to each patient by any resident. Such control is trained through observation, consultation, and direction.

Transitions of Care: The transfer of responsibility for patient care from one provider to another, at the time of check-out to on-call teams, but also applicable in other transitional settings, including transfers between one clinical care setting to another or the scheduled change of providers.

References

Accreditation Council for Graduate Medical Education: https://www.acgme.org/

ACGME Specialty-Specific Milestones:
https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryAssessmentTools.pdf

American Board of Medical Specialties: https://www.abms.org/

ABPN: https://www.abpn.com

American Psychiatric Association: https://www.psychiatry.org/

American Medical Association: https://www.ama-assn.org/

Request Of Elective Rotation

Resident Name:

PGY:

Phone:

Email:

Elective Rotation Topic/Title/Subspecialty:

Resident Mentor/Supervisor Name:

Requested Dates of the Selected Elective:

Electives are selected by the resident in teamwork with the faculty mentor, and approval by the Program Director. Electives should be compatible with the ACGME competency-based goals.

Summary of the rotation including expectations and duties/responsibilities

Describe the Educational Goals and Objectives of this Rotation

---

Resident Signature
Date

Program Director Signature / Approval
Date