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The Warren Alpert Medical School of Brown University

Geriatric Psychiatry Fellowship Training Program

Mission and Overview

The Brown University Department of Psychiatry and Human Behavior in conjunction with Butler Hospital, The Miriam Hospital, Rhode Island Hospital, Providence Veterans Administration Hospital, and the Brown University Center for Gerontology and Health Care Research offer a one or two year clinical Fellowship in geriatric psychiatry. The Geriatric Psychiatry Fellowship Training Program is an intensive clinical experience designed to equip future practitioners with all the skills needed for the practice of geriatric psychiatry, and to provide a foundation in research to train future leaders in geriatric psychiatry.

In the first year, the residents in the program will develop clinical competence in handling the major problems encountered in geriatric psychiatry including depression, anxiety disorders, substance use disorders, late-life psychosis, delirium, dementia, personality disorders, adjustment disorder, and family problems. Residents will also develop specific technical skills including conducting a neurological examination, performing a cognitive assessment, choosing and monitoring psychotherapeutic drug therapy for the frail medically ill patients, the adaptation of psychotherapy, and the administration of electro-convulsive therapy, as well as other neuromodulation procedures. Residents will become comfortable with a variety of general health-care settings, including the nursing home, the acute psychiatric inpatient unit, hospice, the acute medical hospital, and the geriatric clinic. The Geriatric Psychiatry Fellowship Training Program is organized with both continuous experiences as well as rotations. The continuous ongoing experience is through the weekly outpatient geriatric psychiatry clinic. Residents are also expected to have at least a 3 month experience in inpatient geriatric psychiatry, at least 9 month experience in nursing home psychiatry, 4 months of memory clinic, a 4 month experience in consult liaison psychiatry, 4 months of homecare and 4 month exposure to outpatient geriatric medicine clinic. In addition to these experiences, the resident will have a number of clinical rotations to broaden their knowledge and skills in palliative care, neuropathology, neuroimaging, neuropsychiatry, and addictions. In addition, the resident can elect an experience in neuromodulation. During the Geriatric Psychiatry Fellowship Training Program the resident will be given the opportunity to participate in ongoing research activities within the Department in the first year. Upon completion of the first year of training the resident should have the skills necessary to be recognized as a specialist in geriatric psychiatry.

In the second year the residents in the program will develop further competence in dealing with clinical issues in geriatric psychiatry, but also develop a sound foundation in research and hospital administration related to geriatric psychiatry. The second year is specifically designed for residents who wish to become future academicians. Residents will further develop their clinical skills by participating in outpatient treatment, as well as inpatient psychiatric care, and receive further exposure to long-term care settings. During the year, the resident will have an opportunity, under supervision, to assume administrative responsibilities for geriatric psychiatry programs within either a general hospital setting or a psychiatric hospital. This experience should lead to the resident being comfortable with assuming a leadership role within an academic institution. Fifty percent of the time during the second year of the Fellowship will be devoted to research. This will provide the resident an opportunity to gain a solid foundation in all aspects of conducting research by developing their own projects and participating in ongoing research seminars. Upon completion of the second year of training, the resident should have developed skills sufficient enough to commence an academic career in geriatric psychiatry. The second year of training is available to those who are USA permanent residents or citizens, as it is funded by a grant from the Human Resources and Service Administration (HRSA). The Brown University program is only one of ten such programs in the nation. Residents designated as HRSA fellows completing the two-year program also have the option to obtain a Masters of Science or Public Health.

The Brown University Geriatric Psychiatry Fellowship Training Program has a wide range of opportunities and experiences available to residents. Residents will have the opportunity to gain exposure to the broad range of faculty and expertise offered at the Warran Alpert School of Medicine at Brown University.

The geriatric inpatient psychiatry rotation is designed to expose the resident to the full spectrum of acute psychiatric disorders ranging from the dementia's to mood disorders and psychosis that can not be managed in less intensive settings. In addition, the inpatient rotation will offer exposure to neurological and neuropsychiatric problems, as well as to patients who have complicated cormorbid medical conditions that interact with their mental status. During this rotation residents will become proficient in individual psychotherapy, family intervention, milieu therapy, behavioral modification techniques, pharmacological treatments, as well as ECT.
The geriatric medicine rotation will provide an opportunity for the resident to become more proficient in gaining an understanding between the role of medical conditions and their effect on mental state. Residents will be exposed to a full spectrum of medical conditions. The geriatric medicine ambulatory care clinic will give the resident an opportunity to work with their medicine colleagues and understand how dementia and psychiatric disorders present in primary care, and the influence of medical comorbidity on these illnesses. In addition, the resident will gain an appreciation of how the geriatric medicine specialist deals with common medical issues in the elderly.

The geriatric consult liaison rotation will provide a different perspective to the resident as to the interaction between medicine and psychiatry in the aged individual. This rotation will focus on the management of psychiatric patients in the acutely medically ill. Residents will have an opportunity to deal with acute psychiatric problems that may be secondary to the medical condition or a management of ongoing psychiatric conditions. This rotation will also offer an opportunity for the residents to gain an appreciation for the problems encountered by an elderly individual in an acute medical hospital.

These experiences, management of psychiatric problems requiring inpatient psychiatric hospitalization, the management of medical problems in elderly patients, and the management of psychiatric conditions in the acute medical setting will be supplemented by a longitudinal outpatient experience.

Most geriatric patients do not have their psychiatric disorders managed in inpatient settings. In order to gain an appreciation for the broader spectrum of emotional disorders encountered in the geriatric population a year-long longitudinal outpatient geriatric psychiatric experience is required. The geriatric outpatient psychiatry clinic will offer residents an opportunity to do psychopharmacological and psychotherapeutic management of a broad spectrum of psychiatric disorders. Family intervention will also be emphasized along with psychopharmacological treatments.

As a sizable proportion of the nursing home population has psychiatric disabilities, as well being a major focus of geriatric psychiatry, 3 different nursing home experiences will be offered. The goal of the nursing home experience is to provide the resident an opportunity to learn how to manage patients outside of the traditional hospital environment. Residents will be exposed to a broad range of psychiatric conditions and their consequences including anxiety disorders, bipolar disorders, schizophrenia, substance abuse, in addition to the dementias. The residents will gain exposure to pharmacological management, learn to liaison with nursing staff, and provide in-services.

Further exposure geared specifically to the management and the diagnosis of the dementias will be gained in participation in the various memory disorder programs available in the Brown University system. The goal of the memory disorders program is for the resident to become acquainted with the various types of dementia's, how to diagnose and work up dementia's, as well as to be introduced to novel and sometimes experimental treatments that are used in the management of dementing disorders. In addition, the resident will receive more formal exposure to neuropsychological testing, and on appreciation for both the capabilities and limitations of neuropsychological assessments. The memory disorder programs provide formalized experience in working with a multidisciplinary team.

The neurological assessment and the neurological problems and the boundaries between neuropsychiatry and geriatric psychiatry are not well-defined in dealing with the elderly population. The training offered during this Fellowship has, therefore, placed a special emphasis on obtaining a firm foundation in neurological assessment. Exposure to geriatric neurology in the neuropsychiatry rotation will assist the resident in improving their skills in conducting a general neurological examination, as well as to introduce the resident to the management of neurological problems that are commonplace in older populations, such as stroke. Movement disorders are frequently encountered in the elderly population. Upon completion of this rotation, the resident should be well versed in doing a neurological assessment. Neuroimaging procedures are frequently used in geriatric psychiatry and exposure to radiological techniques and nuclear medicine techniques used in assessing patients, therefore, is necessary. The neuroimaging rotation is geared to providing the resident with an understanding of when and why neuroimaging studies should be ordered and for which suspected diagnoses. This rotation will also serve as an introduction in being able to read a CT scan or MRI scan. An understanding of the basis of pathological changes in the brain with age is necessary as new therapies are evolving for dementias and other conditions associated with aging. A rotation in neuropathology will allow residents to begin to learn both from the macroscopic to the microscopic level how aging and aging associated disorders alter the human brain. These skills, however, will be supplemented throughout the training program to complete the resident's appreciation for the interface of neurology and geriatric psychiatry. Such an opportunity will be offered by the neuropathology rotation. Working with behavioral neurologists, the resident will have an opportunity to see how geriatric patients who are on the borderline of psychiatry and neurology are managed by behavioral neurologists. This will give an opportunity to the resident to gain a different perspective on how patients who may not present to psychiatrists are managed, as well as serve as an introduction to geriatric neuropsychiatry.
New treatment modalities are evolving. Brown University is at the forefront of developing these new treatments, including clinical trials in dementia. In addition, Brown University is at the cutting edge of new somatic treatments involving neuromodulation such as Electroconvulsive therapy (ECT), Transmagnetic Stimulation (TMS), Vagal Nerve Stimulation (VNS), and Deep Brain Stimulation (DBS). Residents can elect to receive specialized training in these procedures, where they will also gain an understanding of their role in geriatric mental health treatment.

As the Fellowship training program's primary goal is to train the future specialists in geriatric psychiatry, exposure to three emerging specialized treatment areas will be offered within the program. Addictions are often ignored among the aged population. The use of alcohol and other substances, however, remain prevalent. Participation in a geriatric addictions clinic will offer the resident an opportunity to gain exposure to the complications resulting in addictions that occurs with age and the management of these conditions in the elderly. Home care is a growing area in geriatric psychiatry and the house call has become a rare experience. The home care rotation is designed to expose the resident to the services received by patients within their home, by visiting nurses and home health workers, as well as to offer the resident an opportunity to experience a house call and to appreciate the difference that seeing a patient in their own environment may make. Palliative care and attention to pain management, and caring for those who are dying is too often ignored in medicine. The palliative care rotation provides exposure to hospice care in a variety of settings, in the home, in long-term care and in the inpatient unit.

The future leaders in geriatric psychiatry will be individuals who develop an academic orientation and are not only good researchers, but also have administrative skills. A modest research experience is offered in the first year of training primarily to expose the resident to research and to help guide them in learning how to understand the literature. Residents who choose to go on to a second year, however, will be offered the opportunity to initiate an independent research project and to develop a foundation in research methodology. The administrative geriatric psychiatry experience is geared to providing the resident with an opportunity to gain administrative skills and to prepare the resident to assume a role of leadership in geriatric psychiatry.

The many opportunities offered by the Brown University School of Medicine will allow individuals interested in becoming specialists in geriatric psychiatry to be outstanding clinicians, administrators, and researchers in the field.

06/24/10
ACGME Program Requirements for Graduate Medical Education in Geriatric Psychiatry

ACGME-approved: February 4, 2013; Effective: July 1, 2013
Introduction

Int.A. Residency and fellowship programs are essential dimensions of the transformation of the medical student to the independent practitioner along the continuum of medical education. They are physically, emotionally, and intellectually demanding, and require longitudinally-concentrated effort on the part of the resident or fellow.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident and fellow physician to assume personal responsibility for the care of individual patients. For the resident and fellow, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents and fellows gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s and fellow’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Geriatric psychiatry focuses on prevention, diagnosis, evaluation, and treatment of mental disorders, and signs and symptoms seen in older adult patients. An educational program in geriatric psychiatry must be organized to provide professional knowledge, skills, and opportunities to develop competency through a well-supervised clinical experience.

Int.C. The educational program in geriatric psychiatry must be 12 months in length.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.
I.A.1. The sponsoring institution must also sponsor an Accreditation Council for Graduate Medical Education (ACGME)-accredited program in psychiatry.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows;
I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;
I.B.1.c) specify the duration and content of the educational experience; and,
I.B.1.d) state the policies and procedures that will govern fellow education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

I.B.3. The number of and distance between participating sites must allow for fellows' full participation in all organized educational aspects of the program.

I.B.4. Within at least one of the participating sites there should be an ACGME-accredited program in at least one of the following non-psychiatric specialties: family medicine, geriatric medicine, internal medicine, neurology, or physical medicine and rehabilitation.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

I.A.1.a) The program director must devote on average (over one month) at
least 10 hours per week to the program with 1-2 fellows, or, 15 hours per week, to the program with 3 or more fellows. This must include activities related to administration, didactic teaching and fellow supervision outside of clinical activities, and time spent directly observing fellows or being observed in the clinical setting.

II.A.2. Qualifications of the program director must include:

II.A.2.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

II.A.2.b) current certification in the subspecialty by the American Board of Psychiatry and Neurology (ABPN), or specialty qualifications that are acceptable to the Review Committee; and,

II.A.2.b).(1) The Review Committee accepts only ABPN certification in the subspecialty.

II.A.2.c) current medical licensure and appropriate medical staff appointment.

II.A.3. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. The program director must:

II.A.3.a) prepare and submit all information required and requested by the ACGME;

II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:

II.A.3.c).(1) all applications for ACGME accreditation of new programs;

II.A.3.c).(2) changes in fellow complement;

II.A.3.c).(3) major changes in program structure or length of training;

II.A.3.c).(4) progress reports requested by the Review Committee;

II.A.3.c).(5) responses to all proposed adverse actions;

II.A.3.c).(6) requests for increases or any change to fellow duty
II.A.3.c).7 voluntary withdrawals of ACGME-accredited programs;

II.A.3.c).8 requests for appeal of an adverse action; and,

II.A.3.c).9 appeal presentations to a Board of Appeal or the ACGME.

II.A.3.d) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

II.A.3.d).1) program citations, and/or

II.A.3.d).2) request for changes in the program that would have significant impact, including financial, on the program or institution.

II.A.3.e) develop and implement a supervision policy that specifies lines of responsibility for program faculty members and fellows that is consistent with the supervision policy in the general psychiatry program; and,

II.A.3.f) participate in scholarly activities appropriate to the subspecialty, including local, regional, and national specialty societies, research, presentations, or publication.

II.B. Faculty

II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.

II.B.1.a) In addition to the program director, there must be at least one faculty member certified by the ABPN in the subspecialty.

II.B.1.b) Each participating site must have a designated site director who is responsible for the day-to-day activities of the program at that site with overall coordination by the program director.

II.B.2. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.

II.B.3. The physician faculty must have current certification in the subspecialty by the American Board of Psychiatry and Neurology, or possess qualifications acceptable to the Review Committee.

II.B.4. The physician faculty must possess current medical licensure and appropriate medical staff appointment.
II.B.5. Faculty members must participate in scholarly activities appropriate to the subspecialty, including local, regional, and national specialty societies, research, presentations, or publications.

II.B.6. Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.C.1. Geriatric Care Team

II.C.1.a) The geriatric care team should include representatives from related clinical disciplines, including psychology, neuropsychology, social work, psychiatric nursing, activity or occupational therapy, physical therapy, pharmacy, and nutrition.

II.C.1.b) Qualified clinicians from disciplines within medicine, including one or more of the following: family medicine, internal medicine (including geriatric medicine), hospice and palliative medicine, neurology, and physical medicine and rehabilitation, should be available for participation on the geriatric care team for consultation.

II.C.2. Fellows should have access to professionals representing allied disciplines, including ethics, law, and pastoral care.

II.C.3. There must be a designated program coordinator.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements.

II.D.1. The psychiatry department of the sponsoring institution must be a part of or affiliated with at least one acute care general hospital.

II.D.1.a) The acute care hospital must have a full range of services, including both medical and surgical services, intensive care units, an emergency department, a diagnostic laboratory and imaging services, and a pathology department.

II.D.2. There must be at least one long-term care facility.

II.D.2.a) Such facilities should be either discrete institutions separate from an acute care hospital or formally designated units or services.
II.D.3. There must be an ambulatory care service that provides care in a multidisciplinary environment.

II.D.4. Each participating site must provide teaching facilities and office space.

II.D.5. There must be patients available of each sex and spanning the spectrum of psychiatric diagnoses in late life, and from diverse socioeconomic, educational, and cultural backgrounds.

II.E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Fellow Appointments

III.A. Eligibility Criteria

Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.

III.A.1. Prior to appointment in the program, fellows must have satisfactorily completed either an ACGME-accredited general psychiatry program or a general psychiatry program in Canada accredited by the Royal College of Physicians and Surgeons of Canada.

III.A.2. Prior to appointment in the program, each fellow must be notified in writing of the required length of education.

III.A.3. Prior to appointment in the program, the program director must receive documentation from each fellow’s prior general psychiatry program verifying satisfactory completion of all educational and ethical requirements for graduation.

III.A.3.a) Agreements with applicants made prior to the completion of the general residency must be contingent on this requirement.

III.B. Number of Fellows

The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program’s educational resources must be adequate to support the number of fellows appointed to the program.

III.B.1. The presence of other learners must not interfere with the appointed fellows’ education.
IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;

IV.A.2. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.2.a) Patient Care

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows:

IV.A.2.a).(1) must demonstrate proficiency in diagnosis and treatment of all major psychiatric disorders seen in elderly patients, including adjustment disorders, affective disorders, anxiety disorders, delirium, dementias, iatrogenesis, late-onset psychoses, medical presentations of psychiatric disorders, personality disorders, sexual disorders, sleep disorders, substance-related disorders, and continuation of psychiatric illnesses that began earlier in life;

IV.A.2.a).(2) must demonstrate proficiency in performing the mental status examination that takes into account the special needs of elderly patients, including structured cognitive assessment, community and environmental assessment, family and caregiver assessment, medical assessment, and functional assessment;

IV.A.2.a).(3) must demonstrate proficiency in short-term and long-term diagnostic and treatment planning by using the appropriate synthesis of clinical findings and historical as well as current information acquired from the patient and/or relevant others, including family members, caregivers, and/or other health care professionals;

IV.A.2.a).(4) must demonstrate proficiency in the selection and use of clinical laboratory tests, radiologic and other imaging procedures, and polysomnographic, electrophysiologic, and neuropsychologic tests;

IV.A.2.a).(5) must demonstrate proficiency in recognizing and managing
psychiatric co-morbid disorders, including dementia and depression, as well as agitation, wandering, changes in sleep patterns, and aggressiveness;

IV.A.2.a).(5).(a) This must include competence in the ongoing monitoring of changes in mental and physical health status and medical regimens.

IV.A.2.a).(6) must demonstrate proficiency in recognizing the stressful impact of psychiatric illness on caregivers, assessing their emotional state and ability to function, and providing guidance and protection to caregivers;

IV.A.2.a).(7) must demonstrate competence in recognizing and assessing elder abuse, and providing appropriate interventions; and,

IV.A.2.a).(8) must demonstrate proficiency in managing the care of elderly patients with emotional or behavioral disorders, using age-appropriate modifications in techniques and goals in applying the various psychotherapies (with individual, group, and family focuses) and behavioral strategies.

IV.A.2.b) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows:

must demonstrate proficiency in their knowledge of the following content and skills areas:

IV.A.2.b).(1) biological and psychosocial aspects of normal aging, psychiatric impact of acute and chronic physical illnesses, and biological and psychosocial aspects of the pathology of primary psychiatric disturbances beginning in or continuing into older age;

IV.A.2.b).(2) current scientific understanding of aging and longevity, including theories of aging, epidemiology and natural history of aging, and diseases of elderly patients, to include:

IV.A.2.b).(2).(a) effects of biologic aging on human physiology with emphasis on altered pharmacokinetics, pharmacodynamics, and sensory acuity in elderly patients;

IV.A.2.b).(2).(b) differences and gradations between normal and
abnormal age-related changes with particular reference to memory and cognition, affective stability, personality and behavioral patterns, sleep, and sexuality; and,

IV.A.2.b).(2).(c) successful and maladaptive responses to stressors frequently encountered in elderly patients, including retirement, death of a spouse, role changes, interpersonal and health status losses, financial difficulties, environmental relocations, and increased dependency.

IV.A.2.b).(3) relevance of cultural and ethnic differences, and the special problems of disadvantaged minority groups, as these relate to mental illness in elderly patients;

IV.A.2.b).(4) epidemiology, diagnosis, and treatment of all major psychiatric disorders seen in elderly patients;

IV.A.2.b).(5) American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the fellow and the patient including the dynamics of differences in cultural identity, values and preferences, and power;

IV.A.2.b).(6) indications, side effects, and therapeutic limitations of psychoactive drugs and the pharmacologic alterations associated with aging, including:

IV.A.2.b).(6).(a) changes in pharmacokinetics, pharmacodynamics, and drug interactions;

IV.A.2.b).(6).(b) appropriate medication management and strategies to recognize and correct medication noncompliance; and,

IV.A.2.b).(6).(c) the psychiatric manifestations of iatrogenic influences.

IV.A.2.b).(7) applications and limitations of behavioral therapeutic strategies, and physical restraints;

IV.A.2.b).(8) appropriate use and application of electroconvulsive therapy and other non-pharmacological somatic therapies in elderly patients;

IV.A.2.b).(9) appropriate use of psychodynamic understanding of developmental problems, conflict, and adjustment difficulties in elderly patients which may complicate the
clinical presentation and influence the physician-patient relationship or treatment planning;

IV.A.2.b).(10) appropriate use of psychotherapies as applied to elderly patients, including individual, group, and family therapies;

IV.A.2.b).(11) psychosocial impact of institutionalization;

IV.A.2.b).(12) family dynamics in the context of aging, including intergenerational issues;

IV.A.2.b).(13) ethical and legal issues especially pertinent to geriatric psychiatry, including competence, capacity, guardianship, right to refuse treatment, wills, advance directives, informed consent, elder abuse, the withholding of medical treatments, and federal legislative guidelines governing psychotropic drug prescription in nursing homes and other settings;

IV.A.2.b).(14) current economic aspects of supporting services and practice management, including Title III of the Older Americans Act, Medicare, Medicaid, and cost containment; and,

IV.A.2.b).(15) research methodologies related to geriatric psychiatry, including biostatistics, clinical epidemiology, medical information sciences, decision analysis, critical literature review, and research design (including cross-sectional and longitudinal methods).

IV.A.2.c) Practice-based Learning and Improvement

Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems; and,

IV.A.2.c).(3) demonstrate administrative and teaching skills in the subspecialty.

IV.A.2.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health
professionals.

IV.A.2.d).(1) Fellows must demonstrate competence in effective formal and informal administrative leadership of the mental health care team.

IV.A.2.d).(2) Fellows must demonstrate competence in effectively communicating treatment plans to the patient and the family.

IV.A.2.d).(3) Fellows must demonstrate competence in making appropriate referrals to and obtaining consultations from other health care specialists.

IV.A.2.d).(4) Fellows must demonstrate competence in providing consultations.

IV.A.2.d).(5) Fellows must demonstrate competence in interviewing socioculturally-diverse patients and family in an effective manner which may include those with limited English proficiency, health literacy, vision/sight, and hearing.

IV.A.2.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

IV.A.2.e).(1) Fellows must demonstrate sensitivity and responsiveness to diverse patients, including but not limited to sex, age, culture, race, religion, disabilities, and sexual orientation.

IV.A.2.e).(2) Fellows must demonstrate competence in recognizing and appropriately addressing biases in themselves, others, and the health care delivery system.

IV.A.2.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

IV.A.2.f).(1) Fellows must demonstrate competence in providing continuing care through organizing recommendations from the mental health care team and integrating recommendations and input from primary care physicians, consulting medical specialists, and representatives of other allied disciplines.

IV.A.2.f).(2) Fellows must demonstrate competence in the appropriate
use of community or home health services, respite care, and institutional long-term care.

IV.A.3. Curriculum Organization and Fellow Experiences

IV.A.3.a) The 12-month program must be completed within no more than a two-year period.

IV.A.3.b) Conferences in geriatric psychiatry, including grand rounds, case conferences, seminars, and journal club should be specifically designed to augment the clinical experiences.

IV.A.3.b).(1) Fellows must attend at least 70% of all required didactic components of the program. Attendance by fellows and faculty members should be documented.

IV.A.3.c) The curriculum must include didactic instruction and clinical experiences to enable fellows to achieve all required competency-based outcomes.

IV.A.3.d) As part of their longitudinal care experience, fellows must be assigned to follow and treat patients requiring continuing care.

IV.A.3.d).(1) Fellows should have clinical experience in geriatric psychopharmacology, electroconvulsive therapy (ECT), and using individual and group psychotherapies.

IV.A.3.e) Fellows must have patient care experiences as part of an interdisciplinary geriatric care team.

IV.A.3.f) Fellows must have geriatric psychiatry consultation experience.

IV.A.3.f).(1) Consultation experiences should be formally available on the non-psychiatric services of an acute care hospital.

IV.A.3.f).(2) Experience should include consultation to inpatient, outpatient, and emergency services, as well as consultative experience in chronic care facilities.

IV.A.3.g) Fellows should have experiences that enable them to become familiar with the organizational and administrative aspects of home health care services, outreach services, and crisis intervention services in both community and home settings.

IV.A.3.h) Each fellow must have a minimum of two hours of faculty preceptorship weekly, one of which must be one-to-one preceptorship and one of which may be group preceptorship.

IV.A.3.i) Each fellow must maintain a patient log documenting all clinical experiences.
IV.B. Fellows’ Scholarly Activities

IV.B.1. Fellows must participate in developing new knowledge or evaluating research findings.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate fellow performance in a timely manner.

V.A.1.b) The program must:

V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,

V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.

V.A.1.b).(3).(a) The evaluation must include review and discussion with each fellow of his or her educational record documenting completion of all required components at the time of the evaluation of the program, evaluations of clinical and didactic performance by supervisors and teachers, and patient log documenting all clinical experiences.

V.A.1.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.

V.A.1.d) Assessment should include quarterly written evaluations of all fellows by all supervisors and directors of clinical components of the program.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must become part of the fellow’s permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. This evaluation must:
V.A.2.a) document the fellow’s performance during their education, and

V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.

V.A.3. The final evaluation of each fellow must document proficiency in all required competency-based outcomes.

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

V.B.2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

V.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

V.C.1.a) fellow performance,

V.C.1.b) faculty development, and,

V.C.1.c) program goals and objectives as well as program effectiveness in achieving them.

V.C.1.c).(1) At least one fellow representative and all faculty members should participate in these reviews.

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

V.C.3. At least 80% of the eligible program’s graduates from the preceding six years should have taken the ABPN certifying examination in geriatric psychiatry.

V.C.4. At least 80% of the program’s graduates from the preceding six years taking the ABPN certifying examination for geriatric psychiatry for the first time must pass.

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety
VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.

VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,

VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.

VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;

VI.A.5.b) provision of patient- and family-centered care;

VI.A.5.c) assurance of their fitness for duty;

VI.A.5.d) management of their time before, during, and after clinical assignments;

VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;

VI.A.5.f) attention to lifelong learning;

VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,

VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

VI.A.6. All fellows and faculty members must demonstrate responsiveness
to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient’s care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;

VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.

VI.D. Supervision of Fellows

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care.
Only licensed independent practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient.

VI.D.1.a) This information should be available to fellows, faculty members, and patients.

VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient’s care.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient.

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

VI.D.3.c) Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.

VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.

VI.D.4.c) Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.

VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.

VI.E. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.

VI.F. Teamwork

Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

VI.F.1. Contributors to effective interprofessional teams include consulting physicians, psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients.

VI.G. Fellow Duty Hours
VI.G.1. 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.

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.3. Mandatory Time Free of Duty

Fellows 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.

VI.G.4. Maximum Duty Period Length

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows 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.

VI.G.4.a) It is essential for patient safety and fellow education that effective transitions in care occur. Fellows 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.
VI.G.4.b) Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

VI.G.4.c) In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.c).(1) Under those circumstances, the fellow must:

VI.G.4.c).(1).(a) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

VI.G.4.c).(1).(b) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.c).(2) The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Geriatric psychiatry fellows are considered to be in the final years of education.

VI.G.5.a).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.a).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.

VI.G.5.a).(1).(b) There are no circumstances under which fellows
may stay on duty with fewer than eight hours off.

VI.G.6. Maximum Frequency of In-House Night Float

Fellows must not be scheduled for more than six consecutive nights of night float.

VI.G.7. Maximum In-House On-Call Frequency

Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by fellows 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.

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.

VI.G.8.b) Fellows 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”

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December 19, 2012

Robert Kohn, MD
Director, Geriatric Psychiatry Residency Program
Butler Hospital
345 Blackstone Boulevard
Providence, RI 02906

Dear Dr. Kohn,

The Residency Review Committee for Psychiatry, functioning in accordance with the policies and procedures of the Accreditation Council for Graduate Medical Education (ACGME), has reviewed the information submitted regarding the following program:

Geriatric psychiatry
Butler Hospital/Brown University Program
Butler Hospital
Providence, RI

Program 4074321048

Based on all of the information available to it at the time of its recent meeting, the Review Committee accredited the program as follows:

Status: Continued Accreditation
Maximum Number of Residents: 3
Effective Date: 10/12/2012
Approximate Date of Next Site Visit: 10/01/2017
Cycle Length: 5 Year(s)
Approximate Date of Internal Review: 04/07/2015

The Review Committee commended the program for its demonstrated substantial compliance with the ACGME's Requirements for Graduate Medical Education without citations.

It is the policy of the ACGME and of the Review Committee that each time an action is taken regarding a change in the accreditation status of a program, the residents and applicants (those invited for interviews) must be notified. This office must be notified of any major changes in the organization of the program. When corresponding with this office, please identify the program by name and number as indicated above. Changes in participating sites and changes in leadership must be reported to the Review Committee using the ACGME Accreditation Data System.
Sincerely,

Louise King, MS  
Executive Director  
Residency Review Committee for Psychiatry  
3127555498  
lking@acgme.org

CC:  
Jane Eisen, MD  
Lawrence H. Price, MD

Participating Site(s):  
Brown University/Rhode Island Hospital-Lifespan  
Butler Hospital  
Miriam Hospital-Lifespan  
Veterans Affairs Medical Center (Providence)
American Board of Psychiatry & Neurology, Inc.
Geriatric Psychiatry Core Competencies Outline Version 2.1
Coordinated with the ABPN Core Competencies Outline Version 4.1

I. Geriatric Psychiatry patient Care Core Competencies

A. Geriatric psychiatrists shall communicate effectively and demonstrate caring and respectful behaviors when interacting with geriatric psychiatric patients and their families.

B. Geriatric psychiatrists shall gather essential and accurate information through interviews with their geriatric psychiatric patients, family members, caregivers and other health professionals with attention to:
   1. Relevant history
   2. Mental Status examination including structured cognitive assessment
   3. Functional assessment (e.g., IADL, ADL)
   4. Competency assessments (e.g., decisions regarding treatment, personal care, etc.)
   5. Medical assessment including relevant neurological examination
   6. Recognition and assessment of direct or indirect elder abuse
   7. Family and caregiver emotional state and ability to function
   8. Community and environmental assessment (e.g., community connections, home services, supports, housing, safety, etc.)

C. Geriatric psychiatrists shall develop a multiaxial diagnosis and formulation of biopsychosocial information.

D. Geriatric psychiatrists shall develop an evaluation plan which may include selection and use of ancillary investigations, corroborative history of information, laboratory tests, radiology/imaging, electrophysiologic, polysomnographic and neuropsychologic tests.

E. Geriatric psychiatrists shall make informed decisions about therapeutic interventions based on patient information and preferences, up-to-date scientific evidence in the filed, and clinical judgment.

F. Geriatric psychiatrists shall develop and carry out a comprehensive geriatric psychiatric treatment plan addressing biological, psychological and sociocultural domains, including:
   1. Consultative and primary care (short-term as well as longitudinal management) for geriatric psychiatric patients in both inpatient and outpatient settings
   2. Organization and integration of input and recommendations from multidisciplinary mental health team as well as integrating recommendations and input from primary care physicians, consulting medical specialists and representatives of other allied disciplines
   3. Use of information technology to support patient care decisions and patient education
   4. Communicating treatment plans to and educating geriatric psychiatric patients, their families and caregivers
   5. Initiation and flexible guidance of treatment, with the need for ongoing monitoring of changes in mental and physical health status and medical regimens
   6. Recognition and management of psychiatric co-morbid disorders, as well as the management of other disturbances often seen in the elderly, such as agitation, aggressiveness, wandering, and changes in sleep patterns

G. Regarding pharmacotherapy, geriatric psychiatrists shall:
   1. Recognize drug interactions, non-compliance, psychiatric manifestations of iatrogenic influences, such as multiple or overmedication as well as strategies to correct these issues
   2. Recognize indications for, side effects of, and therapeutic limitations of psychoactive drugs and the pharmacologic alterations associated with aging, including changes in pharmacokinetics and pharmacodynamics

H. Geriatric psychiatrists shall apply appropriate indications for and use electroconvulsive therapy appropriately in the elderly.

I. Regarding psychotherapy, geriatric psychiatrists shall:
1. Identify patients and presenting problems likely to be appropriate for the various psychotherapies (e.g., IPT, CBT, PST, dynamic, reminiscence)
2. Develop a working formulation of the relevant issues for the specific recommended therapy
3. Maintain awareness of appropriate modifications in techniques and goals in applying these psychotherapies and behavioral strategies to the elderly (with individual, group, and family focuses)
4. Understand psychodynamics in relationship to developmental problems, conflict, and adjustment difficulties in the elderly that may complicate the clinical presentation and influence the doctor-patient relationship or treatment planning

J. Regarding behavioral treatments, geriatric psychiatrists shall use non-pharmacologic approaches, with particular reference to applications and limitations of behavioral therapeutic strategies including physical restraints.

K. Regarding social interventions, geriatric psychiatrists shall:
   1. Appropriately use community programs, home health services, crisis and outreach services, respite care, and the need for institutional long-term care
   2. Provide appropriate guidance of and protection for caregivers

L. Regarding management of ethical and legal issues pertinent to geriatric psychiatry, geriatric psychiatrists shall provide competence, guardianship, advance directives, right to refuse treatment, wills, informed consent, elder abuse, the withholding of medical treatments and federal legislative guidelines governing psychotropic prescribing in nursing home.

M. Geriatric psychiatrists shall work with health care professionals, including those from other disciplines, to provide patient-focused care including:
   1. Formal and informal administrative leadership of the geriatric mental health care team which may include representatives from related clinical disciplines, such as psychology, social work, psychiatric nursing, activity or occupational therapy, physical therapy, pharmacology, and nutrition
   2. Liaison with individuals representing disciplines within medicine, such as family practice and internal medicine (including their geriatric subspecialties), neurology, and physical medicine and rehabilitation
   3. Consultation or liaison with geriatric medical teams, where available

N. Geriatric psychiatrists shall provide health care services maintaining mental health and preventing mental health problems in the elderly.

II. Geriatric Psychiatry medical Knowledge Core Competencies

A. Geriatric psychiatrists shall demonstrate knowledge about established and evolving biomedical, clinical and cognitive (e.g., epidemiological and social-behavioral sciences) and the application of this knowledge to the care of geriatric psychiatric patients and their families. Geriatric psychiatrists are expected to:
   1. Demonstrate and investigatory and analytic thinking approach to clinical situations; and
   2. Know and apply the basic and clinically supportive sciences, which are appropriate to their discipline

B. Geriatric psychiatrists shall develop and apply specific knowledge for education in geriatric psychiatry, including:
   1. In the biomedical arena:
      a. Theories of aging – biological, social, and psychological
      b. Age-related changes in organ systems, sensory systems, memory, and cognition
      c. Pharmacologic implications of biological changes
      d. Pharmacokinetics and pharmacodynamics
      e. Special considerations in the sue of psychotropics in the elderly
      f. Frequency and management of side effects
      g. Polypharmacy and drug interactions in the elderly
      h. Psychopathology beginning in or continuing into late life as compared to younger populations with regard to the following:
         1) Epidemiology of late-life conditions
         2) Clinical presentation of late-life conditions
         3) Pathogenesis of late-life conditions
         4) Diagnostic approach and differential diagnoses of late-life conditions
         5) Treatment of late-life conditions
2. In regard to the following disorders:
   a. Mood disorders
   b. Anxiety disorders
   c. Adjustment disorders bereavement
   d. Delirium
   e. Dementia
   f. Psychotic disorders
   g. Substance related disorders
   h. Mental disorders due to a general medical condition including acute and chronic physical illnesses as well as iatrogenesis
   i. Sleep disorders
   j. Sexual disorders
3. Principles and practices of ECT
4. Sexuality in late-life
5. Common neurological disorders of the elder, e.g., Parkinson’s, stroke
6. Psychiatric disorders due to general medical conditions
   a. Complications of medical treatment for systemic disease
   b. Psychological factors affecting physical illness
7. Psychological Issues
   a. Developmental perspective of normal aging with understanding of adaptive and maladaptive responses to psychosocial changes, e.g., retirement, widowhood, role changes, financial, environmental relocation, interpersonal and health status, increased dependency
   b. Psychotherapeutic principles and practice:
      1) Interpersonal
      2) Cognitive Behavioral
      3) Problem-Solving
      4) Supportive
      5) Reminiscence
      6) Dynamic
   c. Personality disorders
   d. Psychological and behavioral therapeutic techniques
   e. Group and activity therapies
8. Cultural and ethnic differences and special problems of disadvantaged minority groups
9. Caregiver and family issues
10. Practice related and policy and legal issue
    a. Role of geriatric psychiatrist in health care systems
    b. Elder abuse
    c. Forensic issues
    d. Current economic aspects of health care supporting services and health care delivery – including but not limited to Title III of the Older Americans Act, Medicare, Medicaid and cost containment
    e. Treatment setting regulations and its impact on treatment and patient outcomes
11. Practice of psychiatry in nursing homes and other long term care facilities

III. Geriatric Psychiatry Interpersonal and Communication Skills Competencies

A. Geriatric psychiatrists shall be able to demonstrate interpersonal and communication skills that result in effective and empathic information exchange and teaming with geriatric psychiatric patients, families, colleagues, staff and systems. Interpersonal skills require an understanding of the geriatric psychiatrist’s role as a consultant to patients and their contextual system. Development of interpersonal skills is enhances by the acquisition of basic information about interpersonal communication.

B. Geriatric psychiatrists shall create and sustain a therapeutic and ethically sound relationship with geriatric psychiatric patients and their families from a spectrum of available ethnic, racial, cultural, gender, socioeconomic and educational backgrounds.

C. Geriatric psychiatrists shall understand the impact of transference and counter transference impact on treatment of geriatric psychiatric patients.
D. Geriatric psychiatrists shall use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning and written skills as appropriate with geriatric psychiatric patients and their families.

E. Geriatric psychiatrists shall communicate effectively and work collaboratively with others as a member of leader of a geriatric psychiatric mental health care team which may include representatives from related clinical disciplines such as psychology, social work, nursing, occupational therapy, activity and physical therapy, pharmacy and nutrition.

F. Geriatric psychiatrists shall communicate effectively and work collaboratively with other health care teams, if available, such as family medicine, internal medicine (including their geriatric subspecialties), neurology and physical medicine and rehabilitation.

G. Geriatric psychiatrists shall facilitate the learning of students and other health care professionals such as other geriatric psychiatrists, medical students, nurses and allied health professionals.

IV. Geriatric Psychiatry Practice-Based Learning and Improvement Competencies

A. Geriatric psychiatrists shall be able to investigate and evaluate their patient care, appraise and assimilate scientific evidence and improve their patient care practices.

B. Geriatric psychiatrists shall be able to recognize limitations in his/her knowledge base and clinical skills and understand and address the need for life long learning.

C. Geriatric psychiatrists shall be able to demonstrate an ability to continually expand his/her knowledge and skills and assesses his/her practice to ensure highly competent evaluation and treatment of psychiatric disorders in older people and their families.

D. Geriatric psychiatrists shall be demonstrate appropriate skills for obtaining up-to-date information from the scientific and practice literature and other sources to assist in the quality care of patients. Geriatric psychiatrists are expected to:
   1. Locate, critically appraise and assimilate evidence from scientific studies and literature reviews related to their geriatric patients mental health problems to determine how quality of care can be improved in relation to ones practice
   2. Apply knowledge of research study designs and statistical methods related to geriatric psychiatry to the appraisal of such clinical studies and other information on diagnostic and therapeutic effectiveness
   3. Use medical libraries and information technology, including internet-based searches and literature and drug databases, e.g., Medline, to manage information, access on-line medical information and support their own education
   4. Facilitate the learning of students and other health care professionals such as other geriatric psychiatrists medical students, nurses, and allied health professionals
   5. Analyze practice experience and perform practice-based improvement activities using a systematic methodology which may include case-based learning, use of best practices, critical literature review, obtaining appropriate supervision or consultation, record review or patient evaluations
   6. Obtain and use information about their own population of geriatric psychiatric patients and the larger population from which their patients are drawn.

V. Geriatric Psychiatry Professionalism Skills Competencies

A. Geriatric psychiatrists must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse geriatric psychiatric patient population.

B. Geriatric psychiatrists shall be expected to demonstrate respect.

C. Geriatric psychiatrists shall demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care.

D. Geriatric psychiatrists shall demonstrate sensitivity and responsiveness to patients’ culture.
E. Geriatric psychiatrists shall demonstrate responsibility for his/her geriatric psychiatric patient’s care by responding to patient communications and other health professionals in a timely manner.

F. Geriatric psychiatrists shall demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care.

G. Geriatric psychiatrists shall review their professional conduct and remediate when appropriate.

H. Geriatric psychiatrists shall participate in the review of the professional conduct of their colleagues.

I. Geriatric psychiatrists shall be aware of safety issues, including acknowledging and remediating medical errors, should they occur.

VI. Geriatric Psychiatry Systems-Based Practice Skills Competencies

A. Geriatric psychiatrists shall be able to treat older people with psychiatric and/or neuropsychiatric problems within the context of multiple, complex intra-organization and extra-organization systems. The resident shall have a working knowledge of the larger context and the diverse systems involved in treating older patients and their family members and understand how to use and integrate multiple systems of care as part of a comprehensive system of care, in general and as part of a comprehensive, individualized treatment plan.

B. Geriatric psychiatrists shall be aware of how types of geriatric psychiatric practice and delivery systems differ from one another.

C. Geriatric psychiatrists shall demonstrate knowledge of community systems of care and assist patients to access appropriate care and other support services. This requires knowledge of treatment settings in the community.

D. Geriatric psychiatrists shall understand how to partner with health care managers and health care providers to assess, coordinate and improve geriatric mental health care and know how these activities can affect system performance. Geriatric psychiatrists shall demonstrate knowledge of community systems of care and assist patients to access appropriate care and other support services. Geriatric psychiatrists shall demonstrate knowledge of the organization of care in each relevant delivery setting and the ability to integrate the care of patients across such settings.

E. Geriatric psychiatrists shall understand how their geriatric psychiatric care and other professional practices affect other health care professionals.

F. Geriatric psychiatrists shall practice cost-effective geriatric psychiatric care and resource allocation that does not compromise quality of care with attention to practice guidelines and community.

G. Geriatric psychiatrists shall advocate for quality patient care and assist geriatric psychiatric patients in dealing with system complexities such as limitation of resources for health care.

H. Geriatric psychiatrists shall be aware of how types of geriatric psychiatric practice and delivery systems differ from one other.

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PATIENT CARE

Residents must be able to provide comprehensive psychiatric medical care that is compassionate, appropriate, and effective for the treatment of mental health problems and the promotion of mental health for older adults suffering from psychiatric and neuropsychiatric disorders.

Residents are expected to:

• communicate effectively and demonstrate caring and respectful behaviors when interacting with geriatric psychiatric patients and their families;

• gather essential and accurate information through interviews with their geriatric psychiatric patients, family members, caregivers and other health professionals with attention to:
  ◦ relevant history;
  ◦ mental status examination including structured cognitive assessment;
  ◦ functional assessment (e.g., IADL, ADL);
  ◦ assessment of decisional capacity (e.g., decisions regarding treatment, personal care, etc);
  ◦ medical assessment including relevant neurological examination;
  ◦ recognition and assessment of direct or indirect elder abuse;
  ◦ family and caregiver emotional state and ability to function;
  ◦ community and environmental assessment (e.g., community connections, home services, supports, housing, safety, etc);

• develop a multiaxial diagnosis and formulation of biopsychosocial information (3);

• develop an evaluation plan which may include selection and use of ancillary investigations, corroborative history or information, laboratory tests, radiology/imaging, electrophysiologic, polysomnographic, and neuropsychologic tests (3);

• make informed decisions about therapeutic interventions based on patient information and preferences, up-to-date scientific evidence in the field, and clinical judgment;

• develop and carry out a comprehensive geriatric psychiatric treatment plan addressing biological, psychological, and sociocultural domains including (3):
  ◦ consultative and primary care (short-term as well as longitudinal management) for geriatric psychiatric patients in multiple settings such as inpatient, outpatient, day programs, nursing home, assisted living,
foster care and home care settings;

- organization and integration of input and recommendations from the multidisciplinary mental health team, as well as integrating recommendations and input from primary care physicians, consulting medical specialists, and representatives of other allied disciplines;

- use of information technology to support patient care decisions and patient education;

- communication of treatment plans to and educating geriatric psychiatric patients, their families, and caregivers;

- initiation and flexible guidance of treatment, with the need for ongoing monitoring of changes in mental and physical health status and medical regimens;

- recognition and management of medical and psychiatric co-morbid disorders, especially their altered presentation in the elderly, as well as the management of other disturbances often seen in the elderly, such as agitation, aggressiveness, wandering, changes in sleep patterns, and aggressiveness;

- pharmacotherapy

  - recognition of drug interactions, treatment non-adherence, psychiatric manifestations of iatrogenic influences, such as polypharmacy as well as strategies to correct these issues;

  - the indications for and the adverse effects and therapeutic limitations of psychotropic drugs, including the pharmacologic alterations associated with aging, such as changes in pharmacokinetics and pharmacodynamics;

- psychotherapy (4)

  - identification of patients and presenting problems likely to be appropriate for the various psychotherapies (e.g., interpersonal therapy (IPT), cognitive behavioral therapy (CBT), problem-solving therapy (PST), dynamic therapy, and reminiscence therapy);

  - development of a working formulation of the relevant issues for the specific recommended therapy;

  - awareness of appropriate modifications in techniques and goals in applying these psychotherapies and behavioral strategies to the elderly (with individual, group, and family focuses);

  - appropriate use of psychodynamic understanding of developmental problems, conflict, and adjustment difficulties in the elderly that may complicate the clinical presentation and influence the doctor-patient relationship or treatment planning;

- behavioral treatments using non-pharmacologic approaches, especially in
dementia patients with particular reference to applications and limitations of behavioral therapeutic strategies, including physical restraints;

- social interventions—the appropriate use of community programs, home health services, crisis and outreach services, respite care, and institutional long-term care, including the appropriate guidance and protection of caregivers;

- management of ethical and legal issues pertinent to geriatric psychiatry, including assessment of decisional capacity, guardianship, advance directives, right to refuse treatment, wills, informed consent, elder abuse, the withholding of medical treatments, end-of-life issues, palliative care and federal legislative guidelines governing psychotropic prescribing in nursing home;

- work with health care professionals, including those from other disciplines, to provide patient-focused care including:
  - formal and informal administrative leadership of the geriatric mental health care team, which may include representatives from related clinical disciplines, such as psychology, psychiatric social work, psychiatric nursing, activity or occupational therapy, physical therapy, psychopharmacology, and nutrition (5);
  - liaison with individuals and teams, where available, representing disciplines within medicine, such as family practice and internal medicine (including their geriatric subspecialties), neurology, and physical medicine and rehabilitation;

- provide health care services aimed at preventing mental health problems or maintaining mental health in the elderly.

**MEDICAL KNOWLEDGE**

Residents must demonstrate knowledge of established and evolving biomedical, clinical and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to the care of geriatric psychiatric patients and their families (6), (7), (8).

Residents are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations; and
- know and apply the basic and clinically supportive sciences, appropriate to their discipline.

Specific knowledge for residency education in geriatric psychiatry includes:

**Biomedical**

- Theories of aging--biological, social, and psychological;
- Age-related changes in organ systems, sensory systems, memory, and cognition;
- Pharmacologic implications of biological changes:
  - pharmacokinetics and pharmacodynamics;
  - special considerations in the use of psychotropics in the elderly;
• frequency and management of side effects;
• polypharmacy and drug interactions in the elderly;

• Psychopathology beginning in or continuing into late life as compared to younger populations with regard to the following:
  ◦ epidemiology;
  ◦ clinical presentation;
  ◦ pathogenesis;
  ◦ diagnosis;
  ◦ differential diagnosis;
  ◦ treatment;

• Attributes of disorders, as specified above, with particular attention to the following:
  ◦ mood disorders;
  ◦ anxiety disorders;
  ◦ adjustment disorders/bereavement;
  ◦ delirium;
  ◦ dementia;
  ◦ psychotic disorders;
  ◦ substance related disorders;
  ◦ mental disorders due to a general medical condition including acute and chronic physical illnesses, as well as iatrogenesis;
  ◦ sleep disorders;
  ◦ sexual disorders;

• Principles and practices of ECT;
• Sexuality in late life;
• Psychiatric aspects of general medical conditions including:
  ◦ complications of medical treatments for systemic disease;
  ◦ psychological factors affecting physical illness;
• Common neurological disorders of the elderly (e.g., Parkinson’s, stroke);
• Common medical problems of the elderly (e.g., falls, incontinence, pain).

**Psychological**
• Developmental perspective of normal aging with understanding of adaptive and maladaptive responses to psychosocial changes (e.g., retirement, widowhood, role changes, financial issues, environmental relocation, interpersonal and health status, and increased dependency);

• Psychotherapeutic principles and practice:
  ◦ Interpersonal;
Cognitive-behavioral;
Problem-solving;
Supportive;
Reminiscence;
Dynamic;
• Personality disorders
• Psychological and behavioral therapeutic techniques;
• Group and activity therapies.

**Sociocultural**
• Cultural and ethnic differences among various groups of people;
• Special problems of disadvantaged minority groups;
• Caregiver and family issues;
• Institutionalization and its impact on individuals and families;
• Practice related and policy and legal issues:
  • Role of geriatric psychiatrist in healthcare systems;
  • Elder abuse;
  • Forensic issues;
  • Current economic aspects of health care supporting services and health care delivery, including, but not limited to, Title III of the Older Americans Act, Medicare, Medicaid, and cost containment;
  • Treatment setting regulations and the impact on treatment and patient outcomes, such as OBRA regulations in nursing homes.
• Ethical issues;
• Practice of psychiatry in nursing homes and other long term care facilities.

**INTERPERSONAL AND COMMUNICATION SKILLS**
Residents must be able to demonstrate interpersonal and communication skills that result in effective and empathic information exchange and teaming with geriatric psychiatric patients, families, colleagues, staff, and systems. Interpersonal skills require an understanding of the geriatric psychiatrist’s role as a consultant to patients and their contextual systems. Development of interpersonal skills is enhanced by the acquisition of basic information about interpersonal communication (6).

Residents are expected to:
• create and sustain a therapeutic and ethically sound relationship with geriatric psychiatric patients and their families from a spectrum of available ethnic, racial, cultural, gender, socioeconomic, and educational backgrounds;
• understand the impact of transference and countertransference on treatment of geriatric psychiatry patients (9);
• use effective listening skills and elicit information using effective nonverbal,
questioning and written skills as appropriate with geriatric psychiatry patients and their families;

• provide information using effective nonverbal, explanatory, questioning, and written skills as appropriate with geriatric psychiatry patients and their families;

• communicate effectively and work collaboratively with others as a member or leader of a geriatric psychiatric mental health care team which may include representatives from related clinical disciplines, such as psychology, psychiatric social work, psychiatric nursing, activity or occupational therapy, physical therapy, psychopharmacology, and nutrition (10);

• communicate effectively and work collaboratively with other health care teams, if available, such as family medicine and internal medicine (including their geriatric subspecialties), neurology, and physical medicine and rehabilitation (10);

• facilitate the learning of students and other health care professionals, such as other residents, medical students, nurses, and allied health professionals.

**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 practices. Residents must be able to recognize limitations in their own knowledge base and clinical skills and understand and address the need for lifelong learning (11). Residents must be able to demonstrate an ability to continually expand their knowledge and skills and assess their practices to ensure highly competent evaluation and treatment of psychiatric disorders in older people and support for their families (6). Residents shall demonstrate appropriate skills for obtaining up-to-date information from scientific and practice literature and other sources to assist in the quality care of patients.

Residents are expected to:

• locate, critically appraise, and assimilate evidence from scientific studies and literature reviews related to their geriatric patients’ mental health problems to determine how quality of care can be improved in relation to practice (11);

• apply knowledge of research study designs and statistical methods related to geriatric psychiatry to appraise clinical studies and other information on diagnostic and therapeutic effectiveness;

• use medical libraries and information technology, including internet-based searches and literature and drug databases (e.g., Medline) to manage information, access on-line medical information and support their own education;

• facilitate the learning of students and other health care professionals, such as other residents, medical students, nurses, and allied health professionals;

• analyze practice experience and perform practice-based improvement activities using a systematic methodology which may include case-based learning, use of best practices, critical literature review, obtaining appropriate supervision and/or consultation, record review and/or patient evaluations (11);

• obtain and use information about their own population of geriatric psychiatric patients and the larger population from which their patients are drawn.

**PROFESSIONALISM**
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse geriatric psychiatric patient population.

Residents are expected to:

• demonstrate respect, compassion, and integrity; a responsiveness to the needs of geriatric psychiatric patients and society that supercedes self-interest; accountability to such patients, society, and the profession; and a commitment to excellence and on-going professional development;

• demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, competence, guardianship, advance directives, wills, elder abuse, and business practices;

• demonstrate sensitivity and responsiveness to patients’ culture, age, gender, disabilities, ethnicity, socioeconomic background, religious beliefs, political leanings, and sexual orientation (12);

• demonstrate responsibility for the care of geriatric psychiatric patients by responding to patient communications and other health professionals in a timely manner, using medical records for appropriate documentation of the course of illness and treatment, coordinating care with other members of the team, and providing coverage if unavailable (12);

• demonstrate understanding of and sensitivity to end-of-life care and issues regarding provision of care (10);*

• review their professional conduct and remediate when appropriate (10);*

• participate in the review of the professional conduct of their colleagues (10);*

• be aware of safety issues, including acknowledging and remediating medical errors, should they occur (10).*

* Indicates that the statement is not an ACGME requirement

**SYSTEMS-BASED PRACTICE**

Residents must be able to treat older people with psychiatric and/or neuropsychiatric problems within the context of multiple, complex intra-organizational and extra-organizational systems. The resident should have a working knowledge of the larger context and the diverse systems involved in treating older patients and their family members and understand how to use and integrate multiple systems of care as part of a comprehensive system of care, in general and as part of a comprehensive, individualized treatment plan (6).

Residents are expected to:

• be aware of how types of geriatric psychiatric practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources;

• demonstrate knowledge of community systems of care and assist patients to access appropriate care and other support services. This requires knowledge of treatment settings in the community, which might include ambulatory, consulting, acute care, partial hospital, adult day care, subacute care,
rehabilitation, nursing homes, assisted living, subsidized senior housing, naturally occurring retirement communities (NORCs), home care, and hospice care settings. The resident should demonstrate knowledge of the organization of care in each relevant delivery setting and the ability to utilize and work with such settings;

- understand how to partner with health care managers and health care providers to assess, coordinate, and improve geriatric mental health care and understand how these activities can affect system performance. The resident shall demonstrate knowledge of how multiple systems of care coordinate as comprehensive systems of care and educate patients concerning such systems of care;

- understand how geriatric psychiatric care and other professional practices affect other health care professionals, the health care organization and the larger society, including how these elements of the system affect their own practice. Particular attention should be paid to development of skills for the practice of ambulatory medicine, including time management, clinic scheduling, and efficient communication with referring physicians as well as utilization of appropriate consultation and referral (9), (10);

- practice cost-effective geriatric psychiatric care and resource allocation that does not compromise quality of care with attention to practice guidelines and community, national and allied health professional resources available both publicly and privately which may enhance the quality of life of such patients (9), (10);

- advocate for quality patient care and assist geriatric psychiatric patients in dealing with system complexities, such as limitation of resources for health care, social and/or financial constraints, and legal aspects of geropsychiatric diseases as they impact patients and their families.

References
Teaching the Geriatric Psychiatry Core Competencies

American Association for Geriatric Psychiatry (AAGP) Steering Committee members: Susan Lieff, MD, MEd; Iqbal "Ike" Ahmed, MD; Blaine Greenwald, MD; William Orr, MD; David Sultzer, MD

The following recommendations are a synthesis of training directors’ suggestions of teaching methods that can be used to meet the Accreditation Council for Graduate Medical Education (ACGME) core competency requirements. The ACGME requirements precede each section (Patient Care; Medical Knowledge; Practice-Based Learning and Improvement; Interpersonal and Communication Skills; Professionalism; and Systems-Based Practice) in italicized text.

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. Residents are expected to:

• communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
• gather essential and accurate information about their patients
• make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
• develop and carry out patient management plans
• counsel and educate patients and their families
• use information technology to support patient care decisions and patient education
• perform competently all medical and invasive procedures considered essential for the area of practice
• provide health care services aimed at preventing health problems or maintaining
**health**

- **work with health care professionals, including those from other disciplines, to provide patient-focused care**

**Recommendations:**

**Interviewing Skills** – Review the unique aspects of interviewing the elderly, address the issues of transference to the elderly and how that might have an impact on the evaluation using:

- Observation should be done early in the year. Use multiple observations of initial interviews judging both content and interpersonal skills. Make observations in multiple settings. Review the interview by discussing observations.
- Traditional methods include classroom teaching; faculty demonstrations, case conferences; and modeling. Use initial faculty demonstration. Interview all new patients seen with attending physicians.
- Innovative methods may include videotaped interviews; clinical trial training; or simulated patients.
- Include assessment in specific areas – Formal interview assessments used in clinical trials, such as the Cornell, Geriatric Depression Scale (GDS), Brief Psychiatric Rating Scale (BPRS), Neuropsychiatric Inventory (NPI). Include evaluation of Activities of Daily Living (ADLs), apraxia, aphasia and evaluation of gait/balance.
- Formal assessments may include:
  - Use of a mock part II of board exam.
  - A videotape review of interviews with different types of patients.
  - Formal feedback from patient and family.

**Mental Status Examination (MSE)** – Present didactics early to teach MSE, especially cognitive mental status.

- Use simulation with the fellow.
- Use simulated patients.
- Use teaching videos that demonstrate MSE with different types of patients.
- Observe fellows performance of mental status examination of patients. Note observation skills.
- Discuss specific tests, rationales for use of Mini Mental Status Exam (MMSE), Modified Mini-Mental State (3MS) Exam, Clock test, Frontal Assessment Battery (FAB), Executive Interview (EXIT). Review testing manuals.
- Observe neuropsychological testing.
- Use comprehensive dementia assessments to assess multiple aspects of MSE skills.

**Competency Assessments** – Provide opportunities to become familiar with competency tools.

- Provide competency evaluations during Consultation Liaison service (Acute hospital, Long-Term Care (LTC) facility, outpatient).
• Assign court- or county-initiated requests for evaluation.
• Participate in local forensic psychiatry teaching programs on issues of competency in the elderly.
• Review testimony in court or mock trials.
• Watch forensic experts interview and testify on competency.
• Suggest tutorials with elder law experts.
• Arrange for home visits with adult protection agencies.

**Family and Caregiver Assessments**
• Encourage participation in dementia clinic family meetings.
• Teach principles of geriatric couples/family therapy.
• Provide opportunities for home visits.
• Encourage participation in caregiver teaching groups.
• Demonstrate the use telemedicine evaluations.
• Arrange for observation of social work family and caregiver evaluations.
• Require attendance or deliver a lecture at an Alzheimer Association caregiver meeting.
• Encourage participation in impotency clinic evaluations of elderly couples.

**Functional Assessment**
• Arrange for observations in occupational therapy assessments (e.g. Kohlman’s Evaluation of Living Skills or KELS, Allen Cognitive Levels Assessment or ACL, driving).
• Encourage participation in rehabilitation medicine clinic and assessments (e.g. for traumatic brain injury or TBI, spinal cord injury or SCI).
• Encourage participation in geriatric medicine or GEM clinics.
• Arrange for observations of physical therapy (PT) assessments.
• Insure familiarity with instrumental activities of daily living (IADL) and basic activities of daily living (BADL) assessment tools.
• Arrange for observations of speech therapy assessments.
• Encourage participation in Impotency/Sexuality assessments.

**Community and Environmental Assessment**
• Encourage participation in home assessments.
• Encourage participation in hospice visits.
• Arrange for observation of social work assessments (inpatient, outpatient, home).
• Obtain Complete Adult Protection Services assessments.
• Demonstrate the use of telemedicine assessments and conferencing.
• Participate in long-term care visits and interact with Directors of Nursing, Medical Directors, etc.
Medical assessment – working with other medical disciplines such as neurologists in geriatric neurology clinics, and with geriatric medicine in a multidisciplinary geriatric evaluation or consultation clinic is key.

- Work with geriatric medicine fellows in multiple settings such as clinics, wards, and home visits.
- Integrate didactic seminars in medicine and neurology taught by geriatric medicine and neurology departments into the geriatric psychiatry seminar series.
- Suggest attending geriatric medicine, neurology and neuroradiology seminars in those departments.
- Consider a one-month medicine or geriatric medicine rotation.
- Include sexual functioning assessment.

Ancillary investigations; laboratory tests; radiology/imaging, electroencephalography (EEG)

- Arrange a visit to the EEG laboratory and brain imaging services.
- Review EEG and scans of all patients.
- Assign reviews of actual scan books to promote recognition of normal and abnormal scans.
- Require attendance at neuroradiology rounds.

Neuropsychologic tests

13. Arrange for an afternoon with a neuropsychologist to observe the neuropsychological testing procedure.
14. Review appropriate indications for and use of a neuropsychologist.
15. De-emphasize routine use of neuropsychiatric testing, especially if appropriate neurocognitive testing is done by the fellow.

MANAGEMENT SKILLS

Formulation of biopsychosocial information into a comprehensive treatment plan

- Provide individual supervision of trainee cases – presentation and critique of treatment plan.
- Review selected documented biopsychosocial treatment plans, with discussion in supervision.
- Provide group supervision, with focus on treatment planning.
- Present didactic information regarding the elements of a comprehensive treatment plan.
- Perform mock oral boards session.
- Promote grand rounds or case conference presentation, with a focus on comprehensive treatment plan.
- Provide multidisciplinary case conferences, to include input and feedback from several clinical care providers (nursing, occupational therapy, geriatric medicine, social work, physical therapy and rehab, etc.).
• Provide clinic, or regular case conferences, that includes cases with multiple and complex diagnoses, and challenging treatment needs.

Pharmacotherapy
• Provide an organized core curriculum that includes each pharmacologic class.
• Include "second-line" treatment strategies for treatment resistant patients in the core curriculum.
• Provide didactic sessions on pharmacokinetic and pharmacodynamic changes over the life span, cytochrome P450 system and drug interactions, psychopharmacologic treatment of dementia, delirium, depression, psychosis and other psychiatric disorders in the elderly, and pharmacologic treatment in patients with common comorbid medical conditions.
• Arrange group supervision, or case conferences, focused on "treatment resistant" cases.
• Provide individual case supervision.
• Hold interdisciplinary conferences with pharmacy.
• Support longitudinal follow-up of patients for supervised management experience in relapse, long term effectiveness, illness morbidity, and residual symptoms.
• Arrange for participation on pharmacy or formulary committee.
• Hold regular journal club or seminar sessions focused on new medical treatment strategies.

Electroconvulsive Therapy (ECT)
• Provide didactic section on indications, risks, procedures, and legal issues in core curriculum.
• Include specific didactics on adverse events, cognitive effects, and the patient with multiple medical problems and medications.
• Arrange a supervised rotation on the ECT service, or during a geropsychiatry inpatient rotation.
• Arrange for observation of an ECT treatment session with review of case notes, and supervision.
• Set up a rotation on ECT consultation service and provide for case review and ECT consideration.
• Brief overview of other potential biologic treatments such as repetitive transcranial magnetic stimulation (rTMS) and Vagal nerve stimulation (VNS).

Psychotherapy
• Include the structure of available psychotherapeutic strategies, and appropriate choice of patients in the core curriculum.
• Incorporate didactic sessions related to developmental issues of aging and common developmental challenges.
• Include didactic sessions on note-taking, coding, billing, privacy, and ethics in psychotherapy.
• Supervise individual psychotherapy cases including brief, crisis-oriented, cognitive-behavioral, interpersonal, or insight-oriented.

• Oversee longitudinal psychotherapeutic treatment plans; working with individuals over the course of one-year minimum.

• Videotape a review of resident’s individual casework or seminar including teaching videotapes.

• Set up a group psychotherapy experience, with supervision and co-leader.

• Review patient logs and case mix.

• Provide experience with couples therapy, family therapy, and caregivers.

**Behavioral treatments**

• Include specialized behavioral treatments in the core curriculum.

• Provide a supervised rotation in a behavioral program.

• Encourage attendance at specialized workshops in behavioral treatment.

• Require participation in a dementia behavioral management group session.

• Arrange for liaison with nursing staff and multidisciplinary staff in the nursing home.

• Encourage development and presentation of a behavioral management program to staff.

**Ability to effectively communicate with patients, families, and caregivers**

• Provide case supervision that includes attention to communication skills.

• Observe in outpatient, inpatient, and consultation settings.

• Encourage fellow to recognize own feelings and attitudes.

• Provide patient survey questionnaires that request feedback on provider communication skills.

• Arrange for fellow’s participation in support groups and family meetings.

**Ability to manage ethical and legal issues pertinent to geriatric psychiatry**

• Include legal issues such as capacity to consent, conservatorships, involuntary detention and treatment, driving privileges, patient’s rights, advanced directives in the core curriculum.

• Include lectures by an elder law attorney in the core curriculum.

• Encourage discussion of legal issues and involvement in legal proceedings related to clinical activities.

• Encourage attendance at mental health court proceedings.

• Encourage participation in hospital ethics committee.

• Hold ethics case conferences.

• Encourage fellow’s role as a leader, not a junior trainee without responsibility for legal and other administrative tasks.

• Require maintenance of an "Interesting Ethical Dilemmas" case notebook.

**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. Residents are expected to:

1. demonstrate an investigatory and analytic thinking approach to clinical situations
2. know and apply the basic and clinically supportive sciences which are appropriate to their discipline

Recommendations:

- Offer a comprehensive geriatric psychiatry core curriculum that includes areas related to geriatric medicine, neurology, neuropsychology, social and anthropological perspectives, ethical-legal issues, spirituality etc.
- Teach through a multiplicity of methods including traditional lectures, seminars, and case conferences. In addition, use participatory methods of teaching such as literature searches, problem-based-learning, journal clubs, and evidence-based-medicine (EBM) methods.
- Provide clinical supervision and case conferences that apply theoretical knowledge to day-to-day clinical care in an integrative fashion.
- Encourage real-time literature searches based on clinical cases and application of the literature to the clinical care of patients.
- Teach principles of EBM and apply these in day-to-day clinical practice. Consider holding EBM case conferences.
- Apply EBM to journal clubs to promote educated consumers of the medical literature.
- Promote review of evidence-based guidelines and expert consensus statements.
- Use problem-based learning (PBL) to solve clinical problems, thus promoting participation in more active learning and less didactics. Encourage development of life-long learning using a PBL approach.
- Teach through other innovative approaches including games such as Jeopardy, Weakest Link, etc.
- Require case reports for journals.
- Address interpretation of industry-sponsored information, including possible biases in industry sponsored research and publications.
- Consider holding quarterly meetings of training programs, video conferencing, journal clubs, or joint conferences with nearby programs. Use regional resources to collaborate rather than compete.
- Encourage attendance at national scientific meetings such as the American Association for Geriatric Psychiatry (AAGP), American Geriatric Society (AGS), American Psychiatric Association (APA), etc.

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 practices. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology
• locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems
• obtain and use information about their own population of patients and the larger population from which their patients are drawn
• apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
• use information technology to manage information, access on-line medical information; and support their own education
• facilitate the learning of students and other health care professionals

Recommendations:

Analyze and assess knowledge and practice experience to ensure highly competent evaluation and treatment of psychiatric disorders in the elderly using a systematic methodology:

• Oral face-to-face faculty-informed self-assessment: Resident meets with Program Director or Program Director’s designated faculty member at entry into the program and every 3 months thereafter to conduct a self-assessment of geropsychiatric/neuropsychiatric knowledge base including evaluation and treatment of psychiatric disorders in the elderly. This process is informed by the resident being asked explicit questions that test current knowledge and by the resident presenting cases utilizing a multi-axial DSM-IV format that incorporates a biopsychosocial formulation. At the conclusion of this process, the resident is asked to self-identify his/her knowledge and practice deficiencies and strengths. Following the resident’s self-assessment, the Program Director or Program Director’s designated faculty member will provide any additional input about perceived knowledge and practice deficiencies and strengths.

• Written self-assessment: At entry into the program and every 4 months thereafter, resident completes a series of multiple choice questions provided by the program that address knowledge about evaluation and treatment of psychiatric disorders in the elderly. Resident scores questionnaire and provides feedback to Program Director about his/her knowledge and practice deficiencies and strengths.

• Resident conducts critical review of the literature to address a knowledge gap or improve a clinical skill.

Establish knowledge of scientific study designs (including cross-sectional and longitudinal approaches and clinical epidemiology) and biostatistical methods.

• Resident participates in research methodology/epidemiology/biostatistical introductory seminar series.

• Resident is provided or referred to relevant biostatistical textbooks/articles.

Insure application of knowledge about scientific study designs and statistical methods to the critical appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness. Assure assimilation of evidence from scientific studies related to their patient’s health problems to enhance clinical care.

• Resident participates in regular journal club wherein he/she critically reviews assigned scientific articles, including data emanating from the pharmaceutical
industry.

- Resident is assigned topic for literature review. He/she conducts extensive literature search and prepares presentation for journal club or other seminar. Resident must critique literature and discuss how new findings may influence clinical practice.

- Resident researches/identifies evidence-based reviews (e.g., meta-analyses by Cochrane group) on relevant geropsychiatric topics and presents findings at journal club or other seminar. Resident concludes how findings may influence clinical practice.

Provide opportunities to use information technology to locate, acquire and manage up-to-date information, access on-line medical information, and support their own education to assist in/enhance the quality care of patients.

- Resident participates in tutorial(s) that are either library-based or office-based on how to locate/retrieve scientific articles via internet-based searches of medical and scientific literature databases (e.g., PubMed). Resident demonstrates capability to supervisor by collaborative topic searches during supervisory session(s).

- Resident learns and utilizes developing electronic medical record capability.

- Resident is introduced to psychiatric informatics applications that include pharmaceutical databases. Resident is issued or purchases a PDA (personal digital assistant) as a tool for organization and improving patient care via portable medical applications. Each handheld computer will be loaded with information to provide decision support at the point of care. Such information includes DSM-IV criteria and numerical codes used to assist in diagnosis and coding; a drug information database (e.g., ePocratesRx from www.epocrates.com) with the capability to check for drug-drug interactions; clinical evidence databases (e.g., Clinical Evidence at www.avantgo.com or www.unboundmedicine.com/cogniq.htm) and a security program (e.g., Certicom movianCrypt www.moviansecurity.com) that encrypts sensitive patient information to enhance Health Information Portability and Accountability Act (HIPPA) compliance, as well as to prevent unauthorized access.*  *This paragraph adapted from UC Davis Psychiatry Newsletter, Fall 2002.

- Resident is introduced to online user-friendly resources for their own (e.g., Psychiatry.Medscape.com; клиникаevidence.com; psychiacomp.com) and for consumers (e.g., webMD.com; American Association of Retired Persons at aarp.org; Alzheimer’s Association at www.alz.org etc.) education.

Provide for continuous evaluation and improvement of knowledge and skills through familiarity with and adherence to "best practices. "

- Resident is exposed to national "consensus statements," "practice parameters," "treatment guidelines," and "expert consensus guidelines" relevant to geriatric psychiatry and geriatric neuropsychiatry.

- Resident is exposed to published assessment and treatment algorithms.

- Resident attends local, regional and national scientific meetings.

- Resident is exposed to mental health evidence-based summaries (e.g., Clinical Evidence; the Cochrane Collaboration; Evidence-Based Mental Health).
Facilitate learning by providing opportunities to teach other students and health care personnel and community-based consumers.

- Resident prepares a faculty-supervised presentation on relevant topic that has been exhaustively researched and gives lecture(s) to staff.
- Resident prepares a faculty-supervised presentation on a relevant topic and participates in organization’s speaker’s bureau to provide lecture(s) to lay public in community-based setting.

Support participation in an individually supervised research or scholarly activity that translates into tangible academic accomplishment.

- Resident develops individual mentored research project that is modest enough in scope to be completed within fellowship year.
- Resident collects data in first half of year and submits abstract for presentation in "Young Investigator" forum of APA Annual Meeting.
- Resident writes paper based on research findings that is edited by research mentor and submitted for publication.
- Resident writes case report of interesting patient and submits for publication.
- Resident identifies topic for which recent literature review is wanting and undertakes comprehensive literature review and mentored write-up that is submitted for publication.
- Resident submits mentored research grant.

Encourage demonstration of attitudinal behaviors that foster lifelong learning; and development of habits of inquiry that are recognized as a continuing professional responsibility. *

- Program cultivates and resident demonstrates a willingness to pursue continuing education and supervised experiences to keep one’s own clinical practice behaviors commensurate with the community standard of care. Achieved via program support of continuing education opportunities including attendance at local and national symposia and organizational meetings.
- Program cultivates and resident demonstrates a willingness to obtain information from electronic databases and scientific literature in geriatric psychiatry and related fields, ensuring clinical practice is consistent with scientific advances. Achieved through exposure during the fellowship of how-to use/access psychiatric informatics and regular journal club participation.
- Program cultivates and resident demonstrates the recognition that the scientific literature must be integrated in an evolutionary manner, realizing that no one study or theory is likely to address all clinical situations. Achieved via regular exposure during the fellowship of critical appraisal of published scientific studies through journal clubs, individual and group supervision, attendance at lectures and grand rounds presentations, and self-study. * This section was adapted from Sexson et al, Academic Psychiatry, Winter 2001.

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. Residents are expected to:

• create and sustain a therapeutic and ethically sound relationship with patients
• use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
• work effectively with others as a member or leader of a health care team or other professional group

Recommendations:
• Use family meetings and family counseling, especially with social workers and case managers, and offer feedback. Provide information without jargon, and with empathy, including discussions of the diagnosis of Alzheimer’s disease, poor prognosis, and death and dying issues.
• Use direct observation, especially during dementia evaluations.
• Teach by example.
• Incorporate feedback from other disciplines
• Require presentations to caregivers at dementia evaluation centers.
• Encourage leading a support group for caregivers.
• Encourage attendance at community events and programs for the elderly, e.g., senior centers and day programs.
• Encourage participation in family meetings on the inpatient unit, often with a social worker.
• Promote working with multidisciplinary teams, and demonstrate effective communication of assessment and treatment plans. Provide opportunities to demonstrate the ability to work through disagreements and conflicts with other disciplines.

PROFESSIONALISM
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
Residents are expected to:

• demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
• demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
• demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities

Recommendations:
• Provide didactics in the basic principles of ethics, and medico-legal issues.
• Provide didactics on the roles of culture, ethnicity, gender, and socio-economic issues in geriatric psychiatry.
• Promote faculty role modeling in their professional interactions with patients, families, colleagues, staff, consultees, students, trainees, employees, etc.

• Hold ethics case conference with different themes and discuss advance directives, competency, end of life, and elder abuse issues.

• Use problem-based format to discuss ethical, business, administrative, managed care, medico-legal, conflict resolution, cultural, resources and rationing of care issues.

• Demonstrate the integration of these issues in case discussions.

• Teach administrative issues through several means including requiring attendance at monthly staff meetings, giving lectures on paperwork management/billing issues, and allow fellows to participate in the billing process.

• Give fellows a title such as Associate Medical Director of inpatient unit, and allow them to deal with issues of managing staff, unit policies, and treating staff, patients and family with respect, compassion, integrity, as well as being responsive to concerns raised.

• Hold discussions of public policy and public advocacy as it impacts psychiatric care issues.

• Discuss the larger context of geriatric psychiatry (e.g., book by Bernard Lo)

**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. Residents are expected to:

• understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice

• know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources

• practice cost-effective health care and resource allocation that does not compromise quality of care

• advocate for quality patient care and assist patients in dealing with system complexities

• know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

**Recommendations:**

During the first week of training, the Program Director and other faculty will provide an overview of the local service system including information about how to access – in each clinical environment in which the resident will rotate – the following services for their patients: medical-surgical and subspecialty medical-surgical consultation including geriatric medicine; medical and psychiatric emergency assessment/treatment; neurology consultation; physical medicine and rehabilitation consultation and physical therapy; dentistry; audiology; pain management and palliative care including hospice; laboratory testing including electrocardiograms (EKGs) and acquisition of laboratory results; structural and functional neuroimaging; neuropsychological testing;
electroencephalography (EEG); social work including disposition planning; aftercare resources (e.g., partial hospital, outpatient clinic, psychosocial club, etc.); psychiatric rehabilitation (e.g., occupational therapy, activity therapy); home care including visiting nurse services; nutritional assessment and dietary counseling; pastoral counseling; genetic counseling; family support groups; bereavement programs; and ethics committee.

During clinical experiences/rotations in which clinical decision-making is supervised by a faculty member, allow residents to experience first-hand - as the patient’s primary geropsychiatric clinician and as a subspecialty geriatric psychiatry consultant in both psychiatric and medical-surgical settings - the clinical interaction/collaboration with all above intra-organizational services in the context of achieving comprehensive geriatric care of patients and their family members. Provide opportunities for residents to:

- Respond to necessary consults and interact with relevant consultants and support services.
- Order and follow-up on appropriate laboratory testing.
- Function as a consultant geriatric psychiatrist to medical-surgical patients in the acute care hospital setting.
- Working in collaboration with social work and other colleagues, participate in the disposition planning of geriatric psychiatry inpatients, geriatric psychiatry outpatients, and medical-surgical patients to whom they are consulting, such that patients are referred to a comprehensive array of necessary services available within the local health system to ensure that optimal care is accessed and achieved.

Promote an understanding of the local/national priority to provide cost-effective, efficient health care that does not significantly compromise quality, including understanding the Medicare/Medicaid systems, the historical antecedents to Managed Care and Managed Medicare, and the current status of Managed Medicare. Provide opportunities for residents to:

- Receive lectures/seminars.
- Receive relevant articles and books.
- Discuss issues with faculty supervisors or visiting faculty in individual meetings and small group forums.
- In the context of clinical work, interface with case managers of Medicare Managed Care "products" during the pre-authorization and ongoing utilization review process.

Encourage participation in cost-effective, efficient health care of the elderly utilizing successful time-management strategies. Provide opportunities for residents to:

- Under the auspices of an assigned supervisory faculty member, conduct efficient initial and follow-up assessments within locally mandated time-frames that are consonant with post-fellowship community practice.
- Employ formatted intake forms and relevant geriatric psychiatry assessment scales that promote efficiency of evaluation/treatment.
- Develop efficient mechanisms for communicating with referring and consulting physicians, communicating with patients and family members, and for
organizing daily clinical tasks, such as computerized scheduling systems, email communication, personal digital assistants (PDAs), scheduled times per day or week for patient/family questions and feedback.

Provide information on current Medicare, managed Medicare, and Medi-gap reimbursement processes and methodologies - including coding for appropriate services and in the case of managed Medicare pre-authorization, utilization review and reauthorization processes - in the contexts of hospital-based inpatient and outpatient services, inpatient and outpatient private practice, and nursing home-based service provision. Provide opportunities for residents to:

- Receive lectures/seminars that include basic principles underlying indemnity and managed Medicare programs.
- Receive articles/book chapters to be discussed in supervision, journal club, or other seminar meetings.
- Be exposed either through didactics or on-site visits to private practice geriatric psychiatrists.
- Receive instruction on appropriate billing practices, including invited talks from local finance department personnel and from representatives of local Medicare intermediaries.
- Attend seminars/courses at local/regional/national professional meetings on Medicare billing and coding.
- Interface with Managed Care case managers during the pre-authorization, utilization review, and re-authorization processes.
- Educate patients and family members about the differences between indemnity and managed Medicare systems.

Relate information about the spectrum of extra-organizational (i.e., outside the local health care environment of the geriatric psychiatry residency) community-based, aging-specific resources and agencies available to help serve the elderly and achieve optimal clinical outcomes, including how to advocate for and access such services for patients and their family members. These include geriatric medical and geropsychiatric programs/practitioners not affiliated with the geriatric psychiatry residency program’s parent institution but more conveniently located to the patient’s home; adult and dementia day care including Alzheimer’s disease and related dementia family support groups; advocacy and public education/service organizations such as the local chapter of the Alzheimer’s Association or the local county department for the aging; home care; senior housing options including subsidized housing, assisted living, and nursing homes (including federal regulations governing psychiatric services); senior citizen centers; psychosocial "clubs"; meals-on-wheels; adult protective services; elder-law services and resources including financial planning/counseling; driving assessment programs; and insurance companies/agents knowledgeable re: long-term care insurance. Provide opportunities for residents to:

- Receive lectures/seminars from local and invited faculty.
- Visit off-campus agencies/programs/housing options/nursing homes.
- Have an ongoing supervised experience as a consulting geriatric psychiatrist in a nursing home and participate in multidisciplinary conferences there.
• Receive or be referred to relevant articles/chapters/resource guides/books.
• Attend meetings of local organizations such as the Alzheimer’s Association and volunteer to be a speaker in a family seminar.
• Observe guardianship and related legal proceedings.

During clinical experiences/rotations in which clinical decision-making is supervised by a faculty member, allow residents to experience first-hand – as the patient’s primary geropsychiatric clinician and as a subspecialty geriatric psychiatry consultant – the clinical interaction/collaboration with all above extra-organizational services in the context of achieving ongoing comprehensive geriatric care of and best outcomes for patients and their family members. Provide opportunities for residents to:

• In collaboration with social work and other colleagues, participate in the disposition planning of geriatric psychiatry inpatients, geriatric psychiatry outpatients, and medical-surgical patients to whom they are consulting, such that patients are referred to appropriate community-based agencies including senior housing options.
• Effectively and collegially collaborate with community-agency(ies) to achieve desired outcome(s) by role modeling senior staff behavior and by being observed and counseled by senior supervisory staff.
• Complete all referral paperwork in a legible and timely manner to ensure efficient transfer of patients to community service providers. Such paperwork will be reviewed by supervisory personnel and feedback provided to the resident.
• Endeavor to achieve aftercare treatment services that are provided by geriatric subspecialists or clinicians with geriatric expertise.
• Endeavor to achieve treatment services that occur in an environment that is as close to home as possible.
• Endeavor to achieve treatment services that occur in the least restrictive environment possible.
• Through role modeling of senior staff behavior, work in a manner that is mutually respectful of all levels of staff in order to achieve optimal outcomes for patients since optimal geriatric care is dependent upon a multidisciplinary team approach.

Increase residents’ knowledge of the diverse systems involved in the treatment of the elderly, and integrate such multiple systems of care in treatment planning including by collaboration with allied health professionals both within and outside the parent institution of the geriatric psychiatry residency program such that patients access optimal services. Provide opportunities for residents to:

• Develop treatment plans that will be critiqued by senior faculty and staff and then amended accordingly by the resident.

Through modeling of supervisor behavior, successfully demonstrate in the Team Meeting context a respect for and collaborative approach with allied health professionals to achieve best outcomes for geriatric patients. Supervisory personnel will provide feedback.
Geriatric psychiatry rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experiences during which residents gain knowledge, skills and practice in the care of geriatric psychiatric patients in an acute inpatient setting. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

**Description of Rotation**

This rotation is a one half to a full day per week 3 or 4 month rotation at Butler Hospital, that allows residents to develop important diagnostic, treatment, and other skills in an inpatient setting. It allows residents to work more independently and to assume increasing responsibility for a varied patient caseload of elderly patients. Residents evaluate and treat geriatric inpatients and have specific supervision with a geriatric psychiatry supervisor who has subspecialty board certification in this area. Residents will also learn to conduct and run family meetings. Residents will learn to be team leaders in staffing. Residents work on a state of the art multidisciplinary 22-bed inpatient unit specifically designed for the care of elderly patients with mental illness associated with aging.

**I. GENERAL INFORMATION**

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Geriatric Inpatient Psychiatry</th>
</tr>
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<tbody>
<tr>
<td>Chiefs of Service</td>
<td>Louis Marino, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Louis Marino, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

**II. FACULTY**

Gary Epstein-Lubow, MD; Louis Marino, MD

**III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION**

**Topics to be covered are based upon:**
- The patients assessed and treated by the residents over the course of the rotation
- The roles of different members of the multidisciplinary team and how to lead a team
- Family assessments and intervention
- Rehabilitation services
- Community services and level of care determination

**Principal teaching methods:**
- Attending supervision
- Multidisciplinary staff meetings
- Weekly morning seminars

**Educational materials provided/referred to residents:**
- **Reading:** Each attending and resident is expected to utilize current psychiatric literature regarding assessment and treatment of psychiatric patients.
- **Computer-assisted educational materials:** All house staff have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located in the outpatient reception area.
- **Other:** Residents are given articles as part of their weekly morning seminar series and by faculty on service.

**IV. SPECIFIC AREAS & EXPECTATIONS**

Residents are expected to regularly review relevant:
- Nursing notes and treatment plans
- Neuroimaging studies
- Laboratory testing results
On this rotation, residents act as the inpatient Psychiatrist to patients over the age of 65 who have a broad range of psychiatric diagnoses including dementia. An initial evaluation will be performed on every new patient or those transferred from another level of care. Daily follow-up assessments will be conducted. Residents will be available to respond to pager calls from the inpatient staff. Residents will provide patients with pharmacological management, assist families in behavioral management, and utilize psychotherapeutic techniques. Among the residents' responsibilities is the application of cost-effective care measures and principles to the actual care of the patients on the service. Residents are expected to communicate as needed with primary care physicians and long-term care institutions. Residents are expected to communicate daily with discharge planning specialists. Residents are expected to be the team leader for their patients in staffing.

V. EVALUATIONS

- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the resident's successful completion of the goals listed below will be carried out by the unit nurse supervisor.
- Evaluation of the resident's successful completion of the goals listed below will be carried out by sampling of inpatients.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION

- The attending assigned will see all patients within 24 hours of admission and will supervise the care of the patient by the house staff, offering guidance but allowing for autonomy.
- The attending will be available for or be present at all activities where their involvement is needed.
- The attending will conduct attending rounds daily. Each attending rounds includes interaction with the patient under discussion as part of the educational session and discussion of the patient from a diagnostic and therapeutic perspective.
- The attending will oversee the care of the patients in the resident's caseload.
- The attending will provide supervision after the fellow has completed their assessment and evaluation of the patient.
- The attending will examine the patients to confirm the resident's findings to guide in establishing the treatment plan.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating their impressions of the resident's performance to the resident throughout the rotation.
- The attending will complete an electronic evaluation for each resident at the end of each month.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION

- Resident serves as treatment provider in conjunction with the attending for all patients assigned to him/her.
- Resident is responsible for initial evaluation of the newly hospitalized patient, documenting a full admission history.
- Resident will discuss the diagnostic and management strategy with the attending on all new patients.
- Resident is responsible for examining and monitoring the progress of their patients on a daily basis, noting all laboratory and other data in a timely manner, discussing the management plans with the team, and writing daily progress notes.
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Resident is responsible for working collaboratively with the multidisciplinary team working with the patient and being the team leader in staffing.
- Resident is responsible for family and patient communication and should serve as liaison between the team and the patient/family.
- The resident will conduct family meetings.
- The resident will learn about the application of electroconvulsive therapy.
- Resident will become proficient in using the Electronic Medical Record.
- Resident is responsible for the dictation of all discharge summaries patients no more than 30 days following the discharge of each patient.
- Resident will not be responsible for the ongoing care of more than 8 patients at a given time.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending upon completion of each month.
- Resident is responsible for having their pager on at all times and responding to calls from the unit staff.

VIII. SCHEDULE DURING THIS ROTATION

Attending Rounds: 8:15 am – 12:00 pm, Monday, Tuesday, Wednesday, Friday; 1:00 pm – 6:00 pm Wednesday, Thursday
On Thursday the Resident will Round at 7:00 am briefly before attending the weekly seminar series at 8:00 am
Grand Rounds: 1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus
IX. GENERAL EDUCATIONAL OBJECTIVES

Objectives - By the end of this rotation, the resident will be able to:

- Provide comprehensive care for up to eight hospitalized patients
- Prepare and present case presentations
- Assess severity of illness and develop prioritization skills necessary to make diagnostic and therapeutic interventions in a timely manner
- Understand the diagnosis, prognosis and management options for major psychiatric illnesses
- Have both a theoretical and practical understanding of geriatric psychopharmacology
- Have both a theoretical and practical understanding of individual psychotherapies as applied to the elderly
- Have both a theoretical and practical understanding of how to conduct a family meeting and provide appropriate family interventions
- Recommend laboratory/imaging tests; medical consultations; neurological consultations; and neuropsychological consultation
- Recommend electroconvulsive therapy and understand its use and application among geriatric patients
- Understand the application and use of rehabilitative services by occupational therapy and physical therapy
- Understand when to obtain and how to interpret neuropsychological testing
- Understand how to manage both acute and chronic co-morbid medical problems on a geriatric psychiatry in-patient unit
- Develop an appreciation for end of life issues
- Understand when and how to obtain guardianship
- Develop an appreciation for cost-efficient care, and proper utilization of resources
- Work in a coordinated fashion with other treatment providers in a multidisciplinary team setting
- Recognize the level of care the patient needs at discharge (e.g., day care, assisted living, nursing home, visiting nurse services)
- Recognize and treat chronic and recent onset primary psychiatric illness in the context of multiple co-morbid conditions, which frequently characterize the late life adult
- Understand the various factors, which influence the use of psychopharmacologic agents in the aged and the role of drug interactions
- Distinguish between normative and pathological neurologic changes in the ageing process
- Be sensitive to the normative stresses of late life as they interact with the various personality styles in the aging person and the changes in psychotherapeutic technique which are most helpful in working with older patients

X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

Competency/Description

<table>
<thead>
<tr>
<th>1. Patient Care</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</table>
| To provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. | - Residents will prepare and present case presentations  
- residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families  
- residents will learn to gather essential and accurate information about their patients  
- residents will learn to make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment  
- residents will learn to develop and carry inpatient management plan  
- the resident will have gained experience working with multiple disciplines including social work, nutrition, early intervention, physical therapy and occupational therapy, care coordination, insurance companies, and nursing in order to provide comprehensive patient care  
- residents will learn to counsel and educate patients and their families  
- residents will provide health care services aimed at | o residents are evaluated by their supervisors  
o residents are evaluated by the nurse supervisor  
o residents are evaluated by patients |
2. Medical Knowledge

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tbody>
<tr>
<td>Residents must demonstrate knowledge about established and evolving biomedical,</td>
<td>Feedback of both oral and written presentations will</td>
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<tr>
<td>clinical, and cognitive (e.g. epidemiological and social-behavioral) sciences and</td>
<td>be provided by attending</td>
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<td>the application of this knowledge to patient care.</td>
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<tr>
<td>- Residents will demonstrate an investigatory and analytic thinking approach to</td>
<td></td>
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<tr>
<td>clinical situations</td>
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<td>- Residents will know and apply the basic and clinically supportive sciences which</td>
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<td>are appropriate to their discipline</td>
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<td>- Residents will learn to generate a differential diagnosis and unique treatment</td>
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<td>plan for each patient encounter</td>
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<td>- Residents will learn to effectively communicate their investigatory and analytic</td>
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<td>thinking approach via written notes and presentations to supervisors and other health</td>
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<td>care professionals</td>
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<td>- Residents will keep abreast of new scientific knowledge, which is obtained via</td>
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<td>didactic sessions, Grand Rounds, critical review of scientific literature, computer</td>
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<td>and web-based resources</td>
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<td>- Residents will actively participate in seminars</td>
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3. Interpersonal and Communication Skills

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tr>
<td>Residents must be able to demonstrate interpersonal and communication skills that</td>
<td>Residents are evaluated by their attending</td>
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<td>result in effective information exchange and teaming with patients, their patients'</td>
<td>Residents are evaluated by the nurse supervisor</td>
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<td>families, and professional associates.</td>
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<td>- Residents will create and sustain a therapeutic and ethically sound relationship</td>
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<td>with patients</td>
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<td>- Residents will scrupulously maintain patient confidentiality, and specifically</td>
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<tr>
<td>reassure patients/families of the confidentiality of their personal and medical</td>
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<td>information</td>
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<td>- Residents will know and be able to describe the proper boundaries of the</td>
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<td>physician/patient relationship, and will consistently and conscientiously avoid any</td>
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<td>breach of these boundaries.</td>
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<td>- Residents will write clearly and legibly when hand-writing instructions or other</td>
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<tr>
<td>information for patients/families</td>
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<tr>
<td>- Residents written communications in patient charts will effectively permit</td>
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<tr>
<td>subsequent caregivers to understand the nature of the patient interaction and the</td>
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<tr>
<td>goals and plans for the encounter as well as future encounters when applicable</td>
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</tbody>
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4. Professionalism

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
<tbody>
<tr>
<td>Residents must demonstrate a commitment to carrying out professional responsibilities,</td>
<td>Attendings will evaluate residents</td>
</tr>
<tr>
<td>adherence to ethical principles, and sensitivity to a diverse patient population</td>
<td>Feedback from nursing staff, other disciplines</td>
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<tr>
<td>- Residents will demonstrate their responsibility to patient care by: (1)</td>
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<tr>
<td>Responding to communication from patients and health professionals in a timely</td>
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<tr>
<td>manner, (2) Establishing and communicating back-up arrangements, including how to</td>
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<td>seek emergent and urgent care when necessary, (3) Using medical records for</td>
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<td>appropriate documentation of the course of illness and its treatment, (4) Providing</td>
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<tr>
<td>coverage if unavailable, (for example, when out of town or on vacation), (5)</td>
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<tr>
<td>Coordinating care with other members of the medical and/or multidisciplinary team,</td>
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<tr>
<td>(6) Providing for continuity of care, including appropriate consultation, transfer,</td>
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<tr>
<td>or referral if necessary - Residents will demonstrate ethical behavior, integrity,</td>
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<tr>
<td>honesty, compassion, and confidentiality in the delivery of care, including</td>
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<tr>
<td>matters of informed consent/assent, professional conduct, and conflict of interest</td>
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<tr>
<td>- Residents will demonstrate respect, sensitivity and responsiveness for and to</td>
<td></td>
</tr>
<tr>
<td>patients and their families, and</td>
<td></td>
</tr>
</tbody>
</table>
their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations.
- Residents will demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care
- Residents will review their professional conduct and remediate when appropriate
- Residents will make reasonable efforts to act as advocates for their patients.
- Residents will truthfully report medical errors of their own to their attending, or Risk Management and to follow hospital protocols in the face of errors. Residents will encourage and facilitate reporting of medical error on the part of professional colleagues
- Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard
- Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice
- Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family
- Residents will create and sustain a therapeutic and ethically sound relationship with patients

<table>
<thead>
<tr>
<th>5. Practice-Based Learning and Improvement</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
</table>
| ➢ Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. | - At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback for the year. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice.  
- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses.  
- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems.  
- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed.  
- The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist  
- The resident will actively participate in lectures and | o Day to day knowledge base evaluated by feedback on diagnoses, and both psychopharmacologic and psychotherapeutic treatment approaches |
discussions with peers and experts on the topics related to the care of their patients
- The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors.
- The resident will facilitate the learning of students and other health care professionals

<table>
<thead>
<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
</table>
| Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals. | - The resident will learn to practice cost-effective health care and resource allocation that does not compromise quality of care  
- The resident will learn how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance  
- The resident will learn how to work with other health care providers to develop and coordinate a care plan for their patients  
- The resident will be familiar with the presence and influences of alternative and complimentary therapies, and its use in their populations and patients  
- The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions. They will learn the legal rights of the uninsured and will work with the appropriate services to assist patients who are under- or uninsured  
- The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies etc. via spoken and written communications when it effects the health of their patients  
- The resident will learn about the various community resources available for patients and will work with case managers and social workers to enable patients to access these resources | o Evaluations from supervisors  
o Feedback from discharge planners |

XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION
Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, inpatients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Geriatric consultation liaison psychiatry rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents learn to perform competent consultation to non-psychiatric medical personnel regarding psychiatric and behavioral problems in elderly medical patients. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

### Description of Rotation

Residents are provided with three half days per week of geriatric consultation liaison psychiatry for four months at The Miriam Hospital and one half day per week for four months at Kent Hospital. Each resident’s assignments are scheduled in order to give the resident broad clinical experience in all areas of consultation psychiatry. Caseloads are limited to those patients age 65 or older, or those with a dementia. Faculty experienced in consultation liaison with added qualifications in geriatric psychiatry provides supervision in the psychiatric evaluation and management of geriatric patients consulted in the general medical hospital.

#### I. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Geriatric Consultation Liaison Psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiefs of Service</td>
<td></td>
</tr>
<tr>
<td>Jeffrey Burock, MD (The Miriam Hospital)</td>
<td></td>
</tr>
<tr>
<td>Robin Stern, MD (Kent Hospital)</td>
<td></td>
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<tr>
<td>Contact Information</td>
<td></td>
</tr>
<tr>
<td>Jeffrey Burock, MD (The Miriam Hospital)</td>
<td></td>
</tr>
<tr>
<td>Robin Stern, MD (Kent Hospital)</td>
<td></td>
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<tr>
<td>Residency Coordinator</td>
<td></td>
</tr>
<tr>
<td>Ema Costa: 455-6421</td>
<td></td>
</tr>
</tbody>
</table>

#### II. FACULTY

Robert Boland, MD; Jeffery Burock, MD; Robert Kohn, MD; Dwayne Heitmiller, MD; Robin Stern, MD

#### III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

- **Topics to be covered are based upon:**
  - The patient population cared for by the team over the course of the rotation
  - Consultation liaison team meetings
  - Cases selected for presentation

- **Principal teaching methods:**
  - Attending rounds
  - Consultation liaison team meetings
  - Weekly morning seminars

- **Educational materials provided/referred to residents:**
  - **Reading:** Each attending and resident is expected to utilize current medical literature in the planning of therapeutic and diagnostic interventions.
  - **Computer-assisted educational materials:** All house staff has access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located on all floors and in the residents’ offices.
  - **Other:** Residents are given articles as part of their weekly morning seminar series and by faculty on service.

#### IV. SPECIFIC AREAS & EXPECTATIONS

- **Residents are expected to regularly review relevant:**
  - Neuroimaging studies
  - Laboratory testing results
  - Neuropsychological testing results

On this rotation, residents act as consultants to other clinical services such as surgery or internal medicine. In addition to providing
diagnostic evaluations, residents will provide recommendations regarding behavioral and psychopharmacological management. Among the residents’ responsibilities is the application of cost-effective care measures and principles to the actual care of the patients on the service. Residents are expected to communicate as needed with discharge planning specialists.

V. EVALUATIONS

- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the resident's successful completion of the goals listed below will be carried out by the consult liaison nurse.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION

- The attending will see all patients and will supervise the care of the patient by the house staff, offering guidance but allowing for autonomy.
- The attending will be available for or be present at all activities where their involvement is needed.
- The attending will conduct attending rounds daily.
- Each attending rounds includes interaction with the patient under discussion as part of the educational session and discussion of the patient from a diagnostic and therapeutic perspective.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will at some time observe each resident in interactions with patients and families, in the performance of aspects of history taking and mental status examination, and will review residents’ consults in order to be able to evaluate the residents’ clinical and communication skills.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION

- Resident performs requested psychiatric consultations assigned to him/her by the consultation liaison service.
- Resident will discuss the diagnostic and management strategy with the attending on all consultations.
- Resident is responsible for follow up assessments of patients on the consultation service, examining and monitoring the progress of those patients, noting all laboratory and other data in a timely manner, discussing the management plans with the team, and writing progress notes as necessary.
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Resident is responsible for working collaboratively with primary service working with the patient.
- Resident is responsible for family and patient communication as needed and may serve as liaison between the service who requested the consultation and the patient/family on an as needed basis.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending and rotation upon completion of each two months.

VIII. SCHEDULE DURING THIS ROTATION

<table>
<thead>
<tr>
<th>Event</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Rounds</td>
<td>1:00 pm – 5:00 pm</td>
<td>Monday, Tuesday, Thursday, Butler Hospital Campus</td>
</tr>
<tr>
<td>Grand Rounds</td>
<td>1st Wednesday of each month, 11:00 am</td>
<td>Ray Hall, Butler Hospital Campus</td>
</tr>
<tr>
<td>Other Conferences</td>
<td>12:00 pm 1st Friday, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital</td>
<td>3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital</td>
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<td></td>
<td>1st 3rd Thursday from 12:00 pm to 1:00 pm, Geriatric Psychiatry Conference, Butler Hospital</td>
<td>1st 3rd Thursday from 12:00 pm to 1:00 pm, Geriatric Psychiatry Conference, Butler Hospital</td>
</tr>
<tr>
<td>Weekly Seminars</td>
<td>Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center</td>
<td>Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital</td>
</tr>
</tbody>
</table>

IX. GENERAL EDUCATIONAL OBJECTIVES

Objectives - By the end of this rotation, the resident will be able to:

- Synthesize medical, neurological, and behavioral history and presentation into a comprehensive neuropsychiatric differential diagnosis
- Perform a complete medical record review as it pertains to psychiatric diagnosis and treatment
- Perform a complete psychiatric review of systems and mental status exam in the medical/surgical patient
- Perform a cognitive exam in efficient fashion, condensing or expanding it as indicated, to generate maximum information regarding cognitive function
- Recognize the difference between abnormal behavior and normal responses in the medically stressed patient, and to be able to provide or prescribe appropriate psychosocial support and interventions
- Prepare and present case presentations
- Be familiar with the use of diagnostic tools and testing in the general hospital patient: neuroimaging, EEG, lumbar puncture,
X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

<table>
<thead>
<tr>
<th>Competency/Description</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
<tbody>
<tr>
<td>1. Patient Care</td>
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</table>
| Residents must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. | - Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.  
- Residents will learn to gather essential and accurate information about their patients  
- Residents will make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment  
- Residents will learn to counsel and educate patients and their families  
- Residents will work with health care professionals, including those from other disciplines, to provide patient-focused care | o Residents are evaluated by their attending on the C-L service  
o Residents are evaluated by the C-L nurse  
o Performance on rounds |
| 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. | - Residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter  
- Residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes, on rounds and didactic teaching sessions  
- Residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, Grand Rounds, critical review of scientific literature, computer and web-based resources  
- Resident will actively participate in seminars and on rounds  
- Residents will understand and apply basic principles of physiology and pathophysiology to specific commonly encountered conditions on the consultation liaison service  
- Residents will demonstrate an investigatory and analytic thinking approach to clinical situation | o Feedback of both oral and written presentations will be provided  
o The attending evaluates residents based on their participation during attending rounds  
o Presentation skills, management decisions and knowledge are evaluated on rounds |
| 3. 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 | - Residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information  
- Residents will make every effort to safeguard patient/family dignity.  
- Residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries.  
- Residents will create and sustain a therapeutic and ethically | o Attendings rate the residents based on bedside interactions  
o Feedback from nursing staff, other disciplines |
sound relationship with patients

- Residents will use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Residents will work effectively with others as a member or leader of a health care team or other professional group
- Residents will ask patient’s/family’s concerns and questions and address these specifically and directly to ensure that patient/family have received information in the desired degree of detail
- Residents will negotiate priorities for problems to be addressed in the particular visit, once all issues have been identified.
- Residents will write clearly and legibly when hand-writing instructions or other information for patients/families
- Residents written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable

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<tr>
<th>4. Professionalism</th>
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<th>Evaluation Method</th>
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<tbody>
<tr>
<td>Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</td>
<td>- Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary</td>
<td>o Attendings evaluate the professionalism on rounds and, bedside interactions o Feedback from nursing staff, other disciplines</td>
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<td>- Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest.</td>
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<td>- Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations.</td>
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<td>- Residents will demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care</td>
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<td>- Residents will know and avoid breach of the boundaries of the physician/patient relationship</td>
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<td>- Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard</td>
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<tr>
<td>- Residents will make every effort to elicit and to accommodate, to the fullest extent of their ability, differing religious and cultural needs and values in delivering medical care– but are under no obligation to accommodate requests based upon any form of identity-group prejudice</td>
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<tr>
<td>- Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and</td>
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will not permit their actions as physicians to be influenced by such prejudice
- Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family

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<tr>
<th>5. Practice-Based Learning and Improvement</th>
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| Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. | - At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice  
- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses  
- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems  
- The resident should maintain an awareness of medical and psychiatric information that directly impacts on the patients they evaluate on the consultation service, for example through directives and publications from their local department of health, or national physician’s organizations.  
- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed  
- The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist  
- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients  
- The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors  
- The resident is expected to facilitate the learning of students and other health care professionals | o Day to day knowledge base evaluated by feedback on differential diagnoses, management plans during  
- o Attending rounds  
- o Seminars |

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<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</table>
| Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on | - The resident will learn how to work within a multidisciplinary team to develop a care plan for the patients they evaluation on the consultation service  
- The resident will become familiar with hospital and community based health care professionals and their roles in groups such as social work, mental health professionals, PT, OT, dietitians, and VNA etc.  
- The resident will learn to identify which is the optimal | o Evaluations from attending  
- o Interactions with staff, nursing, and interdisciplinary team |
| system resources to provide care that is of optimal value. | setting to provide cost-effective and quality patient care for a variety of patient problems  
- The resident will practice cost-effective health care and resource allocation that does not compromise quality of care  
- The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions  
- The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies etc. via spoken and written communications when it effects the health of their patients  
- The resident will learn about the various community resources available for patients and will work with case managers and social workers to enable patients to access these resources. |

**XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION**

Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, hospitalized patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Nursing home psychiatry rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents learn to perform competent consultation to non-psychiatric medical personnel regarding psychiatric and behavioral problems in elderly nursing home patients. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

### Description of Rotation

Residents are provided with one half days per week of nursing home psychiatry for a full year divided into three different rotations for that may range from 1 to 4 months in length differing by attending and nursing homes through The Miriam Hospital. Each resident’s assignments are scheduled in order to give the resident broad clinical experience in all areas of nursing home psychiatry. Faculty experienced in nursing home consultation with added qualifications in geriatric psychiatry provides supervision in the psychiatric evaluation and management of geriatric patients consulted in the nursing home.

<table>
<thead>
<tr>
<th>I. GENERAL INFORMATION</th>
<th>Geriatric Nursing Home Psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Rotation</td>
<td>Geriatric Nursing Home Psychiatry</td>
</tr>
<tr>
<td>Chiefs of Service</td>
<td>Robert Boland, MD; Jeffrey Burock, MD; Richard Goldberg, MD; Romina Smulever, MD (The Miriam Hospital) Luisa Skoble, MD (Providence Veterans Administration)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Romina Smulever, MD (The Miriam Hospital) Luisa Skoble, MD (Providence Veterans Administration)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

### II. FACULTY

Robert Boland, MD; Jeffery Burock, MD; Richard Goldberg, MD; Romina Smulever, MD; Luisa Skoble, MD

### III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

- **Topics to be covered are based upon:**
  - The patient population cared for by the team over the course of the rotation
  - Cases selected for presentation

- **Principal teaching methods:**
  - Attending rounds
  - Weekly morning seminars
  - Direct observation and feedback of resident interviews
  - Discussion of diagnostic and treatment issues on one-to-one basis of cases seen together

- **Educational materials provided/referred to residents:**
  - **Reading:** Each attending and resident is expected to utilize current medical literature in the planning of therapeutic and diagnostic interventions.
  - **Computer-assisted educational materials:** All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located on all floors and in the residents’ offices.
  - **Other:** Residents are given articles as part of their weekly morning seminar series and by faculty on service.

### IV. SPECIFIC AREAS & EXPECTATIONS

Residents are expected to regularly review relevant:

- Nursing home records
- Neuroimaging studies
- Laboratory testing results
On this rotation, residents act as consultants to nursing homes. In addition to providing diagnostic evaluations, residents will provide recommendations regarding behavioral and psychopharmacological management. Among the residents' responsibilities is the application of cost-effective care measures and principles to the actual care of the patients on the service. Residents are expected to communicate as needed with nursing staff and primary care physicians.

V. EVALUATIONS
- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION
- The attending will see all patients and will supervise the care of the patient by the residents, offering guidance but allowing for autonomy.
- The attending will be available for or be present at all activities where their involvement is needed.
- Each attending rounds includes interaction with the patient under discussion as part of the educational session and discussion of the patient from a diagnostic and therapeutic perspective.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will at some time observe each resident in interactions with patients and families, in the performance of aspects of history taking and mental status examination, and will review residents’ consults in order to be able to evaluate the residents’ clinical and communication skills.
- The attending will complete an electronic evaluation for each resident at two month intervals.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION
- Resident performs requested psychiatric consultations assigned to him/her by nursing home.
- Resident will discuss the diagnostic and management strategy with the attending on all consultations.
- Resident is responsible for follow up assessments of patients on the service, examining and monitoring the progress of those patients, noting all laboratory and other data in a timely manner.
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Resident is responsible for working collaboratively with nurses and primary care physicians working with the patient.
- Resident is responsible for family and patient communication as needed and may serve as liaison between the nursing home who requested the consultation and the patient/family on an as needed basis.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending and rotation upon completion of each two months.

VIII. SCHEDULE DURING THIS ROTATION
- Attending Rounds 8:00 am – 12:00 pm Tuesday or Friday depending on rotation block
- Attending Rounds 1:00 pm – 4:00 pm Monday depending on rotation block
- Grand Rounds 1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus
- Other Conferences 12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital
- Weekly Seminars Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center
- Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital

IX. GENERAL EDUCATIONAL OBJECTIVES
- Understand the various factors that influence the presentation of symptoms in the long-term care setting.
- Understand the role of the nursing home staff in managing behavioral problems among nursing home residents.
- Synthesize medical, neurological, and behavioral history and presentation into a comprehensive neuropsychiatric differential diagnosis.
- Perform a complete medical record review as it pertains to psychiatric diagnosis and treatment.
- Perform a complete psychiatric review of systems and mental status exam in the nursing home patient.
- Perform a cognitive exam in efficient fashion, condensing or expanding it as indicated, to generate maximum information regarding cognitive function.
- Recognize the difference between abnormal behavior and normal responses in the nursing home patient, and to be able to provide or prescribe appropriate psychosocial support and interventions.
- Prepare and present case presentations.
- Be familiar with the use of diagnostic tools and testing in the nursing home patient
- Be aware of the diagnosis and evaluation of specific commonly encountered conditions/questions: delirium, dementia and their differentiation from the thought disorder and disorganization of a primary psychotic process, competency
- Be aware of the commonly encountered side effects of psychopharmacologic interventions: sedation, confusion, anxiety, extrapyramidal interactions, neuroleptic malignant syndrome
- Develop an appreciation for cost-efficient care, proper utilization of resources, and patient autonomy
- Work in a coordinated fashion with a multi-disciplinary team
- Present a differential diagnosis and treatment plan, both in writing and via liaison contact, to the patient, family, and requesting nursing home
- Describe the influence of psychological and social variables on the predisposition, onset, course and outcome of somatic illness
- Describe common patterns of psychological and social adaptation to illness in the nursing home

X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

<table>
<thead>
<tr>
<th>Competency/Description</th>
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<tbody>
<tr>
<td>1. Patient Care</td>
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| - Resident must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. | - Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.  
- Residents will learn to gather essential and accurate information about their patients  
- residents will make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment  
- residents will learn to counsel and educate patients and their families  
- residents will work with health care professionals, including those from other disciplines, to provide patient-focused care | residents are evaluated by their attending  
performance on rounds |
| 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. | - residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter  
- residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes, on rounds and didactic teaching sessions  
- residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, grand rounds, critical review of scientific literature, computer and web-based resources  
- resident will actively participate in seminars and on rounds  
- residents will understand and apply basic principles of physiology and pathophysiology to specific commonly encountered conditions on the consultation liaison service  
- residents will demonstrate an investigatory and analytic thinking approach to clinical situation | feedback of both oral and written presentations will be provided  
presentation skills, management decisions and knowledge are evaluated on rounds |
| 3. 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. | - residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information  
- residents will make every effort to safeguard patient/family dignity  
- residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries  
- residents will create and sustain a therapeutic and ethically sound relationship with patients  
- residents will use effective listening skills and elicit and | attendings rate the residents based on bedside interactions  
feedback from nursing staff, other disciplines |
provide information using effective nonverbal, explanatory, questioning, and writing skills
- Residents will work effectively with others as a member or leader of a health care team or other professional group
- Residents will ask patient’s/family’s concerns and questions and address these specifically and directly to ensure that patient/family have received information in the desired degree of detail
- Residents will negotiate priorities for problems to be addressed in the particular visit, once all issues have been identified.
- Residents will write clearly and legibly when hand-writing instructions or other information for patients/families
- Residents written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable

<table>
<thead>
<tr>
<th>4. Professionalism</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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| Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population | - Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary | o Attendings evaluate the professionalism on rounds and, bedside interactions  
 o Feedback from nursing staff, other disciplines |
Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family.

<table>
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<tr>
<th>5. Practice-Based Learning and Improvement</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
</table>
| ➢ Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. | - At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice  
- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses  
- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems  
- The resident should maintain an awareness of medical and psychiatric information that directly impacts on the patients they evaluate on the consultation service, for example through directives and publications from their local department of health, or national physician’s organizations.  
- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed  
- The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist  
- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients  
- The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors  
- The resident is expected to facilitate the learning of students and other health care professionals | ○ Day to day knowledge base evaluated by feedback on differential diagnoses, management plans during  
○ Attending rounds  
○ Seminars |

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<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
</table>
| ➢ Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of | - The resident will learn how to work within a multidisciplinary team to develop a care plan for the patients they evaluation on the consultation service  
- The resident will become familiar with nursing home based health care professionals and their roles in such as social work, PT, OT, dietitians, and CNAs  
- The resident will learn to identify which is the optimal setting to provide cost-effective and quality patient care for a variety of patient problems  
- The resident will practice cost-effective health care and | ○ Evaluations from attending  
○ Interactions with staff, nursing, and interdisciplinary team |
optimal value.

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<tr>
<th>resource allocation that does not compromise quality of care</th>
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<tbody>
<tr>
<td>- The resident will learn how patients finance their nursing home</td>
</tr>
<tr>
<td>- The resident will learn some of the economic realities of nursing home care</td>
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</table>

### XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION

Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, hospitalized patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Geriatric outpatient psychiatry rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experiences during which residents gain knowledge, skills and practice in the care of geriatric psychiatric patients in an outpatient setting. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

### Description of Rotation

This rotation is a 1-year longitudinal assignment one half day per week at The Miriam Hospital. It allows residents to develop important diagnostic, treatment, and other skills in an outpatient setting. It allows residents to work more independently and to assume increasing responsibility for a varied patient caseload of elderly patients. Residents evaluate and treat geriatric outpatients and have specific supervision with a geriatric psychiatry supervisor who has subspecialty boards in this area.

**The Miriam Hospital**

<table>
<thead>
<tr>
<th>I. GENERAL INFORMATION</th>
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</thead>
<tbody>
<tr>
<td><strong>Name of Rotation</strong></td>
</tr>
<tr>
<td><strong>Chiefs of Service</strong></td>
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<tr>
<td><strong>Contact Information</strong></td>
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<tr>
<td><strong>Residency Coordinator</strong></td>
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<tr>
<th>II. FACULTY</th>
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<tbody>
<tr>
<td>Robert Boland, MD; Jeffery Burock, MD; Robert Kohn, MD</td>
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<thead>
<tr>
<th>III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION</th>
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</thead>
<tbody>
<tr>
<td><strong>Topics to be covered are based upon:</strong></td>
</tr>
<tr>
<td>• The patients assessed and treated by the residents over the course of the rotation</td>
</tr>
</tbody>
</table>

| **Principal teaching methods:**                             |
| • Attending supervision                                      |
| • Weekly morning seminars                                   |

| **Educational materials provided/referred to residents:**   |
| • **Reading:** Each attending and resident is expected to utilize current psychiatric literature regarding assessment and treatment of psychiatric patients. |
| • **Computer-assisted educational materials:** All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located in the outpatient reception area. |
| • **Other:** Residents are given articles as part of their weekly morning seminar series and by faculty on service. |

<table>
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<tr>
<th>IV. SPECIFIC AREAS &amp; EXPECTATIONS</th>
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<tbody>
<tr>
<td><strong>Residents are expected to regularly review relevant:</strong></td>
</tr>
<tr>
<td>• Neuroimaging studies</td>
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<tr>
<td>• Laboratory testing results</td>
</tr>
<tr>
<td>• Neuropsychological testing results</td>
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<tr>
<td>• Interagencies from nursing homes and reports from primary care physicians</td>
</tr>
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</table>

On this rotation, residents act as the outpatient psychiatrist to patients over the age of 65 who have a broad range of psychiatric diagnoses. An initial evaluation will be performed on every new patient or those transferred from another level of care. Follow-up visits will be conducted based on the patient’s clinical needs. Residents will be available to respond to emergency telephone calls from clinic patients. Residents will provide patients with pharmacological management, assist families in behavioral management, and utilize psychotherapeutic techniques. Among the residents' responsibilities is the application of cost-effective care measures and principles to the actual care of the patients on the service. Residents are expected to communicate as needed with primary care
V. EVALUATIONS

- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the resident's successful completion of the goals listed below will be carried out by the clinic nurse.
- Evaluation of the resident's successful completion of the goals listed below will be carried out by sampling of outpatients.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION

- The chief of service will oversee the educational experience for the residents.
- The attending will oversee the care of the patients in the resident’s caseload assigned to that particular supervisor.
- The attending will provide supervision after the fellow has completed their assessment and evaluation of the patient.
- The attending will examine the patients to confirm the resident’s findings to guide in establishing the treatment plan.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION

- Resident is responsible for evaluation, treatment, and disposition of psychiatric outpatients.
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Resident is responsible for family and patient communication.
- Resident is responsible for discussing the case with his or her supervisor, other health care professionals involved with the patient and the patient’s family, as dictated by the circumstances.
- Resident is responsible for written or dictated evaluations of all patients assessed and followed.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending upon completion of each two months.
- Resident is responsible for having their beeper on in the event of an urgent call from their patient or the outpatient staff, and if not available arranging appropriate coverage.
- Resident must inform their patients how they can be reached in the event of an emergency

VIII. SCHEDULE DURING THIS ROTATION

| Clinic Hours | 1:00 pm – 4:00 pm, Tuesday or Friday depending on the Rotation block |
| Grand Rounds | 1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus |
| Other Conferences | 12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital |
| | 3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital |
| | 1st and 3rd Thursday from 12:00 pm to 1:00 pm, Geriatric Psychiatry Conference, Butler Hospital |
| Weekly Seminars | Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center |
| | Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital |

IX. GENERAL EDUCATIONAL OBJECTIVES

Objectives - By the end of this rotation, the resident will be able to:

- Assess geriatric outpatients and implement outpatient treatment for individuals with psychiatric and or psychological difficulties
- Develop important diagnostic and treatment skills in an outpatient setting
- Function independently in an outpatient setting with supervision
- Have both a theoretical and practical understanding of geriatric psychopharmacology
- Have both a theoretical and practical understanding of individual psychotherapies as applied to the elderly
- Recommend laboratory/imaging tests
- Prepare and present case presentations
- Develop an appreciation for cost-efficient care, and proper utilization of resources
- Work in a coordinated fashion with other treatment providers
- Recognize when patients need a higher level of treatment (e.g., inpatient hospitalization, partial hospitalization, day care, assisted living, nursing home, visiting nurse services)
- Recognize and treat chronic and recent onset primary psychiatric illness in the context of multiple co-morbid conditions, which frequently characterize the late life adult
- Understand the various factors, which influence the use of psychopharmacologic agents in the aged and the role of drug interactions
Distinguish between normative and pathological neurologic changes in the ageing process.

Be sensitive to the normative stresses of late life as they interact with the various personality styles in the aging person and the changes in psychotherapeutic technique which are most helpful in working with older patients.

## X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

### Competency/Description

#### 1. Patient Care
- Resident must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

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<td>- Residents will prepare and present case presentations</td>
<td>○ Residents are evaluated by their supervisors</td>
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<td>- residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families</td>
<td>○ Residents are evaluated by the nurse coordinator</td>
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<tr>
<td>- residents will learn to gather essential and accurate information about their patients</td>
<td>○ Residents are evaluated by patients</td>
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<td>- residents will learn to make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment</td>
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<td>- residents will learn to develop and carry outpatient management plan</td>
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<td>- residents will learn to counsel and educate patients and their families</td>
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<tr>
<td>- residents will provide health care services aimed at preventing health problems or maintaining health</td>
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<td>- residents will work with health care professionals, including those from other disciplines, to provide patient-focused care</td>
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<td>- residents will use information technology to support patient care decisions</td>
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#### 2. Medical Knowledge
- Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognitive (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

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<td>- residents will demonstrate an investigatory and analytic thinking approach to clinical situations</td>
<td>- Feedback of both oral and written presentations will be provided by attending</td>
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<td>- residents will know and apply the basic and clinically supportive sciences which are appropriate to their discipline</td>
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<td>- residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter</td>
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<td>- residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes and presentations to supervisors and other health care professionals</td>
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<tr>
<td>- residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, Grand Rounds, critical review of scientific literature, computer and web-based resources</td>
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<td>- residents will actively participate in seminars</td>
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#### 3. 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.

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<td>- residents written communications in patient charts will</td>
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effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable

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<td>Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</td>
<td>- Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary</td>
<td>○ Attendings will evaluate residents ○ Feedback from nursing staff, other disciplines</td>
</tr>
<tr>
<td>- Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest</td>
<td>- Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations.</td>
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<td>- Residents will demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care</td>
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<tr>
<td>- Residents will review their professional conduct and remediate when appropriate</td>
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<tr>
<td>- Residents will make reasonable efforts to act as advocates for their patients.</td>
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<td>- Residents will truthfully report medical errors of their own to their attending, or Risk Management and to follow hospital protocols in the face of errors. Residents will encourage and facilitate reporting of medical error on the part of professional colleagues</td>
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<td></td>
</tr>
<tr>
<td>- Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard</td>
<td>- Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard</td>
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</tr>
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<td>- Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice</td>
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<td>- Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family</td>
<td>- Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family</td>
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<td>- Residents will create and sustain a therapeutic and ethically sound relationship with patients</td>
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</table>

5. Practice-Based Learning and Goals and Objectives Evaluation Method

- Attendings will evaluate residents
- Feedback from nursing staff, other disciplines
### Improvement

- Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

- At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback for the year. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice.

- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses.

- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems.

- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed.

- The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist.

- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients.

- The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors.

- The resident will facilitate the learning of students and other health care professionals.

### 6. Systems-Based Practice

- Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals.

- The resident will learn to practice cost-effective health care and resource allocation that does not compromise quality of care.

- The resident will learn how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

- The resident will learn how to work other health care providers to develop and coordinate a care plan for their patients.

- The resident will be familiar with the presence and influences of alternative and complimentary therapies, and its use in their populations and patients.

- The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions. They will learn the legal rights of the uninsured and will work with the appropriate services to assist patients who are under- or uninsured.

- The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies etc. via spoken and written communications when it effects the health of their patients.

- The resident will learn about the various community resources available for patients and will work with case managers and social workers to enable patients to access.

### Evaluation Method

- Day to day knowledge base evaluated by feedback on diagnoses, and both psychopharmacologic and psychotherapeutic treatment approaches.

- Evaluations from supervisors.
XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION

Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, clinic patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Geriatric medicine ambulatory care rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents gain knowledge, skills, and practice in the care of medical issues in geriatric patients. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf of their patients, as well as on their own education. During this rotation fellows will develop competence in primary care and consultation of geriatric patients in the outpatient setting and to develop skills of interacting with office staff and home care nursing staff.

### Description of Rotation

This rotation is a one half day per week for four months with the Brown University Division of Geriatric Medicine based at Providence Veterans Administration Medical Center’s Geriatric Medicine Clinic. It allows residents to develop important diagnostic, treatment, and other skills in an outpatient setting. It allows residents to work more independently and to assume increasing responsibility for a varied patient caseload of elderly patients. Residents evaluate and treat geriatric outpatients and have specific supervision with a geriatric primary care supervisor who has subspecialty boards in this area. A nurse coordinator is available to patients and residents as a resource in the geriatric clinic.

### I. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Geriatric Ambulatory Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiefs of Service</td>
<td>David Dosa, MD (Providence VAMC)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>David Dosa, MD (Providence VAMC)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

### II. FACULTY

David Dosa, MD

### III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

#### Topics to be covered are based upon:

- The patients assessed and treated by the residents over the course of the rotation

**Principal teaching methods:**

- Attending supervision
- Core topics related to outpatient older patients
- Weekly morning seminars

**Educational materials provided/referred to residents:**

- **Reading:** Each attending and fellow is expected to utilize current medical literature in the planning of therapeutic and diagnostic interventions.
- **Computer-assisted educational materials:** All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located in the outpatient reception area.
- **Other:** Residents will be given articles as a part of teaching rounds by faculty on service.

### IV. SPECIFIC AREAS & EXPECTATIONS

Residents are expected to regularly review relevant:

- Laboratory testing results
- Biopsy and autopsy specimens on their patients.
- Diagnostic imaging studies
- Act as a primary care physician
- Act as consultant for out-patient geriatric assessment
- Principles of cost effective patient care in the out-patient setting
V. EVALUATIONS
- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the resident's successful completion of the goals listed below will be carried out by the clinic nurse.
- Evaluation of the resident's successful completion of the goals listed below will be carried out by sampling of outpatients.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION
- The chief of service will oversee the educational experience for the residents.
- The attending will oversee the care of the patients in the resident’s caseload assigned to that particular supervisor.
- The attending will provide supervision after the fellow has completed their assessment and evaluation of the patient.
- The attending will examine the patients to confirm the resident’s findings to guide in establishing the treatment plan.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION
- To be in the clinic on time.
- See all patients scheduled (including "same day" appointments)
- Accept responsibility for the primary care of patients assigned.
- Discuss each patient with a faculty preceptor (interns present on all patients; juniors and seniors present new patients).
- Follow-up on abnormal test results.
- Follow up calls to the patient or caregiver
- Residents will complete an electronic evaluation of the attending at the end of each two months.

VIII. SCHEDULE DURING THIS ROTATION

| Clinic Hours | 1:00 pm – 4:00 pm, Wednesday |
| Grand Rounds | 1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus |
| Other Conferences | 12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital |
| 3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital |
| Weekly Seminars | 1st and 3rd Thursday from 12:00 pm to 1:00 pm, Geriatric Psychiatry Conference, Butler Hospital |
| | Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center |
| | Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital |

IX. GENERAL EDUCATIONAL OBJECTIVES
Objectives - By the end of this rotation, the resident will be able to:
- Provide comprehensive primary care assessment of older patients.
- Use all appropriate screening for elder patients.
- Assess and manage acute problems in the outpatient setting.
- Communicate effectively with older patients and their families.
- Address advance directives and other end of life issues in the outpatient setting.
- Manage chronic illness.
- Perform comprehensive geriatric assessment in the context of a primary care practice and ambulatory geriatric consultation.
- Manage common geriatric syndromes, including syncope, dizziness, falls, incontinence, dementia, confusion, and polypharmacy.
- Communicate with consulting primary care physicians and subspecialists.
- Work as part of an interdisciplinary team.
- Become proficient in use of the Electronic Medical Record.
- Bill appropriately for ambulatory services under Medicare guidelines.

X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

<table>
<thead>
<tr>
<th>Competency/Description</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Care</td>
<td>- Goal: Gather essential and accurate information about their patients</td>
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<tr>
<td></td>
<td>- To perform Routine Physical exam-General as well as problem-focused exam of older persons. To learn and use instruments-ADL, IADL, MMSE, GDS, Gait and Balance,</td>
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<tr>
<td></td>
<td></td>
<td>o Residents are evaluated by their supervisors</td>
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<td>o Residents are evaluated by the nurse coordinator</td>
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<td>o Residents are evaluated by</td>
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</tbody>
</table>
- To do a concise, accurate, and thorough evaluation with patient while working as a member of a team of care givers. To understand limitations in older persons; e.g., hearing loss, memory and vision problems, that may require adjustments while interacting with patients.  
- The resident will access old medical records and obtain information pertaining to previous hospitalizations, clinic visits, laboratory work and studies from all available sources, including the patient, family and primary physician.  
- Goal: Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment. Develop and carry out patient management plans.  
- To involve patient and primary care giver in the decision-making process.  
- To assess, develop & carry out patient management plans for the geriatric syndromes- Dementia, Delirium, Falls, Dizziness, Polypharmacy, Incontinence, Weight/appetite loss et al; Provide written instructions to the patient, conduct advance care planning.  
- To understand principles of rehabilitation, including those applicable to patients with orthopedic, rheumatologic, cardiac, pulmonary, and neurological impairments, and criteria to order outpatient physical therapy.  
- To learn to manage complex patients in outpatient settings; e.g., 6-8 patients in half-day clinic sessions. Prioritize to address most important problem when patient presents with multiple problems; schedule early follow up for other problems.  
- To learn about hospice care, including pain management, symptom relief, comfort care, and end-of-life issues.  
- To learn psychosocial aspects of aging, including interpersonal and family relationships, living situations, adjustment disorders, depression, bereavement, and anxiety.  
- To perform cognition evaluation -History, MMSE, Clock test; order neuropsychological evaluation when indicated.  
- To perform pain assessment and management; educate on side effects and benefits of analgesics.  
- To assess mood problems- Screening questions, Geriatric Depression scale.  
- To appreciate and apply where necessary the basic legal principles by which society governs health care delivery – examples include responsibility to report elder abuse/neglect.  
- Goal: Residents must be able to communicate effectively.  
- To be able to present a history and physical exam in a clear and concise manner.  
- To be able to explain to the patient & family the diagnosis, nature of the disease and the expected clinical course.  
- To be able to effectively communicate medical information in a written format. Notes should be clear, legible, timely and provide content that accurately reflects the patient’s current status and planned management strategies. All notes should indicate time and date, and include a header indicating the role of the author.  
- To refine skills necessary for the coordination of care among primary physicians and consultants  
- Goal: Demonstrate caring and respectful behaviors when interacting with patients and their families. |
- The resident will be observed interacting with patients and critiqued on these interactions.
- Goal: Counsel and educate patients and their families.
- The resident will have experience explaining to patients and their families diagnoses, nature of disease and expected course.
- To learn to counsel and educate patients and families about important issues; e.g., dementia, hyperlipidemia, weight loss, risks of OTC sleeping pills, falls, et al.
- Goal: Provide health services aimed at preventing health problems or maintaining health.
- To educate patient/care givers about risk factors of falls, OTC drugs.
- To learn about the role of all effective preventive services in older patients; e.g., mammogram, PAP smear, colonoscopy, PSA, exercise, immunizations, et al.

### 2. Medical Knowledge

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
<tbody>
<tr>
<td>- Residents must demonstrate knowledge about established and evolving biomedical,</td>
<td>- Feedback of both oral and written presentations will be provided by attending</td>
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<tr>
<td>clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and</td>
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<td>the application of this knowledge to patient care.</td>
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<tr>
<td>- Goal: Demonstrate an investigatory and analytical thinking approach to clinical</td>
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<td>situations.</td>
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<td>- Residents will understand the epidemiology and apply basic principles of physiology</td>
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<td>and pathophysiology to common diseases and geriatric syndromes in older patients;</td>
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<td>and understand the clinical presentation, diagnosis, prevention, prognosis and</td>
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<td>management options for these illnesses.</td>
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<tr>
<td>- Goal: To know and apply the basic and clinically supportive sciences which are</td>
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<td>appropriate to their discipline.</td>
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<tr>
<td>- Residents will learn to generate a differential diagnosis of diseases in older</td>
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<td>patients and unique treatment plan for each patient encounter, learn to</td>
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<td>judiciously use diagnostic tests, laboratory studies to narrow the diagnosis.</td>
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<td>- Residents will keep abreast of new scientific knowledge. This knowledge will be</td>
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<td>obtained via didactic sessions, Grand Rounds, critical review of scientific</td>
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<td>literature (e.g. journal clubs), computer and web-based resources and via</td>
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<tr>
<td>objectives outlined in the Practice Based Learning and Improvement objectives.</td>
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<tr>
<td>- Residents will gain familiarity with Geriatric syndromes—dementia, delirium,</td>
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<td>weight loss, falls, pressure ulcers, dizziness etc.</td>
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<tr>
<td>- Residents will learn to provide comprehensive geriatric assessment in ambulatory</td>
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<tr>
<td>care setting</td>
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### 3. Interpersonal and Communication Skills

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Goal: Residents must create and sustain a therapeutic and ethically sound</td>
<td>o Residents are evaluated by their supervisors</td>
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<td>relationship with patients.</td>
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<td>- Residents will approach patients/families with a friendly, interested, and</td>
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<td>respectful demeanor.</td>
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<td>- Residents will scrupulously maintain patient confidentiality, and specifically</td>
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<td>reassure patients/families of the confidentiality of their personal and medical</td>
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<td>information.</td>
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<td>- To learn about HIPAA rules.</td>
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<tr>
<td>- Be a good listener and sensitive to personal issues with the patient. To</td>
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<tr>
<td>understand that elderly patients may have hearing loss; vision problems; family</td>
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<td>dynamics; elder abuse; elder neglect.</td>
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<td>- Residents will know and be able to describe the proper boundaries of the</td>
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<td>physician/patient relationship, and will consistently and conscientiously avoid</td>
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<td>any breach of these</td>
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</table>
- Appropriately communicate with Caregivers; explaining the trajectory of dementia; breaking the bad news.
- Goal: Residents must elicit and provide information using effective explanatory, questioning, and writing skills.
- Explanatory: Residents will ask patient’s/family’s concerns and questions and address these specifically and directly to ensure that patient/family have received information in the desired degree of detail.
- Residents will clearly identify differences in patient/family and medical perspectives, bringing such differences into open discussion, and explaining the rationales for medical actions that differ from patient/family preferences and values.
- Questioning: Residents will demonstrate skill, clarity, and effectiveness in questioning patients/families, including: beginning each topical exploration with broad, open-ended questions and progressing to more directed questions and specific prompts; avoiding asking more than one question at a time; clarifying patients’/families’ unclear statements.
- Writing: Residents will write clearly and legibly when handwriting instructions or other information for patients/families.
- Residents will help to ensure that written or printed information for patients/families is language-congruent and literacy appropriate, using straightforward language and comprehensible and culturally appropriate illustrations.
- Written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter, as well as future encounters when applicable.
- Residents notes will be dated and timed, and clearly indicate the role of the author.
- Goal: Residents must be able to work effectively with others as a member or leader of a health care team or other professional group
- Appropriately communicate with team members in outpatient setting: home care nursing; social worker; PT; OT; pharmacist.
- Residents will, as continuing fellows themselves, actively seek the advice and knowledge of senior physicians and other parties with knowledge relevant to the care of patients (both in general and in specific individual instances).
- Residents will master the logistics and appropriate use of sub-specialty and specialty consults and their follow-up, including such non-medical resources as Social Work, Case Management, Ethics Committee, Risk Management, et al.
- Goal: Scholarly communication
- Case presentations in clinical teaching rounds, Fundamental series, Journal club, preparing a lecture, M&M, QI project.

<table>
<thead>
<tr>
<th>4. Professionalism</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and</td>
<td>Goal: Residents must demonstrate respect, compassion, and integrity in their professional behavior</td>
<td>Attendings will evaluate residents</td>
</tr>
<tr>
<td></td>
<td>Residents will ask patients/family members how they wish to be addressed; avoid addressing adults by first name unless specifically invited to do so.</td>
<td>Feedback from nursing staff, other disciplines</td>
</tr>
<tr>
<td></td>
<td>Residents will know and avoid breach of the boundaries of the physician/patient relationship, including but not limited to strict avoidance of sexual or romantic suggestiveness</td>
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</tbody>
</table>
| **sensitivity to a diverse patient population** | involvement with patients/family members.  
- Residents will operate with respect for patient confidentiality at all times.  
- Appropriate dress and behavior while working.  
- Goal: Fellows must demonstrate responsiveness to the needs of patients and society that supercedes self-interest.  
- Residents will place patient safety and care above all competing considerations at all times.  
- Residents will make reasonable efforts to act as advocates for their patients.  
- Residents will place patient safety as their first priority, while respecting patient autonomy, without compromising their own safety or the safety of others that they are supervising.  
- Goal: Fellows must demonstrate sensitivity and responsiveness to patients’ culture, age, gender, disabilities, religion, sexual preference, and other parameters of human diversity.  
- Residents will make every effort to elicit and to accommodate to, to the fullest extent of their ability, differing religious and cultural needs and values in delivering medical care— but are under no obligation to accommodate requests based upon any form of identity-group prejudice.  
- Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice.  
- Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family.  
- Residents will use language that is neutral as to assumptions of gender, sexual preference, religion and race/ethnicity, when making general comments and explanations.  
- Residents will be sensitive to cultural, age, gender, disability issues, health care status of older persons of diverse ethnicities, access to health care, cross-cultural assessment of culture-specific beliefs and attitudes towards health care.  
- Appropriate use of an interpreter in clinical care.  |
<table>
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<tbody>
<tr>
<td><strong>5. Practice-Based Learning and Improvement</strong></td>
<td><strong>Goals and Objectives</strong></td>
</tr>
<tr>
<td>- Chart Review and Evaluation by faculty</td>
<td></td>
</tr>
</tbody>
</table>
- Use all resources available to get an accurate history of patient and appropriate work up. Gathering information from old records from the hospital, PMD, subspecialist.
- Use of information technology
- Understanding and navigating transitions of care between different settings - hospital, home, assisted living, nursing home.
- Residents will learn about health disparities existing in the population at large; resources available for uninsured patients.
- Goal: The resident will effectively use information technology to access and manage on-line medical information to support their education, expertise and certification.
- The resident will refine skills in literature search methodologies, using standard web-based medical literature search engines such as Ovid, MD Consult, and Pub med.
- The resident will have familiarity with a variety of computer and hand-held computer-based resources for looking up medications, dosing, and other topics of use to the general internist.
- The resident will use information technology; e.g. www.pogoe.com
- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients.
- The resident is expected to take a proactive approach to enhancing knowledge. The fellow is expected to “think out loud”, ask for guidance, and actively seek input on their practice and knowledge base from mentors.
- Goal: Facilitate the learning of students and other health care professional (To be effective teachers).
- Residents will, as continuing fellows themselves, actively seek the advice and knowledge of senior physicians and other parties with knowledge relevant to the care of patients (both in general and in specific individual instances).

<table>
<thead>
<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
</table>
| ➢ Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals. | - Goal: To partner with Health care managers and health care providers to assess, coordinate patient care.  
- The resident will become familiar with hospital and community based health care professionals and their roles in groups, such as social work, Home care nursing, mental health professionals, PT, OT, dietitians, and VNA et al.  
- The resident will evaluate how interacting with the above groups and health professionals enhances practice.  
- Goal: To practice cost effective health care and resources allocation that do not compromise quality of care.  
- Practice Cost effective care - Ordering appropriate consults and lab tests, use of generic drugs, understanding Medicare Part D.  
- The residents will learn about health insurance programs, especially Medicare and Medicaid, and how they affect patient referrals and prescriptions. They will learn the legal rights of the uninsured and will work with the appropriate services to assist patients who are under- or un-insured.  
- To learn the economic aspects of geriatric medicine - Title III of the Older Americans Act, Medicare, Medicaid, capitation, Medicare Part D and cost containment. | o Evaluations from supervisors |
- **Goal:** Advocate for quality patient care and assist patients in dealing with system complexities.
- The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, insurance companies, et al. as needed to optimize the health of their patients.
- The resident will learn about the numerous community resources available for patients, and will work with case managers and social workers to enable patients to access these resources.
- The resident will advocate for patients within the health care system, and understand the roles of adult protective services and Ombudsman in long-term care.
- **Goal:** The resident will know how types of medical practice and delivery systems differ from one another, and understand how patient care and other professional practices affect other health care professionals and the health care system.
- Understand interaction of their practices with the larger system; Transitions of care between different settings – Hospital, Assisted living, Nursing Home, Hospice care, Home care.
- To learn and apply appropriately ethical and legal issues affecting patient care - limitation of treatment, competency, guardianship, right to refuse treatment, advance directives, designation of a surrogate decision maker for health care, wills, and durable power of attorney for medical affairs.
- To learn to practice appropriate telephone medicine.
- Knowledge of practice and delivery systems- Telephone medicine, Home care certification forms, Billing/coding.

<table>
<thead>
<tr>
<th>XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION</th>
</tr>
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<tbody>
<tr>
<td>Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, clinic patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.</td>
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Geriatric Psychiatry Fellowship Training Program
Brown University Department of Psychiatry and Human Behavior

Geriatric Homecare Psychiatry

Overview of Rotation
Revised date 1209/10

Geriatric homecare psychiatry rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents learn to perform competent consultation and treatment regarding psychiatric and behavioral problems in elderly medical patients who are homebound by conducting a house call. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

Description of Rotation
Residents are provided with one half days per week of geriatric homecare psychiatry for four months through Butler Hospital and Boston University Medical Center. It allows residents to develop important diagnostic, treatment, and other skills by evaluating elderly patients in their home setting. It allows residents to work more independently and to assume increasing responsibility for a varied patient caseload of elderly patients. Half of the homecare visits will be conducted in the city of Boston in order that the resident can experience how older patients, primarily disadvantaged minorities, manage in an urban setting. Residents evaluate and treat geriatric homecare patients and have specific supervision with a geriatric psychiatry supervisor who has subspecialty boards in this area.

Butler Hospital

I. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Geriatric Homecare Psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiefs of Service</td>
<td>Robert Kohn, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Robert Kohn, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

II. FACULTY

Robert Kohn, MD

III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

Topics to be covered are based upon:

- The patients assessed and treated by the residents over the course of the rotation

Principal teaching methods:

- Attending rounds
- Review of formal reports on each visit
- Weekly morning seminars

Educational materials provided/referred to residents:

- **Reading**: Each attending and resident is expected to utilize current medical literature in the planning of therapeutic and diagnostic interventions.
- **Computer-assisted educational materials**: All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located on all floors and in the residents’ offices.
- **Other**: Residents are given articles as part of their weekly morning seminar series and by faculty on service.

IV. SPECIFIC AREAS & EXPECTATIONS

Residents are expected to regularly review relevant:

- Referral information
- Laboratory testing results

On this rotation, residents act as the outpatient psychiatrist to homebound patients over the age of 65 who have a broad range of psychiatric diagnoses. An initial evaluation will be performed on every new patient. Follow-up visits will be conducted based on the patient’s clinical needs. Residents will be available to respond to emergency telephone calls from homebound patients.
will conduct telephone call follow-up assessments on those patients whose symptoms are not yet stabilized. Residents will provide patients with pharmacological management, assist families in behavioral management, and utilize psychotherapeutic techniques. Among the residents' responsibilities is the application of cost-effective care measures and principles to the actual care of the patients on the service. Residents are expected to communicate as needed with primary care physicians and with the referring agency. In addition, residents will learn how to conduct capacity evaluations for guardianship.

V. EVALUATIONS

- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION

- The attending will see all patients and will supervise the care of the patient by the residents, offering guidance but allowing for autonomy.
- The attending will be available for or be present at all activities where their involvement is needed.
- The attending will examine the patients to confirm the resident’s findings to guide in establishing the treatment plan.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident’s performance to the resident throughout the rotation.
- The attending will observe each resident in interactions with patients and families, in the performance of aspects of history taking and mental status examination, and will review residents’ consults in order to be able to evaluate the residents’ clinical and communication skills.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION

- Resident is responsible for evaluation, treatment, and disposition of psychiatric homecare patients.
- Resident is responsible for collecting all relevant information on the patient, including contacting the primary care physician and referring agency.
- Resident is responsible for family and patient communication.
- Resident is responsible for discussing the case with his or her supervisor, other health care professionals involved with the patient and the patient’s family, as dictated by the circumstances.
- Resident is responsible for written or dictated evaluations of all patients assessed and followed.
- Resident is responsible for conducting telephone assessments on those patients who are not yet stabilized but do not have a scheduled home care visit.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending upon completion of each two months.
- Resident is responsible for having their beeper on in the event of an urgent call from their patient and if not available arranging appropriate coverage.
- Resident must inform their patients how they can be reached in the event of an emergency.

VIII. SCHEDULE DURING THIS ROTATION

| Attending Rounds | 1:00 pm – 4:00 pm Wednesday |
| Grand Rounds     | 1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus |
| Other Conferences| 12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital |
|                  | 3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital |
|                  | 1st and 3rd Thursday from 12:00 pm to 1:00 pm, Geriatric Psychiatry Conference, Butler Hospital |
| Weekly Seminars  | Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center |
|                  | Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital |

IX. GENERAL EDUCATIONAL OBJECTIVES

Objectives - By the end of this rotation, the resident will be able to:

- Assess geriatric patients and implement treatment for individuals with psychiatric and or psychological difficulties
- Develop important diagnostic and treatment skills in a homecare setting
- Function independently in an outpatient setting with supervision
- Have both a theoretical and practical understanding of geriatric psychopharmacology
- Have both a theoretical and practical understanding of individual psychotherapies as applied to the elderly
- Recommend laboratory/imaging tests
- Prepare and present case presentations
- Develop an appreciation for cost-efficient care, and proper utilization of resources
- Work in a coordinated fashion with other treatment providers
- Recognize when patients need a higher level of treatment (e.g., inpatient hospitalization, partial hospitalization, day care, assisted living, nursing home, visiting nurse service)
- Recognize and treat chronic and recent onset primary psychiatric illness in the context of multiple co-morbid conditions, which frequently characterize the late life adult
- Understand the various factors, which influence the use of psychopharmacologic agents in the aged and the role of drug interactions
- Distinguish between normative and pathological neurologic changes in the ageing process
- Sensitive to the normative stresses of late life as they interact with the various personality styles in the aging person and the changes in psychotherapeutic technique which are most helpful in working with older patients
- Present a differential diagnosis and treatment plan, both in writing and via liaison contact, to the patient, family, and requesting service.
- Describe the influence of psychological and social variables on the predisposition, onset, course and outcome of somatic illness
- Describe common patterns of psychological and social adaptation to illness
- Access appropriate community resources to meet all care needs at home
- Implement and monitor the appropriate use of in-home services and identify both short and long-term goals
- Coordinate nursing and rehabilitative services as needed to maintain the patient at home
- Identify the environmental, psychosocial and economic factors that affect the patient’s health care needs at home
- Understand the areas of capacity and how to access them: medical, financial, relationships, and residential
- Understand alternatives to guardianship
- Understand the guardianship process

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### X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

<table>
<thead>
<tr>
<th>Competency/Description</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Patient Care</strong></td>
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<tr>
<td>Resident must be able</td>
<td>Residents will prepare and present case presentations</td>
<td>Residents are evaluated by their attending</td>
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<tr>
<td>to provide care that is</td>
<td>Residents will develop the ability to communicate</td>
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<tr>
<td>compassionate,</td>
<td>effectively and demonstrate caring and respectful behaviors</td>
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<td>appropriate, and</td>
<td>when interacting with patients and their families</td>
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<td>effective for the</td>
<td>Residents will learn to gather essential and accurate</td>
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<td>treatment of health</td>
<td>information about their patients</td>
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<td>problems and the</td>
<td>Residents will learn to make informed decisions about</td>
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<tr>
<td>promotion of health.</td>
<td>diagnostic and therapeutic interventions based on patient</td>
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<td>information and preferences, up-to-date scientific evidence,</td>
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<td></td>
<td>and clinical judgment</td>
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<td></td>
<td>Residents will learn to develop and carry outpatient</td>
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<td>management plan</td>
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<td>Residents will learn to counsel and educate patients and their</td>
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<td></td>
<td>families</td>
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<td></td>
<td>Residents will provide health care services aimed at</td>
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<td></td>
<td>preventing health problems or maintaining health</td>
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<td>Residents will work with health care professionals, including</td>
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<td></td>
<td>those from other disciplines, to provide patient-focused care</td>
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<td></td>
<td>Residents will use information technology to support patient</td>
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<td></td>
<td>care decisions</td>
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<td><strong>2. Medical Knowledge</strong></td>
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<tr>
<td>Residents must</td>
<td>Residents will demonstrate an investigatory and analytic</td>
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<tr>
<td>demonstrate knowledge</td>
<td>residents will know and apply the basic and clinically</td>
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<tr>
<td>about established and</td>
<td>supportive sciences which are appropriate to their discipline</td>
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<tr>
<td>evolving biomedical,</td>
<td>residents will learn to generate a differential diagnosis and</td>
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<tr>
<td>clinical, and cognate</td>
<td>unique treatment plan for each patient encounter</td>
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<td>(e.g. epidemiological</td>
<td>residents will learn to effectively communicate their</td>
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<tr>
<td>and social-behavioral)</td>
<td>investigatory and analytic thinking approach via written</td>
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<tr>
<td>sciences and the</td>
<td>notes and presentations to supervisors and other health care</td>
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<tr>
<td>application of this</td>
<td>professionals</td>
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<tr>
<td>knowledge to patient care.</td>
<td>residents will keep abreast of new scientific knowledge,</td>
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<td></td>
<td>which is obtained via didactic sessions, Grand Rounds,</td>
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<td></td>
<td>critical review of scientific literature, computer and web-</td>
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| Evaluation Method         | Feedback of both oral and written presentations will be provided by attending |
|---------------------------| Presentation skills, management decisions and knowledge are evaluated on rounds |
### 3. Interpersonal and Communication Skills

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
</table>
| 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. | - Residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information  
- Residents will make every effort to safeguard patient/family dignity.  
- Residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries.  
- Residents will create and sustain a therapeutic and ethically sound relationship with patients  
- Residents will use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills  
- Residents will work effectively with others as a member or leader of a health care team or other professional group  
- Residents will ask patient’s/family’s concerns and questions and address these specifically and directly to ensure that patient/family have received information in the desired degree of detail  
- Residents will negotiate priorities for problems to be addressed in the particular visit, once all issues have been identified.  
- Residents will write clearly and legibly when hand-writing instructions or other information for patients/families  
- Residents written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable | - Attendings rate the residents based on bedside interactions  
- Feedback from nursing staff, other disciplines |

### 4. Professionalism

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
</table>
| Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population | - Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary  
- Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest.  
- Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations  
- Residents will demonstrate understanding of and sensitivity | - Attendings evaluate the professionalism on rounds and, bedside interactions |
to end of life care and issues regarding provision of care
- Residents will know and avoid breach of the boundaries of the physician/patient relationship
- Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard
- Residents will make every effort to elicit and to accommodate, to the fullest extent of their ability, differing religious and cultural needs and values in delivering medical care— but are under no obligation to accommodate requests based upon any form of identity-group prejudice
- Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice
- Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family

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<tr>
<th>5. Practice-Based Learning and Improvement</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
</table>
| Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. | At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice  
- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses  
- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems  
- The resident should maintain an awareness of medical and psychiatric information that directly impacts on the patients they evaluate on the consultation service, for example through directives and publications from their local department of health, or national physician’s organizations.  
- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed  
- The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist  
- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients  
- The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is | Day to day knowledge base evaluated by feedback on differential diagnoses, management plans during  
- Attending rounds  
- Seminars |
expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors
- The resident is expected to facilitate the learning of students and other health care professionals

<table>
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<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
</table>
|  ➤ Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. | - The resident will learn how to work the Department of Elderly Affairs
- The resident will learn to identify which is the optimal setting to provide cost-effective and quality patient care for a variety of patient problems
- The resident will practice cost-effective health care and resource allocation that does not compromise quality of care
- The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies etc. via spoken and written communications when it effects the health of their patients
- The resident will learn about the various community resources available for patients and will work with case managers and social workers to enable patients to access these resources. | o Evaluations from attending
o Interactions with other agencies |

**XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION**

Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, hospitalized patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Memory clinic rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experiences during which residents gain knowledge, skills and practice in the care and evaluation of patients with dementia or memory complaints in an outpatient setting. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

**Description of Rotation**

This rotation is a one half day per week at Rhode Island Hospital memory disorder program for four months or alternatively at Butler Hospital one day per month for the entire year. It allows residents to develop important diagnostic, treatment, and other skills in the management of memory disordered patients in an outpatient setting. Residents evaluate and treat outpatients and have specific supervision with a neurologist who specializes in memory disorders. Residents learn how to conduct a thorough cognitive assessment, as well as will learn about psychopharmacological treatments that are currently under investigation.

Rhode Island Hospital

### I. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Memory Disorder Clinic</th>
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</table>
| Chiefs of Service         | Brian Ott, MD (Rhode Island Hospital)  
                           | Stephen Salloway, MD, MS (Butler Hospital) |
| Contact Information       | Brian Ott, MD (Rhode Island Hospital)  
                           | Stephen Salloway, MD, MS (Butler Hospital) |
| Residency Coordinator     | Ema Costa: 455-6421    |

### II. FACULTY

Brian Ott, MD; Henry Querfurth, MD, PhD; Stephen Salloway, MD, MS; G. Mustafa Surti, MD

### III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

**Topics to be covered are based upon:**
- The patients assessed and treated by the residents over the course of the rotation

**Principal teaching methods:**
- Attending supervision
- Multidisciplinary team meetings
- Weekly morning seminars

**Educational materials provided/referred to residents:**
- **Reading:** Each attending and resident is expected to utilize current psychiatric literature regarding assessment and treatment of psychiatric patients.
- **Computer-assisted educational materials:** All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located at the outpatient reception area.
- **Other:** Residents are given articles as part of their weekly morning seminar series and by faculty on service.

### IV. SPECIFIC AREAS & EXPECTATIONS

**Residents are expected to regularly review relevant:**
- Neuroimaging studies
- Laboratory testing results
- Neuropsychological testing results
- Interagency from nursing homes and reports from primary care physicians

On this rotation, residents act as the outpatient psychiatrist and/or the neurologist to patients who present with a memory disorder. An initial evaluation will be performed on every new patient. Follow-up visits will be conducted based on the patient’s clinical needs.
Residents will provide patients with pharmacological management and assist families in behavioral management. Among the residents' responsibilities is the application of cost-effective care measures and principles to the actual care of the patients on the service. Residents are expected to communicate as needed with primary care physicians and long-term care institutions.

V. EVALUATIONS
- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION
- The chief of service will oversee the educational experience for the residents.
- The attending will oversee the care of the patients in the resident’s caseload assigned to that particular supervisor.
- The attending will provide supervision after the fellow has completed their assessment and evaluation of the patient.
- The attending will examine the patients to confirm the resident’s findings to guide in establishing the treatment plan.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION
- Resident is responsible for evaluation, treatment, and disposition of psychiatric outpatients.
- Resident is responsible for conducting a complete neurological evaluation and a thorough cognitive assessment.
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Resident is responsible for family and patient communication.
- Resident is responsible for discussing the case with his or her supervisor, other health care professionals involved with the patient and the patient’s family, as dictated by the circumstances.
- Resident is responsible for written or dictated evaluations of all patients assessed and followed.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending at the end of each two months.
- Resident must inform their patients how they can be reached in the event of an emergency

VIII. SCHEDULE DURING THIS ROTATION
- Clinic Hours: 8:00 – 12:00 pm, Tuesday (Rhode Island Hospital); 1 pm – 4:00 pm (Butler Hospital)
- Grand Rounds: 1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus
- Other Conferences: 12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital
- Weekly Seminars: Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center
- Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital

IX. GENERAL EDUCATIONAL OBJECTIVES
Objectives - By the end of this rotation, the resident will be able to:
- Assess memory clinic patients and implement treatment for individuals with dementia and their comorbid behavioral disturbance
- Develop important diagnostic and treatment skills in an outpatient setting
- Develop skills in conducting a thorough cognitive assessment
- Function independently in an outpatient setting with supervision
- Have both a theoretical and practical understanding of psychopharmacology of dementia
- Have both a theoretical and practical understanding of treatments that are being researched for management of dementia
- Recommend laboratory/imaging tests
- Prepare and present case presentations
- Understand when to obtain and how to interpret neuropsychological testing
- Develop an appreciation for cost-efficient care, and proper utilization of resources
- Work in a coordinated fashion with other treatment providers
- Recognize when patients need a higher level of treatment (e.g., inpatient hospitalization, partial hospitalization, day care, assisted living, nursing home, visiting nurse services)
- Recognize and treat chronic and recent onset primary and secondary psychiatric illness in the context of multiple co-morbid conditions, which frequently characterize the late life adult
- Understand the various factors, which influence the use of psychopharmacologic agents in those with dementia and the role of drug interactions
- Distinguish between normative and pathological neurologic changes in the ageing process
- Distinguish between normative and pathological cognitive changes in the ageing process
- Sensitive to the normative stresses of caregivers of patients with dementia

### X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

<table>
<thead>
<tr>
<th>Competency/Description</th>
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<tbody>
<tr>
<td>1. Patient Care</td>
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</table>
| Resident must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. | - Residents will prepare and present case presentations  
- Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families  
- Residents will learn to gather essential and accurate information about their patients  
- Residents will learn to make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment  
- Residents will learn to develop and carry outpatient management plan  
- Residents will learn to counsel and educate patients and their families  
- Residents will provide health care services aimed at preventing health problems or maintaining health  
- Residents will work with health care professionals, including those from other disciplines, to provide patient-focused care  
- Residents will use information technology to support patient care decisions | Residents are evaluated by their supervisors |
| 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. | - residents will demonstrate an investigatory and analytic thinking approach to clinical situations  
- residents will know and apply the basic and clinically supportive sciences which are appropriate to their discipline  
- residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter  
- residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes and presentations to supervisors and other health care professionals  
- residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, Grand Rounds, critical review of scientific literature, computer and web-based resources  
- residents will actively participate in seminars | Feedback of both oral and written presentations will be provided by attending |
| 3. 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. | - residents will create and sustain a therapeutic and ethically sound relationship with patients  
- residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information  
- residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries  
- residents will write clearly and legibly when hand-writing instructions or other information for patients/families | Residents are evaluated by their supervisors |
Residents written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable.

<table>
<thead>
<tr>
<th>4. Professionalism</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tbody>
<tr>
<td>Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</td>
<td>Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary</td>
<td>○ Attendings will evaluate residents  ○ Feedback from nursing staff, other disciplines</td>
</tr>
<tr>
<td></td>
<td>Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest</td>
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<tr>
<td></td>
<td>Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations.</td>
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<td></td>
<td>Residents will demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care</td>
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<td>residents will review their professional conduct and remediate when appropriate</td>
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<td>residents will make reasonable efforts to act as advocates for their patients.</td>
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<td>Residents will truthfully report medical errors of their own to their attending, or Risk Management and to follow hospital protocols in the face of errors. Residents will encourage and facilitate reporting of medical error on the part of professional colleagues</td>
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<td>Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard</td>
<td></td>
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<td></td>
<td>Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice</td>
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<td></td>
<td>Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family</td>
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<td></td>
<td>Residents will create and sustain a therapeutic and ethically sound relationship with patients</td>
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5. 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 practices.

- At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback for the year. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice.
- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses.
- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems.
- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed.
- The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist.
- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients.
- The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors.
- The resident will facilitate the learning of students and other health care professionals.

## 6. Systems-Based Practice

- Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals.

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<tr>
<th>Goals and Objectives</th>
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<tbody>
<tr>
<td>- The resident will learn to practice cost-effective health care and resource allocation that does not compromise quality of care</td>
<td>- Evaluations from supervisors</td>
</tr>
<tr>
<td>- The resident will learn how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance</td>
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<td>- The resident will learn how to work other health care providers to develop and coordinate a care plan for their patients</td>
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<tr>
<td>- The resident will be familiar with the presence and influences of alternative and complimentary therapies, and its use in their populations and patients</td>
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<tr>
<td>- The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions. They will learn the legal rights of the uninsured and will work with the appropriate services to assist patients who are under- or uninsured</td>
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<tr>
<td>- The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies etc. via spoken and written communications when it effects the health of their patients</td>
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<tr>
<td>- The resident will learn about the various community resources available for patients and will work with case</td>
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</tbody>
</table>
XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION
Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, clinic patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Geriatric Neuropathology

Overview of Rotation

Revised date 12/09/10

Geriatric neuropathology rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experiences during which residents learn about the gross and micropathological changes that occur with aging and age specific neurological illnesses including dementia. The rotation requires strong commitment to professionalism and self-guided learning under the supervision of a neuropathologist. The resident will participate in brain cutting and microscopic evaluation of pathological specimens. Self-guided learning is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

Description of Rotation

This rotation is a one-half day per week rotation for four months at Rhode Island Hospital. It allows residents a varied intensive exposure to a wide variety of acute neurological conditions. Geriatric psychiatry residents rotating on neuropathology are closely supervised by the chiefs of neuropathology. The resident will participate in brain cutting to learn neuroanatomy and neuropathology. In addition, they will be assigned pathological samples to review under the microscope to understand the changes that result from aging and specific disease processes. The resident should gain an understanding of the pathological changes found in different types of dementia.

Rhode Island Hospital

<table>
<thead>
<tr>
<th>I. GENERAL INFORMATION</th>
<th>Geriatric Neuropathology</th>
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<tbody>
<tr>
<td>Name of Rotation</td>
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</tr>
<tr>
<td>Chiefs of Service</td>
<td>Susan DeLaMonte (Rhode Island Hospital)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Susan DeLaMonte (Rhode Island Hospital)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

II. FACULTY

Susan DeLaMonte, MD; Edward Stopa, MD

III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

Topics to be covered are based upon:
- Pathological specimens over the course of the rotation
- Cases selected for presentation

Principal teaching methods:
- Attending supervision
- Brain Cutting
- Microscopic Review

Educational materials provided/referred to residents:
- Reading: Each attending and resident is expected to utilize current neuropathology literature regarding assessment age related disorders.
- Computer-assisted educational materials: All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located on each floor of the hospital.
- Other: Residents are given articles as part of their weekly morning seminar series and by faculty on service.

IV. SPECIFIC AREAS & EXPECTATIONS

Residents are expected to regularly review relevant:
- Pathological specimens
- Laboratory testing results
- Clinical history

On this rotation, residents are expected to actively participate in assessment of pathological specimens of the brain. Residents are expected to communicate as needed with the primary attending physician.
V. EVALUATIONS

- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the attendings or chief residents successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION

- The attending will supervise the evaluation of pathology specimens but allow for autonomy.
- The attending will be available for or be present at all activities where their involvement is needed.
- The attending will conduct brain cutting as the clinical rounds.
- The attending will review all neuropathological studies with the residents.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION

- Resident performs requested evaluation of pathology specimens.
- Resident will discuss the diagnostic and pathological findings with the attending.
- Resident is responsible for collecting all relevant information on specimens, including reviewing old medical records.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending and rotation at the end of each two months.

VIII. SCHEDULE DURING THIS ROTATION

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time/Location</th>
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<tbody>
<tr>
<td>Attending Rounds</td>
<td>8:00 am – 12:00 pm, Friday</td>
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<tr>
<td>Grand Rounds</td>
<td>1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus</td>
</tr>
</tbody>
</table>
| Other Conferences      | 12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital  
3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital  
1st and 3rd Thursday from 12:00 pm to 1:00 pm, Geriatric Psychiatry Conference, Butler Hospital |
| Weekly Seminars        | Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center  
Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital |

IX. GENERAL EDUCATIONAL OBJECTIVES

- Obtain an understanding of both gross and microscopic pathological changes that occur with age
- Obtain an understanding of the neuropathological changes found in differing types of dementia
- Prepare and present case presentations
- Work in a coordinated fashion with neuropathology

X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

<table>
<thead>
<tr>
<th>Competency/Description</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
</table>
| 1. Patient Care        | - Residents must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.  
- Residents will learn to gather essential and accurate information about their patient’s specimens  
- residents will make informed decisions about diagnosis based on pathological information  
- residents will work with health care professionals, including those from other disciplines | o Residents are evaluated by their supervisors |
| 2. Medical Knowledge   | - residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate  
- residents will learn to generate a differential diagnosis  
- residents will learn to effectively communicate their investigatory and analytic thinking approach on rounds and didactic teaching sessions  
- residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, Grand Rounds, | - Feedback of both oral and written presentations will be provided by supervisors |
(e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tbody>
<tr>
<td>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.</td>
<td>Residents are evaluated by their supervisors</td>
</tr>
</tbody>
</table>

3. **Interpersonal and Communication Skills**

- Residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information
- Residents will make every effort to safeguard patient/family dignity.
- Residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries.
- Residents will create and sustain a therapeutic and ethically sound relationship with patients
- Residents will use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Residents will work effectively with others as a member or leader of a health care team or other professional group
- Residents will negotiate priorities for problems to be addressed in the particular visit, once all issues have been identified.
- Residents will write clearly and legibly when hand-writing instructions or other information for patients/families
- Residents written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable

4. **Professionalism**

- Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest.
- Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations
- Residents will know and avoid breach of the boundaries of the physician/patient relationship
- Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard
- Residents will make every effort to elicit and to accommodate, to the fullest extent of their ability, differing religious and cultural needs and values in delivering medical care— but are under no obligation to accommodate requests

- Attendings will evaluate residents
Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice.

Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery.

5. Practice-Based Learning and Improvement

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tbody>
<tr>
<td>Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.</td>
<td>At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice. The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses. The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems. The resident should maintain an awareness of medical and psychiatric information that directly impacts on the patients they evaluate on the consultation service, for example through directives and publications from their local department of health, or national physician’s organizations. The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed. The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist. The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients. The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors. The resident is expected to facilitate the learning of students and other health care professionals.</td>
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6. Systems-Based Practice

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tbody>
<tr>
<td>Residents must demonstrate an awareness of and responsiveness to a larger context and system of health care</td>
<td>The resident will become familiar with hospital and community based health care professionals and their roles. The resident will practice cost-effective health care and resource allocation that does not compromise quality of care. The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions.</td>
</tr>
</tbody>
</table>
and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals.

- The resident will learn how to interact and advocate effectively with other physicians.

### XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION

Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, clinic patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Geriatric Psychiatry Fellowship Training Program
Brown University Department of Psychiatry and Human Behavior

Geriatric neuropsychiatry rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experiences during which residents learn to perform competent neurological evaluations and treatment of neurological illnesses on elderly patients with behavioral disorders and individuals with dementia. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

### Description of Rotation

This rotation is a one-half day per week rotation for four months at Butler Hospital or alternatively can be done over the course of month on a 4 day a week schedule. It allows residents a varied intensive exposure to a wide variety of acute and chronic neurological conditions and their relationship to their behavioral presentations. Geriatric psychiatry residents rotating on neuropsychiatry are closely supervised by a behavioral neurologist. The resident will be assigned the elderly patients referred to the neuropsychiatry consultation service, which they will take primary responsibility in the assessment. In addition, the resident will participate with the consultation service in rounds on all the neuropsychiatry patients seen, as well as those presenting to the neurologist’s clinic.

### I. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Geriatric Neuropsychiatry</th>
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<tbody>
<tr>
<td>Chiefs of Service</td>
<td>Kenneth Rickler, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Kenneth Rickler, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

### II. FACULTY

Victoria Chang, MD; Kenneth Rickler MD; Stephen Salloway, MD; Susan Weinman, MD

### III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

**Topics to be covered are based upon:**
- The patients assessed and treated by the residents over the course of the rotation
- Cases selected for presentation

**Principal teaching methods:**
- Attending supervision
- Weekly morning seminars

**Educational materials provided/referred to residents:**
- **Reading:** Each attending and resident is expected to utilize current neurological and neuropsychiatric literature regarding assessment and treatment of psychiatric patients with neuropsychiatric problems.
- **Computer-assisted educational materials:** All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located on each floor of the hospital.
- **Other:** Residents are given articles as part of their weekly morning seminar series and by faculty on service.

### IV. SPECIFIC AREAS & EXPECTATIONS

Residents are expected to regularly review relevant:
- Neuroimaging studies
- Laboratory testing results
- Neuropsychological testing results

On this rotation, residents act as consultants to psychiatrists dealing with acutely mentally ill individuals. In addition to providing diagnostic evaluations, residents will provide recommendations regarding neurological management. Among the residents' responsibilities is the application of cost-effective care measures and principles to the actual care of the patients on the service. Residents are expected to communicate as needed with attending psychiatrist.
V. EVALUATIONS
- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION
- The attending neurologist will see all patients and will supervise the care of the patient by the residents, offering guidance but allow for autonomy.
- The attending will be available for or be present at all activities where their involvement is needed.
- The attending will conduct attending rounds daily.
- Each attending rounds includes interaction with the patient under discussion as part of the educational session and discussion of the patient from a diagnostic and therapeutic perspective.
- The attending will review all neurological imaging studies with the residents.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will at some time observe each resident in interactions with patients and families, in the performance of aspects of history taking and physical examination, and will review residents’ consults in order to be able to evaluate the residents’ clinical and communication skills.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION
- Resident performs requested neurological consultations assigned to him/her by the consultation service.
- Resident will discuss the diagnostic and management strategy with the attending or chief resident on all consultations.
- Resident is responsible for follow up assessments of patients on the consultation service, examining and monitoring the progress of those patients, noting all laboratory and other data in a timely manner, discussing the management plans with the team, and writing progress notes as necessary.
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Resident is responsible for working collaboratively with primary service working with the patient.
- Resident is responsible for family and patient communication as needed and may serve as liaison between the service who requested the consultation and the patient/family on an as needed basis.
- Resident should become proficient in the use of the Electronic Medical Record
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending and rotation at the end of each two months.

VIII. SCHEDULE DURING THIS ROTATION
| Clinic Hours         | 8 am – 12 pm Monday, Tuesday and 1:00 pm – 4:00 pm Wednesday, Friday |
| Grand Rounds        | 1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus |
| Other Conferences   | 12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital |
| 3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital |
| Weekly Seminars     | Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center |
|                      | Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital |

IX. GENERAL EDUCATIONAL OBJECTIVES
Objectives - By the end of this rotation, the resident will be able to:
- Obtain an orderly and detailed neurologic history, conducting a thorough general and neurological examination, and organizing and recording data
- Obtain an understanding of the pathophysiology of cerebrovascular disease, its acute management and management of sequelae including aphasia, and diagnostic evaluation and stroke prevention in geriatric patients
- Develop the skill set needed to evaluate and manage patients with acute and chronic neuromuscular disorders and other neurologic disorders including but not limited to seizures, Parkinson’s disease and related disorders, tardive dyskinesia and related disorders, cerebral neoplasms, elevated intracranial pressure, multiple sclerosis and CNS infections
- Be familiar with the indications for and limitations of clinical neurodiagnostic tests and their interpretation as well as to correlate the information derived from these neurodiagnostic studies with the clinical history and examination in formulating a differential diagnosis and management plan
- Obtain an understanding of the relationship between the neurological problems and the psychiatric or behavioral manifestations
- Prepare and present case presentations
- Work in a coordinated fashion with a multi-disciplinary team
- Interpret brain CTs and MRIs
- Develop an appreciation for cost-efficient care, proper utilization of resources, the importance of after-hospital care planning, and patient autonomy

X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

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<tr>
<th>Competency/Description</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
<tbody>
<tr>
<td>1. Patient Care</td>
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<tr>
<td>- Resident must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</td>
<td>Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families. - Residents will learn to gather essential and accurate information about their patients - residents will make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment - residents will learn to counsel and educate patients and their families - residents will work with health care professionals, including those from other disciplines, to provide patient-focused care</td>
<td>o Residents are evaluated by their supervisors</td>
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<tr>
<td>2. Medical Knowledge</td>
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<tr>
<td>- 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.</td>
<td>residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter - residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes, on rounds and didactic teaching sessions - residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, grand rounds, critical review of scientific literature, computer and web-based resources - resident will actively participate in seminars and on rounds - residents will understand and apply basic principles of physiology and pathophysiology to specific commonly encountered conditions on the consultation service - residents will demonstrate an investigatory and analytic thinking approach to clinical situation</td>
<td>- Feedback of both oral and written presentations will be provided by supervisors</td>
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<tr>
<td>3. Interpersonal and Communication Skills</td>
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<tr>
<td>- 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.</td>
<td>residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information - residents will make every effort to safeguard patient/family dignity. - residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries. - residents will create and sustain a therapeutic and ethically sound relationship with patients - residents will use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills - residents will work effectively with others as a member or leader of a health care team or other professional group - residents will negotiate priorities for problems to be addressed in the particular visit, once all issues have been identified. - residents will write clearly and legibly when hand-writing</td>
<td>o Residents are evaluated by their supervisors</td>
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</table>
4. Professionalism

- Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

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<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</table>
| Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary. | o Attendings will evaluate residents  
| | o Feedback from nursing staff, other disciplines |
| Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest. | |
| Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations | |
| residents will demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care | |
| residents will know and avoid breach of the boundaries of the physician/patient relationship | |
| residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard | |
| residents will make every effort to elicit and to accommodate, to the fullest extent of their ability, differing religious and cultural needs and values in delivering medical care– but are under no obligation to accommodate requests based upon any form of identity-group prejudice | |
| residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice | |
| residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family | |

5. Practice-Based Learning and Improvement

<table>
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<tr>
<th>Goals and Objectives</th>
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</table>
Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

- At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice.
  - The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses.
  - The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems.
  - The resident should maintain an awareness of medical and psychiatric information that directly impacts on the patients they evaluate on the consultation service, for example through directives and publications from their local department of health, or national physician’s organizations.
  - The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed.
  - The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist.
  - The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients.
  - The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors.
  - The resident is expected to facilitate the learning of students and other health care professionals.

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<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tbody>
<tr>
<td>Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals.</td>
<td>- The resident will learn how to work within a multidisciplinary team to develop a care plan for the patients they evaluate on the consultation service. - The resident will become familiar with hospital and community based health care professionals and their roles in groups such as social work, mental health professionals, PT, OT, dietitians, and VNA etc. - The resident will learn to identify which is the optimal setting to provide cost-effective and quality patient care for a variety of patient problems. - The resident will practice cost-effective health care and resource allocation that does not compromise quality of care. - The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions. - The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies etc. via spoken and written communications when it effects the health of their patients. - The resident will learn about the various community resources available for patients and will work with case managers and social workers to enable patients to access</td>
<td>Evaluations from supervisors</td>
</tr>
</tbody>
</table>

- Day to day knowledge base evaluated by feedback on diagnoses, and neurological treatment approaches.
XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION

Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, clinic patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Geriatric Neuroradiology
Overview of Rotation
Revised date 12/09/10

Geriatric neuroradiology rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents learn to interpret MRI and CT scans of the brain. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf of their patients, as well as their own education.

Description of Rotation
This rotation is a one-half day per week rotation for four months at Rhode Island Hospital. It allows residents an intensive exposure to reading brain-imaging studies. Geriatric psychiatry residents rotating on the neuroimaging rotation are closely supervised by a neuroradiologist. The resident will review with the attending and radiology residents MRI, CT scans, PET, and SPECT scans of the brain. To further enhance the resident’s knowledge of neuroanatomy and neuropathology the resident will also review the CD-rom library available to the neuroimaging service.

Rhode Island Hospital

I. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Geriatric Neuroradiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiefs of Service</td>
<td>Jeffrey Rogg, MD (Rhode Island Hospital)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Jeffrey Rogg, MD (Rhode Island Hospital)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

II. FACULTY

Jeffrey Rogg, MD

III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

Topics to be covered are based upon:
- The MRI, CT scans, PET scans, and SPECT scans presented during neuroimaging rounds
- Review of neuroimaging and neuropathology available in the CD rom library

Principal teaching methods:
- Attending supervision
- Weekly morning seminars
- Neuroradiology grand rounds

Educational materials provided/referred to residents:
- **Reading:** Each attending and resident is expected to utilize current literature regarding assessment and diagnosis of neuropathological lesions.
- **Computer-assisted educational materials:** All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located on each floor of the hospital.
- **Other:** Residents are given articles as part of their weekly morning seminar series and by faculty on service.

IV. SPECIFIC AREAS & EXPECTATIONS

Residents are expected to regularly review relevant:
- Neuroimaging studies

On this rotation, residents work along side a neuroradiologist or resident in radiology to learn to read neuroimaging studies. The residents will review the CD-roms in the neuroimaging library.

V. EVALUATIONS

- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.
VI. RESPONSIBILITIES OF ATTENDING ON ROTATION

- The attending or the radiology resident will be responsible for the formal reading of all neuroimaging studies.
- The attending will be available for or be present at all activities where their involvement is needed.
- Each attending rounds includes review of the neuroimaging study under discussion as part of the educational session and discussion of the patient from a diagnostic perspective.
- The attending will review all neurological imaging studies with the residents.
- The attending will at some time observe each resident reading a CT scan and MRI or the brain.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION

- Resident will review all available MRI, CT scans, PET, and SPECT scans of the brain.
- Resident will discuss the diagnostic interpretation with the attending or radiology resident on all films reviewed.
- Resident is responsible to review the neuroimaging studies in the CD-rom library.
- Resident will submit an online evaluation of the attending and rotation upon completion of each two months.

VIII. SCHEDULE DURING THIS ROTATION

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time and Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Rounds</td>
<td>10:00 pm – 12:00 pm, Monday</td>
</tr>
<tr>
<td>Grand Rounds</td>
<td>1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus</td>
</tr>
<tr>
<td>Other Conferences</td>
<td>1st, 3rd, 4th, Wednesday of each month 8:00 am Neurology Grand Rounds; 1st, 5th Wednesday of each month 8:00 am Neuropathology Grand Rounds; 9:40 am Wednesday of each month Neuroradiology Grand Rounds, Rhode Island Hospital Main Auditorium</td>
</tr>
<tr>
<td>12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital</td>
<td></td>
</tr>
<tr>
<td>3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital</td>
<td></td>
</tr>
<tr>
<td>1st and 3rd Thursday from 12:00 pm to 1:00 pm, Geriatric Psychiatry Conference, Butler Hospital</td>
<td></td>
</tr>
<tr>
<td>Weekly Seminars</td>
<td>Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center</td>
</tr>
<tr>
<td></td>
<td>Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital</td>
</tr>
</tbody>
</table>

IX. GENERAL EDUCATIONAL OBJECTIVES

Objectives - By the end of this rotation, the resident will be able to:

- Obtain an understanding of basic neuroanatomy
- Obtain an understanding of non-pathological changes in the brain associated with age
- Obtain an understanding of how vascular disease presents on neuroimaging studies
- Obtain an understanding of how Alzheimer’s disease presents on neuroimaging studies
- Obtain an understanding on which neuroimaging study is most appropriate for given clinical conditions
- Be familiar with the indications for and limitations of neuroimaging studies
- Prepare and present case presentations
- Work in a coordinated fashion with a multi-disciplinary team
- Develop an appreciation for cost-efficient care and proper utilization of resources

X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

<table>
<thead>
<tr>
<th>Competency/Description</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Care</td>
<td>- Residents will learn to gather essential and accurate information about their patients by examining their neuroimaging</td>
<td>○ Residents are evaluated by their supervisors</td>
</tr>
<tr>
<td></td>
<td>- Residents will make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment</td>
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<tr>
<td></td>
<td>- Residents will work with health care professionals, including those from other disciplines, to provide patient-focused care</td>
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</tr>
<tr>
<td>2. Medical Knowledge</td>
<td>- Residents will keep abreast of new scientific knowledge,</td>
<td>- Feedback of</td>
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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.

<table>
<thead>
<tr>
<th>3. Interpersonal and Communication Skills</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
</table>
| ➢ 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. | - Residents will scrupulously maintain patient confidentiality  
- Residents will make every effort to safeguard patient/family dignity.  
- Residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries.  
- Residents will use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills  
- Residents will work effectively with others as a member or leader of a health care team or other professional group | o Residents are evaluated by their supervisors |

<table>
<thead>
<tr>
<th>4. Professionalism</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
</table>
| ➢ Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population | - Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest.  
- Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations  
- Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard  
- Residents will make every effort to elicit and to accommodate, to the fullest extent of their ability, differing religious and cultural needs and values in delivering medical care– but are under no obligation to accommodate requests based upon any form of identity-group prejudice  
- Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice | o Attendings will evaluate residents |

<table>
<thead>
<tr>
<th>5. Practice-Based Learning and Improvement</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Residents must be able to investigate and evaluate their patient care practices,</td>
<td>- At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback. The resident is expected to regularly review both textbook and primary</td>
<td>o Day to day knowledge base evaluated by feedback on diagnoses</td>
</tr>
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</table>
appraise and assimilate scientific evidence, and improve their patient care practices.

source literature to maintain up to date understanding of specific topics that have arisen in practice
- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses
- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems
- The resident should maintain an awareness of medical and psychiatric information that directly impacts on the patients they evaluate on the consultation service, for example through directives and publications from their local department of health, or national physician’s organizations.
- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed
- The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist
- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients
- The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors
- The resident is expected to facilitate the learning of students and other health care professionals

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<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
</table>
| Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals. | - The resident will learn to identify which is the optimal setting to provide cost-effective and quality patient care for a variety of patient problems  
- The resident will practice cost-effective health care and resource allocation that does not compromise quality of care | o Evaluations from supervisors |

XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION
Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, clinic patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Geriatric Psychiatry Fellowship Training Program  
Brown University Department of Psychiatry and Human Behavior

Geriatric Substance Abuse  
Overview of Rotation  
Revised date 12/10/10

Geriatric substance abuse psychiatry rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experiences during which residents gain knowledge, skills and practice in the care of geriatric psychiatric patients with alcohol and drug problems in an outpatient and inpatient setting. In addition, the resident will participate in an alcohol recovery group geared toward elderly patients. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

Description of Rotation
This rotation is a three one half day per week rotation for one month in the Butler Hospital addictions inpatient unit, followed by one month in the addictions day hospital program at Butler Hospital. In addition, the resident will participate in the geriatric addictions recovery group meeting for one month. This experience allows residents to develop important diagnostic, treatment, and other skills in the management of the elderly with substance use issues in the inpatient, partial hospital and group setting. The resident will learn how to safely detoxify patients who are in acute withdrawal, learn the steps involved in recovery, and the difficulties in maintaining abstinence, as well as the specific issues involving older patients. It allows residents to work more independently and to assume increasing responsibility for a varied patient caseload of elderly patients. Residents evaluate and treat geriatric inpatients and outpatients and have specific supervision with a substance abuse supervisor who has subspecialty boards in this area.

Butler Hospital

<table>
<thead>
<tr>
<th>I. GENERAL INFORMATION</th>
<th>Geriatric Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Rotation</td>
<td>Geriatric Substance Abuse</td>
</tr>
<tr>
<td>Chiefs of Service</td>
<td>Michael Fiori, MD; Alan Gordon, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Alan Gordon, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. FACULTY</th>
<th>Michael Fiori, MD; Alan Gordon, MD</th>
</tr>
</thead>
</table>

| III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION | |
| Topics to be covered are based upon: |
| ➢ The patients assessed and treated by the residents over the course of the rotation |
| Principal teaching methods: |
| ➢ Attending supervision |
| ➢ Weekly morning seminars |
| Educational materials provided/referred to residents: |
| ➢ Reading: Each attending and resident is expected to utilize current psychiatric literature regarding assessment and treatment of psychiatric patients. |
| ➢ Computer-assisted educational materials: All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located in the inpatient and day hospital area. |
| ➢ Other: Residents are given articles as part of their weekly morning seminar series and by faculty on service. |

| IV. SPECIFIC AREAS & EXPECTATIONS | |
| Residents are expected to regularly review relevant: |
| ➢ Laboratory testing results |
| ➢ Neuropsychological testing results |
| ➢ Reports from primary care physicians |

On this rotation, residents act as the psychiatrist to patients over the age of 65 who have a substance misuse diagnoses. An initial evaluation will be preformed on every new patient or those transferred from another level of care. Follow-up visits will be conducted
based on the patient’s clinical needs. Residents will be available to respond to emergency telephone calls from the nursing staff. Residents will provide patients with pharmacological management, assist families in behavioral management, and utilize psychotherapeutic techniques. Residents will learn to use pharmacological agents specific to managing substance misuse disorders, as well as non-pharmacological treatments such as Alcoholic Anonymous. Among the residents' responsibilities is the application of cost-effective care measures and principles to the actual care of the patients on the service. Residents are expected to communicate as needed with primary care physicians, and to learn to utilize the Avitar electronic medical record.

V. EVALUATIONS
- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION
- The chief of service will oversee the educational experience for the residents.
- Attendings will oversee the care of the patients in the resident’s caseload assigned to that particular supervisor.
- Attendings will provide supervision after the fellow has completed their assessment and evaluation of the patient.
- Attendings will examine the patients to confirm the resident’s findings to guide in establishing the treatment plan.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will at some time observe each resident in interactions with patients and families, in the performance of aspects of history taking and physical examination, and will review residents’ progress notes in order to be able to evaluate the residents’ clinical and communication skills.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION
- Resident is responsible for evaluation, treatment, and disposition of psychiatric outpatients.
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Resident is responsible for family and patient communication.
- Resident is responsible for discussing the case with his or her supervisor, other health care professionals involved with the patient and the patient’s family, as dictated by the circumstances.
- Resident is responsible for written or dictated evaluations of all patients assessed and followed.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending and rotation upon completion of each two months.
- Resident is responsible to answer their beeper if a problem arises with a patient.

VIII. SCHEDULE DURING THIS ROTATION

<table>
<thead>
<tr>
<th>Event</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Rounds</td>
<td>8:00 pm – 12:00 pm</td>
<td>Monday, Tuesdays; 1:00-4:00 pm Thursday</td>
</tr>
<tr>
<td>Grand Rounds</td>
<td>1st Wednesday of each month, 11:00 am</td>
<td>Ray Hall, Butler Hospital Campus</td>
</tr>
<tr>
<td>Other Conferences</td>
<td>12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital</td>
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<td>Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital</td>
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</tbody>
</table>

IX. GENERAL EDUCATIONAL OBJECTIVES

Objectives - By the end of this rotation, the resident will be able to:
- Assess geriatric outpatients and implement outpatient treatment for individuals with substance abuse or dependence difficulties
- Develop important diagnostic and treatment skills in an outpatient setting
- Function independently in an outpatient setting with supervision
- Have both a theoretical and practical understanding of geriatric management pharmacological treatment of substance misuse
- Have both a theoretical and practical understanding of alternatives to pharmacological treatments as applied to the elderly
- Recommend laboratory tests
- Prepare and present case presentations
- Develop an appreciation for cost-efficient care, and proper utilization of resources
- Work in a coordinated fashion with other treatment providers
- Recognize when patients need a higher level of treatment (e.g., inpatient hospitalization, partial hospitalization, day care, assisted living, nursing home, visiting nurse services)
- Recognize and treat chronic and recent onset substance misuse illness in the context of multiple co-morbid conditions (both
psychiatric and medical), which frequently characterize the late life adult

- Understand the various factors, which influence the misuse of alcohol and drugs in the aged
- Distinguish between normative and pathological use of alcohol in the elderly
- Sensitive to the normative stresses of late life as they interact with the various personality styles in the aging person and the changes in techniques regarding managing substance misuse which are most helpful in working with older patients

## X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

<table>
<thead>
<tr>
<th>Competency/Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| - Resident must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. | - Residents will prepare and present case presentations  
- Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families  
- Residents will learn to gather essential and accurate information about their patients  
- Residents will learn to make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment  
- Residents will learn to develop and carry outpatient management plan  
- Residents will learn to counsel and educate patients and their families  
- Residents will provide health care services aimed at preventing health problems or maintaining health  
- Residents will work with health care professionals, including those from other disciplines, to provide patient-focused care  
- Residents will use information technology to support patient care decisions | ○ Residents are evaluated by their supervisors |
| 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. | - residents will demonstrate an investigatory and analytic thinking approach to clinical situations  
- residents will know and apply the basic and clinically supportive sciences which are appropriate to their discipline  
- residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter  
- residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes and presentations to supervisors and other health care professionals  
- residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, Grand Rounds, critical review of scientific literature, computer and web-based resources  
- residents will actively participate in seminars | ○ Feedback of both oral and written presentations will be provided by supervisors |
| 3. 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 | - residents will create and sustain a therapeutic and ethically sound relationship with patients  
- residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information  
- residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries  
- residents will write clearly and legibly when hand-writing | ○ Residents are evaluated by their supervisors |
4. Professionalism

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tbody>
<tr>
<td>Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</td>
<td>Attendings will evaluate residents</td>
</tr>
<tr>
<td>- Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary</td>
<td>○ Attendings will evaluate residents</td>
</tr>
<tr>
<td>- Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest</td>
<td>○ Attendings will evaluate residents</td>
</tr>
<tr>
<td>- Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations.</td>
<td>○ Attendings will evaluate residents</td>
</tr>
<tr>
<td>- Residents will demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care</td>
<td>○ Attendings will evaluate residents</td>
</tr>
<tr>
<td>- Residents will review their professional conduct and remediate when appropriate</td>
<td>○ Attendings will evaluate residents</td>
</tr>
<tr>
<td>- Residents will make reasonable efforts to act as advocates for their patients.</td>
<td>○ Attendings will evaluate residents</td>
</tr>
<tr>
<td>- Residents will truthfully report medical errors of their own to their attending, or Risk Management and to follow hospital protocols in the face of errors. Residents will encourage and facilitate reporting of medical error on the part of professional colleagues</td>
<td>○ Attendings will evaluate residents</td>
</tr>
<tr>
<td>- Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard</td>
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<tr>
<td>- Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice</td>
<td>○ Attendings will evaluate residents</td>
</tr>
<tr>
<td>- Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family</td>
<td>○ Attendings will evaluate residents</td>
</tr>
<tr>
<td>- Residents will create and sustain a therapeutic and ethically sound relationship with patients</td>
<td>○ Attendings will evaluate residents</td>
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### 5. Practice-Based Learning and Improvement

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
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</thead>
<tbody>
<tr>
<td>• Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.</td>
<td>○ Day to day knowledge base evaluated by feedback on diagnoses, and both psychopharmacologic and non-pharmacological treatment approaches</td>
</tr>
<tr>
<td>- At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback for the year. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice.</td>
<td></td>
</tr>
<tr>
<td>- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses.</td>
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<td>- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems.</td>
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<td>- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed.</td>
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<td>- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients</td>
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<tr>
<td>- The resident will facilitate the learning of students and other health care professionals</td>
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</table>

### 6. Systems-Based Practice

<table>
<thead>
<tr>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals.</td>
<td>○ Evaluations from supervisors</td>
</tr>
<tr>
<td>- The resident will learn to practice cost-effective health care and resource allocation that does not compromise quality of care</td>
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<tr>
<td>- The resident will learn how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance</td>
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<tr>
<td>- The resident will learn how to work other health care providers to develop and coordinate a care plan for their patients</td>
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<tr>
<td>- The resident will be familiar with the presence and influences of alternative and complimentary therapies, and its use in their populations and patients</td>
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<tr>
<td>- The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions. They will learn the legal rights of the uninsured and will work with the appropriate services to assist patients who are under- or uninsured</td>
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<tr>
<td>- The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies etc. via spoken and written communications when it effects the health of their patients</td>
<td></td>
</tr>
<tr>
<td>- The resident will learn about the various community</td>
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resources available for patients and will work with case managers and social workers to enable patients to access these resources

**XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION**

Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, clinic patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Palliative care rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents learn about the management of the death and dying patient in the hospice setting in long-term care, at home, and in inpatient hospice units. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf of their patients, as well as their own education.

**Description of Rotation**

Residents are provided with one half days per week of palliative care for five months through Home and Hospice Care of Rhode Island in conjunction with other palliative care experiences. On this rotation, residents will develop basic competence in the care of patients enrolled in a hospice program and develop enhanced skills in the symptom management. Residents will gain an appreciation for the psychological and psychiatric aspects of death and dying. Residents will learn about pain management of the death and dying patient. Residents evaluate and treat geriatric outpatients and have specific supervision with a geriatric medicine supervisor who specializes in palliative care.

Butler Hospital through Home and Hospice Care of Rhode Island

<table>
<thead>
<tr>
<th>I. GENERAL INFORMATION</th>
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<tbody>
<tr>
<td>Name of Rotation</td>
</tr>
<tr>
<td>Chiefs of Service</td>
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<tr>
<td>Contact Information</td>
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<tr>
<td>Residency Coordinator</td>
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<table>
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<tr>
<th>II. FACULTY</th>
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<tbody>
<tr>
<td>Edward Martin, MD; Theresa Rochon, RN; Joan Teno, MD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topics to be covered are based upon:</td>
</tr>
<tr>
<td>- The patients assessed by the residents and the hospice service over the course of the rotation</td>
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<tr>
<td>- The families assessed by the various support groups and programs of the hospice service</td>
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<tr>
<th>Principal teaching methods:</th>
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<tbody>
<tr>
<td>- Rounds with hospice staff</td>
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<tr>
<td>- Attending support group</td>
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<tr>
<td>- Weekly morning seminars</td>
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<tr>
<th>Educational materials provided/referred to residents:</th>
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<tbody>
<tr>
<td>- Reading: Each attending and resident is expected to utilize current medical literature in the planning of therapeutic and diagnostic interventions.</td>
</tr>
<tr>
<td>- Computer-assisted educational materials: All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located on all floors and in the residents’ offices.</td>
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<tr>
<td>- Other: Residents are given articles as part of their weekly morning seminar series and by faculty on service.</td>
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<tr>
<th>IV. SPECIFIC AREAS &amp; EXPECTATIONS</th>
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</thead>
<tbody>
<tr>
<td>Residents are expected to regularly review relevant:</td>
</tr>
<tr>
<td>- Referral information</td>
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<tr>
<td>- Laboratory testing results</td>
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</tbody>
</table>

Residents will round with the palliative care nurse on inpatient Hulitar hospice unit; on hospice patients in long-term care settings in nursing homes; and with hospice patients who are at home. The resident will also attend a bereavement support group, participate in the spiritual care team, and interact with the social worker. The resident will also provide an in-service on a geriatric psychiatry topic relevant to the hospice program.
V. EVALUATIONS
- Evaluation of the resident’s successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the resident’s successful completion of the goals listed below will be carried out by the hospice nurse.
- Evaluation of the attending’s successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION
- The attending will be available for or be present at all activities where their involvement is needed.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will complete an electronic evaluation for each resident at the end of each month.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION
- Resident is responsible for assessing assigned hospice patients.
- Be an active learner
- Complete assessments including history and physical exams of new patients or consults in a timely fashion. Review them with your preceptor.
- Conduct follow up visits, including speaking with staff, patients, and families.
- Function as a member of treatment team, recognizing the important contributions that each team member makes.
- Provide an in-service to the hospice staff regarding a relevant geriatric psychiatry issue
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending upon completion of each month.

VIII. SCHEDULE DURING THIS ROTATION
- Attending Rounds: 1:00 pm – 4:00 pm Wednesday; 1:00 pm – 4:00 pm Friday
- Grand Rounds: 1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus
- Weekly Seminars: Thursday from 8:00 am to 1:00 pm, Gerontology Center, Brown University Campus

IX. GENERAL EDUCATIONAL OBJECTIVES
Objectives - By the end of this rotation, the resident will be able to:
- Prognosticate and certify a patient for hospice
- Manage pain, dyspnea, anxiety, and other symptoms in a dying patient
- Recognize when the patient is actively dying and counsel the patient and/or family in a sensitive manner
- Educate patient and families on what to expect while dying and formulate care plans that respect patient informed preferences
- Understand the ethics of decision making regarding terminal sedation and of pain and suffering
- Work with multiple disciplines to develop a plan of care for the patient
- Understand and deploy effectively community resources available for dying persons and their families.
- Work in a coordinated fashion with other treatment providers
- Access appropriate community resources to meet all care needs at home or in the long-term care setting

X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

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<thead>
<tr>
<th>Competency/Description</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
<tbody>
<tr>
<td>1. Patient Care</td>
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</tbody>
</table>
| - Resident must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. | - Residents will prepare and present case presentations  
- Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families  
- Residents will learn to gather essential and accurate information about their patients  
- Residents will learn to make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment  
- Residents will learn to develop and carry outpatient management plan  
- Residents will learn to counsel and educate patients and their families | Residents are evaluated by their attending and hospice nurse |
Residents will provide health care services aimed at preventing health problems or maintaining health.
- Residents will work with health care professionals, including those from other disciplines, to provide patient-focused care.
- Residents will use information technology to support patient care decisions.

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.
- residents will demonstrate an investigatory and analytic thinking approach to clinical situations.
- Residents will know and apply the basic and clinically supportive sciences which are appropriate to their discipline.
- Residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter.
- Residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes and presentations to supervisors and other health care professionals.
- Residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, Grand Rounds, critical review of scientific literature, computer and web-based resources.
- Residents will actively participate in seminars.

Feedback of both oral and written presentations will be provided by attending and hospice nurse.

3. 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.
- residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information.
- residents will make every effort to safeguard patient/family dignity.
- residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries.
- residents will create and sustain a therapeutic and ethically sound relationship with patients.
- residents will use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills.
- residents will work effectively with others as a member or leader of a health care team or other professional group.
- residents will ask patient’s/family’s concerns and questions and address these specifically and directly to ensure that patient/family have received information in the desired degree of detail.
- residents will negotiate priorities for problems to be addressed in the particular visit, once all issues have been identified.
- residents will write clearly and legibly when hand-writing instructions or other information for patients/families.
- residents written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable.

Attendings and hospice nurse rate the residents based on bedside interactions.

4. Professionalism
- residents must demonstrate a commitment to
- residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent.

Attendings and hospice nurse evaluate the professionalism on rounds.
carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

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<tr>
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<td>Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations</td>
<td>- Day to day knowledge base evaluated by feedback on differential diagnoses, management plans during</td>
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<tr>
<td>Residents will demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care</td>
<td>- Attending and hospice nurse rounds</td>
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<tr>
<td>Residents will know and avoid breach of the boundaries of the physician/patient relationship</td>
<td>- Seminars</td>
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<tr>
<td>Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard</td>
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<tr>
<td>Residents will make every effort to elicit and to accommodate, to the fullest extent of their ability, differing religious and cultural needs and values in delivering medical care— but are under no obligation to accommodate requests based upon any form of identity-group prejudice</td>
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<tr>
<td>Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice</td>
<td></td>
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<tr>
<td>Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients— including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family</td>
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5. 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 practices.

- At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice
- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses
- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems
- The resident should maintain an awareness of medical and psychiatric information that directly impacts on the patients they evaluate on the consultation service, for example through directives and publications from their local department of health, or national physician’s organizations.
- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed
- The resident will have familiarity with a variety of computer and, bedside interactions
and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist
- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients
- The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors
- The resident is expected to facilitate the learning of students and other health care professionals

<table>
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<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tbody>
<tr>
<td>➢ Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.</td>
<td>- The resident will learn how to work within a multidisciplinary team to develop a care plan for the patients - The resident will learn to identify which is the optimal setting to provide cost-effective and quality patient care for a variety of patient problems - The resident will practice cost-effective health care and resource allocation that does not compromise quality of care - The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies etc. via spoken and written communications when it effects the health of their patients - The resident will learn about the various community resources available for patients and will work with case managers and social workers to enable patients to access these resources.</td>
<td>○ Evaluations from attending and hospice nurse</td>
</tr>
</tbody>
</table>

XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION
Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, hospitalized patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Movement disorder rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents learn to perform competent neurological evaluations and treatment of patients with movement disorders, and in particular Parkinson's disease. The resident will also learn about the longitudinal course of movement disorders, their psychiatric comorbidity, and relationship with dementia. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf of their patients, as well as their own education.

**Description of Rotation**

This rotation is a one-half day per week rotation for four months at Butler Hospital. It allows residents an intensive exposure to a wide variety of movement disorders and their relationship to their behavioral presentations, including dementia. Geriatric psychiatry residents rotating on the movement disorders program are closely supervised by a neurologist specializing in movement disorders. The resident will be assigned patients referred to the clinic, which they will take primary responsibility in the assessment. In addition, the resident will participate in reviewing other patients that may present to the movement disorder clinic.

Butler Hospital

**I. GENERAL INFORMATION**

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Movement Disorder</th>
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<tbody>
<tr>
<td>Chiefs of Service</td>
<td>Joseph Friedman, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Joseph Friedman, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

**II. FACULTY**

Joseph Friedman, MD

**III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION**

Topics to be covered are based upon:
- The patients assessed and treated by the residents over the course of the rotation
- Cases selected for presentation

Principal teaching methods:
- Attending supervision
- Weekly morning seminars

Educational materials provided/referred to residents:
- Reading: Each attending and resident is expected to utilize current neurological literature regarding assessment and treatment of patients with movement disorders.
- Computer-assisted educational materials: All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located on each floor of the hospital.
- Other: Residents are given articles as part of their weekly morning seminar series and by faculty on service.

**IV. SPECIFIC AREAS & EXPECTATIONS**

Residents are expected to regularly review relevant:
- Neuroimaging studies
- Laboratory testing results
- Neuropsychological testing results

On this rotation, residents act as participate in the care and treatment of patients with movement disorders. In addition to providing diagnostic evaluations, residents will provide recommendations regarding neurological management. Among the residents' responsibilities is the application of cost-effective care measures and principles to the actual care of the patients on the service. Residents are expected to communicate as needed with attending psychiatrist.
V. EVALUATIONS

➢ Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
➢ Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
➢ Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION

➢ The attending neurologist will see all patients and will supervise the care of the patient by the residents, offering guidance but allow for autonomy.
➢ The attending will be available for or be present at all activities where their involvement is needed.
➢ The attending will conduct attending rounds daily.
➢ Each attending rounds includes interaction with the patient under discussion as part of the educational session and discussion of the patient from a diagnostic and therapeutic perspective.
➢ The attending will review all neurological imaging studies with the residents.
➢ The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
➢ The attending will at some time observe each resident in interactions with patients and families, in the performance of aspects of history taking and physical examination, and will review residents’ consults in order to be able to evaluate the residents’ clinical and communication skills.
➢ The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION

➢ Resident performs requested neurological consultations assigned to him/her by the consultation service.
➢ Resident will discuss the diagnostic and management strategy with the attending or chief resident on all consultations.
➢ Resident is responsible for follow up assessments of patients on the consultation service, examining and monitoring the progress of those patients, noting all laboratory and other data in a timely manner, discussing the management plans with the team, and writing progress notes as necessary.
➢ Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
➢ Resident is responsible for working collaboratively with primary service working with the patient.
➢ Resident is responsible for family and patient communication as needed and may serve as liaison between the service who requested the consultation and the patient/family on an as needed basis.
➢ Resident must attend weekly educational experiences that are site and rotation-specific.
➢ Resident will submit an online evaluation of the attending and rotation at the end of each two months.

VIII. SCHEDULE DURING THIS ROTATION

| Clinic Hours | 1 pm – 4 pm Monday |
| Grand Rounds | 1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus |
| Other Conferences | 12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital |
| 3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital |
| 1st and 3rd Thursday from 12:00 pm to 1:00 pm, Geriatric Psychiatry Conference, Butler Hospital |
| Weekly Seminars | Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center |
| Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital |

IX. GENERAL EDUCATIONAL OBJECTIVES

Objectives - By the end of this rotation, the resident will be able to:

➢ Obtain an orderly and detailed neurologic history, conducting a thorough general and neurological examination, and organizing and recording data
➢ Obtain an understanding of the pathophysiology of specific movement disorders, its acute management and management of sequlae including psychiatric symptoms and dementia
➢ Develop the skill set needed to evaluate and manage patients with acute and chronic movement disorders and other neurologic disorders including but not limited to Parkinson’s disease and related disorders, tardive dyskinesia and related disorders
➢ Be familiar with the indications for and limitations of clinical neurodiagnostic tests and their interpretation as well as to correlate the information derived from these neurodiagnostic studies with the clinical history and examination in formulating a differential diagnosis and management plan
➢ Obtain an understanding of the relationship between the neurological problems and the psychiatric or behavioral manifestations
➢ Prepare and present case presentations
➢ Interpret brain CTs and MRIs Develop an appreciation for cost-efficient care, proper utilization of resources, the importance of after-hospital care planning, and patient autonomy
## X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

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<th>Competency/Description</th>
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<tbody>
<tr>
<td><strong>1. Patient Care</strong></td>
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</table>
| ✔️ Resident must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. | - Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.  
- Residents will learn to gather essential and accurate information about their patients  
- Residents will make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment  
- Residents will learn to counsel and educate patients and their families  
- Residents will work with health care professionals, including those from other disciplines, to provide patient-focused care | Residents are evaluated by their supervisors |
| **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. | - Residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter  
- Residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes, on rounds and didactic teaching sessions  
- Residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, Grand Rounds, critical review of scientific literature, computer and web-based resources  
- Resident will actively participate in seminars and on rounds  
- Residents will understand and apply basic principles of physiology and pathophysiology to specific commonly encountered conditions on the consultation service  
- Residents will demonstrate an investigatory and analytic thinking approach to clinical situation | Feedback of both oral and written presentations will be provided by supervisors |
| **3. 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. | - Residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information  
- Residents will make every effort to safeguard patient/family dignity.  
- Residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries.  
- Residents will create and sustain a therapeutic and ethically sound relationship with patients  
- Residents will use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills  
- Residents will work effectively with others as a member or leader of a health care team or other professional group  
- Residents will negotiate priorities for problems to be addressed in the particular visit, once all issues have been identified.  
-Residents will write clearly and legibly when hand-writing instructions or other information for patients/families  
- Residents written communications in patient charts will effectively permit subsequent caregivers to understand the | Residents are evaluated by their supervisors |
4. Professionalism

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| Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population | - Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary.  
- Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest.  
- Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations.  
- Residents will demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care.  
- Residents will know and avoid breach of the boundaries of the physician/patient relationship.  
- Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard.  
- Residents will make every effort to elicit and to accommodate, to the fullest extent of their ability, differing religious and cultural needs and values in delivering medical care– but are under no obligation to accommodate requests based upon any form of identity-group prejudice.  
- Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice.  
- Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family. | o Attendings will evaluate residents  
- Feedback from nursing staff, other disciplines. |

5. Practice-Based Learning and Improvement

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<tr>
<th>Goals and Objectives</th>
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<tbody>
<tr>
<td>Residents must be able to investigate and evaluate their knowledge</td>
<td>- At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback. The resident is</td>
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</table>
patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses
- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems
- The resident should maintain an awareness of medical and psychiatric information that directly impacts on the patients they evaluate on the consultation service, for example through directives and publications from their local department of health, or national physician’s organizations.
- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed
- The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist
- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients
- The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors
- The resident is expected to facilitate the learning of students and other health care professionals

<table>
<thead>
<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
</table>
| - The resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals. | - The resident will learn how to work within a multidisciplinary team to develop a care plan for the patients they evaluate on the consultation service
- The resident will become familiar with hospital and community based health care professionals and their roles in groups such as social work, mental health professionals, PT, OT, dietitians, and VNA etc.
- The resident will learn to identify which is the optimal setting to provide cost-effective and quality patient care for a variety of patient problems
- The resident will practice cost-effective health care and resource allocation that does not compromise quality of care
- The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions
- The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies etc. via spoken and written communications when it effects the health of their patients
- The resident will learn about the various community resources available for patients and will work with case managers and social workers to enable patients to access these resources. | ○ Evaluations from supervisors |
Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, clinic patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
The Neuromodulation rotation at Butler Hospital in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents learn about non-pharmacological somatic treatments including vagus nerve stimulation (VNS), transcranial magnetic stimulation (TMS), and electroconvulsive therapy (ECT). The resident may also learn about experimental treatments in ongoing clinical trials. The rotation requires, skills in the evaluation of patients with pharmacoresistant depression, and time and willingness to read about and become familiar with the use of FDA-approved device-based somatic therapies. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

Description of Rotation
This rotation is a one-half day daily for one month at Butler Hospital. The electroconvulsive component can be extended over several additional months. This rotation allows an intensive exposure to a variety of non-pharmacological somatic treatments, their indications, administration, contradictions and side effects. The use of these treatment modalities in geriatric patients will be of particular focus. The resident will conduct consultations on patients who may be candidates for neuromodulation treatment and participate in the administration of treatments themselves.

Butler Hospital

I. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Neuromodulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiefs of Service</td>
<td>Linda Carpenter, MD; Martin Furman, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Linda Carpenter, MD (Butler Hospital)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

II. FACULTY
Linda Carpenter, MD (TMS and VNS); Martin Furman, MD (ECT)

III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

Topics to be covered are based upon:
- Indications for use of Transcranial Magnetic Stimulation (TMS), Vagus Nerve Stimulation (VNS), and Electroconvulsive therapy (ECT) in treatment of depression
- Contraindications, warnings, side effect profiles, and clinical precautions for use of TMS, VNS, and ECT
- TMS: general familiarity with use of the FDA-approved device, it's use and critical steps for coil positioning, the determination of Motor Threshold and “dose” parameters
- TMS: Consultation Evaluation of patients with treatment resistant depression who are potential candidates for this treatment; administration of treatments under supervision
- VNS: general familiarity with use of the programming equipment, programming procedure, side effects management
- ECT: consultation evaluation of patients with treatment resistant depression who are potential candidates for this treatment
- ECT: general familiarity with use of the ECT device and other aspects of treatment, administration of treatments under supervision
- Review of relevant literature on each treatment, general knowledge of the published efficacy and safety data
- Interaction with patients and faculty over the course of the rotation
- Cases selected for presentation/review

Principal teaching methods:
- Attending faculty supervision
- Weekly morning seminars
- Review of literature
- Direct patient care

Educational materials provided/referred to residents:
- Past Training Experience: Each resident is expected to follow current medical standards and utilize skills from residency
training for assessment of patients. Residents are expected to be trained and comfortable with use of the electronic medical record (AVATAR) prior to start of the rotation.

- **Reading/Literature Review:** Residents will be expected to read and apply information provided about specific neuromodulation therapies, and to consult/search literature to address specific questions that arise during treatment of patients.
- **Computer-assisted educational materials:** All residents have access to full-text medical databases, search engines, and retrieval capacity through the university and hospitals’ computer networks and library resources.
- **Other:** Residents are given articles as part of their weekly morning seminar series and by faculty on the service.

### IV. SPECIFIC AREAS & EXPECTATIONS

Residents are expected to regularly review relevant:

- Results of Patients’ Neuroimaging, EEG studies, Laboratory, Neuropsychological testing, and Physical Examination data
- Medical records/reports from other consultants and clinicians (relevant to assessment and care of neuromodulation patients)
- Regulatory or governmental policies or developments impacting patient access to, or clinical application of the various neuromodulation therapies used for depression
- Professional Guidelines or Sources describing current standard of care with regard to neuromodulation therapies

On this rotation, residents will focus on treating patients with treatment resistant depression using neuromodulation therapy. The resident will do consultation evaluations of patients referred for neuromodulation treatments to determine appropriateness, and will have an opportunity to perform treatments under faculty supervision. Residents are expected to communicate as needed with attending psychiatrist/service chief.

### V. EVALUATIONS

- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the overall rotation will be completed by the resident.

### VI. RESPONSIBILITIES OF ATTENDING ON ROTATION

- The attending psychiatrist will see all patients and will supervise the care of the patient by the residents, and allowing autonomy as appropriate.
- The attending will be available for or be present at all activities where their involvement is needed.
- Attending rounds will include interactions with the patient under discussion as part of the educational session, as well as a discussion about the patient from a diagnostic and therapeutic perspective.
- The attending will review all pertinent clinical data with the residents.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will at some time observe each resident in interactions with patients, in the performance of aspects of history taking and physical examination, and will review residents’ consults in order to be able to evaluate the residents’ clinical and communication skills.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

### VII. RESPONSIBILITY OF RESIDENT ON ROTATION

- Resident performs requested patient evaluations assigned to him/her by the attending/faculty physician.
- Resident will discuss the diagnostic impressions and treatment recommendations made (following a new patient evaluation) with the attending/faculty physician.
- Resident is responsible for follow up assessments of patients on the service, examining and monitoring the progress of those patients, noting all laboratory and other data in a timely manner, discussing the progress and treatment plan updates with the team or service staff, and writing progress notes as necessary.
- Resident is responsible for collecting and review of all relevant information on the patient, including old medical records.
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Resident is responsible for working collaboratively with primary service working with the patient.
- Resident is responsible for family and patient communication as needed and may serve as liaison between the service who requested the consultation and the patient/family on an as needed basis.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending and rotation at the end of each two months.

### VIII. SCHEDULE DURING THIS ROTATION

| Clinic Hours       | ECT 6:45 am – 8 am Monday and Friday; TMS/VNS Clinic 8 am – 12 pm Mondays, Tuesdays & Fridays; 1 pm – 4 pm Wednesdays & Thursdays (and by appointment). |
**Grand Rounds**
1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus

**Other Conferences**
12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital
3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital
1st and 3rd Thursday from 12:00 pm to 1:00 pm, Geriatric Psychiatry Conference, Butler Hospital

**Weekly Seminars**
Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center
Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital

**IX. GENERAL EDUCATIONAL OBJECTIVES**

<table>
<thead>
<tr>
<th>Objectives</th>
<th>By the end of this rotation, the resident will be able to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>Obtain an orderly and detailed psychiatric and medical history (including details of past depression treatments, which are particularly relevant to the use of neuromodulation therapies), conduct a thorough general and neurological examination, and organize and report all data on consultation reports</td>
</tr>
<tr>
<td>-</td>
<td>Obtain a general understanding of the mechanisms of action of neuromodulation procedures (ECT, TMS, VNS).</td>
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<tr>
<td>-</td>
<td>Obtain an understanding of the risks, benefits, contraindications and side effects associated with specific neuromodulation procedures, and have sufficient understanding to conduct an informed consent procedure with a patient</td>
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<tr>
<td>-</td>
<td>Gain an understanding of the devices used and the administration of neuromodulation procedures; assist with giving treatments under supervision of attending/service chief physicians</td>
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<tr>
<td>-</td>
<td>Review the literature on treatment resistant depression in elderly patients and be able to summarize major themes</td>
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<tr>
<td>-</td>
<td>Enter relevant documentation into the hospital’s electronic medical record</td>
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</table>

**X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED**

<table>
<thead>
<tr>
<th>Competency/Description</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Patient Care</strong></td>
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</tr>
<tr>
<td>- Resident must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</td>
<td>- Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families. - residents will learn to gather essential and accurate information about their patients - residents will make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment</td>
<td>○ residents are evaluated by their supervisors</td>
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<tr>
<td><strong>2. Medical Knowledge</strong></td>
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<tr>
<td>- Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognitive (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.</td>
<td>- Residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter - residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes, on rounds and didactic teaching sessions - residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, Grand Rounds, critical review of scientific literature, computer and web-based resources - residents will actively participate in seminars and on rounds - residents will understand and apply basic principles of physiology and pathophysiology to specific commonly encountered conditions on the consultation service - residents will demonstrate an investigatory and analytic thinking approach to clinical situation</td>
<td>- feedback of both oral and written presentations will be provided by supervisors</td>
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<tr>
<td><strong>3. Interpersonal and Communication Skills</strong></td>
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<tr>
<td>- residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their</td>
<td>- residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information - residents will make every effort to safeguard patient/family dignity. - residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these</td>
<td>○ residents are evaluated by their supervisors</td>
</tr>
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</table>
patients’ families, and professional associates.

- Residents will create and sustain a therapeutic and ethically sound relationship with patients
- Residents will use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Residents will work effectively with others as a member or leader of a health care team or other professional group
- Residents will negotiate priorities for problems to be addressed in the particular visit, once all issues have been identified.
- Residents will write clearly and legibly when hand-writing instructions or other information for patients/families
- Residents written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable

<table>
<thead>
<tr>
<th>4. Professionalism</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
</table>
| Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population | - Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary
- Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest.
- Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations
- Residents will know and avoid breach of the boundaries of the physician/patient relationship
- Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard
- Residents will make every effort to elicit and to accommodate, to the fullest extent of their ability, differing religious and cultural needs and values in delivering medical care– but are under no obligation to accommodate requests based upon any form of identity-group prejudice
- Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice
- Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and | ○ Attendings will evaluate residents
○ Feedback from nursing staff, other disciplines |
discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family.

<table>
<thead>
<tr>
<th>5. Practice-Based Learning and Improvement</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</thead>
</table>
| Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. | - At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice.  
- The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses.  
- The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems.  
- The resident should maintain an awareness of medical and psychiatric information that directly impacts on the patients they evaluate on the consultation service, for example through directives and publications from their local department of health, or national physician’s organizations.  
- The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed.  
- The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist.  
- The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients.  
- The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors.  
- The resident is expected to facilitate the learning of students and other health care professionals. | ○ Day to day knowledge base evaluated by feedback on diagnoses, and neurological treatment approaches. |

<table>
<thead>
<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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| Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their | - The resident will learn how to work within a multidisciplinary team to develop a care plan for the patients they evaluate on the consultation service.  
- The resident will learn to identify which is the optimal setting to provide cost-effective and quality patient care for a variety of patient problems.  
- The resident will practice cost-effective health care and resource allocation that does not compromise quality of care.  
- The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions. | ○ Evaluations from supervisors. |
XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION

Residents should be mindful of the unique opportunity which they are presented during this Neuromodulation rotation. In caring for these patients in a supervised environment, you are being given the chance to learn and study a highly specialized treatment modality while caring for psychiatric patients with a specific subset of diagnoses and with a relatively greater degree of illness severity. We urge you to embrace your responsibilities and this opportunity while providing assessment of, and care for, patients on this rotation.
Geriatric assessment rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experiences during which residents gain knowledge, skills and practice in the evaluation and care of Veterans who are geriatric psychiatric patients in an outpatient setting. This rotation offers an opportunity to evaluate individuals who may have comorbid substance abuse as well as a history of post-traumatic stress. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

### Description of Rotation

This rotation is a 9 month assignment for one half day per week at the Providence Veterans Administration Medical Center. It allows residents to develop important diagnostic, treatment, and other skills in an outpatient setting. In this rotation residents will have an opportunity to evaluate older patients who have been traumatized by war, have significant comorbid medical and possible substance use problems. It also introduces the resident to the electronic medical record system that is used in the Veterans Hospitals throughout the country, a truly integrated EMR. In addition to doing assessments on new intakes, the resident will follow-up a number of patients. It allows residents to work more independently and to assume increasing responsibility for a varied patient caseload of elderly patients. Residents evaluate and treat geriatric outpatients and have specific supervision with a geriatric psychiatry supervisor who has subspecialty boards in this area.

Providence Veterans Administration Medical Center

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### I. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Geriatric Assessment</th>
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</thead>
<tbody>
<tr>
<td>Chiefs of Service</td>
<td>Luisa Skoble, MD (Providence Veterans Administration)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Luisa Skoble, MD (Providence Veterans Administration)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

### II. FACULTY

Luisa Skoble, MD: Alice Lee Vestner, MD

### III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

#### Topics to be covered are based upon:
- The patients assessed and treated by the residents over the course of the rotation

#### Principal teaching methods:
- Attending supervision
- Weekly morning seminars

#### Educational materials provided/referred to residents:
- **Reading:** Each attending and resident is expected to utilize current psychiatric literature regarding assessment and treatment of psychiatric patients.
- **Computer-assisted educational materials:** All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located in the outpatient reception area.
- **Other:** Residents are given articles as part of their weekly morning seminar series and by faculty on service.

### IV. SPECIFIC AREAS & EXPECTATIONS

Residents are expected to regularly review relevant:
- Neuroimaging studies
- Laboratory testing results
- Neuropsychological testing results
- Interagencies from nursing homes and reports from primary care physicians

On this rotation, residents act as the outpatient psychiatrist to patients over the age of 65 who have a broad range of psychiatric
diagnoses. An initial evaluation will be preformed on every new patient or those transferred from another level of care. Follow-up visits will be conducted based on the patient’s clinical needs. Residents will be available to respond to emergency telephone calls from clinic patients. Residents will provide patients with pharmacological management, assist families in behavioral management, and utilize psychotherapeutic techniques. Among the residents' responsibilities is the application of cost-effective care measures and principles to the actual care of the patients on the service. Residents are expected to communicate as needed with primary care physicians and long-term care institutions.

V. EVALUATIONS

- Evaluation of the resident's successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the resident's successful completion of the goals listed below will be carried out by the clinic nurse.
- Evaluation of the resident's successful completion of the goals listed below will be carried out by sampling of outpatients.
- Evaluation of the attending's successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION

- The chief of service will oversee the educational experience for the residents.
- The attending will oversee the care of the patients in the resident’s caseload assigned to that particular supervisor.
- The attending will provide supervision after the fellow has completed their assessment and evaluation of the patient.
- The attending will examine the patients to confirm the resident’s findings to guide in establishing the treatment plan.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION

- Resident is responsible for evaluation, treatment, and disposition of psychiatric outpatients.
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Resident is responsible for family and patient communication.
- Resident is responsible for discussing the case with his or her supervisor, other health care professionals involved with the patient and the patient’s family, as dictated by the circumstances.
- Resident is responsible for written or dictated evaluations of all patients assessed and followed.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending upon completion of each two months.
- Resident is responsible for having their beeper on in the event of an urgent call from their patient or the outpatient staff, and if not available arranging appropriate coverage.
- Resident must inform their patients how they can be reached in the event of an emergency

VIII. SCHEDULE DURING THIS ROTATION

<table>
<thead>
<tr>
<th>Clinic Hours</th>
<th>Monday 8 am – 12 pm; Thursday 1:00 pm – 4:00 pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Rounds</td>
<td>1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus</td>
</tr>
<tr>
<td>Other Conferences</td>
<td>12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital</td>
</tr>
<tr>
<td></td>
<td>3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital</td>
</tr>
<tr>
<td></td>
<td>1st and 3rd Thursday from 12:00 pm to 1:00 pm, Geriatric Psychiatry Conference, Butler Hospital</td>
</tr>
<tr>
<td>Weekly Seminars</td>
<td>Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center</td>
</tr>
<tr>
<td></td>
<td>Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital</td>
</tr>
</tbody>
</table>

IX. GENERAL EDUCATIONAL OBJECTIVES

Objectives - By the end of this rotation, the resident will be able to:

- Assess geriatric outpatients and implement outpatient treatment for individuals with psychiatric and or psychological difficulties
- Develop important diagnostic and treatment skills in an outpatient setting
- Function independently in an outpatient setting with supervision
- Have both a theoretical and practical understanding of geriatric psychopharmacology
- Have both a theoretical and practical understanding of individual psychotherapies as applied to the elderly
- Recommend laboratory/imaging tests
- Prepare and present case presentations
- Develop an appreciation for cost-efficient care, and proper utilization of resources
- Work in a coordinated fashion with other treatment providers
- Recognize when patients need a higher level of treatment (e.g., inpatient hospitalization, partial hospitalization, day care, assisted living, nursing home, visiting nurse services)
- Recognize and treat chronic and recent onset primary psychiatric illness in the context of multiple co-morbid conditions, which frequently characterize the late life adult
- Understand the various factors, which influence the use of psychopharmacologic agents in the aged and the role of drug interactions
- Distinguish between normative and pathological neurologic changes in the ageing process
- Be sensitive to the normative stresses of late life as they interact with the various personality styles in the aging person and the changes in psychotherapeutic technique which are most helpful in working with older patients

### X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

<table>
<thead>
<tr>
<th>Competency/Description</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Patient Care</strong></td>
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</tr>
<tr>
<td>Residents must be able</td>
<td>Residents will prepare and present case presentations</td>
<td>Residents are evaluated by their supervisors</td>
</tr>
<tr>
<td>to provide care that is</td>
<td>Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families</td>
<td>Residents are evaluated by the nurse coordinator</td>
</tr>
<tr>
<td>compassionate,</td>
<td>Residents will learn to gather essential and accurate information about their patients</td>
<td>Residents are evaluated by patients</td>
</tr>
<tr>
<td>appropriate, and</td>
<td>Residents will learn to make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment</td>
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<tr>
<td>effective for the</td>
<td>Residents will learn to develop and carry outpatient management plan</td>
<td></td>
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<tr>
<td>treatment of health</td>
<td>Residents will learn to counsel and educate patients and their families</td>
<td></td>
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<tr>
<td>problems and the</td>
<td>Residents will provide health care services aimed at preventing health problems or maintaining health</td>
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<tr>
<td>promotion of health.</td>
<td>Residents will work with health care professionals, including those from other disciplines, to provide patient-focused care</td>
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<td></td>
<td>Residents will use information technology to support patient care decisions</td>
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<td><strong>2. Medical Knowledge</strong></td>
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<tr>
<td>residents must</td>
<td>Residents will demonstrate an investigatory and analytic thinking approach to clinical situations</td>
<td>Feedback of both oral and written presentations will be provided by attending</td>
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<tr>
<td>demonstrate knowledge</td>
<td>Residents will know and apply the basic and clinically supportive sciences which are appropriate to their discipline</td>
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<tr>
<td>about established and</td>
<td>Residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter</td>
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<tr>
<td>evolving biomedical,</td>
<td>Residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes and presentations to supervisors and other health care professionals</td>
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<tr>
<td>clinical, and cognate</td>
<td>Residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, Grand Rounds, critical review of scientific literature, computer and web-based resources</td>
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<td>(e.g. epidemiological</td>
<td>Residents will actively participate in seminars</td>
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<td>and social-behavioral)</td>
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<td>knowledge to patient</td>
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<td><strong>3. Interpersonal and</strong></td>
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<tr>
<td><strong>Communication Skills</strong></td>
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<td>residents must</td>
<td>Residents will create and sustain a therapeutic and ethically sound relationship with patients</td>
<td>Residents are evaluated by their supervisors</td>
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<tr>
<td>be able to demonstrate</td>
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<tr>
<td>interpersonal and</td>
<td>Residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these</td>
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<tr>
<td>communication skills</td>
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<tr>
<td>that result in effective information exchange and teaming with patients, their</td>
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patients’ families, and professional associates.

- Residents will write clearly and legibly when hand-writing instructions or other information for patients/families
- Residents written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable

<table>
<thead>
<tr>
<th>4. Professionalism</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tbody>
<tr>
<td>Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</td>
<td>- Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary - Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest - Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations. - Residents will demonstrate understanding of and sensitivity to end of life care and issues regarding provision of care - Residents will review their professional conduct and remediate when appropriate - Residents will make reasonable efforts to act as advocates for their patients. - Residents will truthfully report medical errors of their own to their attending, or Risk Management and to follow hospital protocols in the face of errors. Residents will encourage and facilitate reporting of medical error on the part of professional colleagues - Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard - Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice - Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family</td>
<td>o Attendings will evaluate residents o Feedback from nursing staff, other disciplines</td>
</tr>
<tr>
<td>5. Practice-Based Learning and Improvement</td>
<td>Goals and Objectives</td>
<td>Evaluation Method</td>
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<tr>
<td>Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.</td>
<td>At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback for the year. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice. - The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses. - The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems. - The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed. - The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist - The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients - The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors. - The resident will facilitate the learning of students and other health care professionals.</td>
<td>○ Day to day knowledge base evaluated by feedback on diagnoses, and both psychopharmacologic and psychotherapeutic treatment approaches</td>
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<tr>
<th>6. Systems-Based Practice</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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<tr>
<td>Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals.</td>
<td>The resident will learn to practice cost-effective health care and resource allocation that does not compromise quality of care. - The resident will learn how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance - The resident will learn how to work other health care providers to develop and coordinate a care plan for their patients - The resident will be familiar with the presence and influences of alternative and complimentary therapies, and its use in their populations and patients - The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions. They will learn the legal rights of the uninsured and will work with the appropriate services to assist patients who are under- or uninsured. - The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies.</td>
<td>○ Evaluations from supervisors</td>
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</tbody>
</table>
etc. via spoken and written communications when it affects the health of their patients
- The resident will learn about the various community resources available for patients and will work with case managers and social workers to enable patients to access these resources

**XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION**

Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, clinic patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Neuropsychology

Overview of Rotation

Revised date 12/09/10

The Neuropsychology rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experiences during which residents learn about neuropsychology assessments. They will learn about the different assessment batteries that are available, how they are administered, interpretation of results and when to order them. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

Description of Rotation

This rotation is a one-half day daily for one month at Butler Hospital. The resident will review the indications for neuropsychological testing, when to order testing, and the types of batteries that are routinely used. The resident will observe testing being conducted and conduct neuropsychology testing. The resident will learn to interpret the results of neuropsychological testing and understand its limitations.

Butler Hospital

I. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of Rotation</th>
<th>Neuropsychology</th>
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</thead>
<tbody>
<tr>
<td>Chiefs of Service</td>
<td>Paul Malloy, PhD (Butler Hospital)</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Paul Malloy, PhD (Butler Hospital)</td>
</tr>
<tr>
<td>Residency Coordinator</td>
<td>Ema Costa: 455-6421</td>
</tr>
</tbody>
</table>

II. FACULTY

Paul Malloy, PhD

III. TOPICS/TEACHING METHODS/MATERIALS USED DURING THIS ROTATION

Topics to be covered are based upon:
- Indications for use of neuropsychological testing
- The types of batteries used in neuropsychological testing
- How neuropsychological tests are administered
- The limitations of neuropsychological testing
- The interpretation of neuropsychological testing
- The role of the neuropsychologist in the interdisciplinary team

Principal teaching methods:
- Attending supervision
- Weekly morning seminars

Educational materials provided/referred to residents:
- Reading: Each attending and resident is expected to utilize current medical literature regarding assessment and interpretation of neuropsychological tests.
- Computer-assisted educational materials: All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks. Terminals are located on each floor of the hospital.
- Other: Residents are given articles as part of their weekly morning seminar series and by faculty on service.

IV. SPECIFIC AREAS & EXPECTATIONS

Residents are expected to regularly review relevant:
- Neuroimaging studies
- Laboratory testing results
- Neuropsychological testing results
- Medical records and other consult reports
On this rotation, residents will focus on the use, administration, and interpretation of neuropsychological testing. The resident will observe testing being conducted and will under supervision conduct some testing. Residents are expected to communicate as needed with attending psychologist.

V. EVALUATIONS
- Evaluation of the resident’s successful completion of the goals listed below will be carried out by the attending.
- Evaluation of the attending’s successful completion of the goals listed below will be carried out by the resident.
- Evaluation of the rotation will be completed by the resident.

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION
- The attending psychologist or the psychologist doing the neuropsychological testing will see all patients and will supervise the care of the patient by the residents, and allowing autonomy as appropriate.
- The attending will be available for or be present at all activities where their involvement is needed.
- Each attending rounds includes interaction with the patient under discussion as part of the educational session and discussion of the patient from a diagnostic and therapeutic perspective.
- The attending will review all pertinent clinical data with the residents.
- The attending is responsible for monitoring the progress of the resident on rotation and communicating his impressions of the resident's performance to the resident throughout the rotation.
- The attending will at some time observe each resident in interactions with patients, in the performance of aspects of evaluating patients in order to be able to evaluate the residents’ clinical and communication skills.
- The attending will complete an electronic evaluation for each resident at the end of each two months.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records, laboratory data and neuroimaging.
- Resident is responsible for working collaboratively with the psychologist working with the patient.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending and rotation at the end of each two months.

VIII. SCHEDULE DURING THIS ROTATION

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time/Date</th>
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</thead>
<tbody>
<tr>
<td>Clinic Hours</td>
<td>1 pm – 4 pm Friday</td>
</tr>
<tr>
<td>Grand Rounds</td>
<td>1st Wednesday of each month, 11:00 am, Ray Hall, Butler Hospital Campus</td>
</tr>
</tbody>
</table>
| Other Conferences     | 12:00 pm Fridays, Memory Disorders Clinic Team Meeting, Jade Room, Butler Hospital  
|                       | 3rd Tuesday from 12:30 pm to 1:30 pm, Geriatric Psychiatry Conference, The Miriam Hospital |
| Weekly Seminars       | Wednesday from 9:00 am to 12:00 pm, Center of Excellence, Boston University Medical Center  
|                       | Thursday from 8:00 am to 11:00 am, Geriatric Medicine/Psychiatry Didactics, Rhode Island Hospital |

IX. GENERAL EDUCATIONAL OBJECTIVES

Objectives - By the end of this rotation, the resident will be able to:
- Obtain an orderly and detailed history as outlined by the psychology program
- Obtain an understanding of role of neuropsychology
- Obtain an understanding of when to order neuropsychological assessments.
- Obtain an understanding of the different types of neuropsychological assessments available.
- Obtain an understanding of the limitations of neuropsychological assessments.
- Obtain an understanding of basic interpretation of neuropsychological assessments.
- Gain an understanding of the administration of different neuropsychological testing
- Gain an understanding of the neuroanatomical structures or neuropsychological processes that specific neuropsychological measures are testing
- Review the literature on neuropsychological testing.
- Residents should already be familiar with Avitar electronic medical record

X. GOALS AND OBJECTIVES FOR THIS ROTATION – COMPETENCY-BASED

<table>
<thead>
<tr>
<th>Competency/Description</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Care</td>
<td>- Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.</td>
<td>o Residents are evaluated by their supervisors</td>
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</table>
appropriate, and effective for the treatment of health problems and the promotion of health.

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<tr>
<th>2. Medical Knowledge</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</table>
| 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. | - Residents will learn to gather essential and accurate information about their patients  
- Residents will make informed decisions about neuropsychological testing based on patient information, up-to-date scientific evidence, and clinical judgment | - Feedback of both oral and written presentations will be provided by supervisors |

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<tr>
<th>3. Interpersonal and Communication Skills</th>
<th>Goals and Objectives</th>
<th>Evaluation Method</th>
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</table>
| 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. | - Residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information  
- Residents will make every effort to safeguard patient/family dignity.  
- Residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries.  
- Residents will create and sustain a therapeutic and ethically sound relationship with patients  
- Residents will use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills  
- Residents will work effectively with others as a member or leader of a health care team or other professional group  
- Residents will negotiate priorities for problems to be addressed in the particular visit, once all issues have been identified.  
- Residents will write clearly and legibly when hand-writing instructions or other information for patients/families  
- Residents written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable | ○ Residents are evaluated by their supervisors |

<table>
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<th>4. Professionalism</th>
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| residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and | - Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment, (4) Providing coverage if unavailable, (for example, when out of town or on vacation), | ○ Attendings will evaluate residents  
○ Feedback from neuropsychology staff, other disciplines |
sensitivity to a diverse patient population

5. Practice-Based Learning and Improvement

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<tr>
<td>At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice.</td>
<td>Day to day knowledge base evaluated by feedback on diagnoses, and neurological treatment approaches.</td>
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<tr>
<td>The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses.</td>
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<tr>
<td>The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients’ health problems.</td>
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<tr>
<td>The resident should maintain an awareness of medical and psychiatric information that directly impacts on the patients they evaluate on the consultation service, for example through directives and publications from their local</td>
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</table>
The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, PubMed. The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients. The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors. The resident is expected to facilitate the learning of students and other health care professionals.

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<th>6. Systems-Based Practice</th>
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<tbody>
<tr>
<td>Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals.</td>
<td>- The resident will learn how to work within a multidisciplinary team to develop a care plan for the patients they evaluate on the consultation service. - The resident will learn to identify which is the optimal setting to provide cost-effective and quality patient care for a variety of patient problems. - The resident will practice cost-effective health care and resource allocation that does not compromise quality of care. - The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions.</td>
<td>○ Evaluations from supervisors</td>
</tr>
</tbody>
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**XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION**

Residents should be mindful of the unique opportunity with which they are presented during this rotation. In caring for sick, clinic patients in a supervised environment, you are being given the chance to study in a protected environment while caring for patients with the illnesses you are studying. We urge you not to waste this time but rather to embrace your responsibilities and to study and teach based upon the needs of your patients.
Geriatric Outpatient Psychiatry Clinic Overview

The Mission
The mission of the Geriatric Psychiatry Clinic is to provide highest quality specialized psychiatric diagnosis and treatment services to persons 65 and older, to train psychiatrists to a level of full competence in the continuous management of a senior outpatient population, and to promote an appreciation of clinical research in Geriatric Psychiatry.

Description
The Geriatric Psychiatry Clinic operates in the outpatient offices on the second floor of the Fain Building at The Miriam Hospital and utilizes the resources of the general outpatient program including the waiting room, reception desk, outpatient medical record room, central scheduling, and outpatient administration.

The clinic is staffed by a senior board certified geriatric psychiatrist, with two other geriatric psychiatrists providing back-up. Patients will make initial contact with the reception office who will ensure that paperwork appropriate to that day’s visit is properly filed.

The clinic meets on Tuesday or Friday afternoons from 1:00 – 5:00 PM depending on the residents schedule. Each patient is seen by both a training fellow and a senior geriatric psychiatrist. The fellow meets the patient initially, takes a history and examines the patient then reviews the findings with the senior psychiatrist. The senior psychiatrist examines the patient to confirm the fellow’s findings and then guides the fellow in establishing a treatment plan. The senior psychiatrist takes responsibility for all medical decision making in the treatment of clinic patients, but the fellow has the experience of arriving at a diagnosis, implementing treatment plans, and following geriatric patients over time. It must be made clear to both patient and family that the senior psychiatrist is ultimately responsible for delivering the care and his or her name will appear on any payment notices received from an insurance payer or Medicare.

Referrals
Patients are referred to the Clinic from multiple sources including the inpatient services, the memory clinics, other physicians, and other outside sources, and are also self referred. All referrals are directed to the intake office where initial data is obtained and a first appointment scheduled. Patients are distributed among the fellows by the intake office on a random basis. Patient load for each fellow will be monitored by the Director of Geriatric Psychiatry at The Miriam Hospital with an effort made to keep each fellow’s load at about 20-25 active outpatients or a an equivalent number of patients which can be managed during the four hour weekly clinic time (assuming one hour visits for new patients and half hour visits for follow up patients.).

Services Provided
At the current time the clinic will provide three major services:

1. Initial evaluation: For every patient new to the hospital system, or who has been formerly in treatment and discharged or not seen for more than 6 months, and every patient who is transferred to the clinic from another level of care or referred from the memory Clinic or other hospital treatment program.
2. Follow up visits primarily for medication management: If patients require psychotherapy, group psychotherapy or other services outside the scope of those which can be offered within the medication management visits, those patients will be referred to the appropriate therapists in the community using a consultation request form.
3. Emergency availability: It is well known that telephone calls from geriatric outpatients are an important part of a continuous therapeutic relationship. Managing these calls in an efficient and therapeutic manner is something that fellows must master. Non-clinic hour calls should be reviewed by the senior psychiatrist during clinic supervision.

Fellows will make it clear to all patients and families how that there is a coverage system in place for emergencies off hours and on weekends. Fellows should be available during weekdays to answer emergency telephone calls, and return calls from patients. If a fellow is to be away or unavailable for a period exceeding 24 hours he/she will make clear arrangements for coverage using the appropriate hospital forms. Covering persons may be another fellow, or a senior psychiatrist. A senior psychiatrist will be available at all times for backup and consultation to the treating or covering fellow.

Senior supervising psychiatrists will be available at all times and make appropriate coverage arrangements when they are to be unavailable for more than 24 hours.

Neuropsychology, Neurology, Internal Medicine, Occupational Therapy, and Social Work services can be made available by consultation.

Documentation
A medical record is kept on each patient in the usual The Miriam Hospital outpatient record format. Entries are made by both the fellow and the senior psychiatrist, but the fellow bears primary responsibility for the timely and legible completion of medical record
requirements. The individual progress notes for each session will be attached to the formatted outpatient encounter form and will be preprinted with the patient’s name and the date of the session. The supervisor’s participation is documented by an individualized note at the bottom of the outpatient note, which specifies that the supervisor has met with the patient and recommends the course of treatment. Residents are encouraged to type their notes into the preformatted outpatient template.

The supervisor's entry for initial evaluation must show in individualized written entries that the supervisor has reviewed and confirmed as necessary all historical data collected by the fellow and that the supervisor has conducted an examination of the patient and guided the medical decision making to a conclusion.

**Encounter Forms**

The supervisor must co-sign the progress note and encounter form for every patient seen before the reception office staff can process it. If for some reason the supervisor is not available, (e.g. an emergency session or due to illness) the fellow may see the patient alone and send the encounter form, which is not co-signed by the supervisor to the reception office staff.

12/10/10
Geriatric Psychiatry Inpatient Rotation Overview
Butler Hospital, Senior Specialty Program, Lippitt 1 Unit

Objectives:
- Develop a working knowledge of all aspects of the functioning of an inpatient geriatric psychiatry unit.
- Understand the use of behavioral and pharmacologic treatment interventions in geriatric patients.
- Improve skills regarding independent management of geriatric inpatients.
- Develop skills in leading an interdisciplinary team in the effective treatment of geriatric inpatients.

Expectations:
- Carry a daily caseload based on level of training:
  - Medical Student or Junior Resident: three to five inpatients
  - Senior Resident: four to six inpatients
  - Fellow: five to seven inpatients
- Identify the patients assigned to you by placing your name on the Unit Census Board next to the attending’s name, so all staff understand that you can be contacted regarding your patients.
- Be certain that unit staff know how to contact you by pager or other means.
- Assume primary responsibility for each assigned patient throughout the admission, assessment, treatment, and discharge phases of their hospitalizations. This includes but is not limited to the following activities:
  1. When possible, evaluate all assigned patients prior to treatment team rounds.
  2. Attend treatment team rounds (beginning at 8:30AM) every day except Thursday.
  3. In rounds, provide concise commentary regarding your assigned patients.
  4. If possible, immediately following treatment team, round with attending. During and after these rounds, discuss diagnosis, treatment and discharge planning issues for each patient.
  5. Write medication and consultation orders in the morning, whenever possible.
  6. Respond to pages from unit staff in a timely way on all assigned patients at all times.
  7. Sign all telephone-orders within 24 hours of their writing.
  8. For each new patient, establish who the primary family contact person is and speak with that person by telephone on the first hospital day, prior to instituting medication changes.
  9. If active medical problems exist, contact the community physician(s) involved.
  10. For (almost) all new patients, order a baseline EKG and assess recent labs and institute any necessary lab orders for the same day or the following morning.
  11. If there is an established outpatient psychiatrist, contact that person or obtain progress notes.
  12. Reconcile initial medications by comparing the Patient Medication Profile (PMP) to the initial admission orders, being certain to review any notes from pharmacy, and document any medications that may have been recently started, changed or discontinued.
  13. Speak with the assigned Care Planner regarding family and community physician contacts.
  14. Be available for scheduled family meetings.
  15. Complete all required inpatient assessments in Avitar on first hospital day and all subsequent days.
  16. Complete daily progress note on all subsequent days, including discharge day.
  17. Complete all discharge paperwork on the day prior to discharge, including 1) discharge summary form, 2) patient instruction form, 3) interagency paperwork, and 4) prescriptions, if necessary.
  18. On the day of discharge, again use the PMP to reconcile medications compared to the admission medications, and make note of any changed or discontinued Rx. Place this noted form in the chart behind the patient instruction form.
  19. Following discharge, within 2 days, complete the discharge summary.

Supervision and Didactic Education:
- Clinical supervision will be provided daily during patient rounds.
- Weekly physician group supervision / teaching rounds will occur on either Mondays or Wednesdays from 11:30 to 12:30.
- Whenever possible, discuss medication orders with the attending psychiatrist or medicine / neurology consultant prior to writing the order(s).
- Once complete, progress notes will be discussed with the attending psychiatrist.
- Attend the combined geriatric medicine and geriatric psychiatry seminars on Thursday mornings in the conference room at the Center for Gerontology and Health Care Research.
- Attend the Geriatric Psychiatry Case Conference and Journal Club on Thursdays at noon.
- Attend the Memory and Aging Program clinical consensus conference on Fridays at noon in the Jade Room at Butler Hospital.
- Consider identifying one clinical topic each month for didactic education. Research these topics and prepare a 10 to 15 minute summary to be discussed during the last week of each month.

Additional Elective Opportunities:
• Consider scheduling one morning each week for observation of ECT. This would occur from 7 – 8AM.
• Consider following one geriatric patient in the Butler Hospital Partial Psychiatry Program, Focus Track. If none of your patients are discharged to this program, you may choose to set aside a day to observe the program without following a patient there. Alternatively, you may want to visit a geriatric day care program in the community; again, you could choose one that cares for a patient you treated on L1.

Revised 12/10/2010
# Fellow, MD – ROTATION SCHEDULE

## DATE

**Rotation 1 – 3 Months**

### MONDAY

<table>
<thead>
<tr>
<th>Location</th>
<th>Rotation</th>
<th>Supervision</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIPPITT 1 Butler Hospital</td>
<td>Geriatric Psychiatry Inpatient</td>
<td>Louis Marino, MD, Gary Epstein-Lubow, MD</td>
<td>8:00 AM – 4:00 PM</td>
</tr>
</tbody>
</table>

### TUESDAY

<table>
<thead>
<tr>
<th>Location</th>
<th>Rotation</th>
<th>Supervision</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIPPITT 1 Butler Hospital</td>
<td>Geriatric Psychiatry Inpatient</td>
<td>Louis Marino, MD, Gary Epstein-Lubow, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Geriatric Psychiatry Inpatient Except 4th Tuesday of Month</td>
<td>Louis Marino, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>1st Floor Weld Building, Room 167</td>
<td>Memory Disorders Clinic</td>
<td>Stephen Salloway, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Miriam Hospital Fain Building, Room 267</td>
<td>Geriatric Psychiatry Conference TBA – 3rd Tuesday of Month</td>
<td>Robert Kohn, MD</td>
<td>12:30 PM – 1:30 PM</td>
</tr>
<tr>
<td>Miriam Hospital Fain Building, Room 267</td>
<td>Outpatient Geriatric Psychiatry Clinic Except 4th Tuesday of Month</td>
<td>Robert Kohn, Laura Stanton, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>LIPPITT 1 Butler Hospital</td>
<td>Geriatric Psychiatry Inpatient Every 4th Tuesday of Month</td>
<td>Louis Marino, MD, Gary Epstein-Lubow, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>Miriam Hospital Fain Building, Suite 2B</td>
<td>Psychotherapy Supervision 3rd Tuesday of Month</td>
<td>Thomas Sheeran, PhD</td>
<td>4:00 PM – 5:00 PM</td>
</tr>
</tbody>
</table>

### WEDNESDAY

<table>
<thead>
<tr>
<th>Location</th>
<th>Rotation/Conferences</th>
<th>Supervisor/Conference Coordinators</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston University Medical Center</td>
<td>Geriatric Lecture for the HRSA Grant – Center of Excellence</td>
<td>Robert Kohn, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>LIPPITT 1 Butler Hospital</td>
<td>Geriatric Psychiatry Inpatient (Brief Rounds Prior to Lectures)</td>
<td>Louis Marino, MD, Gary Epstein-Lubow, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>Rhode Island Hospital APC Building</td>
<td>Geriatric Medicine Lectures</td>
<td>Aman Nanda, MD, G. Mustafa Surti, MD</td>
<td>8:00 AM – 10:00 AM</td>
</tr>
<tr>
<td>Butler Hospital Center House Rear, 3rd Floor, Room C310</td>
<td>Geriatric Psychiatry Seminars Supervision Meeting</td>
<td>Robert Kohn, MD</td>
<td>12:00 PM – 1:00 PM</td>
</tr>
<tr>
<td>LIPPITT 1 Butler Hospital</td>
<td>Geriatric Psychiatry Inpatient</td>
<td>Louis Marino, MD, Gary Epstein-Lubow, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
</tbody>
</table>

### THURSDAY

<table>
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<tbody>
<tr>
<td>LIPPITT 1 Butler Hospital</td>
<td>Geriatric Psychiatry Inpatient</td>
<td>Louis Marino, MD, Gary Epstein-Lubow, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Butler Hospital – Weld Building 2nd Floor, Room 212</td>
<td>*Memory Disorders Clinic Team Meeting</td>
<td>Stephen Salloway, MD</td>
<td>12:00 PM – 1:00 PM</td>
</tr>
<tr>
<td>LIPPITT 1 Butler Hospital</td>
<td>Geriatric Psychiatry Inpatient</td>
<td>Louis Marino, MD, Gary Epstein-Lubow, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
</tbody>
</table>

### FRIDAY

- Brown University Academic Grand Rounds: 11:15 AM - 12:15 PM, 1st. Wednesday of each month (September thru June only), Butler Hospital, Ray Hall Conference Center.
- Boston University Lectures on Wednesdays begin at 8:00 AM.
- Geriatric Medicine Lectures (8-10 AM) and Geriatric Psychiatry Lectures (10-11 AM) at Rhode Island Hospital.
- *Memory Disorders Clinic Team Meeting – Fridays 12:00 – 1:00 PM, Optional.
- Miriam Hospital Geriatric Lecture, 3rd, Tuesday of every month, 12:30 - 1:30 PM
- OPTIONAL – ECT on Monday, Tuesday, Friday am with Dr. Furman
# Fellow, MD – ROTATION SCHEDULE

**DATE**

Rotation 3 – 4 Months

## MONDAY

<table>
<thead>
<tr>
<th>Location</th>
<th>Rotation</th>
<th>Supervision</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veterans Hospital</td>
<td>Geriatric Psychiatry Evaluations</td>
<td>Alice Lee Vestner, MD, Luisa Skoble, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Movement Disorders Clinic</td>
<td>Joseph Friedman, MD</td>
<td>1:00 PM – 4:00 PM</td>
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## TUESDAY

<table>
<thead>
<tr>
<th>Location</th>
<th>Rotation</th>
<th>Supervision</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miriam Hospital, Fain Building, Room 267</td>
<td>Nursing Home 3rd and 5th Tuesday of Month</td>
<td>Robert Boland, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Rhode Island Veterans Home 480 Metacom Ave., Bristol, RI 02809</td>
<td>Nursing Home 2nd and 4th Tuesday of Month</td>
<td>Luisa Skoble, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Butler Hospital, 1st Floor Weld Building, Room 167</td>
<td>Memory Disorders Clinic 2nd Tuesday of Month</td>
<td>Stephen Salloway, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Miriam Hospital, Fain Building, Room 267</td>
<td>Geriatric Psychiatry Conference TBA – 3rd Tuesday of Month</td>
<td>Robert Kohn, MD</td>
<td>12:30 PM – 1:30 PM</td>
</tr>
<tr>
<td>Miriam Hospital, Fain Building, Room 267</td>
<td>Outpatient Geriatric Psychiatry Clinic Except 1st Tuesday of Month</td>
<td>Robert Kohn, MD, Laura Stanton, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>Miriam Hospital, Fain Building, Room 267</td>
<td>Nursing Home 1st Tuesday of Month</td>
<td>Romina Smulever, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>Miriam Hospital, Fain Building, Suite 2B</td>
<td>Psychotherapy Supervision 3rd Tuesday of Month</td>
<td>Thomas Sheeran, PhD</td>
<td>4:00 PM – 5:00 PM</td>
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## WEDNESDAY

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<tr>
<th>Location</th>
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<tbody>
<tr>
<td>Boston University Medical Center</td>
<td>Geriatric Lecture for the HRSA Grant – Center of Excellence</td>
<td>Robert Kohn, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Veterans Hospital</td>
<td>Geriatric Medicine Clinic</td>
<td>David Dosa, MD</td>
<td>1:00 PM – 4:00 PM</td>
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## THURSDAY

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<tr>
<th>Location</th>
<th>Rotation/Conferences</th>
<th>Supervisor/Conference Coordinators</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhode Island Hospital, APC Building</td>
<td>Lectures</td>
<td>Aman Nanda, MD, G. Mustafa Surti, MD</td>
<td>8:00 AM – 10:00 AM, 10:00 AM – 11:00 AM</td>
</tr>
<tr>
<td>Butler Hospital, Center House Rear, 3rd Floor, Room C310</td>
<td>Supervision Meeting</td>
<td>Robert Kohn, MD</td>
<td>12:00 PM – 1:00 PM</td>
</tr>
<tr>
<td>Kent Hospital</td>
<td>Geriatric Consult Liaison</td>
<td>Robin Stern, MD</td>
<td>1:00 PM – 4:00 PM</td>
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## FRIDAY

<table>
<thead>
<tr>
<th>Location</th>
<th>Rotation/Meeting</th>
<th>Supervisor/Meeting Coordinator</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhode Island Hospital, 2nd Floor, Room 212</td>
<td>Neuropathology</td>
<td>Susan DeLaMonte, MD, Edward Stopa, MD</td>
<td>8:30 AM – 11:30 AM</td>
</tr>
<tr>
<td>Butler Hospital – Weld Building Home &amp; Hospice Care of RI 1085 North Main Street Providence, RI 02904</td>
<td>*Memory Disorders Clinic Team Meeting Hospice Palliative Care Outpatient/NH</td>
<td>Stephen Salloway, MD, Theresa Rochon, RN</td>
<td>12:00 PM – 1:00 PM, 1:00 PM – 4:00 PM</td>
</tr>
</tbody>
</table>

- Brown University Academic Grand Rounds: 11:15 AM - 12:15 PM, 1st. Wednesday of each month (September thru June only), Butler Hospital, Ray Hall Conference Center.
- Boston University Lectures on Wednesdays begin at 8:00 AM.
- Geriatric Medicine Lectures (8-10 AM) and Geriatric Psychiatry Lectures (10-11 AM) at Rhode Island Hospital.
- *Memory Disorders Clinic Team Meeting – Fridays 12:00 – 1:00 PM, Optional.
- Miriam Hospital Geriatric Lecture, 3rd Tuesday of every month, 12:30 - 1:30 PM
<table>
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<tbody>
<tr>
<td>Rhode Island Hospital</td>
<td>Geriatric Medicine Lectures</td>
<td>Aman Nanda, MD</td>
<td>8:00 AM – 10:00 AM</td>
</tr>
<tr>
<td>APC Building</td>
<td>Geriatric Psychiatry Seminars</td>
<td>G. Mustafa Surti, MD</td>
<td>10:00 AM – 11:00 AM</td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Supervision Meeting</td>
<td>Robert Kohn, MD</td>
<td>12:00 PM – 1:00 PM</td>
</tr>
<tr>
<td>Center House Rear, 3rd Floor, Room C310</td>
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</tr>
<tr>
<td>Veterans Hospital</td>
<td>Geriatric Psychiatry Evaluations</td>
<td>Alice Lee Vestner, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Luisa Skoble, MD</td>
<td></td>
</tr>
</tbody>
</table>

- Neurology Grand Rounds/Neuropsychiatry Grand Rounds: 8:00 - 9:00 AM, 1st, 3rd, and 4th. Wednesday of each month. Rhode Island Hospital, Main Auditorium. (Required for those who are doing Neurology Consult rotation).
- Neuropathology Grand Rounds: 8:00 - 9:00 AM, 2nd, and 5th. Wednesday of each month. Rhode Island Hospital, Main Auditorium. (Required for those who are doing Neuropathology rotation).
- Neuroradiology Grand Rounds: 9:40 - 10:40 AM, Wednesday. Rhode Island Hospital, 3rd Floor Conference Room A, (Required for those who are doing Neuroradiology rotation).
- Brown University Academic Grand Rounds: 11:15 AM - 12:15 PM, 1st. Wednesday of each month (September thru June only), Butler Hospital, Ray Hall Conference Center.
- Boston University Lectures on Wednesdays begin at 8:00 AM.
- Geriatric Medicine Lectures (8-10 AM) and Geriatric Psychiatry Lectures (10-11 AM) at Rhode Island Hospital.
- *Memory Disorders Clinic Team Meeting – Fridays 12:00 – 1:00 PM, Optional.
# Fellow, MD – ROTATION SCHEDULE

**DATE**

**Rotation 1 – 1 Month ADDICTION OPTION**

## MONDAY

<table>
<thead>
<tr>
<th>Location</th>
<th>Rotation</th>
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</tr>
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<tbody>
<tr>
<td>Butler Hospital</td>
<td>Geriatric ADP</td>
<td>Alan Gordon, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Miriam Hospital</td>
<td>Nursing Home</td>
<td>Romina Smulever, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>Fain Building, Room 267</td>
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## TUESDAY

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<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butler Hospital</td>
<td>Geriatric ADP</td>
<td>Alan Gordon, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Fain Building, Room 267</td>
<td>Memory Disorders Clinic</td>
<td>Stephen Salloway, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Geriatric Psychiatry Conference</td>
<td>Robert Kohn, MD</td>
<td>12:30 PM – 1:30 PM</td>
</tr>
<tr>
<td>Home &amp; Hospice Care of RI</td>
<td>Hospice Palliative Care</td>
<td>Edward Martin, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>Providence, RI 02904</td>
<td>Inpatient Unit</td>
<td></td>
<td></td>
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</tbody>
</table>

## WEDNESDAY

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<tr>
<th>Location</th>
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<tbody>
<tr>
<td>Home &amp; Hospice Care of RI</td>
<td>Geriatric Medicine Lectures</td>
<td>Robert Kohn, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Providence, RI 02904</td>
<td>Geriatric Psychiatry Seminars</td>
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</tr>
<tr>
<td>Veterans Hospital</td>
<td>Supervision Meeting</td>
<td>Robert Kohn, MD</td>
<td>12:00 PM – 1:00 PM</td>
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## THURSDAY

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<tr>
<td>Rhode Island Hospital</td>
<td>Lectures</td>
<td>Aman Nanda, MD</td>
<td>8:00 AM – 10:00 AM</td>
</tr>
<tr>
<td>APC Building</td>
<td>Geriatric Medicine Lectures</td>
<td>G. Mustafa Surti, MD</td>
<td>10:00 AM – 11:00 AM</td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Geriatric Psychiatry Seminars</td>
<td>Robert Kohn, MD</td>
<td>12:00 PM – 1:00 PM</td>
</tr>
<tr>
<td>Center House Rear, 3rd Floor, Room C310</td>
<td>Supervision Meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans Hospital</td>
<td>Geriatric Psychiatry Evaluations</td>
<td>Alice Lee Vestner, MD</td>
<td>1:00 PM – 4:00 PM</td>
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<tr>
<td></td>
<td></td>
<td>Luisa Skoble, MD</td>
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## FRIDAY

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<th>Rotation/Meeting</th>
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<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butler Hospital</td>
<td>Geriatric Addiction</td>
<td>Alan Gordon, MD</td>
<td>9:30 AM – 10:30 AM</td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Geriatric Addiction</td>
<td>Alan Gordon, MD</td>
<td>10:30 AM – 12:00 PM</td>
</tr>
<tr>
<td>Butler Hospital – Weld Building, 2nd Floor, Room 212</td>
<td>*Memory Disorders Clinic Team Meeting</td>
<td>Stephen Salloway, MD</td>
<td>12:00 PM – 1:00 PM</td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Neuropsychology</td>
<td>Paul Malloy, PhD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
</tbody>
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- *Memory Disorders Clinic Team Meeting – Fridays 12:00 – 1:00 PM, Optional.
- Miriam Hospital Geriatric Lecture, 3rd. Tuesday of every month, 12:30 -1:30 PM
## Fellow, MD – ROTATION SCHEDULE

### NEUROMODULATION OPTION

**DATE**

**Rotation 1 – 1 Month**

<table>
<thead>
<tr>
<th>Location</th>
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<th>Supervision</th>
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<tbody>
<tr>
<td><strong>MONDAY</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Butler Hospital</td>
<td>Neuromodulation</td>
<td>Linda Carpenter, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Miriam Hospital</td>
<td>Nursing Home</td>
<td>Romina Smulever, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>Fain Building, Room 267</td>
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<td></td>
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<tr>
<td><strong>TUESDAY</strong></td>
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</tr>
<tr>
<td>Butler Hospital</td>
<td>Neuromodulation</td>
<td>Linda Carpenter, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Memory Disorders Clinic</td>
<td>Stephen Salloway, MD</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>1st Floor Weld Building, Room 167</td>
<td>1st Tuesday of Month</td>
<td></td>
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</tr>
<tr>
<td>Miriam Hospital</td>
<td>Geriatric Psychiatry Conference</td>
<td>Robert Kohn, MD</td>
<td>12:30 PM – 1:30 PM</td>
</tr>
<tr>
<td>Fain Building, Room 267</td>
<td>TBA – 3rd Tuesday of Month</td>
<td></td>
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</tr>
<tr>
<td>Miriam Hospital</td>
<td>Outpatient Geriatric Psychiatry Clinic</td>
<td>Robert Kohn, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>Fain Building, Room 267</td>
<td>Except 1st Tuesday of Month</td>
<td>Laura Stanton, MD</td>
<td></td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Neuromodulation</td>
<td>Linda Carpenter, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>Miriam Hospital</td>
<td>Psychotherapy Supervision</td>
<td>Thomas Sheeran, PhD</td>
<td>4:00 PM – 5:00 PM</td>
</tr>
<tr>
<td>Fain Building, Suite 2B</td>
<td>3rd Tuesday of Month</td>
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<td></td>
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<tr>
<td><strong>WEDNESDAY</strong></td>
<td></td>
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</tr>
<tr>
<td>Veterans Hospital</td>
<td>Geriatric Homecare</td>
<td>TBA</td>
<td>8:00 AM – 12:00 PM</td>
</tr>
<tr>
<td>Home &amp; Hospice Care of RI</td>
<td>Hospice Palliative Care</td>
<td>Edward Martin, MD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
<tr>
<td>1085 North Main Street</td>
<td>Inpatient Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providence, RI 02904</td>
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<tr>
<td><strong>THURSDAY</strong></td>
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</tr>
<tr>
<td>Rhode Island Hospital</td>
<td>Lectures</td>
<td>Aman Nanda, MD</td>
<td>8:00 AM – 10:00 AM</td>
</tr>
<tr>
<td>APC Building</td>
<td>Geriatric Medicine Lectures</td>
<td>G. Mustafa Surti, MD</td>
<td>10:00 AM – 11:00 AM</td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Geriatric Psychiatry Seminars</td>
<td>Supervision Meeting</td>
<td>Robert Kohn, MD</td>
</tr>
<tr>
<td>Center House Rear, 3rd Floor, Room C310</td>
<td></td>
<td></td>
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<tr>
<td>Veterans Hospital</td>
<td>Geriatric Psychiatry Evaluations</td>
<td>Alice Lee Vestner, MD</td>
<td>1:00 AM – 4:00 PM</td>
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<tr>
<td></td>
<td></td>
<td>Luisa Skoble, MD</td>
<td></td>
</tr>
<tr>
<td><strong>FRIDAY</strong></td>
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</tr>
<tr>
<td>Geriatric Alcohol Group</td>
<td>Geriatric Addiction</td>
<td>Alan Gordon, MD</td>
<td>9:30 AM – 10:30 AM</td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Geriatric Alcohol Group</td>
<td>Linda Carpenter, MD</td>
<td>10:30 AM – 12:00 PM</td>
</tr>
<tr>
<td>Butler Hospital – Weld Building</td>
<td>*Memory Disorders Clinic Team Meeting</td>
<td>Stephen Salloway, MD</td>
<td>12:00 PM – 1:00 PM</td>
</tr>
<tr>
<td>2nd Floor, Room 212</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Butler Hospital</td>
<td>Neuropsychology</td>
<td>Paul Malloy, PhD</td>
<td>1:00 PM – 4:00 PM</td>
</tr>
</tbody>
</table>

- Brown University Academic Grand Rounds: 11:15 AM - 12:15 PM, 1st. Wednesday of each month (September thru June only), Butler Hospital, Ray Hall Conference Center.
- Boston University Lectures on Wednesdays begin at 8:00 AM.
- Geriatric Medicine Lectures (8-10 AM) and Geriatric Psychiatry Lectures (10-11 AM) at Rhode Island Hospital.
- *Memory Disorders Clinic Team Meeting – Fridays 12:00 – 1:00 PM, Optional.
- Miriam Hospital Geriatric Lecture, 3rd. Tuesday of every month, 12:30-1:30 PM
- OPTIONAL – ECT on Monday, Tuesday, Friday am with Dr. Furman and ECT CONSULTS
DIDACTIC SCHEDULE GOALS AND OBJECTIVES

I. Fundamentals of Geriatrics – Brown University (Rhode Island Hospital)
   a. Required for first year geriatric psychiatry fellows
   b. Aman Nanda, MD (Course Coordinator)
   c. Case presentations, journal article presentations, academic leadership and research skills seminar, and seminars on issues related to nursing home care and medical directorship. The first several months consist of didactics given by specialist covering the broad spectrum of issues in geriatric medicine. Subsequently the first hour consists of alternating case presentations with a review of evidence based literature and journal club where pertinent articles in geriatric medicine are reviewed in depth and criticized. Geriatric medicine and geriatric psychiatry fellows alternately make these presentations. The second hour becomes a series of brief seminars on nursing home care, nursing home medical directorship, academic leadership and introduction to research in geriatrics.
   d. Geriatric psychiatrists, geriatric medicine residents, geriatric medicine attendings, geriatric nurses, gerontology graduate students
   e. 2 hours (8-10 AM) a week, Thursdays, throughout the year

II. Geriatric Psychiatry Weekly Seminar – Brown University (Rhode Island Hospital)
   a. Required for first year geriatric psychiatry fellows
   b. Ghulam Surti, MD; Robert Kohn, MD (Course Coordinators). Specific lectures will be given by various members of the faculty of the Brown University Medical School.
   c. This seminar will consist of both didactic and reading materials in which the residents will review aging process, principals of evaluation and diagnosis, psychiatric disorders, cultural and epidemiology, treatment, medical legal, ethical and financial issues in the aging.
   d. Geriatric medicine residents and gerontology graduate students
   e. 1 hours (10-11 AM) a week, Thursdays, throughout the year

III. Geriatric Psychiatry Case Conference and Journal Club – Butler Hospital
   a. Required for first and second year geriatric psychiatry fellows
   b. Louis Marino, MD (Course Coordinator)
   c. Research conducted by the faculty in geriatric psychiatry will be presented. Discussion will be held on methodological issues and the relevance to the current literature in geriatric psychiatry. The presentation may also be of an article in the geriatric psychiatry literature. A session each month will be devoted to the treatment of difficult cases. Each geriatric psychiatry fellow will present twice a year.
   d. Members of the geriatric psychiatry training program, psychiatry residents, psychology interns, nurses, and social workers
   e. 3 times a month, except for the months of July, August and September

IV. Memory Disorders Clinic Team Meeting – Butler Hospital
   a. Elective for first and second year geriatric psychiatry fellows
   b. Stephen Salloway, MD (Course Coordinator)
   c. This is a multidisciplinary team meeting that reviews cases of dementia. Neurology, radiological and psychiatric presentation of pathology is discussed.
   d. Attended by geriatric psychiatrists, neurologists, nurses, psychiatry residents and medical students
   e. 1 hour every week throughout the year

V. Department of Psychiatry and Human Behavior Academic Grand Rounds – Brown University (Butler Hospital)
   a. Required for first and second year geriatric psychiatry fellows
b. Invited speakers of national and international reputation  
c. Presentation of "state of the art", research and treatment. Psychiatry academic grand rounds are held monthly at Butler Hospital for the Department of Psychiatry and Human Behavior.  
d. All faculty of the Department of Psychiatry and Human Behavior, psychiatry residents, psychology interns and medical students  
e. 1 hour monthly throughout the academic year, September - June  

VI. **Neurology Grand Rounds – Rhode Island Hospital**  
   a. Required only for geriatric psychiatry fellows in the neuroradiology rotation  
   b. Invited speakers of national and international reputation  
   c. Presentations on research pathology and treatment in neurology  
   d. Department of neurology faculty, residents and medical students  
   e. 1 hour monthly throughout the year  

VII. **Neuropathology Grand Rounds – Rhode Island Hospital**  
   a. Required only for geriatric psychiatry fellows in the neuroradiology rotation  
   b. Invited speakers of national and international reputation  
   c. Presentations on research neuropathology  
   d. Department of neurology faculty, residents and medical students  
   e. 1 hour monthly throughout the year  

VIII. **Neurosurgery Conferences – Rhode Island Hospital**  
   a. Required only for geriatric psychiatry fellows in the neuroradiology rotation  
   b. Invited speakers of national and international reputation  
   c. Presentations on research pathology and treatment in neurosurgery  
   d. Department of neurology faculty, residents and medical students  
   e. 1 hour monthly throughout the year  

VIX. **Center of Excellence in Geriatrics – Boston University Geriatric Medicine Program (Boston Medical Center)**  
   a. Required for first year geriatric psychiatry fellows  
   b. Various speakers for the seminar series from Boston University  
   c. Develop the clinical, scientific, and educational skills necessary to become effective leaders, providers, and teachers of geriatric psychiatry. The intent of this series is to provide case-based instruction in geriatrics, evidence-based medicine, clinical teaching, and health care systems.  
   d. Geriatric medicine, geriatric dentistry, and geriatric oncology fellows, in addition to faculty scholars from other specialties at Boston University interested in increasing their knowledge of geriatrics.  
   e. 2.5 hours weekly for 35 weeks.
OSCE GOAL AND OBJECTIVES

Description/Setting
The OSCEs occur midway through the first year of geriatrics fellowship training. During this 90-minute session, fellows engage in three standardized patient cases that present communication challenges even to seasoned geriatricians. The goal of this formative exercise is for geriatric medicine fellows to gain experience in dealing with these challenging situations in a safe, nonthreatening environment. Fellows receive feedback on their performance immediately upon completion of each case.

Each case proceeds as follows:
1. Prior to entering the room to interact with the standardized patient (SP), the fellow reads a one to two page description that introduces the clinical scenario and lists the task for the station.
2. The fellow has 15 minutes in which to gather pertinent history and then communicate the assessment and plan to the patient. The fellow does not have to perform a physical exam in any of the cases.
3. While the fellow is interacting with the SP, a geriatrics faculty member will be viewing the interaction via a video monitor located elsewhere in the Clinical Skills Center.
4. The final 15 minutes of the station is a feedback session, performed jointly by the geriatrics faculty and the standardized patient. The faculty member provides feedback regarding the content of the fellow’s interview, assessment and plan. The standardized patient provides feedback regarding the fellow’s communication skills.

Interpersonal and Communication Skills
Goal
Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. During the OSCEs, fellows are expected to effectively communicate with patients about their chief complaints, some of which are challenging in nature.

Objectives
First year fellows will:
1. Communicate with sensitivity about challenging topics.
2. Utilize appropriate language to communicate with patients who have different health literacy levels.

Professionalism
Goal
Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. During the OSCEs, fellows are expected to demonstrate compassion, integrity, and respect for others, as well as sensitivity and responsiveness to a population with diversity in such areas as culture, race, and religion.

Objectives
First year fellows will:
1. Remain open-minded, nonjudgmental, and tolerant when discussing health care matters with patients from diverse backgrounds.
2. Demonstrate awareness of their responsibilities as health care providers in dealing with ethically challenging situations.
3. Demonstrate accountability to patients, society, and the profession.

Teaching Methods
For each of the three cases, the fellows should have received prior teaching on related topics, either during formal didactic sessions or informal case-based teaching related to day-to-day patient care.

Assessment Method—Program Evaluation: While the attending physician will be viewing your interaction via video monitoring, he/she will be completing a checklist of items that have been determined to be essential to address during the history taking and patient counseling portions of the interview. The
standardized patient completes a form that rates fellows’ performance on six communication skills: organization, types of questions utilized, pacing, development of rapport, allowing the patient to ask questions of the health care provider, and the quality of the closing.

**Level of Supervision**
Not applicable.
HRSA GRANT OVERVIEW

The HRSA Grant is a collaborative effort between Boston University and Brown University. As of 1997, the American Board of Internal Medicine requires only one year of clinical training to be board eligible for subspecialty board certification in Geriatrics. Funding for a second year of training for academic geriatricians, dentists, and psychiatrists who seek to develop clinical teaching, administrative and research skills is far less available. This training grant allows us to meet the needs of a second year of training for our fellows who wish to become leaders as well as clinicians in the fields of geriatric medicine, dentistry, and psychiatry. Our training program in geriatric medicine, dentistry and psychiatry fulfills the needs outlined in the National Goals, Healthy People 2010, the Geriatric Education White Paper, and the National Standards for Culturally and Linguistically Appropriate Services in Health Care.

We have developed a comprehensive core clinical and didactic curriculum for geriatric medicine, dentistry and psychiatry fellows together. Each of the three disciplines also has its own specific curriculum. Where possible, we have integrated medicine, dental and psychiatry didactic and clinical experiences. We train geriatric academic faculty to become leaders in their fields.

The Center of Excellence in Geriatric Medicine at Boston University Medical Center funded by a HRSA grant between Boston University and Brown University. The nine-month program involves participation one-half day per week in small-group interactive educational sessions organized into modules. Modules are structured as follows:

1. Geriatrics Content Module. Small-group, interactive seminars address topics in geriatric medicine, using a case-based, evidence-based approach to the extent possible. Topics include: geriatric assessment and multidisciplinary teams, health promotion and disease prevention, cognitive impairment, mobility disorders and falls, substance abuse, elder abuse, urinary incontinence, polypharmacy, and the biology of aging. The module is presented over a two-month period.

2. Clinical Teaching Module. This module is based on the clinical educator curriculum developed by the Stanford Faculty Development Center. It consists of seven interactive seminars over approximately two months, covering the following topics: 1) Learning Climate; 2) Control of Session; 3) Communication of Goals; 4) Understanding and Retention; 5) Evaluation; 6) Feedback; and 7) Self-directed Learning.

3. Evidence-Based Medicine Module. This Four-week module consists of training in the techniques of evidence-based medicine and provides guidance in developing skills for the finding, filtering and judging of relevant clinical medical information. Fellows learn: 1) to derive focused questions from patient care problems; 2) to use MEDLINE in a productive and time-efficient manner to retrieve information related to the question; 3) to review articles critically, emphasizing the concepts of internal and external validity; and 4) to apply information thus obtained to answer the specific clinical questions.

4. Health Care Systems Module. In order to develop and successfully administer academic clinical programs, faculty need better understanding of administrative and management issues. This module includes: 1) health care systems and the impact of environmental factors on clinical programs and practice; 2) clinical, financial and ethical aspects of managed care in geriatric practice; 3) fundamentals of health care finance and reimbursement systems; and 4) operational management and quality improvement.
PROFESSIONAL LICENSURE

1. All fellows must have an active medical license awarded by the Rhode Island Department of Health, Board of Licensure and Discipline. They may have either a limited license (training license) or a full Rhode Island medical license. A full license supersedes the limited license. Fellows continuing into a second year of training must have a full Rhode Island medical license.

2. All fellows must have an active medical license awarded by the Department of Health of Massachusetts. They may have either a limited license (training license) or a full Massachusetts medical license in order to do the homecare rotation. A full license supersedes the limited license.

3. It is against the law to practice medicine without an active medical license.

4. The Rhode Island limited license (training license) is awarded through the sponsoring institution (Butler Hospital). Its authority is specifically limited to the practice of medicine in a supervisory training context at one of the Brown affiliated hospitals or training sites. The Massachusetts limited license is awarded through the sponsoring institution Boston Medical Center.

5. A fellow is specifically prohibited from moonlighting under the authority of a limited license. However, a fellow may apply for a moonlighting license through the hospital, which will employ them and be signed off by the fellowship training director.

6. A fellow is eligible for reimbursement by the Geriatric Psychiatry Fellowship Training Program for their active medical license up to the cost of a limited license.

7. A fellow who does not hold an active medical license (training license or full Rhode island license) has no standing in the Geriatric Psychiatry Fellowship Training Program and will ordinarily be placed on administrative leave without pay or terminated. A fellow may not provide clinical care without an active license.

8. A completed application for renewal or initial limited license with the appropriate application fee must be delivered to the Geriatric Psychiatry Fellowship Training Program Office by June 1 prior to the beginning of each academic year. A fellow who does not meet this deadline cannot be assured of a position beginning July 1 of the academic year.

9. The renewal dates for a full active Rhode Island license are the same as the renewal dates for a limited license (July 1 - June 30). Fellows must provide the Geriatric Psychiatry Fellowship Training Program Office with copies of their current, active Rhode Island license.

10. To be eligible for a full, active medical license in the state of Rhode Island, graduates of U.S. and Canadian medical schools must complete 2 years of an approved residency. Graduates of non-U.S. medical schools must complete 3 years of an approved residency (effective December 22, 2000).

11. When you apply for a full state license, you must also apply for a federal Drug Enforcement Registration. The DEA Interactive Registration Form is available at www.deadiversion.usdoj.gov/drugreg/regs_apps/index.html. The fee for the DEA Registration is $210.00 for three years. The Residency will reimburse you for this fee only if needed in conjunction with a required license (#9). You will not be reimbursed if you are using the full license for the purposes of moonlighting.

Revised 2/24/11
AMA Guidelines on Gifts to Physicians From Industry

Many gifts given to physicians by companies in the pharmaceutical, device, and medical equipment industries serve an important and socially beneficial function. For example, companies have long provided funds for educational seminars and conferences. However, there has been growing concern about certain gifts from industry to physicians. Some gifts that reflect customary practices of industry may not be consistent with the Principles of Medical Ethics. To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:

1. Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or use by family members.

2. Individual gifts of minimal value are permissible as long as the gifts are related to the physician’s work (e.g., pens and notepads).

3. The Council on Ethical and Judicial Affairs defines a legitimate “conference” or “meeting” as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.

4. Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company’s representative may create a relationship that could influence the use of the company’s products, any subsidy should be accepted by the conference’s sponsor who in turn can use the money to reduce the conference’s registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.

5. Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians’ time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses.

6. Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional or specialty medical associations.

7. No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician’s prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures. (II) Issued June 1992 based on the report, “Gifts to Physicians from Industry,” adopted December 1990; (JAMA. 1991; 265: 501 and Food and Drug Law Journal.1992; 47:445-458); Updated June 1996 and June 1998.

For additional information go to www.ama-assn.org/go/ethicalgifts
**BUTLER HOSPITAL:**

Term of Service is from July 1 to June 30.

The salary listed below is for the academic year 2013 - 2014

Salary is paid bi-weekly in 26 equal paychecks

<table>
<thead>
<tr>
<th>PGY</th>
<th>Salary</th>
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<tr>
<td>5</td>
<td>$64,423</td>
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<tr>
<td>6</td>
<td>$68,042</td>
</tr>
</tbody>
</table>
The Brown University Geriatric Psychiatry Fellowship Training Program, the Department of Psychiatry and Human Behavior (The Department) and Butler Hospital (The Hospital) offer and the Physician hereby accepts appointment as Resident/Fellow (The Resident) under the following terms and conditions:

Geriatric Psychiatry Resident: _____________________________________________

Level Training (PG Year): ____________________________

Duration: (One year) From: ________________ To: ________________

Annual Stipend: ____________________________

I. GENERAL PROVISIONS

A. The Department, as program Administrator, shall be responsible for providing a residency program that meets the standards of the General and Special Requirements of the Essentials for Accredited Residency Programs as prescribed by the Accreditation Council for Graduate Medical Education and/or that is accepted by the American Board of Psychiatry and Neurology.

B. The Hospital, as employer and business administrator, shall be responsible for:

1. Providing a training program that meets the standards of the General and Special Requirements of the Essentials for Accredited Residency Programs as prescribed by the Accreditation Council for Graduate Medical Education and/or that is accepted by the American Board of Psychiatry and Neurology and,

2. Providing payment of a stipend in regular installments, subject to stipulations specified herein and Hospital policies regarding payroll production and payment for disabilities whether related or non-related to the training program. The Hospital’s obligation to provide said program and payments at all times is subject to The Resident’s performance hereunder.

C. The Resident, in consideration of the above, agrees to:

1. Participate in safe, effective and compassionate patient care under supervision, commensurate with his/her level of advancement and responsibility.

2. Participate fully in the educational activities of The Department’s Geriatric Psychiatry Fellowship Training Program and, as reasonably required, assume responsibility for assisting in the teaching and supervision of other Residents and students.

3. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures and policies of the other institutions participating in activities and rotations assigned as part of this specific training program.

4. Assure The Hospital that he/she is eligible for limited medical registration or full licensure as a physician in the state of Rhode Island.

5. Participate in institutional committees and councils, especially those that relate to patient care activities.

6. Develop a personal program of self-study and professional growth with guidance from the Director of Geriatric Psychiatry Fellowship Training Program and academic faculty.

7. Conform to The Hospital (or to any health care facility or agency to which assigned) bylaws, policies, procedures and regulations and applicable federal and state laws.

8. Apply cost containment measures as appropriate in the provision of patient care.
9. Complete all patients’ medical records within the time period specified by The Hospital (or to any health care facility or agency to which assigned). Failure to comply may result in disciplinary action.

10. Refrain from any form of discrimination or sexual, racial, ethnic or other harassment. Racial, sexual or ethnic harassment includes any actions which have the purpose or effect of creating an intimidating, hostile or offensive working environment on the basis of race or ethnicity. Sexual Harassment includes offensive and/or unwelcome sexual advances, request for sexual favors and other verbal or physical conduct of a sexual nature, when such conduct has the purpose or effect of creating an intimidating, hostile or offensive working environment. Failure to comply with this requirement may result in disciplinary action up to and including termination.

II. TERMS OF APPOINTMENT AND GUIDELINES FOR EVALUATION

A. Execution of this contract signifies The Resident’s commitment to accept an appointment as Resident for the academic year _______________. The Resident agrees not to engage in interviews for, or to discuss placement in, other Graduate Medical Education programs for the academic year ______________. 

B. It is agreed that the initial term of the Agreement shall be for a period of one year as specified herein. The parties agree to a non-binding understanding that, subject to the Resident’s performance of duties, the structure and capacity of the program, the financial capacity and needs of The Hospital (or to any health care facility or agency to which assigned) and a favorable recommendation from the Director of Geriatric Psychiatry Fellowship Training Program, The Resident with his/her agreement, will be reappointed annually through the completion of the normal course of training of the respective program.

C. The Parties further agree that under no circumstances will The Resident terminate this Agreement prior to its expiration date without 30 days prior written notice to The Department.

D. Both parties acknowledge and agree to the terms of The Department’s Policy and Procedure Statement, Guidelines for Resident’s Evaluation attached hereto and incorporated herein by reference.

E. The Resident acknowledges his/her understanding that acceptance to and completion of this training program in no respect guarantees or implies any right to medical staff appointment or granting of medical staff privileges in any other capacity or any other employment nor does completion entitle The Resident to any subsequent consideration for appointment by The Department.

III. BENEFITS

A. Vacation: Vacations will be scheduled during the term of this Agreement with the Geriatric Psychiatry Fellowship Training Program Director. Vacation schedules must take into consideration the needs of the program and are subject to the approval of the Director. The amount of vacation is set forth in Appendix A.

B. Employee Benefit Plans: Coverage under The Hospital employee benefit program, for Health Insurance, Dental Insurance, and Life Insurance is available to Residents. The type of coverage offered will be governed by The Hospital’s benefits policies as in effect from time to time for salaried employees during the term of this Agreement. Copies of specific policies currently in effect are available from the Butler Hospital Human Resources Department. If The Hospital conducts a re-enrollment of its health plan(s) during the term of this Agreement, The Resident will be offered the opportunity to re-enroll according to The Hospital’s benefits policies in effect at the time for its salaried employees; provided, however, that the amount of premium paid by The Resident for the benefit coverage elected will be the premium in effect at that time for salaried employees.

C. Workman’s Compensation, long-term disability insurance and life insurance are provided as set forth in Appendix A.

D. Professional Liability Insurance Coverage (Malpractice) is provided to all Residents. Professional liability insurance coverage is provided through The Hospital’s insurance policy for all activities and rotations undertaken as part of The Resident’s training program. Coverage for limited extra-curricular activities (moonlighting) is provided and must be arranged by The Resident in consultation with the Training Director and The Hospital. Any Resident who provides services beyond those assigned as part of the specific training program and for which a training program stipend is received, whether or not The Resident receives (or was to receive) other compensation, is considered to be moonlighting.
E. Leave-of-Absence Benefits: Benefits are provided to Residents in accordance with The hospital’s leave-of-absence policy, a copy of which is available from the Human Resources Department of The Hospital. Specific training schedule accommodations must be agreed to in advance by the Geriatric Psychiatry Residency Training Program Director.

F. Limited medical Registration: If The Resident is not eligible for or does not desire full medical licensure, The hospital will register The Resident and pay for Limited medical Registration in Rhode Island. Practice of any kind of outside activities and rotations assigned as part of the specific training program are governed by the terms of the limited registration.

G. Living Quarters (while on duty): Only on-call rooms are provided by The Hospital (or to any health care facility or agency to which assigned). “Living quarters while on duty” consist of a shared overnight room which The Hospital will provide without expense to The Resident.

This agreement must be signed by all parties and returned to the Geriatric Psychiatry Fellowship Training Program Director prior to beginning training.

In witness whereof the parties hereto have subscribed their names.

Brown University Geriatric Psychiatry
Fellowship Training Program

______________________________  _______________________
Signature                                    Date
Director, Brown University Geriatric Psychiatry
Fellowship Training Program

Name: Robert Kohn, MD

Butler Hospital

______________________________  _______________________
Signature                                    Date
President

Name: Patricia R. Recupero, JD, MD

Resident

______________________________  _______________________
Signature                                    Date

Name: ________________________________

04/05
I. VACATION

PGY-5  4 weeks
PGY-6  4 weeks

II. WORKMAN’S COMPENSATION

Residents are covered by Butler Hospital’s Workman’s Compensation plan for on-the-job injuries.

III. LONG-TERM DISABILITY INSURANCE

After six months of an illness or injury which prevents work, residents would receive monthly earnings consistent with their individually chosen option, at the time of the occurrence.

IV. LIFE INSURANCE

Residents are covered for a life and accidental death or dismemberment benefit for an amount equal to 1 and 1/2 times their annual salary up to a maximum of $50,000.
VACATION TIME

1. Vacation time is not accrued, in contrast to the statement in the employee handbook, but is based on the geriatric fellow's academic year. The entire time for that year is available as of July 1. A week is considered as comprising 5 working days and the weekend immediately following. For the purposes of accounting time available, only weekdays are counted.

   PGY-5+  4 weeks vacation

2. Any vacation time not taken during that academic year does not carry over to the next year and is not bought back. Other constraints (see guidelines below) are determined by the Director of the Geriatric Psychiatry Fellowship Training Program and the Policy Committee. These guidelines are in place in order to preserve the academic goals of clinical assignments.

   GUIDELINES
   Maximum  3 days per 1-month assignment.
   Maximum 1 week per 2-month assignment.
   Maximum 2 weeks per 3-month or 4-month assignment.
   Maximum 3 weeks per 6-month or 8-month assignment.

3. Conference time and vacation time are combined when observing these limits for time away from a clinical rotation (see conference time/funding).

4. Obtain prior written approval from faculty attending. Have the faculty attending fax and mail a signed Butler Hospital Leave of Absence Request to the Geriatric Psychiatry Fellowship Training Program office a minimum of two weeks prior to the anticipated leave.

5. Personal days and Conference Time taken during a clinical assignment should not, combined with vacation time, exceed the vacation time maximum.

6. Submit Butler Hospital leave slip (attached) to Geriatric Psychiatry Fellowship Training Program office and obtain approval from clinical supervisor and Director or Associate Director of the Geriatric Psychiatry Fellowship Training Program prior to relevant pay period.

7. Arrange vacation time of more than 1-week duration at beginning or end of clinical assignment unless the clinical supervisor and Geriatric Psychiatry Fellowship Training Program office give explicit approval for other arrangements. Vacation leave in excess of two contiguous weeks is discouraged.

8. Requesting vacation in July is discouraged. Some clinical rotations have specifically prescribed times for vacation due to continuity issues. Fellows are referred to the service attending to review these specific guidelines.

9. Discuss requests for exceptions to guidelines with faculty attending and Director or Associate Director of the Geriatric Psychiatry Fellowship Training Program and obtain written approval well in advance.

10. Arrange coverage for all clinical responsibilities, including all patient care and DOC responsibilities a minimum of two weeks prior to anticipated vacation time. Inform the Geriatric Psychiatry Fellowship Training Program office of coverage arrangements in writing on the Butler Hospital Coverage Responsibilities form (see attached).

11. Since Fellows are salaried employees they are not eligible for “comp time”. This “comp time” policy is different from the policy in the Butler Employee handbook.

12. Fellows are urged to carefully plan out their vacations for the entire year at the start of the academic year so they can use all of the allowed vacation time.

13. Vacation leave in excess of two contiguous weeks is discouraged and requires explicit approval from the Director/Associate Director of the training program.
COVERAGE RESPONSIBILITIES

FOR: ___________________________ DATES: ___________________________

RESPONSIBILITIES FOR INPATIENTS WILL BE COVERED BY:

DR. ___________________________

RESPONSIBILITIES FOR OUTPATIENTS WILL BE COVERED BY:

DR. ___________________________

RESPONSIBILITIES FOR NURSING HOMES PATIENTS WILL BE COVERED BY:

DR. ___________________________

RESPONSIBILITIES FOR HOME CARE PATIENTS WILL BE COVERED BY:

DR. ___________________________

OTHER CLINICAL RESPONSIBILITIES WILL BE COVERED BY:

DR. ___________________________

SPECIFY: ___________________________

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☐ ADMISSIONS BUTLER HOSPITAL

☐ SWITCHBOARD BUTLER HOSPITAL

☐ LIPPITT UNIT BUTLER HOSPITAL

☐ MIRIAM HOSPITAL PSYCHIATRY DEPARTMENT

☐ EMA COSTA

DEADLINES: NO LATER THAN ONE WEEK PRIOR TO SCHEDULED ABSENCE

2/24/11
HOLIDAY AND SICK LEAVE

Fellows may observe up to 11 holidays and one float day per year according to the guidelines of Butler Hospital. **Fellows will observe the holiday schedule of the hospital at which they are working.** If required to work a holiday a “comp day” does not accrue. Over the course of the four years, this circumstance generally evens out.

**Butler Hospital Holidays:**

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independence Day</td>
<td>July</td>
</tr>
<tr>
<td>Victory Day</td>
<td>August</td>
</tr>
<tr>
<td>Labor Day</td>
<td>September</td>
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<td>Columbus Day</td>
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<td>Veterans Day</td>
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<td>Thanksgiving Day</td>
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<td>Christmas Day</td>
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<td>New Years Day</td>
<td>January</td>
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<tr>
<td>President's Day</td>
<td>February</td>
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<tr>
<td>Float Day*</td>
<td>April</td>
</tr>
<tr>
<td>Memorial Day</td>
<td>May</td>
</tr>
</tbody>
</table>

*Float Day is an extra holiday. It accrues on April 1 and must be used by June 30 or else it is forfeited.

Sick days: These accumulate from year to year. There are 12 of these days per year and are accrued on a bi-weekly basis.

02/24/11
SICK LEAVE AND BEREAVEMENT LEAVE POLICY

1. All sick time or leave must be requested from the Geriatric Psychiatry Fellowship Training Program Office with the approval of the clinical supervisor.

2. The fellow must notify the Geriatric Psychiatry Fellowship Training Program Office immediately (on the day of absence) of any sick leave taken. The fellow must also file a written leave request as soon as possible (see attached).

3. Sick leave in excess of three working days requires a physician note.

4. Sick leave does accumulate during the fellowship. Any accumulated sick leave is forfeited upon leaving the fellowship.

5. All fellows are eligible for up to three days of Bereavement Leave over the above all other leave allowances. Bereavement Leave is awarded upon the death of a first-degree relative for the purposes of funeral responsibilities. Fellows are required to complete a Butler Hospital Leave of Absence Request form for bereavement leave.
EXTENDED LEAVE POLICY

1. During the period of fellowship training absence due to sickness, pregnancy or parental leave for greater than twenty consecutive work days (four work weeks) is considered extended leave. When extended leave can be anticipated fellows are requested to consult with the training directors to coordinate the absence with their educational needs and requirements.

2. After twenty consecutive days of absence for any cause (vacation, sick leave, conference leave, leave without pay) no academic credit will be given for the period of absence.

3. After a total of twenty days absence, individual review with the Director or Associate Director of the Geriatric Psychiatry Fellowship Training Program is necessary.

4. Although a fellow may receive academic credit for periods of up to twenty days absence, the Director of the Geriatric Psychiatry Fellowship Training Program may require the Fellow to do additional work in a given clinical area in order to complete requirements of the fellowship, as stipulated by ACGME and ABPN.

5. Call for periods for which academic credit is given will be made up, but no call should be made up for periods for which no academic credit is given.

6. A fellow’s clinical duties and responsibilities during extended leave will be reassigned in collaboration with the Director or Associate Director of the Geriatric Psychiatry Fellowship Training Program, clinical site supervisor, and the fellow on leave. Ordinarily, clinical site responsibilities will be reassigned by the site supervisor, outpatient responsibilities will be distributed to other Fellows, and call will be distributed to other fellow’s clinical faculty.

7. Ordinarily a fellow will be paid during periods of extended leave according to the policy of the host institution and the limits of accumulated sick and vacation time.

8. Benefits will continue to be provided by the host institution according to their extended leave policies.

9. Malpractice insurance will be suspended during extended leaves of absence and reinstated upon return.

10. The fellow is required to report periods of extended leave to the RI Board of Medical Licensure and Discipline.
BUTLER HOSPITAL

LEAVE OF ABSENCE REQUEST

I, ________________________________, request approval for leave of absence for the period of __________________________, 20___, TO __________________________, 20___.

Number working dates __________________________ and/or Number working hours __________________________

(Check all that apply) For sick leave specify nature of disabling illness:

Vacation with pay ☐
Sick leave with pay ☐
Holiday with pay ☐
Balance without pay ☐
Other ☐ Explanation __________________________________________________________

Sick leave of more than 3 days must be accompanied by a physician’s note.

Date ______________________ 20___ Employee’s Signature __________________________________

_____________________________ OR ______________________________
Immediate Supervisor Department Head
ACADEMIC CREDIT GUIDELINES

1. Credit will be granted for those clinical assignments, which the fellows have substantially completed. These guidelines acknowledge that unexpected absence due to sickness or bereavement may occur after previously approved time off has been taken and do not override the vacation guidelines.

2. Guidelines for “substantial completion”
   - 3 weeks in a one-month rotation (one week absence)
   - 7 weeks in a two-month rotation (one week absence)
   - 10 weeks in a three-month rotation (two week absence)
   - 14 weeks in a four-month rotation (two week absence)
   - Time completed but no greater than 4 weeks (20 working days) of absence in a rotation of five months or greater.

3. Academic credit is distinct from salary reimbursement. Fellows will receive salary reimbursement according to the sick leave policy of assigned payroll site.

4. Successful completion of all required assignments is a pre-requisite for graduation from the program. Absences which interfere with the educational progress of the fellow, even if less than the above noted times, will be discussed with the individual fellow by the fellow’s supervisor and with the Director or Associate Director of the Geriatric Psychiatry Fellowship Training Program.

5. Absences in excess of the above guidelines will be made up by the fellow. This will be done by completing the assignment during elective time later in the fellowship. Make-up time periods will be rounded up to the nearest whole week.

6. Absence includes vacation, conference time, sick time, personal time, bereavement and extended leave.
CONFERENCE TIME AND FUNDING

1. Fellows are encouraged to incorporate the practice of attending conferences into their professional development. Ordinarily academic credit is awarded for conference attendance; thus, fellows are asked to carefully consider their selection of conferences.

2. In selecting conferences and requesting conference leave the educational benefit of the activity should be the determining factor. To obtain conference time and reimbursement the fellow must submit in writing, in advance, a request to attend the conference. A copy of the conference announcement should be included. Written approval should be obtained from the Geriatric Psychiatry Fellowship Training Program office prior to the meeting. Any funding for attending a meeting or a conference which is being provided from sources other than the fellowship must be disclosed to the Director or Associate Director of the Geriatric Psychiatry Fellowship Training Program at the time the request for permission is submitted. The Geriatric Psychiatry Fellowship Training Program believes continuing education is a critical aspect of professional practice. Therefore we encourage fellows to develop the “habit” of attending educational conferences, grand rounds, workshops and training's. Fellows may attend one conference per year with a period of absence up to the limit described in #5.

3. Obtain prior written approval from unit chief.

4. Submit a Butler Hospital leave slip to the Geriatric Psychiatry Fellowship Training Program office and obtain approval by the Director or Associate Director of the Geriatric Psychiatry Fellowship Training Program prior to relevant pay period.

5. Note coverage arrangements for all patient care responsibilities on the coverage form. Arrange coverage for all clinical responsibilities, including all patient care and DOC responsibilities. Inform the Geriatric Psychiatry Fellowship Training Program office of coverage arrangements.

6. Conference Leave, maximum allowable leave is 5 working days per conference, and two conferences per year. Fellows are strongly encouraged to attend the annual meeting of the American Association for Geriatric Psychiatry.

7. Conference attendance will generally be limited to the period August through May.

8. Requests for conference time to be taken back-to-back with vacation time are discouraged. Conference time and vacation time are combined when observing the limits from time away from a clinical rotation (see vacation time).

9. Fellows are expected to provide receipts for all expenses including travel, parking and transportation, meals, hotel expenses, and conference registration fees. Reimbursement will not be made for expenses, which are not adequately documented by an original receipt.

10. Discuss requests for exceptions to these guidelines with the Director or Associate Director of the Geriatric Psychiatry Fellowship Training Program Office, and obtain written approval well in advance.

11. Fellows who present a paper at a conference may make additional requests for time and funding. Fellows are strongly encouraged to contribute to the scientific programs of national professional organizations. Approval must be requested in writing and in advance from the residency training office. Additional funding to a maximum of $500.00 per year may be available.

12. Any funds received from drug companies, other supporting agencies, or as honoraria, should be deposited to the fellowship account. Scholarships, which cover the actual cost of transportation, housing, registration and meals, need not be deposited to the fellowship.

13. Expenditures must be requested in writing and in advance. Requests must be approved by the Director or Associate Director of the Geriatric Psychiatry Fellowship Training Program. Receipts are required. All receipts must be received prior to the end of the academic year.

Conference/Travel Allowance: $1,000
GERIATRIC PSYCHIATRY FELLOW
BENEFITS AND EXPENSES

1. Fellows are eligible for reimbursement for the following expenses:

   Rhode Island Limited License          $ 25.00 per year
   Rhode Island CMD Registration         $ 50.00 per year
   DEA Registration                      $210.00  (once in 3 years)
   Rhode Island Full License             $350.00 (application fee)
                                          $350.00 (medical licensure)
                                          $250.00 (yearly fee)
   Massachusetts Limited License         Covered by Boston Medical Center
   APA Member-in-Training Dues           $105.00 per year
   AAGP Member-in-Training Dues          $ 75.00 per year
   Book Allowance                        $ 200.00 per year

FELLOWS ASSIGNED TO A MASSACHUSETTS TRAINING SITE ARE REQUIRED TO APPLY FOR A MA LICENSE AT LEAST 4 MONTHS IN ADVANCE OF BEGINNING THE ASSIGNMENT. CONTACT GERIATRIC MEDICINE PROGRAM AT BOSTON MEDICAL CENTER. IT IS THE FELLOW'S RESPONSIBILITY TO INITIATE THE PROCESS.

2. All requests for reimbursement must be accompanied by an appropriate sales slip or receipt in the case of the request for book reimbursement. The sales slip must itemize the name of the book and author as well as the price.

3. Reimbursements will be disbursed on a quarterly basis. Requests for reimbursement for each quarter must be submitted to the Geriatric Psychiatry Fellowship Training Program office by September 15, December 15, March 15, and June 15th of each year. Requests will then be batched and processed. Reimbursement generally follows within 2 weeks.
DUTY HOUR POLICY

In accordance with the ACGME requirements regarding work/duty hours, the Brown University Geriatric Psychiatry Training Program complies with the following duty hour schedule:

Duty hours are defined as all clinical academic activities related to the residency program, i.e. patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during all activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

1. Duty hours will be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and in-house moonlighting.

2. Residents will be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four week period, inclusive of in-house call.

3. Adequate time for rest and personal activities will be provided. This will consist of a 10-hour time period provided between all daily duty periods, and after in-house call.

4. Residents will not be assigned on-call in-house duty more often than every third night.

5. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care. No New patients will be assigned during six-hour post call.

6. Residents could be assigned on-call duty from home occasionally.

7. Moonlighting is permitted in accordance with the Institutional and Program Policies on Moonlighting Activities.

Residents will be required to provide documentation of on-duty hours weekly.

Revised 6/25/2010
GUIDELINES FOR WEEKEND INPATIENT COVERAGE RESPONSIBILITIES

The following guidelines have been developed to clarify resident on-call responsibilities as doctor-on-call (DOC) and as a physician responsible to inpatients. They have been developed to address the educational goals of DOC and inpatient training, to conform to ACGME requirements, and to accommodate the DOC responsibilities at the various hospitals.

1. Residents rotating on inpatient services are responsible for the off-hour clinical needs of their patients except on weekends.

2. Residents must be free of inpatient and DOC responsibilities at least one weekend per month (Saturday & Sunday).

3. DOC assignments need to take precedent over inpatient coverage responsibilities. With the approval of their supervisory attending, residents are permitted to fulfill inpatient coverage responsibilities on the same day as DOC responsibilities.

4. Residents are expected to keep their pagers off on weekends.

5. Residents doing their inpatient rotation should not be paged or called regarding patients that they are following on the inpatient geriatric unit from 8 AM Saturday morning - 8 AM Monday morning. The assigned attending for the geriatric psychiatry inpatient unit will be responsible for those patients.

6. For the geriatric psychiatry residents’ outpatients who need to speak to a physician on a weekend, the outpatient attending or his/her coverage will handle all telephone calls from 8 AM Saturday morning - 8 AM Monday morning.
THE LOTTERY

On occasion more fellows request a clinical site, supervisor, vacation time or other limited resource/commodity than can be accommodated. In an effort to be fair, and recognize this validity of each fellow’s circumstances, the training directors will utilize a lottery mechanism to allocate the resource. The order of assignment of fellows will be determined by drawing names out of a hat. All first year fellows, however, will get each of the required rotations and training. Second year fellows will be given preference over first year fellows for resources that do not prejudice the training of first year fellows.
MOONLIGHTING

1. Residents may only moonlight with the permission of the Fellowship Training Director or Associate Fellowship Training Director. Permission must be obtained in advance of all moonlighting in order to review academic standing, licensure, and malpractice coverage.

2. Residents in academic difficulty (special evaluation or academic probation status) may not moonlight.

3. Moonlighting activities must not interfere with the clinical duties assigned by the residency. Total hours worked per week including moonlighting may not exceed 80 hours. Residents must remain compliant with ACGME work-hour rules taking into consideration their moonlighting shifts.

4. In order to moonlight, a resident must obtain a full medical license or a moonlighting license from the appropriate state authorities. No moonlighting may be done on the resident's limited license.

5. The resident must obtain appropriate malpractice insurance coverage for all moonlighting activities.

6. Residents must report moonlighting activities semiannually to the training office on the semi-annual self evaluation form.

7. In order to do moonlighting, the resident must have passed USMLE or COMLEX Step 3.

8. Residents are not permitted to perform moonlighting duties concurrently with pager call duties that may require the resident to go any of the hospitals in the Brown Program.

Revised 06/25/2010
During academic year ________________ I have no commitments of any kind involving moonlighting activities and will have none, except for the activities listed below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Hospital</th>
<th>Frequency on Call/Month Night/Weekend</th>
<th>Has written approval for this activity been received from the Director/Associate Director of the Geriatric Psychiatry Fellowship Training Program</th>
<th>Date of Approval</th>
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<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td>NO</td>
<td>YES</td>
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<tr>
<td>2.</td>
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<td>NO</td>
<td>YES</td>
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<tr>
<td>3.</td>
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<td>NO</td>
<td>YES</td>
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</tbody>
</table>

Changes to moonlighting activity since report dated ________________ are listed below.

<table>
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<tr>
<th>Location</th>
<th>Hospital</th>
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<tr>
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<td></td>
<td>NO</td>
<td>YES</td>
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<tr>
<td>2.</td>
<td></td>
<td></td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

Fellow's Name __________________________________________ Fellow's Signature ___________ Date ___________

Reviewed by __________________________________________ Date ___________
Director/Associate Director, Geriatric Psychiatry Fellowship Training Program
SEXUAL, RACIAL AND ETHNIC HARASSMENT

The Brown University School of Medicine Psychiatry Residency will observe the policies of Brown University pertaining to sexual, racial, or ethnic harassment. Resident concerned about harassment is encouraged to discuss their concerns with the training directors.

**How to Assess and Manage a Complaint of Sexual Harassment.**

**Definition:** Two types of sexual harassment in education are described\(^1\). **Quid pro quo** sexual harassment occurs when a school employee or agent explicitly or implicitly conditions a student’s participation in an educational program or activity, on the student’s submission to unwelcome sexual advances, requests for sexual favors or the verbal, non-verbal or physical conduct of a sexual nature. **Hostile environment** sexual harassment occurs when unwelcome sexual conduct is sufficiently persistent, severe or pervasive as to limit a student’s ability to participate in or benefit from an educational program or activity or to create a hostile or abusive educational environment. The behavior of “a school employee, another student, or a non-employee third party” can create a hostile environment.


**Obligation under the Law.** Once a school official has knowledge of harassment, then the school has a responsibility to take appropriate steps to change the situation. This may include re-assignment of the student or suspension of the harasser. Even if the student doesn’t complain but the school still has knowledge of the harassment, the school is still liable. Students must be protected from retaliation by harasser after a complaint is made.

**General Guidelines for handling a trainee complaint.**

1. Arrange a meeting.

2. Listen, be empathic, establish details (name, place and time).

3. Ask about any prior interactions with this person (appropriate or inappropriate).

4. Ask if they know of any other incidents of alleged harassment from this person.

5. Involve trainee in problem solving:

   a) Describe the school’s liability and responsibility to correct the situation and to protect from the trainee from retaliation.

   b) Arrange a change in rotation / preceptor.

   c) It may be unclear if the incident meets the legal definition of harassment. A useful first step is to call the Consultants to the Office of Women in Medicine on Sexual Harassment to review the case and the most appropriate procedure to follow. If it does not meet the legal standard of harassment, it will certainly constitute mistreatment and appropriate actions and informal reporting can occur.

   d) If the behavior meets the legal definition of harassment, then the school must take appropriate action. In the hospitals, the human resources department receives the complaint and takes over the investigation. If the harasser works in a small community based setting without such a department, then options might include filing a complaint with the Board of Registration, who would take over the case and using their own lawyers, conduct an investigation. State Medical Associations also have ethic boards where complaints can be heard. If the person holds a university appointment, a formal complaint can be made to the university. The complaint can be made to the EEO/AA Committee or to the Office of the Dean. The student always has the option of filing their own complaint using their own lawyer.
Butler Hospital Risk Management

Procedure for Response to Legal Matters

(Subpoena, Suit, Deposition, etc.)

In the event of receiving documents or phone calls concerning legal matters, the procedure is as follows:

1. Call the hospital Risk Manager, Walter Dias, at 455-6272 and inform him of the situation. Mr. Dias will take the information on the matter and ask for copies of any documents. He will contact the hospital attorney for any matter requiring legal representation, and will answer questions and manage details. If he is unavailable, Camille Hamel, of Risk Management, will handle the matter and can be reached at the same phone number.

2. Call the Medical Director for Medical Administration, Dr. Martin Furman, at 455-6369, and also notify him of the matter. He will assist with any clinical issues involved.

Please take the above steps before making any responses or arrangements concerning the legal matter.
MEDICAL MALPRACTICE INSURANCE

All fellows are covered by professional liability insurance for services provided as an official part of the geriatric psychiatry fellowship. This insurance does not cover moonlighting activities.
Butler HIPAA Privacy Notice

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION ("PHI")

This notice explains how we use and share your protected health information ("PHI" for short). We are required by law to protect the privacy of PHI, and to provide you with this notice and follow the privacy practices described in it.

PHI includes information that we create or receive about your past, present, or future physical or mental health or condition, the provision of health care to you, or the payment for health care provided to you.

We may change the terms of this notice and our privacy practices at any time. Any change we make will apply to the PHI we already have as well as to any new PHI we create or receive. When we change our practices, we will promptly change this notice and post it in our main reception area and our web site at www.butler.org.

III. HOW WE MAY USE AND SHARE YOUR PHI

We may use and share PHI for many different reasons. Below, we describe the different reasons and give you some examples.

A. Use of PHI for Treatment, Payment, or Health Care Operations. We may use and share PHI for the following reasons:

1. For treatment. We may use and share PHI with physicians, nurses, medical students, and others who provide you with health care services or are involved in your care. For example, if you are being treated for diabetes, we may share PHI with your primary care physician in order to coordinate your care.

2. For payment. We may use and share PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may share PHI with your health plan to get paid for the health care services we provided to you. We may also share PHI with billing companies and companies that process our health care claims.

3. For health care operations. We may use and share PHI to operate this hospital. For example, we may use PHI in order to evaluate the quality of health care services that you receive, or to evaluate the health care professionals who provide health care services to you. We may also share PHI with our accountants, attorneys, and others in order to make sure we are complying with the laws that affect us.

B. Other uses of PHI. We may also use and share your PHI for the following reasons:

1. Reports required by law. We will disclose PHI when we are legally required to do so by federal and state law. For example, we may use PHI to make mandatory reports to various government agencies about suspected child or elderly abuse and/or neglect, communicable diseases; problems with medical and other products, and reactions to medications; and certain types of deaths and injuries.

2. Health oversight. We may disclose your PHI to government agencies authorized by law to license, audit, inspect, or investigate health care providers and the health care system.

3. Research. We may use and disclose your PHI for research purposes, provided that certain procedures are followed. Depending on the circumstances, state law may require us to obtain your written consent before using and disclosing your PHI for research purposes. If state law requires us to obtain your consent, we will do so before using or disclosing your PHI for research purposes.

4. To avoid harm. Consistent with state law, we may report PHI to the police or other appropriate persons, in order to avoid a serious threat to the health or safety of a person or the public.

5. Appointment reminders and health-related benefits or services. We may use PHI to give you appointment reminders; or give you information about treatment choices or other health care services or benefits we offer.

6. Legal proceedings. We may disclose PHI pursuant to a valid court order, search warrant, and, under certain circumstances, in response to a subpoena or other discovery request.
C. When You May Object to Our Use of Disclosure of PHI.

1. Disclosures to family or others. Unless you tell us not to, if we think it is in your best interest, we may tell your lawyer, your guardian or conservator (if any), or a member of your family that you are a patient at Butler.

2. Disclosures to the Mental Health Advocate. Unless you tell us not to, we may tell the Mental Health Advocate your name and when your treatment at Butler began.

D. When Our Use or Disclosure of PHI Requires Your Prior Written Authorization. We must ask for you written authorization for any use or disclosure of PHI not described in sections III-A, B, or C above. If you authorize us to use or disclose your PHI, you can later withdraw the authorization and stop any future use or disclosure of your PHI based on it.

You can remove an authorization by written request to the Correspondence Specialist, Clinical Information Services Department, Butler Hospital, 345 Blackstone Blvd., Providence, RI 02906 (401-455-6321).

IV. YOUR RIGHTS REGARDING YOUR PHI

A. Your Right to Request Limits on Our Use of PHI. You may ask that we limit how we use and share your PHI. We will consider your request but are not legally required to agree to it. If we agree to your request, we will follow your limits, except in emergency situations.

B. Your Right To Choose How We Send PHI to You. You may ask that we send information to you at a different address (for example, to your work address rather than your home address) or by different means (for example, by mail instead of telephone). We will agree to your request, as long as we can easily provide the information in the way you requested.

C. Your Right to View and Get a Copy of PHI. You have the right to view or obtain a copy of your PHI. Your request must be in writing. However, there are some circumstances in which we may deny your request. If we deny your request, we will tell you, in writing, our reason(s) for the denial and explain what appeal rights, if any, you have.

If you request a copy of your PHI, we may charge a fee for it if permitted to do so by law. Instead of providing the PHI you requested, we may offer to give you a summary or explanation of the PHI, as long as you agree to it, and to the cost, in advance.

D. Your Right to a List of the Disclosures We Have Made. You have a right to get a list of the disclosures we have made of your PHI. Some disclosures will not be listed, however. For example, the list will not include disclosures made for the purpose(s) of treatment, payment, or health care operations, or disclosures that you authorized or that were made directly to you.

We will report disclosures made within the six years prior to your request, unless you request a shorter timeframe. However, our obligation to account for disclosures begins with disclosures made after April 13, 2003.

If you ask for more than one accounting within a twelve-month period, we may charge you a fee for every accounting provided after the first one. For a list of disclosures, you must submit a request to the Correspondence Specialist, Clinical Information Services Department, Butler Hospital, 345 Blackstone Blvd., Providence, RI 02906 (401-455-6321)

E. Your Right to Correct or Update Your PHI. If you feel that there is a mistake in your PHI or that important information is missing, you may request a correction. Your request must be in writing and include the reason for the request. Your request must be made to the Correspondence Specialist, Health Information Management Department, Butler Hospital, 345 Blackstone Blvd., Providence, RI 02906 (401-455-6321).

We may deny your request for a variety of reasons. If we deny your request, we will inform you in writing of the reason(s) for the denial and explain your rights responding to the denial.

If we agree to your request, we will change your PHI, inform you of the change, and tell others who need to know about the change to your PHI.

F. Your Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, even if you agreed to receive it electronically. You may request a paper copy at any time.
V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice, wish to file a complaint about our privacy practices, feel that we may have violated your privacy rights, or disagree with a decision we made about your PHI, please contact our Privacy Officer: Associate Medical Director for Quality and Regulations, 345 Blackstone Blvd., Providence, RI 029906, (401)-455-6296).

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

VI. EFFECTIVE DATE OF THIS NOTICE

This notice is in effect as of April 14, 2003, and supersedes any prior versions of this notice.
1. The Psychiatry Residency Review Committee of the ACGME requires fellows to maintain a confidential patient log of all patients they treat. It further requires that this log be reviewed by the Director or Associate Director of the Geriatric Psychiatry Fellowship Training Program (or designee) to evaluate the adequacy and breadth of clinical experiences. This log may also be requested upon demand during an ACGME site visit.

2. All fellows must maintain a log of all patients they treat during their geriatric psychiatry fellowship. This includes patients seen during doctor-on-call and emergency psychiatry, but not during telephone call. A separate log should be maintained for each clinical experience.

3. This log must be periodically reviewed by the fellow’s general outpatient supervisor to assess the adequacy and breadth of clinical syndromes and treatment modalities. This log will also be reviewed during the semi-annually.

4. A copy of a sample log sheet is attached.
Seminar Attendance

1. Residents are required to attend a minimum of 70% of their seminars. This requirement meets the new ACGME Psychiatry-RRC guidelines.

2. Documentation of attendance is secured by each resident signing to attest to their attendance during the scheduled seminar and completing the seminar evaluation form. A binder with the copies of the attendance log and evaluations are kept in the geriatric psychiatry fellowship office.

3. Fellow attendance is reviewed at each bi-annual meeting with the Geriatric Psychiatry Fellowship Directors.

4. Failure to meet the 70% threshold or misrepresenting attendance will constitute grounds for initiating the Guideline for Resident Evaluation and may jeopardize the resident’s standing in the fellowship.

5. For the purpose of calculating percent attendance, eligible seminars (the denominator) do not include lectures given during the following: Butler Hospital PAS and approved vacation, conference or sick leave.

3/12/05
SUPERVISION GUIDELINES

Each fellow is expected to contact his/her assigned supervisor(s) at the beginning of each rotation to set up a regularly scheduled, mutually convenient time for supervision. Clinical supervision of Fellows will generally be provided by the clinical site supervisor. Supervision should also address issues around the parameters of clinical practice such as fees, scheduling, missed appointments and confidentiality.

Supervision ordinarily focuses on medication management, psychodynamic theories, cultural and/or social issues and resources, and other issues relevant to a general outpatient practice setting. Supervisors are expected to review clinical material including process notes, videotapes, audiotapes and, at a minimum, clinical notes. Supervisors are expected to co-sign clinical notes. Supervisors are expected to verbally evaluate fellow’s midway through the rotation and provide a written formal evaluation at the conclusion of the rotation.

Supervisor Evaluation

Supervisors are expected to evaluate the resident midway (every two months) through the rotation and at the conclusion of the rotation.
Brown Psychiatry Residencies’ Policy Regarding Resident Due Process

I. Selection
Brown Psychiatry Residencies (including the General Psychiatry Residency and the Geriatric Psychiatry Fellowship) have as their policy to consider all candidates for residency training regardless of race, sex, creed, nationality, age, or sexual orientation. Performance in medical school, personal letters of recommendation, official letters of recommendations, achievements, humanistic qualities, and qualities thought important to Psychiatry will be used in the selection process.

II. Evaluation and Advancement of House Officers
There is a clearly stated process for the evaluation and advancement of residents and fellows (hereafter referred to as trainees) in the Brown Psychiatry Residencies.

A. Evaluation of Residents
1. Each resident is evaluated by the Training Director and/or the Associate Training Director with the assistance of the teaching staff, for evidence of satisfactory progressive scholarship and professional growth, including demonstrated ability to assume graded and increasing responsibility for patient care. The evaluations must be accurately documented, dated and signed by both the evaluator and the resident.
2. The evaluations will be based in part on written reviews provided by faculty members at the end of each rotation.
3. The evaluations are performed at least semi-annually.
4. The evaluation of performance is discussed with the resident. When weaknesses or deficiencies are identified, steps are taken promptly to improve performance and counsel the resident where appropriate.
5. The evaluations are based on the following elements:
   - Fund of medical knowledge and application of that knowledge
   - Judgment
   - Personal character traits displayed and interpersonal skills
   - Clinical and technical skills
   - Ability to assume increased responsibility for patient care
   - Ethical and Professional Conduct
6. The residents are evaluated against the same criteria (A.4 above) when assigned to any participating hospital or program.

B. Advancement of Residents
Advancement of residents to the next level of the program depends upon the resident’s performance and qualifications. The Brown Psychiatry Residencies have criteria and goals which are expected to be met by a resident before he or she is advanced to the next level of training in the program. These criteria and goals are reviewed annually by the program and the program director and are made known to the residents and faculty.

C. Dates of Notification
Decisions about advancement or reappointment are concluded by the program director and communicated to the residents no later than four months prior to the end of the house officer’s current contract.

III. Supervision
Faculty are ultimately responsible for the clinical care given to patients. Supervision of residents may be provided by a combination of upper level residents and faculty. Each participating hospital identifies supervisory faculty for given periods.

IV. Assurance of Due Process for Residents
A. Grievances
Residents who feel they have been treated unfairly under the interpretation or application of a policy, rule or procedure may file a grievance. Residents who believe that they may have a complaint involving sexual harassment are advised to follow the procedure set forth in the Resident Handbook on “Sexual Harassment”. Reasonable efforts should be made within the residency program to resolve grievances on an informal basis. The grievance process shall be conducted without the presence of legal counsel. This grievance procedure is not applicable to any decision regarding probation, suspension, non-renewal or termination. Resident appeals of these actions must be filed under the appeals process (see below).

A request for formal resolution of a grievance shall be submitted in writing by the resident to the Program Director within thirty (30) days following the date when the resident first had knowledge of the incident that gave rise to the grievance. The Program Director shall notify a faculty member of the Policy Committee. The Program Director may elect to respond and resolve the grievance, or may in his/her judgment, request that the faculty member of the Policy Committee review and adjudicate the grievance. The faculty member of the Policy
Committee may elect to respond to the grievance or may elect to convene a committee of three members of the Policy Committee, one member may be selected by the resident. The Program Director, faculty member of the Policy Committee or the committee may review any records, or interview any persons whom they consider helpful for resolution of the grievance. The committee or the faculty member of the Policy Committee will provide a decision of the grievance to the Program Director within thirty (30) days.

Residents who believe that they may have a complaint involving their training program, Program Director or faculty may submit the grievance in writing to the Chair of the Department of Psychiatry and Human Behavior. The Chair may elect to respond to the grievance or may elect to convene a committee of three members of the Policy Committee, one member may be selected by the resident. The Chair or the committee may review any records or interview any persons whom they consider helpful for resolution of the grievance. The committee will provide a decision of the grievance to the Chair. The Chair shall advise the resident in writing of the proposed resolution of the grievance within thirty (30) business days after receiving the notification of the grievance. If the resident dissatisfied with the decision reached, he or she may appeal to the Chair within 14 days of receipt of the decision. The decision of the Chair shall be final.

B. Procedures Prior to Initiating Formal Disciplinary Action

Coordinators of clinical assignments and/or supervisors will bring to the attention of the Director of Residency Training performance by a resident that may require "special evaluation". Such performance includes, but is not limited to: absence from clinical service serious enough to impair the expected performance of clinical duties; failure to provide for the clinical care of patients assigned by the coordinator of the clinical rotation under the direct clinical supervision of faculty psychiatrists; behavior toward patients or staff of a clinical service that jeopardizes the expected standards of clinical care for a patient or patients for whom the resident is responsible on that clinical service under the direction of faculty supervisors; failure to maintain adequate and expected clinical records; limitation of knowledge base serious enough to prevent the resident from performing the clinical duties at the expected level of clinical competence.

Initially, problems contributing to the inability of the resident to perform at a standard expected of a resident at his/her level will be discussed with the resident by the clinical coordinator of the service to which the resident is assigned. The clinical coordinator will inform the Director of Residency Training of the problems being experienced by the resident and the plans for their resolution.

Persistence of problems involving inadequacy of performance by a resident, unethical behavior, or the possibility of a need arising for a temporary leave of absence by a resident will be discussed in detail with the Director of Residency Training. The Director of Residency Training will confer with all faculty who may be able to contribute further information to the clarification of the problems the resident may have been experiencing during the present and previous clinical assignments. On the basis of this information, the Director of Residency Training will discuss with the resident a plan of study and clinical experience sufficient to bring the resident up to the expected level of performance.

If the remedial training efforts are unsuccessful or where performance or misconduct is of a serious nature, Program Director may initiate formal disciplinary action as described below.

C. Formal Disciplinary Action

Disciplinary action may be taken for due cause, including but not limited to any of the following:

a. failure to satisfy the academic or clinical requirements of the training program;

b. professional incompetence, misconduct or conduct that might be inconsistent with or harmful to patient care or safety;

c. consistently substandard performance;

d. conduct which calls into question the professional qualifications, ethics, or judgment of the trainee;

e. failure to function in a cooperative and reasonable manner with other trainees, employees, medical staff, patients, volunteers and/or visitors of the Hospital;

f. violation of the bylaws, rules, regulations, policies, or procedures of the medical staff, Hospital, or applicable department, division or training program, including, without limitation, any violation of the Hospital sexual harassment policy;

g. scientific misconduct.

D. Specific Procedures

Formal disciplinary action may include, but is not limited to probation, suspension, or termination of the trainee from the training program during an academic year. Except under circumstances requiring an immediate emergency disciplinary action to preserve acceptable standards of care, safety, integrity or ethics at the Hospital, the following procedures will be followed.

1. Training Program Probation
   A. General
i. Training program academic probation (or "probation") means a temporary modification of the trainee's training program participation or responsibilities, designed to facilitate the trainee's accomplishment of program requirements. Generally, a trainee will continue to fulfill training program requirements while on probation, subject to the specific terms of the probation.

ii. In the event that the steps described above for special evaluation of a resident's performance do not enable the resident to reach a level of performance expected of a resident at his/her level, the Director of Residency Training, after consultation with other faculty members who have had recent and ongoing contract with the resident in question, will notify the resident that he/she is being placed on “Academic Probation”. This notification will be in writing and will specify the identified areas of persisting problems in meeting the standard of performance expected of a resident at his/her level. The notification of Academic Probation will specify the remedial actions necessary for the resident to achieve an adequate level of performance.

A resident will ordinarily be placed on “Academic Probation” for consistently substandard work in any one of the following areas:

- Clinical Assignments
- Professional relationships with peers
- Professional relationships with the community
- Doctor-on-call
- Professional relationships with supervisors
- Mock Board examinations
- Didactic seminars
- UTP (psychotherapy or general outpatient treatment)

iii. Designation of Academic Probation will apply for three months. Written evaluation of the resident's performance in the areas designated as problematic will be provided to the Director of Residency Training monthly by the clinical coordinator and other faculty in whose area of supervision the resident has been performing below the expected standard. The Director or Associate Director of Residency Training will meet at least monthly with the resident to monitor the progress of the written plan of remediation. Residents on probation will not be permitted to do any moonlighting.

iv. If the standard of performance by a resident in this category reaches a satisfactory performance level by the end of the three month period of Academic Probation, the resident will be given full academic credit for the preceding months. The Director of Residency Training will inform the resident in writing that his/her performance has achieved the expected level and the period of an Academic Probation is thereby terminated.

v. In the event that the standard of performance by the resident during or at the conclusion of a period of three months of Academic Probation does not reach the expected standard for a resident at his/her level, the Director of Residency Training, in consultation with other faculty who have direct experience of the resident's performance during the period of Academic Probation, and in consultation with the Chair of the Department of Psychiatry and Human Behavior, may take one of the following actions:

1. Suspend the resident's clinical privileges in the event that his/her performance standard jeopardizes the safety and/or clinical care of patients. Academic credit will not be given during
2. Continue the period of Academic Probation for an additional and final three months. No resident can remain on Academic Probation for more than six months in total over the course of their training. If the resident's performance remains inadequate, he/she may not continue as a resident in the program. The resident will be informed in writing of his/her termination from the program.

B. Right to Review

1. The decision to place a resident on Academic Probation is subject to appeal. The resident may request an appeal within one week of the formal written notice. This appeal must be made in writing to the Program Director. Within one week, the Program Director will appoint a faculty member of the Policy Committee to review the case. This appointed faculty member must not have been directly involved in the evaluation of the resident during any period of “Special Evaluation” or academic difficulty. The appointed faculty member will be charged with determining the adequacy of documentation of the resident’s inadequate or problematic performance, the steps designated to resolve those areas of problematic or inadequate performance, and may recommend oral and/or written examination of the resident to further document the standard of knowledge and performance. The faculty reviewer will report to the Program Director within two weeks. The resident and Program Director will abide by the decision of the faculty reviewer.

During any appeal process the resident is expected to satisfy the terms of the written plan of remediation.
2. Suspension
   A. General
     i. The Program Director, after consultation with the Chair, may temporarily suspend the trainee from training program duties by placing him or her on an unpaid leave of absence for seriously deficient performance or seriously inappropriate conduct. A voluntary leave of absence that is approved by the Program Director in advance shall not be considered a suspension or other form of disciplinary action.
     ii. The Program Director shall provide the trainee with written notification of the reasons for the suspension, the required method and timetable for correction, and a date upon which the decision will be re-evaluated. The trainee shall be requested to acknowledge being advised of his/her suspension by signing the notification; refusal to do so shall be noted by the Program Director, setting forth the reasons for refusal if stated by the trainee. The written notification shall include a statement that suspension, if final, may be reported to the Rhode Island Board of Medical Licensure and Discipline. The written notification should also advise the trainee of his or her right to request a review of the suspension in accordance with the procedures outlined below. This notice shall precede the effective date of the suspension, unless a serious risk to patient care or the health or safety of an employee warrants immediate suspension, in which case the notice shall be provided at the time of the suspension.

   B. Right to Review
     i. The trainee shall have the right to a review of the suspension decision. To initiate such a review, the trainee must submit a written request for a review of the suspension to the Chair of the Department of Psychiatry and Human Behavior within five (5) business days of the trainee's receipt of the notification. Failure to make a timely request for a review will constitute a waiver of the trainee’s right to a review.
     ii. If the trainee requests review of the suspension, the Chair or his/her designee(s) shall meet with the trainee within ten (10) business days and afford the trainee an opportunity to provide any information in his or her defense. After this meeting, the Chair or his/her designee(s) following consultations with the Program Director and other appropriate individuals, if any, will render a final decision.
     iii. The trainee shall receive written notification of the decision of the Chair and the reasons for and consequences of the decision.
     iv. There is no further appeal from a decision to suspend a trainee.
     v. No trainee shall remain on suspension for more than three months in total over the course of his/her training. If the reasons for the suspension have not been resolved at the end of the three-month period, he/she may not continue as a trainee in a training program. The trainee will be informed in writing of his/her termination from the program pursuant to this provision.
     vi. Suspension is reportable to the Rhode Island Board of Medical Licensure and Discipline and part of the trainee’s permanent record.

3. Involuntary Termination From the Program During an Academic Year
   A. General
     i. The Program Director, after consultation with the Policy Committee, shall have authority to terminate a trainee from a training program, for reasonable cause, including but not limited to a failure satisfactorily to fulfill the requirements of the training program. Prior to the recommendation for termination of any trainee, the Program Director shall consult with the Chair of the Department of Psychiatry and Human Behavior and the Policy Committee. Dismissal of a trainee during an academic year shall constitute a termination. Failure to continue a trainee in a program beyond the academic year or failure to certify successful completion of a training program does not constitute a disciplinary action, as discussed more fully in Sections 6 and 7 below.
     ii. Written notice of a recommendation of termination from a program, including the reasons for the decision and the effective date, shall be provided by the Program Director to the trainee. The trainee shall be requested to acknowledge being advised of his/her involuntary termination by signing the notification; refusal to do so shall be noted by the Program Director, setting forth the reasons for refusal if stated by the trainee. The notice shall include a statement that termination, if final, may be reported to the Rhode Island Board of Medical Licensure and Discipline, and that an explanatory statement may also be submitted to the Accreditation Council of Graduate Medical Education of the American Medical Association. The notice shall also state that the trainee may request a formal review of the termination in accordance with the procedures described below.

   B. Right to Review
     i. A resident may appeal the decision of termination from the program by writing to the Chair of the Department of Psychiatry and Human Behavior within one week of receiving written notification of a recommendation of termination. Within two weeks of receiving a written request of appeal the Chair will appoint a review committee consisting of three senior faculty members who have not been directly involved in the evaluation of the resident during any of the period of special evaluation or Academic Probation. The
Review Committee will be charged with determining the adequacy of the documentation of the resident’s inadequate or problematic performance, the steps designated to resolve those areas of problematic or inadequate performance, and may recommend oral and/or written examination of the resident to further document the standard of knowledge and performance. The Review Committee will report within one month of being constituted, to the Chair who will make a final decision regarding the appeal. The resident and the Program Director will abide by the decision of the Department Chair. The written request must specify the reasons the trainee believes his/her case warrants review and special consideration. Failure to make a timely request for a review will constitute a waiver of the trainee’s right to a review.

ii. If the request for a review is timely, the Review Committee can request a hearing before the Review Committee and two residents. The program director shall not serve on the committee if he or she made the recommendation to terminate or if he or she desires to be, or is to be, called as a witness at the hearing. In such event, the Chair shall appoint one other faculty member to the committee, which shall select a chairperson. The committee will conduct the hearing as soon as practicable, but in no instance more than 30 days from the date of receipt of the trainee’s request for a review. By mutual agreement of the parties, this time may be further extended.

iii. The committee’s sole function shall be to ascertain whether or not (a) there was any reasonable basis to recommend termination, and (b) the provisions of this Policy were substantially adhered to. It shall not be the function of the committee to recommend alternative disciplinary action.

iv. The resident at his/her own expense, may be accompanied by counsel at the hearing with whom he/she may confer, and counsel for other interested parties, as determined by the Committee, shall be entitled to attend. Such counsel shall be entitled to participate as may be determined in advance by the Committee. Furthermore, a record shall be kept of the hearing.

v. Prior to the hearing, the trainee and the Review Committee will exchange pertinent information concerning their respective presentations, including a list of witnesses. Prior to the hearing, the trainee and the Review Committee will be given copies of, or be permitted to review, documents that will be submitted at the hearing. Both the trainee and the Review Committee are responsible for contacting their respective witnesses, scheduling the order of their presentations at the hearing and coordinating the witnesses’ appearance with the committee chairperson. The committee may prepare specific procedure guidelines for use at the hearing.

vi. Both the Program Director and the trainee may present witnesses and submit documentary material to the committee. Both parties will be permitted to question the other party and its witnesses and rebuttal statements may be made by either party on evidence presented by the other party.

vii. The committee will render a written decision which shall be forwarded to the trainee and the Program Director within 14 days after completion of the hearing. Based on the committee’s decision, the Program Director may reconsider the proposed disciplinary action. If the Review Committee disagrees with the recommendation to terminate, then it shall, after discussion with Program Director, decide upon an alternative action, which action shall be communicated to the trainee and the Program Director for implementation.

viii. The trainee’s stipend and benefits will continue during the period of the hearing process until action by the Review Committee, except that the stipend and benefits will cease at the end of the current appointment period should the hearing process continue beyond that period.

4. Independent Evaluation
If an evaluation of the trainee’s performance by the Program Director and/or designee suggests a situation (such as, but not limited to: medical/mental health, behavioral and/or substance abuse problems) which places the trainee or his/her patients at risk, the Program Director may require an independent evaluation by the Physician’s Health Committee of the Rhode Island Medical Society. The purpose of this independent evaluation is to determine the trainee’s ability to perform his/her clinical duties and responsibilities. This independent evaluation may be required on its own or in addition to other formal disciplinary action described above.

5. Other Disciplinary Actions
A trainee who is aggrieved by a formal disciplinary action other than probation, suspension or termination, may request a review of the action under the procedures described in Section D.1(B) above.

6. Nonrenewal of Contract
Failure in performance to progress academically or professionally may be cause for a Program Director, after consultation with the Chair, to choose not to renew a trainee’s contract. The resident must be provided with a written notice from the Program Director of intent not to renew the resident’s contract no later than four months prior to the end of the resident’s current contract. The trainee shall be requested to acknowledge being advised of the program’s intent to not renew the trainee’s contract by signing the notification; refusal to do so shall be noted by the Program Director, setting forth the reasons for refusal if stated by the trainee. The notice shall also state that the trainee may request a formal review of the intent not to renew in accordance with the procedures described below. If the primary reason(s) for the non-renewal occur(s) within the four months prior to the end of the contract, the program director must provide the resident with as much written notice of the intent not to renew as the circumstances will
reasonably allow, prior to the end of the contract. Evaluation by the teaching faculty must be considered when a Program Director decides to non-renew the contract for academic reasons. If the trainee is not already on probation or suspended when the decision to not renew is made, then the trainee should be informed and/or be placed in a remedial program prior to the decision to not renew his/her contract. When the decision to non-renew the contract is made, if the trainee is in remedial status, the remedial status may be extended to cover the remainder of the employment period. The Chair should be notified of any decision by a Program Director of any non-renewal of contract prior to the notification of the trainee.

A failure to continue a trainee in a program beyond the current academic year does not constitute a disciplinary action.

A. Right to Review
   i. The trainee shall have the right to a review of the intent not to renew decision and shall be informed of this right. To initiate such a review, a trainee must submit a written request for a review of the intent not to renew to the Chair within five (5) business days of the trainee's receipt of the notification of the intent not to renew decision. Failure to make a timely request for a review will constitute a waiver of the trainee’s right to a review.
   ii. If the trainee requests review of the intent not to renew, the Chair shall meet with the trainee within ten (10) business days and afford the trainee an opportunity to provide any information on his or her behalf. After this meeting, the Chair, following consultation with the Program Director, will render a final decision.
   iii. The trainee shall receive written notification of the decision of the Chair and the reasons for and consequences of the decision.
   iv. There is no further appeal from a decision to not renew a trainee’s contract.

7. Failure to Promote to Next Level of Training.
   The decision to re-appoint and promote a trainee to the next level of post-graduate training shall be based on the amount of academic credit received for the year as determined by the Program Director upon review of the trainee’s performance. The Program Director shall consider all evaluations of the trainee’s performance and any other criteria that is deemed appropriate by the Program Director. Any trainee who is, in the opinion of the Program Director, subject to not being promoted due to academic performance should be placed in a remedial training program and should be notified at the earliest opportunity of any decision to reduce or restrict the credit given for one or more rotations during a given academic year. If the trainee continues in the program but his/her performance continues to be unsatisfactory, he/she may be placed on the next level of discipline. In the event a trainee is in a remedial training program at the time of the contract renewal, the Program Director may choose to (i) extend the existing contract for the length of time necessary to complete the remediation process, not the exceed six months; (ii) promote the trainee to the next level; or (iii) non-renew the contract pursuant to Section 6 above.

A failure to provide full credit for a rotation or academic year or a failure to certify successful completion of a training program does not constitute a disciplinary action, and the trainee shall have no right to appeal such actions.

3/21/05
Residents are important to the continuous evaluation and improvement of the Fellowship. They provide informed feedback on all aspects of the Fellowship and participate in problem solving and implementation efforts. There are several formal mechanisms for this involvement. The Training Directors and the Policy Committee use this information to change the program.

1. All Residents complete an evaluation form at the conclusion of a clinical rotation evaluating the supervisor and the clinical experience.

2. All Residents complete an evaluation form at the conclusion of each seminar.

3. All residents complete a self-appraisal in the beginning of the fellowship training program and at its conclusion.

4. A mock style board examination will be done during the 1st month of training, and then after the 8th month in order to evaluate the resident’s ability to illicit information and develop treatment plans among geriatric patients.

5. A multiple choice examination will be given during the first week of training and then one prior to conclusion of 1st year of training to evaluate increase in knowledge.

6. One Resident will be a full member of the GME Committee.

7. The Residents meet at least once a month with the Director and/or Associate Director, over lunch to review Fellowship issues.

8. All Residents will be evaluated using computer generated evaluations every two months on their performance in their clinical rotations. Each rotation covers a four-month period. Verbal feedback will be given throughout the rotation to the Residents. Their clinical supervisors will do the evaluations.

9. A summary of the Residents' performance will be compiled for review by the Geriatric Psychiatry Fellowship Training Program Committee. A semi-annual report of the Residents' progress will be prepared based on evaluations and other feedback received about the Residents' performance. A final report of the Residents' performance for each year will be generated from the quarterly and semi-annual reports.

8/19/04; Revised 3/9/05
BROWN UNIVERSITY GERIATRIC PSYCHIATRY FELLOWSHIP
EVALUATION OF ATTENDING PHYSICIAN

Attending Physician: ___________________________ Service/Rotation: ___________________________

Trainee ID number: ___________________________ Year: ___________________________

For each of the following criteria, please rate (3) the attending physician whose rotation you have just completed.

**Availability:**

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<td>Stated goals clearly and concisely</td>
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<td>Keep discussions focused on case or topic</td>
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<td>Asked questions in non-threatening way</td>
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<td>Emphasized problem-solving, (thought processes leading to decisions)</td>
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<td>Integrated social/ethical aspects of medicine</td>
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<td>Stimulated trainees to read, research, and review pertinent topics</td>
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<td>Provided references</td>
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<td>Used generic drug names</td>
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<td>Followed up on previous assignments</td>
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<td>Observed resident providing clinical care</td>
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<td>Placed the patient’s interests first</td>
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<td>Displayed sensitive, caring, respectful attitude toward patients</td>
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<td>Established rapport with team members</td>
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<td>Showed respect for residents</td>
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<td>Encouraged resident self-reflection</td>
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<td>Demonstrated gender, cultural and sexual orientation sensitivity</td>
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<td>Recognized own limitations; was appropriately self-critical</td>
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<td>Encouraged residents to bring up problems</td>
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<td>Identified conflict of interest and other ethical issues</td>
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### Practice-Based Learning and Improvement:

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<td>Explicitly encouraged further learning</td>
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<td>Motivated residents to self-learn</td>
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<td>Evaluation residents ability to analyze or synthesize knowledge</td>
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<td>Utilized current case material to focus learning goals</td>
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### Medical Knowledge:

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<th>Not Observed</th>
<th>Marginal</th>
<th>Satisfactory</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrated broad knowledge of medicine</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Was up-to-date</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Used relevant medical/scientific literature in supporting clinical advice</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Discussed pertinent aspects of population and evidence-based medicine</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

Comments:________________________________________________________________________

### System-Based Practice:

<table>
<thead>
<tr>
<th>Not Observed</th>
<th>Marginal</th>
<th>Satisfactory</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewed expectations of each resident at beginning of rotation</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Provided useful and timely feedback including constructive criticism to residents</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Balanced service responsibilities and teaching functions</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Integrated resident into treatment team</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Facilitated transition to new health care system</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

Comments:________________________________________________________________________

### Areas where most/highest quality teaching was available:

________________________________________________________________________

### Areas where least/lowest quality teaching was available:

________________________________________________________________________

### Recommendations:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

- Would you recommend that this faculty member continue to serve as an attending physician for the training program?

### Overall Comments:

________________________________________________________________________

________________________________________________________________________

Return to Fellowship Office by: _________________________________

03/01/0
Clinical Assignment: _______________________  DATES: ___________________

Supervisor: _______________________  Other Supervisor(s): __________________

Clinical Activities:
Average caseload (hours/week): ________  Was the schedule workable? ________
Were the facilities (office, physical plant) adequate? ________  Was the case material varied? ________

Teaching (include only teaching specific to this clinical assignment):
Amount of teaching (hours/week) by:
Attending: ________  Other Resident: ________  Other Faculty (please list them): ________

Was the teaching:
Applicable to the clinical material? ________  Presented well? ________  At appropriate level? ________

Rapport: Please comment on your work with:
Residents:

Other faculty supervisors:

Clinical staff:

Unit administrative staff:
What did you like most about this clinical assignment?

What did you like least about this clinical assignment?

How would you suggest changing this clinical assignment?

Please comment on particularly outstanding and/or unsatisfactory teaching you experienced on this assignment:

Reviewed by GPFTP Director/Associate Director: ____________________________ Date 7/97
# Resident's Evaluation of Seminar/Workshop

**Seminar/Workshop:**

**Seminar Leader:**

**Date:**

**Topic:**

<table>
<thead>
<tr>
<th>Evaluation of Seminar/Workshop</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement of stated learning objectives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relevance and practicality of topic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informative in terms of current knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usefulness in patient management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of audiovisual equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was the presentation free of commercial bias? **Yes** ____  **No** ____

If no, indicate specific examples:

<table>
<thead>
<tr>
<th>Evaluation of Speaker</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulation of thinking and interest</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity of presentation and explanations</td>
<td></td>
<td></td>
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<tr>
<td>Responsiveness to questions</td>
<td></td>
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<tr>
<td>Audio Visual equipment</td>
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</tbody>
</table>

Comments:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Reviewed by GPFTP Director/Associate Director: ________________________ Date __________________________

7/97

Revised: 7/00; 8/02; 10/2/02
<table>
<thead>
<tr>
<th>Interpersonal and Communication Skills</th>
<th>Unable to Evaluate</th>
<th>Poor</th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate your ability to create and sustain therapeutic, ethically sound relationships with your patients, maintaining appropriate boundaries</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to use effective listening skills</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to elicit and provide information using effective verbal and nonverbal communication skills</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to use effective writing skills</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Rate your ability to work effectively with others as a member or leader of a health care team or other professional group</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Medical Knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Rate your ability to demonstrate &amp; analytic approaches to clinical situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to know and apply basic and clinical sciences appropriate to your discipline</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Patient Care</td>
<td></td>
<td></td>
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<tr>
<td>Rate your ability to communicate effectively and demonstrate caring respectful behaviors when interacting with patients and their families</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to gather essential and accurate information about your patients</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to make informed decisions about diagnostic &amp; therapeutic interventions based upon patient information and preferences, up to date scientific evidence and clinical judgment</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to develop, carry out and modify management plans</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to counsel and educate patients and their families</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to use information technology to support patient care decisions and patient education</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to perform competently all medical and psychiatric procedures considered essential for your area of practice</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement</td>
<td>Unable to Evaluate</td>
<td>Poor</td>
<td>Below Average</td>
<td>Average</td>
<td>Above Average</td>
<td>Excellent</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------</td>
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<td>---------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Rate your ability to analyze your clinical practice to identify important learning needs and construct goals/plans for improvement</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to locate, appraise, and assimilate evidence from scientific studies related to your patients’ health problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to obtain information about your own population of patients and the larger population from which your patients are drawn</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to critically appraise the literature on diagnosis, prognosis, therapy and harm</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to use information technology to manage information, access on-line medical information and support your learning needs</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to effectively teach students and other health care professionals</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Professionalism</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate your ability to demonstrate respect, compassion, integrity: responsiveness to needs of patients and society that supercedes self interest; accountability to patients, society and profession; commitment to excellence and on-going professional development</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to demonstrate an understanding and commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent and business practices</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Rate your ability to demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td><strong>System – Based Practices</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate your ability to understand how your patient care and other professional practices affect other health care professionals, Duke health system, and the larger society, and how these elements of the system affect your own practice</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to know how types of medical practice and delivery systems differ from one another including methods of controlling health care costs and allocating resources</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to practice cost-effective health care and resource utilization that does not compromise quality of care</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to advocate for quality patient care and assist patients in dealing with system complexities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Research &amp; Scholarly Activities</td>
<td>Unable to Evaluate</td>
<td>Poor</td>
<td>Below Average</td>
<td>Average</td>
<td>Above Average</td>
<td>Excellent</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>------</td>
<td>---------------</td>
<td>---------</td>
<td>---------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Rate your ability to perform electronic searches to answer your questions</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to become efficient in your searching</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to know the best sources for current evidence to answer your questions, and use a varied array of sources</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to use MeSH headings, limiters, thesaurus, EBM filters, and shortcuts when searching MEDLINE</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to effectively teach students and other health care professionals searching skills</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to change your patient care practices based on best available evidence, your patients’ preferences and your clinical judgment</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Rate your ability to justify whether or not to apply critically appraised findings to an individual patient</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td><strong>Miscellaneous Questions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do You Moonlight? (0=“No” 5= “Yes”)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Do You Moonlight outside the system or inside the system? (i.e. the same hospitals you train in)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>How often do you moonlight? (just answer “0” on the sliding scale and write in the answer)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Do you feel you moonlight not enough, enough, or too much? (0=not enough, 3=enough, 5=too much)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
RESIDENT’S NAME: ___________________________  EVALUATOR(S) (PLEASE PRINT):
__________________________________________

Rotation dates: ____/____/200__ to ____/____/200__  Rotation location:
__________________________________________

Instructions for scoring: Rate the resident’s skill in each of the categories 1-6, using the descriptions on pages 3-5 as a guide. Darken bubbles ● with pen or pencil completely. Place emphasis on written comments at the end.

### ROTATION EVALUATION RATINGS

<table>
<thead>
<tr>
<th>Category</th>
<th>Not competent</th>
<th>Falls below expectations</th>
<th>Good, solid work</th>
<th>Exceeds expectations</th>
<th>Far exceeds expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. PATIENT CARE</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1A. Diagnostic Skills, Assessment and Evaluation</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>1B. Ability to Develop Rapport and Therapeutic Alliance</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>1C. Psychotherapy</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>1D. Pharmacotherapy</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>1E. Treatment Planning</td>
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<tr>
<td>1F. Patient Communication and Education</td>
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<tr>
<td><strong>2. MEDICAL KNOWLEDGE</strong></td>
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<td>2A. Pharmacotherapy</td>
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<tr>
<td>2B. Psychotherapy</td>
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<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>2C. Descriptive and Differential Diagnosis</td>
<td>○</td>
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<td>○</td>
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<td><strong>3. PRACTICE BASED LEARNING</strong></td>
<td>○</td>
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<td><strong>4. INTERPERSONAL AND COMMUNICATION SKILLS</strong></td>
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<td>4A. Working Relationships</td>
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<td>○</td>
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<tr>
<td>4B. Ability to Establish Rapport</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>4C. Verbal Presentation</td>
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<td>○</td>
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<tr>
<td><strong>5. PROFESSIONALISM</strong></td>
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<tr>
<td>5A. Management of Clinical Responsibility</td>
<td>○</td>
<td>○</td>
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<tr>
<td>5B. Documentation</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>5C. Teaching</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>5D. Ethical Decision-Making, Honesty, Cultural Sensitivity</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5E. Personal Qualities</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5F. Administrative Skills</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>6. SYSTEMS-BASED CARE</strong></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Overall Rating

Not competent  Falls below expectations  Good, solid work  Exceeds expectations  Far exceeds expectations

Methods of Assessment

Direct observation  Records review  Discussion with resident  Video/Audio tape  Process notes

Report from staff  Feedback from patients  Formal presentation  Feedback from medical students  Other

General Comments:

Other areas of special talent:

Other areas where more work is needed (Please elaborate on all unsatisfactory ratings [to the left of the gray column] and any significant discrepancies between overall rating and specific ratings):

I HAVE REVIEWED THIS PERFORMANCE EVALUATION WITH THE RESIDENT. _____ DATE: ________________

(Faculty Signature)

I HAVE REVIEWED THIS EVALUATION WITH THE FACULTY MEMBER. ___________ DATE: ________________

(Resident Signature)

PLEASE RETURN TO EMA COSTA VIA INTER-INSTITUTIONAL MAIL BY: ________________

Reviewed by GPFTP Director/Associate Director: ____________________________ Date: ________________

03/16/05

Thank you
**Please Note:** The gray column identifies competence at satisfactory levels. The two columns to its left denote unsatisfactory performance. The column to the immediate right of the gray column denotes performance beyond satisfactory levels and is inclusive of the elements specified in the gray column. The extreme right column includes the two elements to its immediate left as well.

### 1. **PATIENT CARE** (THE APPLICATION OF KNOWLEDGE IN THE CLINICAL SETTING)

<table>
<thead>
<tr>
<th>1A. Diagnostic Skills, Assessment and Evaluation</th>
<th>Unable to summarize and organize psychiatric history. Often rambling or confused</th>
<th>Disorganized. Limited differential diagnosis with some omissions. Lacks biopsychosocial format</th>
<th>Accurate, comprehensive history with description of intrapsychic and situational conflicts. Careful and complete differential diagnosis</th>
<th>Well organized. Able to present coherent and relevant biopsychosocial formulation. A skillful diagnostician</th>
<th>Outstanding discussion that reflects thorough understanding of illness and patient situation. Recognizes the value and limitations of various diagnostic tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>1B. Ability to Develop Rapport and Therapeutic Alliance</td>
<td>Frequently unable to engage patient in an interview. Insensitive. Disrespectful</td>
<td>Adversarial with patients. Doesn’t form a therapeutic alliance</td>
<td>Makes patients comfortable and engages them in the process of evaluation and treatment. Good patient compliance and follow-up</td>
<td>Can engage patients well. Perceived as capable. Very respectful. Able to elicit cooperation even in awkward situations</td>
<td>Has the patient’s full confidence. Works exceptionally well even with difficult patients. Maximizes adherence to treatment</td>
</tr>
<tr>
<td>1C. Psychotherapy</td>
<td>Unable to establish therapeutic alliance or to formulate treatment plan or goals. Cannot utilize even the most rudimentary strategies of therapy</td>
<td>Significant deficiencies, but aware of the influence of past experiences on current symptoms. Unable to utilize psychotherapy along with medication</td>
<td>Appreciates transference, identifies major dynamic themes. Applies appropriate psycho-therapeutic techniques, even in the medication management setting. Uses psychotherapeutic skills within clinic setting</td>
<td>Comfortable therapist who identifies, understands, and utilizes transference and counter transference. Identifies symptoms more amenable to specific psychotherapeutic technique</td>
<td>Actively and aggressively pursues experience in various psychotherapies. Able to incorporate multiple patients into their routine. Manages powerful feelings with grace and efficacy</td>
</tr>
<tr>
<td>1D. Pharmacotherapy</td>
<td>Unable to formulate effective drug treatment plans. May be reckless or even dangerous at times</td>
<td>Usually able to select a first line treatment. Some understanding of side effects profiles and symptom-focused therapy</td>
<td>Selects the best drug treatment based on the patient’s illness, side effects and drug interactions. Able to appreciate the influence of medical history</td>
<td>Algorithmic approach to medication management. Expanded knowledge of options. Able to adapt fund of knowledge to real-world patient situations</td>
<td>Outstanding ability to formulate treatment plans that address idiosyncrasies refractory cases, and complications. Skilled at maximizing compliance</td>
</tr>
<tr>
<td>1E. Treatment Planning</td>
<td>Unreliable. Fails to plan. Misses changes in patient’s mental status and/or fails to follow up</td>
<td>Erratic in planning and follow up. Slow to see changes in patient status. Does not schedule follow up visits within appropriate time frames</td>
<td>Adequate management plans and follow up with recognition of changes in condition. Appropriate follow up of patients, sees unstable patients for frequent visits until stable</td>
<td>Thoughtful, detailed management. Quickly recognizes changes. Skilled treatment plans in outpatient setting. Avoids unnecessary hospitalization</td>
<td>Efficient and insightful management plans with many options and awareness of the risk/benefit of each</td>
</tr>
<tr>
<td>1F. Patient Communication and Education</td>
<td>No effort to involve the patient or to provide information/education. Minimizes interaction with the patient</td>
<td>Provides partial information. Little concern for patient autonomy and informed decision making</td>
<td>Discusses treatment options thoroughly. Actively informs the patient of options, risks, etc. Verifies patient understanding of indications of medications, dosing and side effects</td>
<td>Helps the patient to feel informed and involved in treatment decisions. Spends extra time to ensure adequate understanding</td>
<td>Gains the patient’s full confidence by carefully explaining complex treatment strategies and empathically establishing a mutual information exchange</td>
</tr>
</tbody>
</table>
### 2. MEDICAL KNOWLEDGE (FUND OF KNOWLEDGE INCLUDING CONCEPTUAL THEORY AND SCIENTIFIC LITERATURE)

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A. Pharmacotherapy</td>
<td>Major deficiencies in the fundamentals. No appreciation of advanced techniques. Requires constant and extensive supervision. Has difficulty applying basic knowledge. Rarely uses secondary or tertiary strategies. Good fundamental psychopharmacologist who is generally able to apply advanced techniques for difficult and refractory cases. Very solid basics. Often suggests alternative strategies and is aware of recent advances in the field. Understands rational approach to combination and augmentation of medications. Mastery of fundamental psychopharmacology. Excellent grasp of advance techniques and in-depth knowledge of the most recent literature.</td>
</tr>
<tr>
<td>2B. Psychotherapy</td>
<td>Does not grasp the styles and applications of different types of psychotherapy. Rarely suggests this intervention. Some difficulty with necessary concepts such as transference, resistance, and defense. Limited appreciation of combined therapy. Good basic knowledge of various psychotherapies, their unique vocabularies, and applications. Rarely hesitates to employ this treatment. Expanded understanding of different strategies including their complexities and subtleties. Thoughtful about risks &amp; potential benefits of intervention. Excellent theoretical psychiatrist who is fluent in the terminology and rationales for various methods. Adept biopsychosocial modeling. Well-read in classic and modern literature.</td>
</tr>
<tr>
<td>2C. Descriptive and Differential Diagnosis</td>
<td>Cannot interpret or synthesize data, no prioritization, likely to miss major disorder. Some difficulty with interpretation of data and prioritization of issues. Forms adequate differential diagnosis with appropriate prioritization of issues. Effectively integrates data, incorporates subtleties, thoughtful prioritization. Understands complex issues and problem interactions.</td>
</tr>
</tbody>
</table>

### 3. PRACTICE-BASED LEARNING (RESIDENT’S ABILITY TO APPLY DAILY CLINICAL PRACTICE TO OWN LEARNING AND DEVELOPMENT)

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unable to incorporate his/her own experience. Limited or no ability to use rounds or patient care as learning experiences. Struggles to benefit from ward teaching. Erratic response to feedback from faculty &amp; ancillary personnel. Uses clinical examples to learn treatment planning, differential diagnoses and follow-up. Steadily adds individual patient data to fund of knowledge. Formulates treatment in response to an expanded awareness of his/her experience. Uses rating scales &amp; objective measures of efficacy. Consistently and accurately utilizes clinical experience to improve patient care. Readily gathers &amp; applies current literature to his/her own patients.</td>
</tr>
</tbody>
</table>

### 4. INTERPERSONAL AND COMMUNICATION SKILLS

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4B. Patient-Specific Skills</td>
<td>Avoids contact, insensitive, inattentive to patient’s feelings. Occasionally insensitive or thoughtless. May be superficial or callous. Empathic and attuned. Listens and conveys information easily and effectively. Excellent communicator perceived by the patient as open, helpful and capable. Attains the patient’s full confidence. Able to work adeptly with even difficult patients.</td>
</tr>
<tr>
<td>4C. Verbal Presentation</td>
<td>Inaccurate, major omissions, rambling, inappropriate comments. Disorganized, unfocused, some omissions, gives irrelevant or inaccurate information. Complete, includes all basic information, with positives and relevant negatives. Follows standard format. Well organized, thorough, precise. Effectively integrates data. Appreciates subtleties. Concise, comprehensive. Polished presentations, tailored to situation. Outstanding, discussion reflects thorough understanding of disorder &amp; patient situation.</td>
</tr>
</tbody>
</table>
### 5. PROFESSIONALISM

<table>
<thead>
<tr>
<th>5A. Management of Clinical Responsibility</th>
<th>Inappropriate, antagonistic attitude. Late to clinical responsibilities with no regard to inconvenience of others. Unprepared. Often absent or unreachable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inaccurate. Major omissions. Disorganized. No appreciation of the legal risks inherent in charting. Repeated errors in documentation of services and deficiencies in chart reviews.</td>
<td></td>
</tr>
<tr>
<td>UFocused notes with many omissions or marked over-inclusion. Many late and/or untimely entries. Records are insufficient for documentation of service.</td>
<td></td>
</tr>
<tr>
<td>Complete documentation that includes all basic information and satisfies legal expectations. Some awareness of documentation requirements for outpatient reimbursement.</td>
<td></td>
</tr>
<tr>
<td>Well organized and thorough. Precise charting that reflects appreciation for the medical record as a part of the patient’s care. Routinely considers documentation necessary for various CPT codes.</td>
<td></td>
</tr>
<tr>
<td>Concise without losing completeness. Always time able to use the medical record as an important tool both patient care, medico legal affairs, and documentation of services provided.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5B. Documentation</th>
<th>Never teaches. Often ignores the students or only expects them to provide service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rarely teaches and ineffective when the attempt is made. No active organization of educational endeavors.</td>
<td></td>
</tr>
<tr>
<td>Solid clinical teacher who adds didactic sessions to the student’s and lower level resident’s workday.</td>
<td></td>
</tr>
<tr>
<td>Above average bedside teacher who conveys difficult aspects of psychiatric knowledge to learners of all levels.</td>
<td></td>
</tr>
<tr>
<td>Exceptional and enthusiastic teacher. Systematically covers many areas of psychiatry for all the members of the team. Regularly arranges educational experiences.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5C. Teaching</th>
<th>Does not accept moral standards for decision making. Prejudiced. Dishonest. Attempts to cover up errors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregularly applies moral standards. Not always impartial. May try and minimize or camouflage mistakes and shortcomings.</td>
<td></td>
</tr>
<tr>
<td>Applies moral standards to personal and clinical decisions relevant to the role of resident. Admits errors. Aware of cultural differences.</td>
<td></td>
</tr>
<tr>
<td>Ethical and reasoned decision making process. Acknowledges equality of all people.</td>
<td></td>
</tr>
<tr>
<td>Exceptional decision-make who respects human dignity without bias. Utilizes cultural differences to maximize care delivery.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inefficient. Requires frequent input to motivate. Poorly responsive to feedback. Occasionally inappropriately dressed. Overestimates ability.</td>
<td></td>
</tr>
<tr>
<td>Effective and reliable. Flexible person who implements feedback effectively. Appropriately seeks help. Professional appearance and demeanor.</td>
<td></td>
</tr>
<tr>
<td>Eager learner who is efficient, conscientious, and helpful. Seeks feedback. Accepts the inevitability of errors.</td>
<td></td>
</tr>
<tr>
<td>Highly motivated and exceptionally productive. Always helpful. Appropriately seeks new responsibility. Accentuates the abilities of the rest of the team. Share-success and credit readily.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5E. Personal Qualities</th>
<th>Unable to supervise or inappropriately supervises. Cannot make decisions. Fails to complete paperwork and reports.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marginally effective at supervision. Inconsistent appreciation for necessary documentation standards and paperwork.</td>
<td></td>
</tr>
<tr>
<td>Able to coordinate and supervise a team. Good planner. Ensures that necessary documentation is complete and timely.</td>
<td></td>
</tr>
<tr>
<td>Easily adapts to the administrative and supervisory role. Independently coordinates team function.</td>
<td></td>
</tr>
<tr>
<td>Exemplary organizer, supervisor, leader. Fosters excellence within team. Encourages compliance with documentation and require paperwork.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5F. Administrative Skills</th>
<th>No appreciation of the various structures used to provide mental health care. Frequently mismanages patients due to these deficiencies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant weaknesses in ability to adapt treatment to the available resources of the patient.</td>
<td></td>
</tr>
<tr>
<td>Recognizes the realities of various public &amp; private sector mental health systems. Organizes treatment with regard to payer specifications. Understands algorithms used in public, outpatient settings.</td>
<td></td>
</tr>
<tr>
<td>Thoughtful, detailed management of patients with appropriate regard to a patient’s financial ability to comply with treatment. Actively seeks additional resources for patients.</td>
<td></td>
</tr>
<tr>
<td>Well-versed in current mental health financing including carve-outs, public funding &amp; private resource. Develops elegant &amp; imaginative strategies to maximize care.</td>
<td></td>
</tr>
</tbody>
</table>

### 6. SYSTEMS-BASED CARE (ABILITY TO ADAPT TO MENTAL HEALTH CARE FUNDING AND TO DIFFERENT TYPES OF DELIVERY SYSTEM)

<table>
<thead>
<tr>
<th></th>
<th>No appreciation of the various structures used to provide mental health care. Frequently mismanages patients due to these deficiencies.</th>
</tr>
</thead>
<tbody>
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<tr>
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<tr>
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<td></td>
</tr>
<tr>
<td>Well-versed in current mental health financing including carve-outs, public funding &amp; private resource. Develops elegant &amp; imaginative strategies to maximize care.</td>
<td></td>
</tr>
<tr>
<td>How was this doctor at:</td>
<td>Never</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Demonstrates caring and respectful attitude towards patients (Patient Care)</td>
<td>1</td>
</tr>
<tr>
<td>Demonstrates caring and respectful attitude towards coworkers (Professionalism)</td>
<td>1</td>
</tr>
<tr>
<td>Exercises informed decision-making based on patient information and preferences, up-to-date evidence and clinical judgment (Patient Care)</td>
<td>1</td>
</tr>
<tr>
<td>Develops, documents, and carries out patient management plans (Patient Care)</td>
<td>1</td>
</tr>
<tr>
<td>Counsels and educates patients and families (Patient Care)</td>
<td>1</td>
</tr>
<tr>
<td>Performs assessments of patients competently (Patient Care)</td>
<td>1</td>
</tr>
<tr>
<td>Works effectively and respectfully with other members of the healthcare team (Professionalism)</td>
<td>1</td>
</tr>
<tr>
<td>Demonstrates investigatory and analytic thinking (Medical Knowledge)</td>
<td>1</td>
</tr>
</tbody>
</table>
Brown University Geriatric Psychiatry Fellowship Training Program  

Patient Satisfaction Questionnaire

Thank you for taking a few minutes to help us evaluate your doctor. We use the information you provide us to give feedback to our doctors as part of their training and professional growth so that they may improve their performance with you and others.

You may give this questionnaire to the clerk/receptionist, or return it by mail to Ema Costa, 345 Blackstone Blvd., Providence, RI 02906.

Doctor’s Name: ____________________________     Date of visit: ____________________________

Location: ____________________________     Your Name (optional): ____________________________

<table>
<thead>
<tr>
<th>How was this doctor at:</th>
<th>Unacceptable</th>
<th>Acceptable</th>
<th>Excellent</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greeting you, putting you at ease?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Warmth, friendliness, not being rude?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Listening to you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Treating you with respect?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Understanding cultural or language differences if present?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Explaining findings and treatment options?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Including you and your needs in plans for treatment?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Demonstrates an interest in geriatrics &amp; reviews age related concerns with you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>After seeing this doctor, would you:</th>
<th>Never</th>
<th>Probably</th>
<th>Definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Say that you were satisfied?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Say that you had confidence in your doctor?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Return to see him/her?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Recommend him/her to others?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Any additional comments you would like to make would be welcomed:
(please use the back of this form if needed)

03/16/05
Brown University Geriatric Psychiatry Fellowship Training Program
Semi-Annual Evaluation of Geriatric Psychiatry Resident

<table>
<thead>
<tr>
<th>Resident Name: ________________________________</th>
<th>Evaluator Name/Title: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midpoint or Endpoint Evaluation (chose one):</td>
<td>Date:</td>
</tr>
</tbody>
</table>

**Guidelines:** Please rate the resident on the following areas as demonstrated in rounds, with patients, and in your interactions with this physician. These ratings should reflect the expectation of a resident at a PGY-5 level. This evaluation should be discussed with the resident

**Key:** NP=Skill not present; SE= Skill emerging; SP= Skill present; I= Insufficient information

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>NP</th>
<th>SE</th>
<th>SP</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicate effectively and demonstrates caring and respectful behavior when interacting with patients and families.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gathers essential and accurate information:</strong> Resident can take a complete history, including corroborative information, including mental status, cognitive assessment, caregiver and community resource assessments, functional and capacity assessments, elder abuse assessments.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>Resident develops and carries out patient evaluation plan, including ancillary assessments such as EEG, radiology, neuropsychological assessment, as well as social or medical issues that might complicate treatment or compliance.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>Resident develops and carries patient management plans/treatment plans with a multiracial diagnosis and formulation, including organizing and integrating multidisciplinary recommendations, and using information technology to support decisions.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td><strong>Communication</strong> to health professionals, patients and families are clear, thorough, well-organized and sensitive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident is able to recognize and manage co-morbid disorders such as sleep disturbance and agitation.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>Resident is able to understand the role of pharmacotherapy including drug interactions, iatrogenic side effects, appropriate indications. Resident understands the pharmacodynamic and kinetic changes associated with aging.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>Resident is able to understand and apply the appropriate use of ECT in the elderly.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>Resident is able to understand and apply the appropriate use of psychotherapy in the elderly, including choosing a modality, creating a formulation and understanding how the patient's age, medical problems, developmental issues and dynamic issues may complicate and influence the treatment.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>Resident is able to understand and apply the appropriate use of behavioral interventions in the elderly particularly relating to agitation and limiting the use of restraints.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>Residents able to understand and apply the appropriate use of social interventions in the elderly, including an awareness of community programs, home, help, respite care, need for Long Term Care, and providing guidance for patients and caregivers.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td><strong>Patient-focused care:</strong> Resident clearly has the patient's best interests in mind in working with you and other health professionals, and can act as a liaison with other disciplines in medicine as well as related health fields.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides services in the service of maintaining function and prevention health problems in the elderly.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td><strong>Medical Knowledge (Clinical Science)</strong></td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td><strong>Use an investigatory and analytic approach</strong> to clinical situations. Is able to make informed and reasonable decisions regarding the need for psychotherapy, psychopharmacology, and other treatment modalities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knows and applies a basis and clinically supportive scientific fund of knowledge.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>Medical Knowledge (Clinical Science) Continued</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>---</td>
</tr>
<tr>
<td>Develop and apply knowledge related to theories of aging (biological, psych and social)</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>Develop and apply knowledge related to age related changes (sensory, cognitive, organ systems, etc.)</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
</tr>
<tr>
<td>Develop and apply knowledge related to pharmacology (including pharmacodynamics, kinetics, special concerns, side effects, polypharmacy and drug interactions)</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
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<tr>
<td>Develop and apply knowledge related to psychopathology (epidemiology, clinical presentations, pathogenesis, diagnostic approach, differential, treatment related to the full spectrum of psychiatric, sleep and cognitive disorders, including those due to a general medical condition)</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
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<tr>
<td>Develop and apply knowledge related to principles and practice of ECT</td>
<td>NP</td>
<td>SE</td>
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<tr>
<td>Develop and apply knowledge related to sexuality in late life</td>
<td>NP</td>
<td>SE</td>
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<tr>
<td>Develop and apply knowledge related to common neurologic disorders (e.g. Parkinson's, stroke)</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
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<tr>
<td>Develop and apply knowledge related to psychology of aging (e.g. adaptive and maladaptive responses to psychosocial changes (retirement, bereavement, health status), as well as personality disorders)</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
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<tr>
<td>Develop and apply knowledge related to psychotherapies (e.g. IPT, CBT, reminiscence, dynamic, group)</td>
<td>NP</td>
<td>SE</td>
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<td>I</td>
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<tr>
<td>Develop and apply knowledge related to culture and ethnicity as it relates to aging and psychiatric and cognitive concerns</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
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<tr>
<td>Develop and apply knowledge related to Caregiver and Family Issues</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
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<tr>
<td>Develop and apply knowledge related to Policy and Legal issues (e.g. Elder abuse, forensic issues, health care economics and the law (Medicare, Medicaid, Title III, treatment settings and regulations))</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
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<tr>
<td>Develop and apply knowledge related to Provisions of Psychiatric Care in Nursing Homes and other Long Term Care Settings.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
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<tr>
<td><strong>Interpersonal and Communication Skills</strong></td>
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<tr>
<td>Use an investigatory and analytic approach to clinical situations. Is able to make informed and reasonable decisions regarding the need for psychotherapy, psychopharmacology, and other treatment modalities.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
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<tr>
<td>Knows and applies a basis and clinically supportive scientific fund of knowledge.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
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<tr>
<td>Creates and sustains a therapeutic relationship with patients and their families, to a spectrum of and with regard for ethnicity, culture, race, gender and SES.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
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<tr>
<td>Interpersonal and communication skills are adequate, including the following: listens actively, provides information to patients and families appropriately, asks clear questions, provides opportunities for feedback and questions, has good written communication skills.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
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<tr>
<td>Understand the impact of transference and counter transference.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
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<tr>
<td>Communicate effectively and work collaboratively as a member and or leader of a multidisciplinary teams.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
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<tr>
<td>Facilitate the learning of other professionals including students, residents, nurses, social workers, etc.</td>
<td>NP</td>
<td>SE</td>
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<tr>
<td><strong>Practice-Based Learning and Improvement</strong></td>
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<tr>
<td>Open to supervision, analyzes performance and implements practice-based improvement activities (reading, discussions, etc.)</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
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<tr>
<td>Able to critically consider &quot;best practices&quot; and implement evidence-based treatment decisions, including knowledge of study designs and statistical methods of clinical studies as relevant.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
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<tr>
<td>Motivated learner who demonstrates initiative in managing information, accessing on-line medical information, and supporting clinical care and patient education through teaching, mentoring, being a role model.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
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<tr>
<td>Analyze practice experience and perform practice base improvement (e.g. supervision, record review etc.)</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
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<tr>
<td><strong>Professionalism</strong></td>
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<tr>
<td>Demonstrates respect, integrity, and a responsiveness to the needs of patients and society that supersedes self-interest; commitment to professional responsibilities, and acts in a timely manner</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
<td>I</td>
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<tr>
<td>Demonstrate a commitment to excellence, and to self-assessment and remediation, including acknowledging and remediating medical errors.</td>
<td>NP</td>
<td>SE</td>
<td>SP</td>
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### Professionalism Continued

| Demonstrates a **commitment to ethical principles** pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices. | NP | SE | SP | I |
| Demonstrates **sensitivity and responsiveness to cultural differences**, including awareness of one's own and one's patient’s cultural perspectives. | NP | SE | SP | I |
| Demonstrates understanding of and sensitivity to issues of end of life care. | NP | SE | SP | I |

### Systems-Based Practice

| Practices **cost-effective healthcare and resource allocation** that does not compromise on quality of care (i.e. orders appropriate lab or diagnostic tests). | NP | SE | SP | I |
| **Advocates for quality patient care** and assists patients dealing with system complexities. | NP | SE | SP | I |
| **Knows how to work with healthcare managers** and healthcare providers to assess, coordinate, and improve healthcare; know how these activities can impact system performance. | NP | SE | SP | I |

Awards or honors received during this reporting period:
1.
2.

Areas of particular strength/skill:
1.
2.

Areas requiring attention/improvement:
1.
2.

Suggestions/goals for professional growth/achievement:
1.
2.

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Robert Kohn, MD, Director
Geriatric Psychiatry Fellowship Training Program

Robert Boland, MD, Associate Director
Geriatric Psychiatry Fellowship Training Program

**Resident feedback:**

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Resident Signature/Date

3/10/05
Meetings with Residents

RESIDENT/YEAR IN FELLOWSHIP: _____________
BROWN UNIVERSITY GERIATRIC FELLOWSHIP TRAINING PROGRAM

Annual Summary Evaluation

RESIDENT/YEAR IN FELLOWSHIP: ___________________________  RATING PERIOD: ___________________________

SUPERVISOR: ___________________________________________  DATE: ____________________________
### Geriatric Psychiatry “Board Style” Assessment

<table>
<thead>
<tr>
<th>Fellow: __________________________________________</th>
<th>Attending: __________________________________________</th>
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<tbody>
<tr>
<td>No appropriate greeting or introduction</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Disorganized interview, does not redirect, asks many questions at once</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Poor eye contact, closed posture</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Intrusive or withholding</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Disrespectful, unsupportive, judgmental, poor listener</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Patient uncomfortable, appears to feel corner, pressured (given particular patient)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Misses important information</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Abrupt or insensitive closing</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

### Mental Status Examination:

**Incomplete, misses important information e.g., suicidality, psychotic symptoms.**

| 1 2 3 4 5 | Complete, covers all important areas |

### Presentation:

**Disorganized, incomplete, glib, unfocused. Unable to extract info from interview e.g. thought process. Mental status findings.**

| 1 2 3 4 5 | Concise, organized; through; pertinent + and –’s. Uses logical approach to presentation |

### Discussion:

- **Diagnostic skills:** Misses pertinent information, only very basic diagnoses, poor differential.
  - 1 2 3 4 5 | Complete differential including medical, and psychiatric illnesses, Attuned to dynamic issues and nuances of behavior. |

- **Formulation of Problem List:** Incomplete, not aware of social or medical issues.
  - 1 2 3 4 5 | Able to think through the psychiatric, medication, social, financial and medical issues. Good knowledge of differential. |

- **Treatment Plan:** Not aware of multiple systems with which pt. is interacting, and how soc and medical factors might complicate treatment and compliance.
  - 1 2 3 4 5 | Understands the multiple systems with which the pt is dealing, and the social, financial, community and medical issues that may complicate treatment. |

- **Knowledge of Pharmacology:** Does not understand psychopharmacology, drug interactions or side effects.
  - 1 2 3 4 5 | Understands complex pharmacological issues, issues with aging and side effects. |

- **Fund of Knowledge:** Inadequate, poorly organized or applied information.
  - 1 2 3 4 5 | Extensive knowledge; able to integrate information. |

### Comments:

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</table>

Signature: __________________________________________          Date: __________________________
Completion of Training Letter

began his/her training in geriatric psychiatry at Brown University on and generally met (or exceeded or far exceeded) expectations for residents at his/her level of training on all categories of evaluations.

He/she will have completed the following time-based geriatric psychiatry required rotations:

- Months of Inpatient Geriatric Psychiatry – Butler Hospital (4 months)
- Months of Outpatient Geriatric Psychiatry – Butler Hospital (12 months)
- Months of Neuropsychiatry Consults – Butler Hospital (4 months)
- Months of Nursing Homes Consults – Miriam Hospital (8 months)
- Months of Palliative Clinic - Butler Hospital (4 months)
- Months of Neurology Memory Clinic – Rhode Island Hospital (4 months)
- Months of Geriatric Ambulatory Care Clinic – Butler Hospital (4 months)
- Months of Geriatric Medicine Long Term Care – Eleanor Slater Hospital (4 months)
- Months of Nursing Home Consults – Rhode Island Hospital (4 months)
- Months of Addiction Clinic – VA Hospital (4 months)
- Months of Neuroradiology – Rhode Island Hospital (4 months)
- Months of Home Care Consults – Butler Hospital (4 months)
- Months of Consult Liaison – Miriam Hospital (4 months)
- Months of Neuropathology Consults – Rhode Island Hospital (4 months)
- Elective Rotation

Performed in an ethical manner and related satisfactorily with colleagues. had no documented evidence of unethical or unprofessional behavior in his/her training record. At the time of graduation, he/she demonstrated sufficient professional ability to practice competently and independently.

Robert Kohn, MD, Director
Brown University Geriatric Psychiatry Fellowship Training Program

Date
Verification of Resident’s Experience

Resident Name: ____________________________________________________________

Date entered Geriatric Psychiatry Fellowship Training Program: __________________

______ Months of Inpatient Geriatric Psychiatry – Butler Hospital (4 months)

______ Months of Outpatient Geriatric Psychiatry – Butler Hospital (12 months)

______ Months of Neuropsychiatry Consults – Butler Hospital (4 months)

______ Months of Nursing Home Consults – Miriam Hospital (8 months)

______ Months of Memory Clinic – Rhode Island Hospital (4 months)

______ Months of Palliative Care - Butler Hospital (4 months)

______ Months of Neuropathology – Rhode Island Hospital (4 months)

______ Months of Geriatric Medicine Long Term Care – Eleanor Slater Hospital (4 months)

______ Months of Nursing Home Consults – Rhode Island Hospital (4 months)

______ Months of Addiction Clinic – VA Hospital (4 months)

______ Months of Neuroradiology – Rhode Island Hospital (4 months)

______ Months of Home Care Consults – Butler Hospital (4 months)

______ Months of Consult Liaison – Miriam Hospital (4 months)

______ Months of Geriatric Medicine Ambulatory Care– Butler Hospital (4 months)

______ Elective Rotation _____________________________________________________________

______ Elective Rotation _____________________________________________________________

______ Elective Rotation _____________________________________________________________

Dates of semiannual evaluation: ______________________________________________________

Dates of review of multiple choice exam: ________________________________________________

Dates of review of practical exam (Mock Boards): _________________________________

Dates of review of patient log documentation: ____________________________________________

Date left Geriatric Psychiatry Fellowship Training Program: _________________________

Date completed Geriatric Psychiatry Fellowship Training Program: _____________________

3/9/05
Research Training in Brown University Geriatric Psychiatry

Geriatric Psychiatry Training Program Fellowship Year 1

1. Residents can elect to have up to have 10% of their time devoted to research activities.

2. Residents are expected to identify a faculty member (members) who has established ongoing research in geriatric psychiatry whom they wish to use as a mentor, either to participate in ongoing research activities or to develop an independent project.

3. The research mentor will meet with the Resident regularly

   a. If the Resident is participating in ongoing research, then the mentor will go over related research issues with the geriatric psychiatry Resident including issues surrounding methodology, data analysis and preparation of research manuscripts. The purpose of these sessions is to expose Residents to research to better prepare them in understanding and reading the medical literature.

   b. If the Resident has an independent research project, the mentor, in addition to the above, will monitor that the Resident is progressing in the appropriate fashion in completing the project. Furthermore, the mentor should make sure that the project that the Resident is undertaking is reasonable in scope for the level of training. It is unlikely that an independent project can be done with only 10% time, and would require in additional use of one's own time.

   c. The mentor will also insure that research activities do not interfere with clinical responsibilities.

4. The geriatric Resident's research time is designed to be a learning experience to expose the Resident to research, and not to serve as a research assistant.

Geriatric Psychiatry Training Program Fellowship Year 2

1. Geriatric psychiatry Residents who continue into the second year of the program should be individuals who are more academically oriented. Therefore, these Residents should, as above, identify a research mentor among the faculty participating in Brown University Geriatric Psychiatry Fellowship Training Program, and that mentor will assume the responsibilities as described above.

2. Residents in the second year of training are expected to devote 50% of their time to research related activities. Therefore, they should work on designing an independent project and not merely participate in the current ongoing research activities of their mentor. Such a project can, however, be an off-shoot or a piggy-back to a current project.

3. The goal of the independent project is for the Resident to gain experience in data collection, research design and methodology, data analysis, and manuscript preparation.

4. In order to enhance the Resident's research education, the geriatric psychiatry Resident will be encouraged to take research related courses at Brown University (there is no guarantee that the training program can reimburse tuition) and/or participate in ongoing research seminars available within the Brown University Department of Psychiatry and Human Behavior.

5. See Brown University Web Site for current research activities of faculty members in the Brown University Geriatric Psychiatry Fellowship Training Program. An ongoing copulation of research activities among faculty members will be maintained by the training program in order to facilitate the matching of Residents to mentors. Residents are strongly encouraged to also consider participating in research activities in the Center for Gerontology and Health Care Research and the Brown University Geriatric Neuropsychiatry Research and Treatment Program.
Useful Web-sites

Accreditation Council for Graduate Medical Education (ACGME) – www.acgme.org

American Association of Geriatric Psychiatry (AAGP) - www.aagppa.org

American Psychiatric Association (APA) – www.psych.org

American Board of Psychiatry and Neurology (ABPN) – www.abpn.com


Federal Credentials Verification Service (FCVS) – www.fsmb.org


Massachusetts Boards of Registration in Medicine – www.massmedboard.org - interactive and downloadable application forms

Rhode Island Department of Health Home Page – www.health.state.ri.us - links to license verification/status. Interactive and downloadable license application forms available at – www.docboard.org/ri/licinfo.htm