MANUAL OF GENERAL INFORMATION

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A. OVERALL EDUCATIONAL GOALS FOR THE PSYCHIATRIC RESIDENCY TRAINING PROGRAM

- To provide an educational experience which assures that graduating residents will possess the clinical skills and knowledge to prepare them for the independent practice of psychiatry while exposing them to the wide range of career opportunities including clinical practice, teaching, research, and administrative psychiatry.
- To provide this educational experience such that residents successfully pass the written and oral examinations for certification in psychiatry by the American Board of Psychiatry and Neurology.
- To foster the development of psychiatrists who practice critical thinking including an evidence-based approach in all aspects of their work.
- To provide a learning environment that will lead to an understanding and appreciation of the methods and findings of scientific research and which will foster progress towards a research career, if that is the trainee’s intent.
- To provide the didactics and experiences necessary to assure that residents attain competence in the core skill areas required by the Accreditation Council for Graduate Medical Education (ACGME). The core skill areas are:

  1. **PATIENT CARE** - Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
  2. **MEDICAL KNOWLEDGE** - Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
  3. **PRACTICE-BASED LEARNING AND IMPROVEMENT** - Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practice.
  4. **INTERPERSONAL AND COMMUNICATION SKILLS** - Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families, and professional associates.
  5. **PROFESSIONALISM** - Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
  6. **SYSTEMS-BASED PRACTICE** - Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
B. **EDUCATIONAL GOALS AND OBJECTIVES OF TRAINING BY POSTGRADUATE YEAR**

**PGY-1**

The knowledge, skills, and attitudes to be acquired during the PG-1 year of residency in order to demonstrate progress toward achievement of these competencies are:

1. **Patient Care** – residents are expected to:
   - Conduct an assessment interview in which rapport with the patient is established and an adequate initial data base is obtained
   - Perform a physical examination adequate to detect possible presence of acute medical, surgical, and neurological conditions
   - Determine when consultation is needed for evaluation and treatment of medical problems
   - Write clear, well-organized, accurate and appropriately detailed notes and discharge summaries
   - Construct an appropriate differential diagnosis and an appropriate treatment plan
   - Monitor treatment, including assessing treatment outcomes and recognizing when changes are needed
   - Maintain good relations with patients and support them through a course of treatment

2. **Medical Knowledge** – residents are expected to:
   - Demonstrate an adequate knowledge of clinical diagnosis
   - Demonstrate a basic knowledge of the major classes of medications, including indications, contraindications, prescribing parameters, side effects and significant interactions

3. **Practice-Based Learning and Improvement** – residents are expected to:
   - Use supervision effectively to improve knowledge, skill and professional attitudes
   - Seek and use the scientific literature relevant for his/her patients
   - Select and use computer data bases
   - Recognize and learn from his/her own errors

4. **Interpersonal and Communication Skills** – residents are expected to:
   - Present a case in a clear well-organized, and appropriately detailed manner
   - Convey relevant information clearly to patients and their families
   - Listen to and communicate clearly with other professionals
   - Be an effective teacher and supervisor of medical students
5. **Professionalism – residents are expected to:**

- Be reliable in attending to patient care and administrative responsibilities
- Recognize ethical issues and strive to maintain high ethical standards
- Demonstrate considerate and sensitive behavior in dealing with patients, their families and other professionals

6. **Systems-Based Practice – residents are expected to:**

- Demonstrate awareness of the role of social, medical, vocational and financial factors in the patient’s care
- Identify and make appropriate referrals to other care providers and coordinate care shared by such providers
- Work effectively with a multi-disciplinary treatment team
- Demonstrate basic knowledge of the relative costs of care options and attempt to conduct cost-effective care
The knowledge, skills, and attitudes to be acquired during the PG-2 year of residency in order to demonstrate progress toward achievement of these competencies are:

1. **Patient care – residents are expected to:**

   - Demonstrate proficiency related to psychiatric disorders in assessing and initiating appropriate treatment in children, adolescents, adults, and geriatric patients
   - Demonstrate ability to integrate information obtained into a formulation of the biological, psychological, and social/environmental factors specific to the development of each patient’s disorder
   - Refine performance of the mental status examination with ability to detect more subtle findings and relating these to diagnostic and therapeutic decisions.
   - Demonstrate ability to use appropriately screening, diagnostic and follow-up psychiatric tests such as the BECK, BPRS, AIMS, and CAGE
   - Broden skills in the prescription of psychotropic medications, with specific attention to the needs of the elderly
   - Gain experience and competence in all aspects of electroconvulsive therapy
   - Begin to take a leadership role in the coordination of patient care and discharge planning
   - Empathize with patients suffering from psychiatric illness so as to understand the effect of the illness upon their lives
   - Demonstrate ability to identify patients appropriate for long-term psychotherapy
   - Establish ongoing therapeutic relationships with patients, addressing fluctuations in the course of their illness and situation, and managing their treatment needs
   - Recognize the common manifestations of suicidal risk, and institute appropriate management
   - Recognize signs and symptoms of potential assaultive behavior and institute appropriate management
   - Accurately diagnose patients using DSM IV-TR criteria and Axes 1 through 5
   - Recognize symptoms and signs of underlying medical or neurological disorders and recommend or institute appropriate diagnostic work-up and/or treatment
   - Document concisely yet thoroughly the findings, conclusions and rationale for the recommended plan of care
   - Demonstrate ability to develop a comprehensive treatment plans for hospitalized patients, monitor the plan’s outcome, and modify as needed
   - Recognize patients’ major motivations, fears, limitations and strengths that contribute to or impede their treatment

2. **Medical Knowledge – residents are expected to:**

   - Know in detail the diagnostic criteria and the usual progression of symptoms of the major DSM-IV psychiatric illnesses
   - Know the fundamentals of the major psychiatric diagnoses relevant to children, adolescents, adults, and geriatric patients
• Know the value and use of screening, diagnostic and follow-up psychiatric tests such as the BECK, BPRS, AIMS, and CAGE
• Know the reliability, validity, and clinical applications of the generally accepted diagnostic, psychological and cognitive tests
• Know the relevance of co-morbidity between medical (including neurological) and psychiatric conditions
• Know the types of psychiatric diagnoses that commonly co-occur and the treatment and management of such patients
• Know the stages of normal cognitive and emotional development throughout the life-span
• Know the methods for developing an understanding of each patient’s psychopathology in terms of biological, psychological and social factors
• Know the major theoretical viewpoints of the phenomenology and etiology of psychiatric disorders
• Know the descriptions of personality features disorders and defense mechanisms
• Know the basics of neurobiological understanding of psychiatric disorders including receptors and neurotransmitter systems, neuroanatomy, and the physiological functioning of the nervous system and understand their clinical relevance and application
• Know the indications, contraindications, side effects, doses and potential interactions of all prescribed psychotropic medications, and understand their differences in pertinent to children, adolescents, adults, and geriatric patients
• Know the ethical concepts important to psychiatric practice
• Know the basic forensic issues pertinent to children, adolescents, adults, and geriatric patients
• Know the ethical concepts specific to children, adolescents, adults, and geriatric patients
• Know the clinical and demographic factors and signs associated with the risk of suicide, homicide and potential assaultiveness
• Know the basics of unconscious conflict, ego deficits, ego mechanisms of defense, and transference
• Know the basics of CBT principles such as core beliefs, cognitive distortions and automatic negative thoughts

3. Practice-Based Learning and Improvement – residents are expected to:

• Develop increased skills to read the literature critically, understanding its importance in clinical application
• Exhibit ability to critically self-evaluate clinical practices and demonstrate improvement as a result of such evaluations
• Exhibit the development of habits of self-education
• Appreciate the value of research and the need to read the literature critically
• Use information technology resources to access on-line medical information
• Demonstrate ability to locate, critique, and assimilate evidence from scientific studies and relate knowledge to clinical practice
• Utilize supervision effectively to improve knowledge, skills and professional attitudes
4. **Interpersonal and Communication Skills – residents are expected to:**

   - Increase effectiveness as a teacher and supervisor of medical students, junior residents and other health care personnel

5. **Professionalism – residents are expected to:**

   - Maintain a professional attitude at all times with children, adolescents, adults, and geriatric patients and their relatives or caregivers, even when the circumstances make interaction irritating or unpleasant
   - Demonstrate reliability and increased autonomy in attending to patient care and administrative responsibilities while maintaining understanding of appropriate degrees of supervision

6. **Systems-Based Practice – residents are expected to:**

   - Communicate with and listen to case managers and managed care personnel in an effective manner resulting in improved patient care
   - Work professionally and in tandem with the treatment teams of mental health professionals, as well as Emergency Department staff, referring providers, consultants and personnel from community agencies
   - Begin to take a leadership role in the coordination of each patient’s care
   - Integrate the often expanded interdisciplinary services inherent in the comprehensive care of children, adolescents, and geriatric patients.
   - Undertake an increased role in utilization review and continuous performance improvement activities
   - Advocate for quality patient care and assist patients in dealing with system complexities
PGY3

The knowledge, skills, and attitudes to be acquired during the PG-3 year of residency in order to demonstrate progress toward achievement of these competencies are:

1. **Patient Care – residents are expected to:**

   - Competently diagnose and treat a variety of outpatients with a broad range of psychiatric disorders, seen regularly and frequently for both focused and long-term management, using a variety of treatment modalities
   - Provide consultative services and ongoing care for psychiatric outpatients referred by other physicians and non-medical therapists
   - Broaden skills in the prescription of psychotropic medications, with specific attention to the needs of the ambulatory patient who may be followed by a number of providers also prescribing medications and who may require long term management of adverse and therapeutic effects of medication
   - Gain experience and competence in prescribing and monitoring electroconvulsive therapy as an outpatient maintenance treatment for appropriate patients
   - Gain further experience and competence treating patients utilizing various brief, intermediate, and long-term psychopharmacologic modalities
   - Develop and utilize psychiatric formulations to generate a comprehensive treatment plan
   - Manage time effectively and efficiently to meet the care needs of patients in various outpatient psychiatric clinic settings
   - Write clear, well-organized, accurate, and succinct notes appropriate to an outpatient care setting
   - Demonstrate basic proficiency in the techniques of psychodynamic psychotherapy, brief and crisis intervention, combined psychopharmacology and psychotherapy, cognitive/behavioral psychotherapy, and supportive psychotherapy

2. **Medical Knowledge – residents are expected to:**

   - Know the structure and functioning of private, local and federal government psychiatric services
   - Know the funding sources and the structure of county, state and federal government agencies that support these agencies
   - Know the common clinical problems for which psychiatric consultation is most often indicated and their effective and practical management.
   - Know the psychological factors common to those suffering medical and surgical illness and their impact on the plan of treatment and outcome
   - Know in detail the common presentations, usual progressions, and effective treatments of DSM-IV disorders seen in general outpatient psychiatric clinic settings
   - Know in detail the common presentations, usual progressions, and effective treatments of DSM-IV disorders seen in specialized groups of psychiatric outpatients including children and adolescents, older adults, those with retardation/developmental disabilities and psychiatric illness, those with co-morbid substance abuse, those with Axis II disorders, those presenting as diagnostic
dilemmas with complex medical/surgical, co-morbidities, and those suffering from chronic mental illness

- Further expand knowledge of generally accepted diagnostic, psychological, and cognitive tests, and their clinical applications particularly as it pertains to the outpatient setting
- Know the value and application of clinical rating scales in the ongoing care of patients
- Know the principles and specifics of psychopharmacology as they pertain to patients of all ages and with various co-morbid medical and psychiatric disorders
- Broaden understanding of the major theories and viewpoints of psychiatry in the context of the field’s history
- Possess knowledge of the major psychotherapeutic modalities (psychodynamic psychotherapy, brief and crisis intervention, combined psychopharmacology and psychotherapy, cognitive/behavioral psychotherapy, supportive psychotherapy, group, family and marital therapy) and their application in the treatment of psychiatric outpatients over both a short-term and long-term basis
- Know the indications for, and appropriate utilization of, a continuum of care, including crisis intervention, partial hospital, intensive outpatient, and traditional outpatient services
- Know the rational and practical application of interactive video (telepsychiatry) in caring for psychiatric patients in remote under-served areas
- Have knowledge of the administrative opportunities within the field of psychiatry
- Demonstrate knowledge of all classes of psychotropic medication, including strategies for treating resistant or atypical illness
- Understand the ways in which pharmacologic and non-pharmacologic treatments may interact

3. **Practice-Based Learning and Improvement – residents are expected to:**

- Demonstrate critical understanding of research methods and their application to clinical problems
- Participate in local, state and federal and professional organizations that can impact the future care of psychiatric patients
- Gain increasing autonomy in all aspects of patient care
- Assume increasing responsibility for on-going self-assessment and continuing education needs

4. **Interpersonal and Communication Skills – residents are expected to:**

- Empathize with patients who have special needs and/or are suffering from chronic psychiatric illness so as to understand the effect of the illness upon their lives
- Work effectively with patients on a long term basis in negotiating and communicating treatment goals and expectations
- Work effectively with other professionals and paraprofessionals in diverse outpatient, inpatient, and consultative settings.
5. **Professionalism – residents are expected to:**

- Establish and maintain a professional long-term relationship with patients, their families, consultants, non-medical providers, and concerned others
- Communicate consistently and long-term in a respectful manner with patients, mental health co-workers, consultants, technicians and other professionals in the evaluation management, and treatment of patients

6. **Systems-Based Practice – residents are expected to:**

- Be familiar with systems issues affecting the care and needs of patients being treated in diverse inpatient, outpatient, and consultative settings
- Know the appropriate facilities and resources for triage, referral for hospitalization and ambulatory psychiatric care
- Understand coding, billing, managed care, utilization review, risk management, and performance improvement issues
- Know the financial, legal and regulatory factors involved with initiating and maintaining a psychiatric practice in diverse settings
- Advocate for needs of the patients and take a leadership role in the coordination of services by medical personnel, therapists and case managers
- Treat patients, as a member of a mental health team, in various specialized settings such as intensive outpatient, televideo, or MR clinics or partial hospitalization sites.
- Enhance experience and understanding of forensic issues such as competency assessments and treatment of outpatients committed to therapy or otherwise mandated for treatment by the courts
- Enhance experience and understanding of psychiatric patients involved in compensation claim issues often seen in an outpatient setting including those related to social security disability and workman’s compensation
- Have the opportunity to serve on committees relevant to the improvement of patient care, the School of Medicine educational programs, the administration of the Medical Center inpatient and ambulatory care services, and liaison activities with community organizations
- Understand the current and potential societal, fiscal, and governmental pressures that impact the field of psychiatry in general and the care of patients specifically
The knowledge, skills, and attitudes to be acquired during the PG-4 year of residency in order to demonstrate progress toward achievement of these competencies are:

1. **Patient Care – residents are expected to:**
   - Maintain and enhance patient care skills in new resident chosen patient care settings (e.g., private practice, state hospital, prisons, sleep clinics)
   - Enhance emergency psychiatry and consultation skills with increased exposure to such patients
   - Gain experience and develop skills in treating patients with pain related needs in a specialty pain clinic
   - Gain experience and develop skills in treating patients with opioid dependence in a methadone clinic
   - Gain experience and develop skills in treating child and adolescent patients in child inpatient, outpatient, and consult services
   - Gain experience and develop skills in treating patients in a hospital emergency room setting
   - Continue to develop longer term psychotherapeutic experiences with patients seen in prior years of residency while continuing to utilize various brief and intermediate psychotherapies
   - Demonstrate enhanced proficiency in the techniques of psychodynamic psychotherapy, brief and crisis intervention, combined psychopharmacology and psychotherapy, cognitive/behavioral psychotherapy, and supportive psychotherapy

2. **Medical Knowledge – residents are expected to:**
   - Know details of a broad range of psychiatric knowledge, especially in areas in which clinical electives taken (e.g., sleep medicine, psychotherapy, psychological testing, forensics, child and adolescent psychiatry, emergency psychiatry)
   - Enhance psychiatric knowledge previously learned by continued review and updating of these areas sufficient to successfully complete Part 1 of the ABPN examination

3. **Practice-Based Learning and Improvement – residents are expected to:**
   - Assume increasing responsibility for on-going self-assessment and continuing education needs
   - Enhance knowledge and skills in areas of special interest or weakness. Examples of such elective enhancements may include experience in: basic and clinical research; additional exposure to clinical areas such as community, geriatric, child, addiction, forensic or administrative psychiatry; advanced work in interpreting and performing neuropsychological testing; exposure to specific psychotherapeutic methods; other
diverse clinical exposures as proposed by the resident and approved by the psychiatric faculty

- Demonstrate ability to undertake and complete a scholarly activity related to a topic in psychiatry (paper appropriate for peer review, presentation to colleagues, presentation at meeting, participation in research, etc)

4. **Interpersonal and Communication Skills – residents are expected to:**

- Effectively communicate with long term patients while preparing them for changes in treatment providers or completion of treatment
- Effectively communicate information as well as direction to others when in a leadership role in a treatment team or other patient care setting

5. **Professionalism – residents are expected to:**

- Be aware of and utilize senior status and leadership positions to role model professional behavior to others
- Develop the necessary objectivity, initiative, judicious decision making, and foresight inherent in the role of more complex and responsible patient care and administrative positions

6. **Systems-Based Practice – residents are expected to:**

- Comfortably accept and utilize leadership skills in educational, administrative and clinical settings
- Understand sound administrative principles and common administrative pitfalls
- Know the financial, legal and regulatory factors involved in post residency professional employment and development
- Organize educational/scientific/administrative material and teach it to others in the medical care system
- Mentor junior residents in navigating complexity of medical care system
C. RESIDENCY REQUIREMENTS

1. Certifications

a. BCLS/ACLS Certification. Residents in all psychiatry programs are required to be certified in BLS prior to the entry of the psychiatry residency program and to keep BCLS certification current throughout their residency. Initial ACLS certification in the PGY1 contract year will be provided by the Office of Graduate Medical Education prior to beginning residency. General psychiatry residents are not required to renew their ACLS certification after their PGY1 year. However, Internal Medicine/Psychiatry residents are required to keep their ACLS certification current throughout their five years of training.

b. Crisis Prevention Training. The KUMC Psychiatry Residency Program requires certification in the Nonviolent Crisis Intervention Training Program. This program is a half-day program that promotes safe, nonharmful behavior management system designed to help human service providers provide for the best possible care, welfare, safety and security of disruptive, assaultive and out-of-control individuals even during their most violent moments. Training is required to meet the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

2. Curriculum

The four-year (48-month) psychiatry residency curriculum consists of the following rotations:

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>4 months</td>
</tr>
<tr>
<td>Neurology</td>
<td>2 months</td>
</tr>
<tr>
<td>Inpatient Adult Psychiatry</td>
<td>6-16 months</td>
</tr>
<tr>
<td>Child/Adolescent Psychiatry</td>
<td>2-3 months</td>
</tr>
<tr>
<td>Consultation/Liaison Psychiatry</td>
<td>2-4 months</td>
</tr>
<tr>
<td>Community Psychiatry</td>
<td>1 month (may be done during outpatient)</td>
</tr>
<tr>
<td>Emergency Psychiatry</td>
<td>1-3 months</td>
</tr>
<tr>
<td>Outpatient Adult Psychiatry</td>
<td>12 months (minimum)</td>
</tr>
<tr>
<td>Geriatric Psychiatry</td>
<td>1 month</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>1 month</td>
</tr>
<tr>
<td>Electives</td>
<td>0-6 months</td>
</tr>
</tbody>
</table>

Forensic Psychiatry experience - throughout training and available as elective

In general, rotations are completed as follows: inpatient during the first two years; child and adolescent, consultation/liaison, community, and emergency psychiatry during the second, third, or fourth years; adult outpatient clinic in the third or fourth years; and electives in the third or fourth year. However, there will be considerable variation among individual residents’ schedules. Residents may be required to do inpatient rotations and first call on certain rotations in their PGY3 or PGY4 years. Schedules for July - June are determined the preceding spring. Residents should make requests as early as possible for the rotation sequence preferred. Although every effort will be made to honor each request, it is rare that a resident's schedule can be exactly as requested due to scheduling difficulties that involve the entire residency program. Residents should advise the Residency Director of their priorities.
To ensure that residents receive adequate training on all rotations, any resident who misses more than 25% of any rotation will be required to repeat the rotation.

3. **Continuity Clinic**

PG2, 3, 4 & 5 residents have a weekly continuity outpatient clinic, which residents attend unless they are assigned to a rotation at the Topeka VA Medical Center or the Psychiatry Emergency Liaison Service at KUMC. Additionally, Internal Medicine/Psychiatry residents may not be able to rotate in the continuity clinic due to specific rotation assignments while assigned to Medicine.

4. **Didactics and Required Meetings**

   a. **Summer Basic Series** (8:00 a.m. - 12:00 a.m. Tuesdays, July and August. All Incoming Residents): A series of introductory lectures covering clinical and other "basics" important to incoming residents.

   b. **Residents Meeting with the Program Directors/Chief Residents** (12:00 noon. First Tuesday of each month, Sept. through June. All Residents). The Chief Residents conduct the first 30 minutes of the meeting and immediately following are joined by the Program Directors. This is an opportunity to discuss problems, ask questions, catch up on announcements and get to know other residents in the program. Lunch is provided by the Department.

   c. **GME Core Competency Conferences** (12:00 noon. Second Tuesday of each month. July-June. All Residents). Presentations are primarily case based and interactive. Quarterly presentations will be cross-disciplinary, analyzing systems errors in patient care. These presentations will incorporate the Vanderbilt matrix or other appropriate interactive tools to more effectively integrate Core Competencies (Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practice Based Learning and System-based Practice) with the Institute of Medicine 6 Aims for Improvement (safe, effective, patient centered, timely, efficient and equitable) patient care.

**Didactics**

   a. **Weekly Lecture Series** (8:00 a.m. – 12:00 p.m. Tuesdays, Sept. through June. All Residents). A core curriculum is presented by staff, residents, and guest lecturers.

      i. *PGY1 and PGY2 internal medicine/psychiatry residents should attend psychiatry lectures while assigned to psychiatry and medicine services. Psychiatry residents rotating on medicine as part of their four-month medicine requirement should not attend psychiatry lectures except during the Summer Basic Series. Beginning September, they should attend didactic offerings presented by that medicine service.

      ii. **Residents assigned to a Topeka VA psychiatry service are not expected at Topeka on Tuesdays. Those residents should attend lectures at KUMC on Tuesday mornings. In addition, at the beginning of your
Topeka psychiatry rotation, you will receive instruction regarding the afternoon activity, which is a journal article review. At the end of your Topeka psychiatry rotation, a meeting will be scheduled for you to discuss your written review.

b. **Interview Skills Teaching Sessions** (4:30 p.m. – 6:00 p.m. Mondays, year round. All Outpatient Residents). A series of teaching sessions throughout the resident’s adult outpatient rotation on patient interviewing skills, including those necessary for board examination.

c. **Psychiatry Grand Rounds** (11:00 a.m. – 12:30 p.m. Fridays, Sept. through June, Sudler Auditorium, 3rd Floor Sudler. All Residents). A series of guest speakers present on worthy topics.

   i. *PGY1 and PGY2 internal medicine/psychiatry residents should attend Psychiatry Grand Rounds while assigned to psychiatry. Psychiatry residents rotating on medicine as part of their four-month medicine requirement should not attend Psychiatry Grand Rounds, but should attend didactic offerings presented by that medicine service.

   ii. **Residents assigned to a psychiatry rotation at the Topeka VA Medical Center should attend Psychiatry Grand Rounds at that location rather than KUMC Psychiatry Grand Rounds.

d. **PLS/Consult Case Conference.** (12:00 p.m. Tuesdays, various dates. PGY3 and PGY4 Residents).

e. **Inpatient Case Conference.** (12:00 p.m. Tuesdays, various dates. PGY1 and PGY2 Residents).

f. **Other Didactic Offerings.** Various other didactic sessions are held in conjunction with specific rotations, including neurology; internal medicine; outpatient psychiatry; child and adolescent psychiatry; and rotations at the KCVA ("mini"grand rounds). PGY1 residents rotating on primary medicine services and Neurology are expected to attend the didactics required of other residents in the assigned department.

5. **Didactic Attendance Policy**

   Attendance at didactic activities is a mandatory part of training. Attendance is monitored with regular review by the Residency Director and Departmental RRC. **There are no excused absences. Residents must attend at least 75% of didactic activities.**

   Residents are expected to sign in for each lecture and indicate the time they arrived. Residents will not be given credit for lectures if they arrive more than 15 minutes past the start time of the lecture. Lecture Attendance shall be figured twice a year during the periods September through January and February through June. Any resident who drops below 75% for a period will be placed in the first call pool at KUMC or KCVA. If that resident is already in the first call pool, he/she will get an extra call. Any resident who drops below 75% for a period will also be required to meet with the program directors. Should the program directors become concerned
about any individual resident’s attendance, whether they meet the 75% minimum or not, the program directors will meet with the resident for discussions and monitoring at the program directors’ discretion.

6. Duty Hours

Residency programs in the United States must comply with the Accreditation Council for Graduate Medical Education’s duty hours standards, which limit resident duty hours to a maximum of 80 hours a week and set other restrictions on duty hours. The standards, which the ACGME Board of Directors approved in February 2003 and updated in 2011, are the culmination of two years of work to develop common duty hours standards for residents in all specialties that balance the needs of patient care, resident well-being and academic and clinical education. Residency Programs that fail to comply with the new standards will face adverse accreditation action, including loss of accreditation. Residents are expected to report their work hours, including the time that they arrive and leave the hospital for call shifts, honestly and accurately. The program reviews each resident’s duty hours weekly to ensure compliance and to address concerns.

The Department of Psychiatry strictly enforces the ACGME duty hour regulations with which every resident should be familiar:

- **Maximum Hours of Work per Week**
  Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

- **Moonlighting**
  Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in Internal and External Moonlighting must be counted towards the 80-hour Maximum Weekly Hour Limit. PGY-1 residents are not permitted to moonlight.

- **Mandatory Time Free of Duty**
  Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

- **Maximum Duty Period Length**
  Duty periods of PGY-1 residents must not exceed 16 hours in duration.

Duty periods of PGY-2, PGY-3 and PGY-4 residents may be scheduled to a maximum of 24 hours of continuous duty in the hospital.

We encourage our residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
It is essential for patient safety and resident education that effective transitions in care occur. PGY-2, PGY-3 and PGY-4 residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

**Minimum Time Off between Scheduled Duty Periods**
PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

PGY-2, PGY-3 and PGY-4 residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

**Maximum Frequency of In-House Night Float**
Residents must not be scheduled for more than six consecutive nights of night float.

Residents should not be scheduled for more than four consecutive weeks of night float during the required one-year, full-time outpatient psychiatry experience.

Residents should not be scheduled for more than a total of eight weeks of night float during the one-year of consecutive outpatient experience.

**Maximum In-House On-Call Frequency**
PGY-2, PGY-3 and PGY-4 residents must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

**At-Home Call**
Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit.

The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

*While rotating on internal medicine, residents assigned to inpatient services who stay in the evening for “short call” and check out to a night float resident, the requirement of ten hours off between shifts can be shortened to 8-10 hours as follows:

a. This applies to residents who are not on overnight call and who sign-out to night float teams.

b. The 8-10 hour break may not be applied more than twice per week (i.e., every fourth day).

c. The 8-10 hour break may not be applied to other rotations.

d. The break must never be less than 8 hours.*
e. A shorter break must not adversely affect resident well being, patient care, or resident education, and the program must provide safeguards against resident fatigue and sleep deprivation.

f. Residents will remain compliant with the 80-hour work week and with other duty-hours limitations.

Residents are expected to be rested and alert during duty hours, and the resident and resident’s attending medical staff are collectively responsible for determining whether the resident is able to safely and effectively perform his/her duties.

If a scheduled duty assignment is inconsistent with the Resident Agreement or the Institutional Duty Hours and Call Policies, the involved resident shall bring that inconsistency first to the attention of the Program Director for reconciliation or correction. If the Program Director does not reconcile or correct the inconsistency, it shall be the obligation of the resident to notify the Department Chair or Associate Dean for Graduate Medical Education, who shall take the necessary steps to reconcile or correct the raised inconsistency.

7. Eligibility

See Section 4 of the GME Housestaff Policies and Procedures Manual for specific requirements on Eligibility, Transfer, Application, and Appointment of Residents.

8. E-mail Policy

Residents are required to check their KUMC e-mail daily. It is essential that residents stay in touch with the KUMC e-mail system, which is the most commonly used form of communication at KUMC.

9. Evaluations

There are a number of ways in which residents are evaluated. The most frequent is the online evaluation by the attending physician at the end of each rotation (or quarterly, whichever is sooner). This evaluation is divided into the six core competencies and assessed on a 5-point rating scale. For example, an attending may be asked the extent to which the resident effectively uses consult services and responds by agreeing with one of five statements (ranging from inadequate to excellent), with statements designed to assess how well the resident has succeeded in this category. These evaluations are necessarily subjective and are based on the faculty evaluator’s own personal standards and experience with previous residents. Each evaluation is usually discussed with the resident. All monthly written assessments are reviewed by the Program Director. A satisfactory performance is expected in each of the assessed competencies. A low satisfactory or less is cause for concern and results in close monitoring by the Program Directors and Residency Review Committee and is discussed at the resident’s semi-annual meeting. Consistently low scores may lead to probation.

Evaluations are intended to be drafted with an emphasis on constructive assistance with particular suggestions for improvement. However, if the resident feels that the evaluation is unfair, inaccurate or unwarranted, then it is his/her right to refute the legitimacy of the evaluation with a written response. This will be reviewed by the Program Director, and further action will
be taken as needed to clarify the discrepancy. The resident’s written response will become part of the resident’s permanent file.

Residents are also evaluated by clinical skills examination and evaluated patient interviews.

Semi-annually, the program directors meet with the resident individually. The purpose of these sessions is to review the resident’s progress, provide feedback, counseling, assistance and solicit resident suggestions for program improvement.

Residents have ready access to the contents of their personal file, which is kept in the residency office. Semi-annual review summaries are provided to each resident following their meeting. In addition to regularly reviewing residents’ performance, program leaders annually review each resident’s personal file of service evaluations, clinical competency exams, PRITE scores, standardized patient performance and other performance documentation for the year. An important aspect of the evaluation process is the feedback that the Program Director receives from residents regarding the educational performance of their attending physicians. This feedback is utilized by the Program Director and Chair of Psychiatry to make faculty education assignments. If faculty members are not able to provide adequate educational services to the residents, then they will no longer be able to participate in this education process. The resident’s evaluation of faculty is anonymous; these evaluations are batched and unidentified when shared with faculty.

Resident evaluations of attending faculty members are completely anonymous and are not released until ten online evaluations have been completed. Neither the faculty member nor the Residency Director (or anyone else) will be able to link specific faculty evaluations with specific residents. Residents are also required to complete a program evaluation annually. A summary of who receives and can view data regarding all evaluations in the E-Value system is as follows:

**Who can see what?**

<table>
<thead>
<tr>
<th></th>
<th>Program</th>
<th>Faculty of Resident</th>
<th>Resident of Faculty</th>
<th>Faculty of Program</th>
<th>Resident of Program</th>
<th>Peer</th>
<th>Nurse of Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Director</td>
<td>PSYC</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Program Coordinator</td>
<td>PSYC</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Resident</td>
<td>PSYC</td>
<td>4</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>Faculty</td>
<td>PSYC</td>
<td>N/A</td>
<td>1</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

On an annual basis, a yearly program evaluation is undertaken by the Residency Review Committee during the program’s annual curriculum meeting, which includes all faculty and chief
residents. This meeting includes the evaluation and review of ACGME survey data, resident performance, faculty development, graduate performance, and program quality. Based on this evaluation, program goals and objectives are developed with input from program leadership, faculty and residents.

9. **Examinations**

   a. **PRITE.** The Psychiatry-Resident-In-Training-Examination (PRITE) is given annually in October. All residents (Internal Medicine/Psychiatry, Addiction Psychiatry and first year Child Psychiatry residents included) must take the examination in order to fulfill the requirement for an annual formal examination of cognitive knowledge as required in the Essentials of Accreditation of Residencies. Resident evaluation will not be based solely on this examination. However, scores will be reviewed in conjunction with observations of clinical performance and participation in academic sessions, in considering the resident’s overall progress in the program.

   PRITE scores are confidential information and will not be released to anyone except the Residency Director and faculty, without the resident’s permission. PRITE scores are used as well for program evaluation. If the majority of residents in a particular PGY year do poorly in certain areas, this may indicate a need to reassess the curriculum.

   b. **USMLE Step 3.** Residents are required to take USMLE or COMLEX Part 3 before the end of their PGY2 year.

   c. **Evaluated Patient Interview.** Residents must complete one evaluated patient interview in their PGY1 year and two evaluated interviews each subsequent year. Internal Medicine/Psychiatry residents are required to complete one evaluated patient interview per year. The interview may be part of a regular weekly conference or conducted as a separate live interview. The staff member observing the interview need not be your supervisor. The completion of each interview evaluation must be submitted in writing by the observing faculty. **It is the responsibility of the resident to ensure that this is completed and that the interview evaluation is submitted to the Residency Office.**

   The resident’s skills are evaluated as follows:

   - ability to interview patients and families
   - ability to establish an appropriate doctor/patient relationship
   - ability to elicit an appropriate present and past psychiatric, medical, social, and developmental history
   - ability to assess mental status
   - ability to provide a relevant formulation, differential diagnosis and provisional treatment plan
   - ability to make an organized presentation of the pertinent history, including the mental status examination
d. **Clinical Skills Examination.** In addition to the evaluated patient interview as described above, all residents must complete three clinical skills examinations during the course of their residency. In each examination, residents must make an organized presentation of pertinent history, including the mental status examination. Residents must demonstrate competence in the following:

- establishing an appropriate doctor/patient relationship
- psychiatric interviewing
- case presentation

Each of the required three evaluations is conducted by a board-certified psychiatrist. At least two of the evaluations must be conducted by different board-certified psychiatrists. Demonstration of the competencies during the three required evaluations is required prior to completing the program.

11. **Patient Log**

Each resident is required to keep an electronic log of all psychiatric patients seen for the first time by that resident (both hospitalized and ambulatory). For the residents’ convenience, paper templates for keeping track of the required information on patients may be obtained from the Residency Coordinator. The data kept in the paper templates must be entered into the electronic log regularly.

Data obtained from each resident’s electronic log is reviewed by the program director regularly.

12. **Scholarly Activity**

Residents are required to complete an approved scholarly activity as part of the criteria for graduation. Specifically, the activity can be a research project, a review paper of publishable quality or a poster or presentation at a regional or national meeting or a major lecture/presentation including a full Psychiatry Grand Rounds. All residents are required to present a summary of their scholarly activity at a special Resident Grand Rounds before completion of their residency training.

13. **Supervision**

Clinical training includes regularly scheduled supervision. The frequency, duration, and types of supervision will change as residents advance in training, demonstrate professional and clinical competence, and earn the confidence of their supervisors. By providing patient care oversight and teaching, supervisors foster the safe, high quality, and competent care of patients managed by residents. As role models, supervisors teach, evaluate, and enhance the knowledge, skills, and attitudes of their residents with respect to patient care and career development. Supervisors require adequate time in their schedules to meet with residents.

Residents are expected to follow the policies of the individual sites and services on which they are rotating. They should also proactively seek out educational opportunities including
supervision and demonstrate the highest degree of professionalism in utilizing these opportunities.

The responsibilities of faculty regarding supervision of residents within the adult psychiatric residency program include the following:

a. **PRIMARY SITE PROGRAM DIRECTOR:** The program director is responsible for assuring that the overall supervisory experiences of residents are arranged to achieve both proper patient care and attainment of the competency based goals and objectives associated with each PG year of training and each rotation.

b. **SITE SPECIFIC PSYCHIATRY SUPERVISORS:** The site specific psychiatry supervisor, a credentialed physician affiliated with the residency program, is responsible for oversight of residency supervision on the clinical rotations at a specific training site. This site specific supervisor assures that there are rotation specific supervisors who have ultimate responsibility for patient care provided by residents under their supervision, that all care by residents is directly supervised at all times by appropriately credentialed physicians, that these supervisors are known to all residents through printed (or electronically available) schedules and that the degree of resident responsibilities for patient care is contingent on the specific resident’s competency and PG level of training. Furthermore, the site specific supervisor assures that the rotation specific faculty provide direct and indirect supervision of residents through resident case presentations, conducting chart reviews, assisting or demonstrating procedures, and providing other educational experience relative to the rotation. The site specific supervisor is responsible to the primary site residency training director for proper oversight of these responsibilities as well as to his/her other site specific supervisor(s).

c. **ROTATION SUPERVISOR/ATTENDING:** The rotation supervisor, a credentialed physician affiliated with the residency program and under the direction of the site specific supervisor, is responsible for directly supervising residents in the management of patients on his/her service. This supervision includes seeing patients with residents, listening to and providing feedback on their presentations of new and established patients, answering directed questions, reviewing and assessing resident charting, and providing other educational experiences relative to the rotation including guidance and role modeling in the areas related to the six core competencies. The rotation supervisor insures that he/she is accessible to residents to supervise cases encountered during designated shifts. The rotation supervisor or designee is also responsible for reviewing the educational goals and objectives with each resident as they begin the rotation and for the evaluation of each resident at the end of the rotation or after three months (whichever comes first).

d. **INDIVIDUAL PSYCHIATRY SUPERVISORS:** This supervisor, a credentialed psychiatrist affiliated with the residency program, is responsible for the individual supervision of a resident for one hour weekly. This supervisor serves as a mentor to the resident and may discuss diverse issues related the resident’s training including but not limited to such areas as discussion of cases, assignment and review of psychiatric related literature, advice on career development and opportunities, and self or other assessments of resident performance. Psychiatry supervisors are assigned by the residency office to PG1 through PG4 residents. Both supervisors and residents are responsible for determining a mutually agreeable time to meet
weekly for one hour (PG4) or two hours (PG1 and PG2). PG3 residents rotating in
the outpatient clinic are assigned a day and time for psychiatry supervision.
Residents are responsible for submitting to the residency office quarterly attendance
logs signed by their supervisor indicating that these meetings have occurred.

e. INDIVIDUAL PSYCHOTHERAPY SUPERVISORS: This supervisor, a credentialed
psychiatrist or other psychotherapist affiliated with the residency program, is
responsible for the clinical and educational supervision of residents regarding their
psychotherapy cases. Residents are to discuss all their psychotherapy cases with
their psychotherapy supervisor. This supervision may include direct observation of
live or taped resident interviews, resident observation of supervisor conducted
interviews, resident case presentations, chart reviews or other direct or indirect
methods. Psychotherapy advisors are assigned by the residency office for all PG3
and PG4 residents and both supervisors and residents are responsible for
determining a mutually agreeable time to meet for one hour weekly. PG3 residents
rotating in the outpatient clinic are assigned a day and time for psychotherapy
supervision. Residents are responsible for submitting to the residency office
quarterly attendance logs signed by their supervisor indicating that these meetings
have occurred.

14. Time Reporting

Residents are required to keep track of their hours worked by entering the information via the
online E-Value system. Time entry for the previous week (Monday-Sunday) is required to be
entered into the system by 9:00 a.m. every Monday morning. Residents who are consistently
late in entering their time will be reported to the Program Director. Instructions and training for
time entry are provided by the Residency Office during orientation. The website for entering
duty hours is www.e-value.net. Residents may log in using their KU login and password and the
institution code “KUMC.”
D. **GENERAL INFORMATION**

1. **Call Schedule**

The call schedule is devised by the KCVA Chief Resident and prepared by the Residency Coordinator. The first draft of the call schedule will be emailed to all residents as soon as it is completed, followed by the final version with staff information when it is released from the Chair's office. Instructions for making changes are listed at the bottom of the call schedule and will also be sent out with the final schedule. Residents with special requests should notify the KCVA Chief Resident.

2. **Clothing Allowance**

Three white coats and scrubs are provided at the beginning of residency. Scrubs should be turned back in to the Residency Office at the end of the PGY2 year.

3. **Credit Union**

Residents and their immediate families are eligible for membership in the Credit Union. They offer several savings programs, including a passbook account, Certificate of Deposit, and a money market fund, all at competitive rates. They make loans to qualified persons for any good reason. Other services include a notary service, traveler’s checks, and a VISA card. The Credit Union is located 1037 Delp (8-5375).

4. **Computer Services.**

Each resident is assigned a KUMC Network login and password for access to email, clinical data and the Internet. KUMC email can be accessed from outside KUMC via the Internet. Residents have access to computers throughout the department and in designated resident areas. Residents are required to check their KUMC email daily regardless of rotation.

5. **Dress Code and Decorum**

White coats may be worn in all patient care areas and are required on certain rotations as determined by hospital policy and/or their staff supervisor. Residents are expected to present a clean, neat and professional appearance at all times. Beards and mustaches are allowed as long as they are properly maintained. Residents must wear the Medical Center identification badge and nametag when involved in clinical or administration activities.

**Scrubs should ONLY be worn at night when on call or while rotating in the PLS.**

Conduct consistent with the dignity and integrity of the medical profession is required in all contacts with patients, families, and other health professionals. Patient confidentiality is clearly a paramount issue, and discussions of any patient-related matters must not be conducted in public areas.

The use of alcoholic beverages or drugs that impair judgment while on duty is prohibited, as is the consumption anywhere on the Medical Center premises. Refer to the Housestaff Policies and Procedures Manual for more detail.
6. **Elective Rotations**

The Residency Review Committee must approve all requests for elective time. The request must be submitted in writing a minimum of one month prior to the beginning of the elective period. Residents are evaluated in writing by the elective supervisor(s) and depending on the type of educational experience, a written report or research paper related to the elective rotation may be required. Elective applications may be obtained from the Residency Coordinator.

7. **Health and Disability Insurance**

Health insurance is provided for all residents and dependants for a minimal charge and is payroll deducted. Disability insurance is supplied for all residents by KUMC. The premium paid by KU provides coverage for $1,000 per month on a long-term basis, if a resident should become disabled. Additional coverage may be purchased by the individual. The disability insurance may be converted to a private plan following residency.

8. **Housestaff Policies and Procedures Manual**

This manual presents the institutional guidelines, policies, and procedures governing a wide range of resident issues at the University of Kansas School of Medicine and Medical Center. It is distributed to residents at the time they sign their contract. It can also be accessed through the Internet at http://gme.kumc.edu/documents/GMEManual.pdf.

9. **Keys**

The Residency Coordinator distributes the keys to the Olathe Resident Lounge and Library, Olathe Inpatient Units and Common Areas. Keys for the inpatient units must be returned to the Residency Office at the end of a KUMC rotation. Clinic keys should be obtained by the Outpatient Clinic Manager. All keys must be returned to the residency office upon the completion of residency.

10. **Library Services**

The Resident Library is located in the Residency Office. All library materials must be signed out. The main library requires an ID number to check items out. All residents have access to the library’s computer resources through the KUMC network.

11. **Mail Room**

Every resident is assigned her/his own box in 1012 Olathe. It should be checked and emptied frequently.

12. **Meal Cards**

Residents assigned to first call duties at KUMC are entitled to paid meals in the hospital cafeteria. Meal cards will be distributed at the beginning of a resident’s first rotation at KUMC. Residents should keep this card until they are no longer call eligible at KUMC, at which time, it should be turned in to the Residency Office.
13. **Moonlighting and Locum Tenens Privileges**

After completion of their PGY2 year, residents are allowed to moonlight in accordance with the policies outlined in the Housestaff Manual. PGY3 residents wishing to moonlight must have achieved a global score of 40th percentile or above (compared to their postgraduate peer residents nationally) on psychiatry **AND** neurology on the most recent PRITE. Residents doing training on a J1 visa are not eligible to moonlight outside the institution sponsoring their visa. Moonlighting residents are not allowed to work more than 96 hours per two months. A resident wishing to moonlight must have a permanent license in the applicable state. Individual malpractice coverage must be provided by the resident or his moonlighting employer at the maximum level of at least $1,000,000/3,000,000. Evidence of the coverage must be submitted along with the Department’s request forms. The extrainstitutional practice must be outside normal business hours of 8:00 a.m. to 5:00 p.m. and must not interfere with call duties or performance in the residency program. Any violation of these regulations will result in immediate termination of these privileges. Requests must be submitted well in advance and must be approved by the Residency Review Committee, the Department Chairman and the Executive Dean.

Moonlighting must never interfere with a resident’s primary responsibilities to his/her program. Moonlighting residents are expected to be present, appropriately rested and prepared to carry out their obligations to their educational programs. The Program Director, Department Chair, or Associate Dean for Graduate Medical Education will summarily suspend the privilege to moonlight should a resident’s performance in a program deteriorate. The resident’s performance will be monitored by the Program Director.

Moonlighting residents must adhere to the policies set forth by the ACGME regarding duty hours. Please refer to the GME manual section 16 for comprehensive details regarding the institutional policy related to moonlighting.

14. **Pagers**

All residents are assigned an alphanumeric pager to carry during residency. When assigned to a KCVA rotation, residents should carry both their KCVA and KUMC pagers. Residents are expected to return pages in a timely manner. Residents will be responsible for the replacement cost of a lost or stolen pager.

15. **Parking Permit**

The Department pays for one parking permit in the red zone for each resident. The Residency Coordinator has information regarding parking. Cars will be ticketed if parked in an improper location/zone. If for any reason a different car must be driven that does not have a displayed permit, Parking Services must be notified between 8:00 a.m. and 5:00 p.m. that day.

Back-up call residents who must come in on an emergency basis between the hours of 5 p.m. to 7 a.m. Monday to Friday, or 24 hours on Saturday and Sunday are allowed to park in the slots marked “Reserved 5pm to 7am Resident Parking” outside the Emergency Room to the west of the heart hospital in front of the Sudler building on the west side of the police parking spots.
16. Paychecks

The first paycheck will not be received until approximately one month after training has begun. Thereafter, residents are paid every two weeks, on Fridays.

17. Personal/Sick/Unpaid Leave

Residents may request up to three months per year of leave for reasons of personal or family illness, serious health condition, disability, or the birth or adoption of a child. In most cases, residents elect to use allotted vacation and sick leave before taking unpaid leave. If time is taken as unpaid leave, stipend payments are suspended for that period, but all other benefits continue. Any unpaid leave that exceeds 4 weeks must be made up at the end of the residency program.

For a brief illness or for other medical reasons, residents are allowed up to 10 days sick leave per year. These days do not carry over from one contract year to the other and are clearly not to be abused. Please refer to the Housestaff Policies and Procedures Manual for further details.

For women who are breast-feeding after returning to work, please refer to http://www2.kumc.edu/hr/benefits/expressstation.html for information on the University’s Lactation Support Policy.

Residents who are aware of a medical leave in advance of the leave should submit their leave request electronically to the Psychiatry Chief Residents.

Residents assigned to the Outpatient Clinic may make requests for leave less than 4 hours by completing a white leave request form available from the Residency Office or the Outpatient Clinic. This form should be submitted to the Residency Coordinator, who will have the request approved and block the requesting resident’s clinic schedule for the time requested.

Leave time may not exceed 25% of any rotation.

RESIDENTS ARE REQUIRED TO NOTIFY THE RESIDENCY COORDINATOR AS WELL AS THE APPROPRIATE PERSONNEL AT THEIR ASSIGNED ROTATION BEFORE THEIR SHIFT BEGINS IF NOT REPORTING TO WORK DUE TO SICK OR MEDICAL LEAVE.

18. Photocopying/FAX

Residents have access to the department copier located 1012 Olathe. The department FAX machine is also located in 1012 Olathe. The FAX number is 913-588-6414. (For professional use only).

19. Professional Development Fund

The Department provides $600.00 per year reimbursement for psychiatry residents and $800.00 per year reimbursement for medicine/psychiatry residents for such things as books, journal subscriptions, conferences and other educational expenses. Contact the Residency Coordinator to obtain a "Professional Development Reimbursement Request" form. Attach original documentation of expenses and submit to the Residency Office. Any unused funds for a year shall be carried over to the next year and added to the next year’s balance.
20. **Resident Code of Professional and Personal Conduct**

The Resident Code of Professional and Personal Conduct is described fully in Section 7 of the GME Policies and Procedures Manual. Specifically, this section includes the following University policies applicable to all KUMC residents:

1. Professionalism Initiative
2. Dress
3. Impaired Physician and Substance Abuse Policy
4. Alcohol, Drugs and Tobacco
5. State Ethics Policy (K.S.A. 46-237a)
6. KUMC Vendor Relations Policy
7. Resident and Fellow Files
8. GME Resident and Financial Accountability Policy
9. Ombudsman Guidelines for Residents

21. **Storm Lounge**

The Shawn Storm M.D. Memorial Resident Lounge is located on the first floor of Sudler, just adjacent to the Child Psychiatry faculty offices. This is for use of the entire housestaff body. The door has restricted access through a keypad—the entry code is 157.

22. **Vacation Leave**

Residents are provided a maximum of 3 weeks (15 days) per year. The resident's stipend is covered during this time. Vacation time does not carry over from year to year. This amount is pro-rated for partial years (residents who start mid-year, etc.). Vacation requests should be submitted in early July for the time period July-December and in early January for the time period January-June. Residents who request their vacation one year in advance will receive preference if a conflict arises with another resident’s vacation request. The Chief Residents will have the discretion to allow changes if adequate coverage is in place.

Vacation requests will not be approved for the last two weeks of June and the first two weeks of July. The Residency Review Committee will have the authority to approve vacation requests for these times only under extraordinary circumstances.

While on the required, limited time rotations (ex. Child and Adolescent Psychiatry, Neurology, Medicine, Community Psychiatry, Emergency Psychiatry, and Consultation/Liaison services), vacation is limited.

All vacation requests must be initiated electronically. Coverage must be arranged by the requesting resident before submitting it electronically to the Chief Resident. The Chief Resident will send the electronic request to the Residency Coordinator for final processing and Program Director approval. Once approved, the Residency Coordinator will block the requesting resident’s clinic schedule for the requested time and notify the clinic staff of the resident’s leave dates. While on a V.A. service, residents need to submit additional vacation paperwork which may be obtained from the psychiatry secretary at the V.A. Requests will be considered on a first-come-first-served basis.
Internal Medicine/Psychiatry residents must obtain approval from the Internal Medicine Clinic at least 60 days in advance before sending the request to the Chief Resident for processing.

Residents assigned to the Outpatient Clinic may make requests for leave less than 4 hours by completing a white leave request form available from the Residency Office or the Outpatient Clinic. This form should be submitted to the Residency Coordinator, who will have the request approved and block the requesting resident’s clinic schedule for the time requested.

**Leave time may not exceed 25% of any rotation.**

**Requests for vacation or professional leave submitted less than 30 days in advance will not be considered.**

E. **RESIDENT WORK ENVIRONMENT**

The Program provides an educational and work environment in which residents may raise and resolve issues without fear of intimidation or retaliation. This includes the following:

Provision of an organizational system for residents to communicate and exchange information on their work environment and the residency program, a process by which individual residents can address concerns in a confidential and protected manner.

The Sponsoring Institution must provide services and develop systems to minimize the work of residents that is extraneous to their GME programs and ensure that the following conditions are met:

1. **Food services**: Residents on duty must have access to adequate and appropriate food services 24 hours a day in all institutions.

2. **Call rooms**: Residents on call must be provided with adequate and appropriate sleeping quarters, if necessary.

3. **Support services**: Patient support services, such as intravenous services, phlebotomy services, and laboratory services, as well as messenger and transporter services, must be provided in a manner appropriate to and consistent with educational objectives and patient care.

4. **Laboratory/pathology/radiology services**: There must be appropriate laboratory, pathology, and radiology services to support timely and quality patient care in the ACGME-accredited programs. This must include effective laboratory, pathology, and radiologic information systems.

5. **Medical records**: A medical records system that documents the course of each patient's illness and care must be available at all times and must be adequate to support quality patient care, the education of residents, quality assurance activities, and provide a resource for scholarly activity.

6. **Security/safety**: Appropriate security and personal safety measures must be provided to residents at all locations including but not limited to parking facilities, on-call quarters,
hospital and institutional grounds, and related clinical facilities (e.g., medical office building).

F.  RESIDENT STANDING, PROGRESS, AND PROMOTION

Residents are evaluated by their attending staff and nursing staff quarterly or at the end of each rotation (whichever is earlier). Evaluations are available for review on line when they are completed. Residents being evaluated will receive an email notification when an evaluation has been completed. Residents are also evaluated by medical students. Medical student evaluations are not viewable on line, but will be discussed with each resident during their semi-annual meeting with the Residency Director.

These evaluations are to insure that residents are progressing satisfactorily from rotation to rotation and that deficiencies relative to promotion to the next PGY level, if present, can be addressed as soon as possible. In addition to rotation evaluations, information from other sources will be considered. These include attendance records for required academic sessions, reports from past remedial programs, results of written examinations, and informal reports. Residents are reviewed as to performance by the Residency Director and, as appropriate, at Residency Review Committee Meetings at regular intervals, at least twice yearly. Please refer to the Housestaff Policies and Procedure Manual for details of the recommended institutional guidelines pertaining to progress and promotions.

G.  REMEDIATION, PROBATION, CORRECTIVE ACTION, AND DUE PROCESS

Concerns regarding any aspects of a resident’s performance are brought before the Departmental RRC. One or two low satisfactory grades will result in informal counseling. A poor grade or unsatisfactory rotation evaluation will result in formal counseling, which may include development of a remediation plan, repetition of the rotation or probation. Consistently poor performance may suggest a need for adverse action. Very specific guidelines from the School of Medicine govern remediation, probation, and due process/grievance procedures pertaining to any such actions. Please refer to the appropriate section in the Housestaff Policy and Procedure Manual for details.

Whenever the Residency Director is informed of significant concern regarding a resident’s performance, the resident involved will be contacted and given the opportunity to provide a response. The resident may provide this response by any or all of the following: in the form of a written document, through verbal communication with the residency director, or by personal appearance before the departmental Residency Review Committee. The RRC will subsequently review the facts and make a decision as to whether this information should be included in the resident’s permanent file. If a decision is made to place the material in the resident’s file, both criticism and response will be included. Supervising faculty may include, in correspondence regarding concerns about resident’s performance, a proviso that same not be placed in the resident’s file if difficulties are corrected within a given time frame.
H. GRIEVANCE PROCEDURE

Grievable matters are those relating to the interpretation of, application of, or compliance with the provisions of the Resident Agreement, the policies and procedures governing graduate medical education, and the general policies and procedures of the University of Kansas Medical Center. Questions of capricious, arbitrary, punitive or retaliatory actions or interpretations of the policies governing graduate medical education on the part of any faculty member or officer of the Psychiatry Residency Training Program are subject to the grievance process. Complaints of illegal discrimination, including failure to provide reasonable accommodations and sexual harassment, are processed in accordance with the Medical Center policies and procedures that are administered through the Equal Opportunity Office. Should a resident in the Department of Psychiatry have a grievance or be dissatisfied with any aspect of the Program, he/she is encouraged to initially discuss the issue with his/her attending or the Chief Residents. If this is felt by the resident to be inappropriate or the issue is not satisfactorily resolved, timely discussion with the Program Directors is highly recommended. Documentation of the issues and a statement of dissatisfaction by the aggrieved resident may be helpful, and is also encouraged, particularly when making an appeal to the Department's Residency Review Committee.

In general, the resident will first discuss any grievance with the Chief Residents. If this fails to provide adequate closure to the grievance, then he/she is directed to speak with one of the Program Directors. Issues can best be resolved at this stage and every effort should be made to achieve a mutually agreeable solution. If the grievance is not resolved to the satisfaction of the resident after discussion with the Program Director, the resident has the option to present the grievance, in writing, to the Office of Graduate Medical Education. In situations where the grievance relates to the Chair or Program Director, or where the resident believes that a fair resolution cannot be attained by presenting the grievance to those individuals, he/she may present the grievance in writing directly to the Office of Graduate Medical Education. The Associate Dean for Graduate Medical Education will meet with the resident, the Program Director, the Chair and one or more of the program’s Chief Residents to determine the cause and validity of the complaint and to determine the means of redress.

In addition to the above avenues, residents may communicate with the faculty ombudsman for the institution. The ombudsman is an academic faculty member in good standing without alignment or administrative connection to either program leadership or School of Medicine/GME Leadership. The ombudsman will serve as a sounding board/resource to residents with questions or concerns about their program, faculty, or school of medicine. The ombudsman is also considered a neutral party and trusted intermediary during any administrative process at the request of an involved resident. Residents may access the ombudsman by email at ombudsman@kumc.edu. Should the meeting with the Associate Dean fail to resolve the grievance to the satisfaction of the resident, the resident may request that he/she be heard by the Executive Dean. Any action(s) taken in good faith by the Executive Dean addressing the grievance will be final.
I. **CRITERIA FOR GRADUATION**

1. Satisfactory completion of training program goals and objectives as outlined in the “Program Requirements for Residency Education in Psychiatry” section of the Directory of Graduate Medical Education Programs, and in the General Information section of this Manual.

2. Completion of USMLE/COMLEX Step 3.

3. Absence of any serious errors in clinical judgment, or in the case of such errors, successful completion of any corrective remedial training.

4. 75% attendance at, appropriate preparation for, and active participation in all didactic seminars and conferences.

5. Consistent participation in all required individual supervision and clinical experiences and submission of documentation of such.

6. Absence of any documented evidence of unethical or unprofessional behavior or any serious question of clinical competence.

7. Completion of Scholarly Activity approved by the Department’s Residency Review Committee.

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

9. Successful completion of three clinical skills examinations.

10. Submission of the Graduate Medical Education Clearing Form to the Residency Coordinator.

J. **THE RESIDENCY REVIEW COMMITTEE (Educational Policy Committee)**

**Function:** The Residency Review Committee is responsible for advising the residency director regarding the overall administration and operation of the postgraduate residency training program in psychiatry and shall assist the residency director in the planning, organization and supervision of the program. In conjunction with the residency director, the committee shall ensure that the objectives, rules, and regulations of the training program meet the requirements and adhere to the policies set forth by the Graduate Medical Education (GME) committee of the University of Kansas Medical School. Its activities shall include, though not necessarily be limited to, the following:

- Selection of applicants for admission to the program
- Monitoring and evaluation of residents throughout their training
- Review and advise with respect to promotions of residents
• Review and advise adverse academic or disciplinary actions regarding resident progress or behavior and consider appeals regarding these actions submitted by residents
• Conduct regular reviews of each training site, identify areas of concern, suggest methods of improvement when needed and monitor changes
• Review on a timely basis the competencies, training goals and objectives for each post graduate year and each major rotation
• Approve all elective rotations and, when necessary, requests for leave of absence
• Review the didactic and clinical curriculum on a timely basis
  o Ensure that the content of all courses is in keeping with the competencies, goals, and objectives established for the residency program
  o Review time allocation for each course and establish a teaching schedule
  o Review feedback from the residents’ group on course content, format and instructors
  o Review evaluations of teachers and recommend adjustments as necessary
• Undertake other activities as may be requested by the residency director or departmental Chair with respect to the training program

Membership:
• Psychiatry Residency Program Director and Director of KUMC Adult Outpatient Psychiatry, (B. Liskow, M.D.)
• Associate Residency Program Directors and Attending, KUMC Consultation/Liaison Psychiatry (A. Mayorga, M.D./L. Shenkman, M.D.)
• Chair of Psychiatry (W. Gabrielli, Jr., M.D., Ph.D.)
• Site Director, Residency Program (E. Yaffe, M.D.)
• Attending, Adult Inpatient Psychiatry (D. Ambrose, M.D.)
• Attending, SAARTP (A. Din, M.D.)

Voting Members:
• Chair of Psychiatry (W. Gabrielli, Jr., M.D., Ph.D.)

KUMC
• Director, Internal Medicine/Psychiatry Residency Program (T. Long, M.D.)
• Director, KUMC Division of Child and Adolescent Psychiatry and Director of the Child and Adolescent Psychiatry Residency Program (S. Cain, M.D.)
• Director, KUMC Division of Psychology (E. Penick, Ph.D.)
• Director, KUMC Methadone Clinic (W. McKnelly, M.D.)
• Director, KUHA Inpatient Adult Psychiatry (L. Larsen, M.D.)
• Director of the Addiction Psychiatry Residency Program (J. Campbell, M.D.)
• Child and Adolescent Psychiatry Resident Representative

Johnson County Mental Health Center, Inc.
• Medical Director, Johnson County Mental Health Center (J. Lauchland, M.D.)

Wyandot Center for Community Behavioral Healthcare, Inc.
• Medical Director, Wyandot Center for Community Behavioral Health Care (C. Day, M.D.)

VA Eastern Kansas Health Care System
Chief of Psychiatry, VA Eastern Health Care System (W. Mack, M.D.)
Attending, Geriatric Psychiatry/Palliative Care (M. Buenaver, M.D.)

Current Chief Residents

Frequency of Meetings: Monthly or at the discretion of the Psychiatry Residency Director

K. THE LIAISON COMMITTEE

Function: The Liaison Committee is a resident selected advisory group responsible for obtaining resident feedback, identifying areas within the residency program for improvement, proposing solutions and new resident policy. This committee has 10 total members (two members from each postgraduate level and two internal medicine/psychiatry representatives). Information is gathered by postgraduate year and relayed to program administration during Liaison Committee meetings. This information is then further discussed by residency administration and often the department’s Residency Review Committee. Its activities shall include, though not necessarily be limited to, the following:

- Create an environment of resident feedback and respect
- Allow residents to identify areas of concern and function independently to propose solutions
- Review and identify residency and curriculum issues Including, but not limited to didactics, vacation policy, attendance policy, on call issues, service-specific concerns
- Allow residents from multiple sites to provide feedback to their peers that will be relayed to residency administration
- Act as a liaison between the residents and the residency administration in a supportive environment conducive to change and constructive thought

Membership:

Associate Residency Program Director (L. Shenkman, M.D.)

Resident Members:
PGY1
Nischal Sagar, M.D.
Amanda Klass, D.O.

PGY2
Swapnil Rath, M.D.
Davil Willey, M.D.

PGY3
Adeel Ansari, M.D.
Sri Venkata Uppalapati, M.D.

PGY4
Md. Mushfiqur Rahman, M.D.
Adeel Meraj, M.D.
Frequency of Meetings: Monthly or at the discretion of the Associate Residency Program Director

K. RESIDENT SELECTION POLICY

Please see the policy outlined below regarding selection procedures for the appointment of residency to the program.

Initial Application Screening

The initial screening of applicants is done by the residency program coordinator. As applications are received, the coordinator will outline the following for the program director’s review:

1. USMLE or COMLEX Scores. The coordinator will note the number of times the applicant took the examination in order to receive a passing score.

Secondary Screening

The secondary screening of applicants is done by the program directors by reviewing the initial screening criteria noted by the coordinator, and outlining and evaluating the following:

1. Year of Graduation. If greater than 10 years, the coordinator will note what type of work the candidate has been engaged in since graduation from medical school.

2. Experience in the Field of Psychiatry/Behavioral Health. The coordinator will outline any notable experience, either by education or work experience, in the field of psychiatry/behavioral health.

3. Personal Statement. The program directors read the applicant’s personal statement and evaluates it based on the following:
   - Command of the English language
   - Stated genuine interest in psychiatry/behavioral health
   - Overall quality of the statement
   - Dean’s Letter
   - Medical Transcripts
   - Letters of reference
   - Any potential items for concern

Additional Screening

If the program director is unable after the secondary screening to make a decision on whether or not to invite a candidate, the application will be sent to one of the other program directors or
another member of the Selection Committee for their review. After receiving feedback from the committee reviewer, the program director will decide whether or not to extend an invitation to the candidate.

Each candidate that is selected for interview will be invited via email by the residency program coordinator. Once the applicant is schedule, they will be sent an email with an interview confirmation and instructions for the interview day.

Interview Process

Fifteen interview dates are selected and up to 8 candidates may be interviewed per interview day. One KUMC Program Director and the KCVA Site Director participate in every candidate interview day. Two other faculty interviewers are scheduled for each interview day for a total of four faculty interviewers. All interviews take place at KUMC in Olathe Pavilion. On a given day, each interviewer will have up to 8 resident interviews, 25-30 minutes each. Each interviewer is given all application materials for each applicant to be interviewed in their scheduled day. Each interviewer is asked to complete a resident candidate evaluation form and also an individual ranking form for each candidate they interview. Interviewers are asked to have all forms completed at the end of the daily interview session, and all four faculty interviewers meet at that time to discuss the applicants interviewed and assign them a quartile (based on every applicant they have ever interviewed) and daily rank.

This information is transferred by the residency coordinator into an Access database so that at the time of the annual ranking meeting in February, applicants may be sorted based on composite scores at the time of their interview.

Candidates are treated to a luncheon outside of the Medical Center after their interviews so that the resident candidates may meet with a select group of current residents. This is done so that the candidates may ask the residents questions they may not feel comfortable asking a faculty member or a member of the program administration. Also, it gives the candidates and residents time to speak freely about the program, its strengths and weaknesses, etc. The chief resident takes the candidates on a campus tour and fields any other questions the resident candidates may have about the program.

Annual Ranking Meeting

The annual ranking meeting is held in place of the regularly scheduled Residency Review Committee on the second Friday of February and open to Selection Committee members for that particular year. The Selection Committee is comprised of the departmental Residency Review Committee and all faculty members who interviewed resident candidates. Also, the Chief Residents are included on the Selection Committee, as they spend a significant amount of time with resident candidates during their interviews. Candidates are ranked based on their composite scores by the faculty interviewers the day of their interview.

The members of the Selection Committee decide as a group which order in which to rank the applicants, and occasionally the decision is made not to rank a candidate.