

GERIATRIC PSYCHIATRY

FELLOWSHIP HANDBOOK



2013 - 2014 YEAR

Table of Contents

Sponsoring Institute	
UAMS	5
UAMS / PRI (Psychiatric Research Institute)	5-6
UAMS / UNIVERSITY HOSPITAL	6
UAMS / RIOA (Reynolds Institute of Aging)	6-7
Participating Institution	
CAVHS (Central Arkansas Veterans Health Care)	7
AHC (Arkansas Health Center)	8
Program Goals	
Aims of Fellowship	8
General Program Goals	8
GERIATRIC FACULTY	
Program Director (Lou Ann Eads, MD)	9
Assistant Program Director (Lewis Krain, MD)	9
Key Teaching Faculty	9
Monica Shotwell, MD (CAVHS / GO TEAM)	9
Dinesh Mittal, MD (CAVHS / SCHOLARLY ACTIVITY)	9
Lawrence Miller, MD (ACHC)	10
Robert Elbert, MD (CAVHS)	10
Marcus Wellen, MD (CAVHS C&L)	10
Stanley Luke Crawford, MD (AHC)	10
DEPARTMENT PSYCHIATRY & BEHAVIORAL SCIENCES	
Faculty Roster	11-15
Program Personnel	16
APPLICATION PROCESS	17
ROTATION DIAGRAM	
Clinical Pathway	18
Research Pathway	18
ROTATION OVERVIEWS	
UAMS/PRI Inpatient	19-20
AHC / Long Term Care in Benton (Nursing Home)	20-22
UAMS/ SHC Outpatient Neurology	22
UAMS / SHC Geriatric Medicine Outpatient	22-23
UAMS / SHC Dementia Clinic	23-25
UAMS / SHC Psych Outpatient Medication Management	25
UAMS / Hospice – Palliative Care	26-27
CAVHS 1H Inpatient – Geriatric Psychiatry	27-28
CAVHS GO TEAM (COMMUNITY LONG TERM CARE)	28-29
CAVHS OUTPATIENT THERAPY & MED MANAGEMENT	30
CAVHS C&L (acute & sub-acute)	30-31
CAVHS Neurology Movement Disorder Clinic	32
ECT (UAMS & CAVHS)	32

SITE SPECIFIC GOALS & OBJECTIVES	
AHC / Long Term Care	33
UAMS / PRI Inpatient	34
UAMS/SHC Neurology	35
UAMS / SHC Geriatric Medicine RIOA	36
UAMS / SHC Dementia Clinic	37
UAMS / SHC Psych Outpatient Medication Management	38
UAMS Hospice – Palliative Care	39
CAVHS 1H Inpatient	40
CAVHS Outpatient Therapy & Medication Management	41
CAVHS GO Team (VA Community Long Term Care)	42
CAVHS Neurology Movement Disorder Clinic	43
CAVHS C&L (acute and sub-acute consults)	44
SCHOLARLY ACTIVITY	45-46
EVALUATIONS	
Evaluation Policies	47-48
Skills & Competencies to be Mastered Upon Completion	48
PATIENT LIST & DUTY LOG	49
POLICIES	
Fatigue	50
Leave	51
Reappointment & Promotion	52-53
Academic & Other Disciplinary Actions	54-56
Probation / Suspension / Dismissal	
Selection & Appointment	57-59
Supervision	60
Due Process	61
Duty Hours & Work Environment	62-63
Moonlighting	63
Criminal Background Check	64
GENERAL INFORMATION	
Contractual Agreement	65
ID Badges	65
Holidays	65
Leave	65-66
Library	66
Mailboxes	66
Pagers	66
Parking	67
Pay Schedules	67
Professional Liability Insurance	67
Resident Participation Non-departmental Activity	67
2007-2008 Resident Salary & Benefit	67
Suicide by Patient	67
Website	68
Appendix I: Sample Resident Contract	69-71
Appendix II: 2010-2011 DIDACTIC SCHEDULE	72-79

Appendix III: Evaluations	80-
Goals and Objectives Review	80
Supervisor Evaluation of Fellow	81-83
Program Director Eval	84-85
Summative Statement	86
Self Reflection Review (for Quarterly Meeting with Director)	87
Resident Eval Individual Rotation (NOT ANONYMOUS)	88-90
Resident Eval of Individual Faculty/Site (ANONYMOUS)	91
Resident Eval of Program (ANONYMOUS)	92
360 Evaluations	93-98

Sponsoring Institution

UNIVERSITY OF ARKANSAS for MEDICAL SCIENCES (UAMS)

The residency/fellowship in Geriatric Psychiatry is sponsored by the UAMS College of Medicine. Training is supported by both UAMS and Central Arkansas Veterans Healthcare System (CAVHS).

The University of Arkansas for Medical Sciences was founded in 1879 by eight physicians. UAMS is composed of a variety of colleges, including the College of Nursing, the College of Medicine, the College of Health Related Professions, the College of Pharmacy, the College of Public Health, and a Graduate School. UAMS is committed to excellence in: patient care, research, and outreach. The campus houses six Institutes of Excellence: (1) Winthrop P. Rockefeller Cancer Institute, (2) Harvey and Bernice Jones Eye Institute, (3) Myeloma Institute for Research and Therapy, (4) Donald W. Reynolds Institute of Aging, (5) Jack Stephens Spine and Neurosciences Institute, and (6) Psychiatric Research Institute (PRI).

UAMS is home of Arkansas's only teaching hospital, with clinics covering every medical specialty. Its staff includes more than 1,100 doctors committed to improving the health of Arkansas. University Hospital is the teaching hospital on the UAMS campus and opened a 540,000 square foot expansion in January of 2009, including a new Emergency Room. Also, there are a wide variety of specialty outpatient clinics on the campus. In addition to the care faculty provide at UAMS, they also provide care at the Central Arkansas Veterans Hospital (CAVHS), and the Arkansas Children's Hospital (ACH). UAMS ranks in the top 20% of all US Colleges & Universities in research funding from the Federal Government. Their outreach program includes 8 Area Health Education Centers (AHECs) and a comprehensive Rural Hospital Program.

It is the goal of the UAMS College of Medicine to help tomorrow's health-care professionals acquire not only the ultimate in medical skills but also professional and ethical standards that will aid them in their careers.

A. **PSYCHIATRIC RESEARCH INSTITUTE (PRI)**: PRI is located on the UAMS campus and is one of the most innovative psychiatric treatment and research facilities in the nation. PRI is a joint venture between the Department of Psychiatry and UAMS and offers a variety of outpatient clinics, inpatient care, and research space in one state of the art structure designed to treat thousands of patients each year.

PRI is housed in a five story, 100,000 square foot building and is one of nine such psychiatric facilities in the United States. The \$32 million center includes 40 inpatient beds. On the fifth floor there are 10 beds dedicated to the care of children ages 2-12 and 10 beds dedicated to the acute care of adult patients. On the sixth floor there are 8-10 beds for geriatric psychiatry and 10-12 for med-psych. Additionally, there is an ECT SUITE, on the sixth floor. The first floor is home the PRI's administration and support staff and house the Division of Health Services Research (DHSR), one of the country's largest and most comprehensive health services research centers. The second floor houses the Walker Family Clinic, which consolidates many of PRI's outpatient services and includes a number of specialty programs, including treatment for addictive and eating disorders. In addition, PRI is a training site for psychiatric residents for psychotherapy and psychotropic medication management. The Fred and

Louise Dierks Research Laboratories are located on the fourth floor and include the Center for Addiction Research and a methadone clinic.

One of the unique aspects of PRI is the neuroimaging center, which contains a 3 Tesla magnetic resonance imaging (MRI) system. The \$2.2 million mechanism is twice as powerful as a standard MRI machine and weighs approximately 10,000 pounds and is used for both clinical and research purposes. It is one of only two in the state of Arkansas and is capable of capturing detailed images of blood flow and brain activity. It will also process those images faster than standard MRI systems, providing medical personnel with improved diagnostic capabilities.

B. UNIVERSITY HOSPITAL: University Hospital is a tertiary care and Trauma hospital located on the UAMS campus and is the primary teaching hospital for a variety of medical disciplines. In January of 2009 opened a 540,000 square foot expansion. The Hospital provides services for a variety of outpatient medical clinics on the UAMS campus. The advanced care provided at UAMS Medical Center (inpatient and outpatient) has been one of the reasons the US News and World Report has named it one of America's best, in recent years. Due to the level and variety of care provided at University Hospital, a number of psychiatric needs are found and provided for during an individual's hospital stay.

C. REYNOLDS INSTITUTE OF AGING (RIOA): The RIOA house the Department of Geriatric Medicine and provides care to individual's 65 years of age and older, in a variety of situations and is an important teaching site for physicians. This care is provided by two primary divisions; one at UAMS and one on the CAVHS campus.

The UAMS Division is housed in the Reynolds Institute of Aging (RIOA), which supports both clinical care and research. A variety of services are provided to the senior receiving care at UAMS, including: outpatient primary care at the Senior Health Clinic (SHC), inpatient acute care at University Hospital, home bound care through the House Calls Program, and sub-acute / long term care through the Long Term Care Division.

The Senior Health Center provides outpatient primary care for seniors on the UAMS campus. It also houses a number of specialty clinics for seniors, including: dementia, geriatric psychiatry outpatient medication management, neurology, renal, and gynecology.

The Long Term Care Division's geriatricians serve as medical directors for a number of nursing homes in the Little Rock area. The geriatricians, physician assistants (PA), and geriatric APNs (medicine and psychiatric) provide comprehensive medical care for sub-acute, rehabilitative and chronic care (LTC/nursing home) patients.

The House Calls program continues the ideal of the "black box doctor". The House Calls geriatricians provide primary care to the housebound elderly.

The Hospice / Palliative care section provides care for those suffering from incurable illness and deals with end of life issues.

Additionally, the UAMS/RIOA geriatricians also, run an inpatient unit at University Hospital, to care for patients referred from the Senior Health Clinic, the House Calls Program, and the LTC / rehab facilities the Long Term Care Division provides services to.

Furthermore, there is a variety of research projects pertinent to the field of geriatrics ongoing at RIOA.

The CAVHS Geriatric Division, provides services to geriatric patients eligible to receive care at a VA facility. A variety of services provided by this division, includes: GRECC (Geriatric Research, Education, and Clinic Center), GEM unit (Geriatric Evaluation and Management Unit), Adult Day Health Care Center, Home Based Primary Care, Extended Care Unit, and Respite Care Program.

Participating Institutions

1. Central Arkansas Veterans Healthcare System (CAVHS)

CAVHS is considered a flagship of the VA, and is one of the busiest VA medical centers in the country. CAVHS is composed of two separate campuses, one in Little Rock and one in North Little Rock.

CAVHS contains 291-bed general medical and beds, a 152-bed Extended Care Unit, a 119-bed Domiciliary, outpatient clinics, and research facilities. The medical center is comprised of two campuses - the John L. McClellan hospital in Little Rock focuses more on acute care, while the Towbin Healthcare Center in North Little Rock facility provides more long-term, chronic care for our patients. Both campuses offer a wide range of inpatient and outpatient services. Furthermore, the system serves as a teaching facility to more than 1,200 students and residents; its principal affiliate is UAMS. Additionally, the system reaches out to veterans through a variety of Community Based Outpatient Clinics and programs.

The Little Rock campus is the home of the John L. McClellan Memorial Veterans Hospital. This hospital is an acute tertiary hospital, which was constructed in 1984, adjacent to the UAMS campus. This facility is a referral center for six states and includes inpatient units for Medicine, Neurology, Surgery, Orthopedics, and Neurosurgery. There are intensive units for Medicine, Surgery, and Cardiology.

The North Little Rock campus (approximately 15 miles from the Little Rock campus) is the home of the North Little Rock / Towbin Hospital, which was constructed in 1982 and is considered a subacute facility. This facility is on the historic grounds of Fort Roots and is the primary home for Psychiatry. The CAVHS Psychiatry Department offers a variety of services to a wide and divergent population, found in a six region area. Inpatient services provided include: acute adult unit, geriatric psychiatry unit, and a CMI (chronically mentally ill) unit. Also, psychiatry provides psychiatric consultation to a variety of other units at the North Little Rock Campus, including a nursing home unit and a PM&R rehabilitation unit. Likewise, there is a wide variety of outpatient psychiatric services also provided, including: medication management, therapy (group and individual), PTSD programs, and chemical dependence programs. Outreach Home based care programs of geriatric medicine and psychiatry, and auxiliary services for the homeless veteran are also available.

2. Arkansas Health Center (AHC)

This facility is located in Benton Arkansas, approximately 30 miles from the Little Rock CAVHS/UAMS campuses. A LTC (long term care) / nursing home building and a separate CMI (chronic mental ill) building is found on the campus, providing for approximately 350 beds, of which 6 beds are classified as SNF (skilled nursing facility) beds. A variety of health care services (physical and mental) are provided to the residents. The fellow will assist two geriatric psychiatrists provide care to geriatric patients on this campus. Additionally, a variety of disciplines are involved in the multidiscipline care of the patients, including: pharmacy, dietary, social work, nursing, physicians, dental, recreation therapy, physical therapy, occupational therapy, psychology, etc.

Program Goals:

AIMS: The aim of our program is to provide advanced training to residents with a strong interest in Geriatric Psychiatry. Our primary goal is to cultivate Psychiatrists with an expertise in the field of Geriatric Psychiatry, who will go on to become leaders in the field. Their expertise is expected to cover a wide pathway, including: clinical practice, teaching, research, and consultation. Additionally, we assist in the training of general psychiatry residents in the specialty area of geriatric psychiatry.

PROGRAM GOAL: The goal of advanced residency training in geriatric psychiatry is to produce specialists in the delivery of skilled and comprehensive psychiatric medical care of older adults, suffering from psychiatric and neuropsychiatric disorders. This program is structured to train residents / fellows in all aspects of geriatric psychiatry to prepare them for clinical practice in the geriatric population, geriatric research, and geriatric consultation skills.

Geriatric psychiatry is that area of psychiatry which focuses on prevention, diagnosis, evaluation, and treatment of mental disorders and signs/symptoms seen in older adult patients. The goals for the Geriatric Psychiatry Fellowship at UAMS & CAVHS aim to provide professional knowledge, skill, and opportunities to develop competencies through a well-supervised clinical experience.

The six goals of the residency training in geriatric psychiatry is designed to produce specialists in the delivery of skilled and comprehensive psychiatric medical care of older adults suffering from psychiatric and neuropsychiatric disorders.

1. **GOAL:** The geriatric psychiatry fellowship provides advanced training for the resident to function as an effective consultant in the subspecialty. To accomplish this goal, the fellowship emphasizes: scholarship, self-instruction, development of critical analysis of clinical problems, and the ability to make appropriate decisions.
2. **GOAL:** Clinical experience in the geriatric psychiatry fellowship includes opportunities to assess and manage elderly inpatients and ambulatory patients of both sexes with a wide variety of psychiatric problems. To fulfill this goal, the geriatric psychiatry residents is given the opportunity to provide both primary and consultative care for patients in both inpatient and outpatient settings in order to understand the interaction of normal aging and disease as well as to gain mastery in assessment, therapy, and management.
3. **GOAL:** The geriatric psychiatry fellowship program includes training in the biological and psychosocial aspects of normal aging.
4. **GOAL:** The fellowship program includes instruction in the psychiatric impact of acute and chronic physical illnesses
5. **GOAL:** The geriatric psychiatry fellowship provides instruction in the biological and psychosocial aspects of the pathology of primary psychiatric disturbances beginning in or continuing into older age.

6. **GOAL:** The geriatric psychiatry fellowship focused on multidimensional biopsychosocial concepts of treatment and management as applied both in inpatient facilities (acute and long-term care) and in the community or home settings. The fellowship rotations places an emphasis on the medical and iatrogenic aspects of illness as well as on sociocultural, ethnic, economic, ethical, and legal considerations that may affect psychiatric management.

Geriatric Faculty

Program Director

Lou Ann Eads, MD: Dr. Eads serves as the Program Director of the Geriatric Psychiatry Residency. She is an Assistant Clinical Professor in the UAMS Department of Psychiatry. As the Program Director, Dr. Eads is responsible for the oversight and organization of all educational activities within the Geriatric Psychiatry program and the monitoring of the progress of each resident.

Dr. Eads received her M.D. degree from UAMS in 1996. She completed a residency in General Psychiatry at UAMS, in 2000 and a residency/fellowship in Geriatric Psychiatry at Saint Louis University, in Saint Louis Missouri, in 2001. Dr. Eads is certified by the American Board of Psychiatry and Neurology (ABPN) in General Psychiatry. Additionally, she has added qualifications/ subspecialty certification in Geriatric Psychiatry and Psychosomatic Medicine.

Dr. Eads runs the inpatient geriatric psychiatry unit at UAMS PRI and sees outpatients at UAMS/RIOA-SHC, with a specialty in dementia.

Assistant Program Director

Lewis Krain, MD: Dr. Krain serves as the Assistant Program Director of the Geriatric Psychiatry Residency. He is a clinical Assistant Professor in the Department of Psychiatry at UAMS and is a staff psychiatrist at CAVHS. Additionally, he serves as an Associate Residency Director for the UAMS General Psychiatry Program. Dr. Krain is boarded in General Psychiatry.

Dr. Krain completed a residency in General Psychiatry at the University of Michigan, Ann Arbor and completed a two year fellowship in Geriatric Psychiatry from the University Of Michigan, Ann Arbor.

Key Teaching Faculty

Joshua Woolley, MD: Dr. Woolley is part of the teaching faculty of the Geriatric Psychiatry Program. He has been a staff psychiatrist with CAVHS since 2011. Also, he holds an appointment in the UAMS Department of Psychiatry, as an adjunct professor.

Dr. Woolley completed Medical School at the University of Arkansas for Medical Sciences. He completed his four year residency and his geriatric psychiatry fellowship at UAMS. Dr. Woolley is board eligible by the American Board of Psychiatry and Neurology (ABPN) in both General and Geriatric Psychiatry.

Dinesh Mittal, MD: Dr. Mittal is a full time staff psychiatrist at CAVHS. Additionally, he holds a position with the UAMS Department of Psychiatry, as an Associate Professor. Prior to coming to CAVHS/UAMS in 2004, Dr. Mittal served as the Medical Director of Geropsychiatry and Outpatient Clinic for the VA in Jackson, Mississippi. Additionally, he held an Associate Professor slot with the Department of Psychiatry for the University of Mississippi School Of Medicine. Dr. Mittal will primarily supervise research and scholarly activity of the resident and assist with didactics.

Dr. Mittal completed a MBBS MD in 1980 from the University of Rohtak, in India. In 1984 he completed an Orthopedics residency in India. In 1992 he completed a residency in Psychiatry from the University of Mississippi. In 2003, he completed a geriatric psychiatry research program, sponsored by the University California, in San Diego, California. Dr. Mittal is certified by the American Board of Psychiatry and Neurology (ABPN) in Psychiatry and also has added qualifications / subspecialty certification in Geriatric Psychiatry.

Robert Ebert, MD: Dr. Ebert is a Research Instructor for the UAMS Department of Geriatrics. He is also a staff psychiatrist for CAVHS. Dr. Elbert is boarded in General Psychiatry.

Dr. Elbert completed his General Psychiatry Residency at the University of Oklahoma, Tulsa. He completed a fellowship in Geriatric Psychiatry from Duke University.

John Spollen, MD: Dr. Spollen is a staff psychiatrist for CAVHS for the Consult Liason Service. Additionally, he holds a position with the UAMS Department of Psychiatry, as the Vice Chair for Education. Dr. Spollen is ABPN boarded in General Psychiatry.

Dr. Spollen completed a General Psychiatry residency from the Medical University of South Carolina. He is board certified in Psychosomatic Medicine and General Psychiatry.

**DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES
FACULTY ROSTER**

CHAIR

Interim Marie Wilson Howells Professor

Jeff Clothier, M.D.

UNIVERSITY HOSPITAL DIVISION

Professor & Chair Emeritus:

Frederick G. Guggenheim, M.D.

Professor Emeritus:

Roscoe A. Dykman, Ph.D.

Professor:

James Clardy, M.D.

Jeff Clothier, M.D.

G. Richard Smith, M.D.

Larry Miller, M.D.

Zach Stowe, M.D.

Associate Professor:

Gail Eisenhauer, M.D.

Jennifer Fausett, Ph.D.

Ben Guise, M.D.

Greg Krulin, M.D.

Erick Messias, M.D.

Assistant Professor:

Ricardo Caseda, M.D.

Lou Ann Eads, Ph.D.

Betty L. Everett, Ph.D.

Caris Fitzgerald, M.D.

Lewis Krain, M. D.

Irving Kuo, M.D.

Terri Miller, Ph.D.

Gary Schroeder, Ph.D.

Laura H. Tyler, Ph.D., LPC

Adjunct Professor:

Richard C. Lippincott, M.D.

Instructor:

Sonya Canfield, APN

Shona Ray, M.D.

PRI NORTHWEST ARKANSAS

Associate Professor: Michael Hollomon, M.D.
Jon Rubenow, D.O.
Gerald Stein, M.D.

Assistant Professor: Keith Berner, M.D.
Bradley Goodson, M.D.

DIVISION OF HEALTHCARE SERVICES RESEARCH

Professor: Brenda Booth, Ph.D.
John Fortney, Ph.D.
JoAnn Kirchner, Ph.D.
Teresa Kramer, Ph.D.
Richard R. Owen, M.D.
Jeffrey Pyne, M.D.
Greer Sullivan, M.D.

Associate Professor: Geoffrey Curran, Ph.D.
Ellen Fischer, Ph.D.

Assistant Professor: Teresa Hudson, Pharm.D.

Instructor: Terri Davis, Ph.D.
Jeff Smith, ABD
Angie Waliski, Ph.D.

DIVISION OF PEDIATRIC PSYCHIATRY

Professor Emeritus: Patricia Youngdahl, Ph.D.

Director : Jody Brown, M.D.

Professor: Patrick Casey, M.D.

Assistant Professor: Mark Andersen, M.D.
Jody Brown, M.D.
Jessica Carbajal, M.D.

Instructor: Steven Domon, M.D.
Gail Eisenhauer, M.D.
Molly Gathright, M. D.
Jennifer Gess, Ph.D.
Terri Miller, Ph.D.
Angie Shy, M.D.
John Webber, M.D.
Veronica Williams, M.D.
Bruce Cohen, M.S.

VA MENTAL HEALTH DIVISION

ACOS for Mental Health, VAMC
and Assistant Professor:
Professor: Tina McClain, M.D.
John Fortney, Ph.D.
Lawrence Labbate, M.D.
Richard Owen, M.D.
Greer Sullivan, Ph.D.

Associate Professor: Kathy Henderson, M.D.
Tim A. Kimbrell, M.D.
Eugene Kuc, M.D.
Dinesh Mittal, M.D.
John Spollen, M.D.

Assistant Professor: Grace Aikman, Ph.D.
Patricia Gibson M.D.
Erica Hiett, M.D.
Mark Hinterthuer, Ph.D.
Irving Kuo, M.D.
William Meek, M.D.
Michelle Ransom, M.D.
Glen White, Ph.D.
Greg Wooten, M.D.

Instructor: Mark Worley, M.D., Ph.D.
Kelley Burrow, M.D.

Tracy Haselow, M.D.
Jeremy Hinton, M.D.
Jacquelyn Martin, M.D.
Janette McGaugh, M.D.
Shanna Palmer, M.D.
Shane Sparks, M.D.
Lisa Snow, M.D.
Joshua Woolley, M.D.

ARKANSAS STATE HOSPITAL

Assistant Professor and Medical Director: Steve Domon, M.D.
Professor: Puru Thapa, M.D.
Assistant Professor: Joe Alford, Ph.D.
Kara D. Belue, M.D.
Natalie Brush-Strode, M.D.
April Coe-Hout, Ph.D.
Megan Edwards, Psy.D.
Lisa Evans, Ph.D.
Robert Forrest, M.D.
Raymond Molden, M.D.
Joao Ramos, M.D.
Carl Reddig, Ed.D.
James Shea, M.D.
Rush Simpson, M.D.
Stacy Simpson , M.D.
Brandon Wall , M.D.
Jennifer Whitmere, Ph.D.
Veronica Williams, M.D.
Adjunct Professor: Josh King, J.D.
J. Thomas Sullivan, J.D.

CENTER FOR ADDICTION RESEARCH

Professor: Michael Mancino, M.D.
Alison Oliveto, Ph.D.
Assistant Professor: Maxine Stitzer, Ph.D.

BRAIN IMAGING RESEARCH CENTER

Professor: Clint Kilts, Ph.D.
Assistant Professor: Andy James, Ph.D.

VOLUNTARY ADULT FACULTY DIVISION

Associate Clinical Professor: Philip Mizell, M.D.
Clinical Instructor: Ali M. Hashmi, M.D.

Program Personnel

Office of Education Staff

Janis Cockmon

501-526-8148

Ashley Lavender

501-526-8159

LaTanya Poole

501-526-8161

UAMS Housestaff Office

Dwana McKay, Director

501-686-5356

Arkansas State Hospital

Main number

501-686-9000

Judy Sipes, Medical Director's office

501-686-9354

PRI (PSYCHIATRIC Research Institute):

Main number

501-526-8100

Walker Family Clinic

501-526-8200

Center for Addictions Research (4th floor)

501-526-8400

UAMS/RIOA – SHC

Main Number

501-686-6219

Arkansas Health Center (AHC)

Main Number

501-860-0500

Dr. Megan Edwards, Clinical Director

501-860-0534

CAVHS

Main Number

501-257-1000

Geriatric Psychiatry Unit

501-257-1000, ext 52733

Outpatient Desk / 1L

501-257-3460

APPLICATION PROCESS

RESIDENCY / FELLOWSHIP:

The Geriatric Psychiatry Fellowship Program is accredited for one resident per year. The training year was approved as a clinical training year. Applicants to the program must have satisfactorily completed an ACGME-accredited general psychiatry residency to be considered for admission.

Selection Procedure

Program applicants must submit:

1. A current CV;
2. A letter of recommendation from your training director including your date of completion (or anticipated date) and standing in the program;
3. Two additional letters of recommendation;
4. A copy of your medical school transcript;
5. A copy of USMLE scores; the applicant must have successfully completed Steps I, II, and III and be eligible for licensure in the state of Arkansas
6. ECFMG certificate (for foreign medical school graduates) and copy of current visa status.
7. A personal statement regarding your interest in the field of geriatric psychiatry. In this statement, please include your vision of your involvement in the field of Geriatric Psychiatry after completion of the fellowship.

The deadline for applications for the 2012-2013 academic year is negotiable. Materials should be sent to:

Lou Ann Eads, MD
UAMS / PRI, Slot 554
Department of Psychiatry
4301 West Markham
Little Rock, Arkansas 72205

The application packet is reviewed by the Program Director, when all of the above materials are received. Applicants who are selected for an interview will be contacted by phone at the number listed in their application packet unless they request notification by email or regular mail. All interviewees will be given written notification of the terms, conditions, and benefits of appointment and employment on the day of the interview.

The complete policy of the UAMS College of Medicine Graduate Medical Education Committee on recruitment and appointment of residents may be viewed online at www.uams.edu/gme/1.200.html.

Block Diagram of Rotation Schedule

GERIATRIC PSYCHIATRY CLINICAL PATHWAY
(REVISED) .25 UAMS Stipend, .75 VA Stipend

		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
JULY	AM	PRI/INPT	PRI/INPT	PRI/INPT PLUS***	PRI/INPT	PRI/INPT
	PM	VA NURSING HOME	SHC DEMENTIA	VA MEDICINE GERI	VA NEUROLOGY	PSYCH OUTPT MED MGMT
AUG	AM	PRI/INPT	PRI / INPT	PRI/INPT PLUS ***	PRI /INPT	PRI /INPT
	PM	VA NURSING HOME	SHC DEMENTIA	VA MEDICINE GERI	VA NEUROLOGY	PSYCH OUTPT MED MGMT
SEPT	AM	PRI/INPT	PRI/INPT	PRI/INPT PLUS ***	PRI/INPT	PRI/INPT
	PM	VA NURSING HOME	SHC DEMENTIA	VA MEDICINE GERI	VA NEUROLOGY	PSYCH OUTPT MED MGMT
OCT	AM	PRI/INPT	PRI/INPT	PRI/INPT PLUS ***	PRI/INPT	PRI/INPT
	PM	VA NURSING HOME	SHC DEMENTIA	VA MEDICINE GERI	VA NEUROLOGY	PSYCH OUTPT MED MGMT
NOV	AM	VA IH INPT GERI PSYCH	VA IH INPT GERI PSYCH	VA IH INPT GERI PSYCH PLUS ***	VA IH INPT GERI PSYCH	VA IH INPT GERI PSYCH
	PM	VA NURSING HOME	SHC DEMENTIA	VA MEDICINE GERI	VA NEUROLOGY	PSYCH OUTPT MED MGMT
DEC	AM	HOSPICE – PALL (VA)	HOSPICE – PALL (VA)	HOSPICE – PALL (VA)	HOSPICE – PALL (VA)	HOSPICE PALL(VA)
	PM	HOSPICE – PALL (VA)	HOSPICE – PALL (VA)	HOSPICE – PALL (VA)	HOSPICE – PALL (VA)	HOSPICE PALL(VA)

		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
JAN	AM	VA 1H INPT GERIPSYCH	VA C/L	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH
	PM	VA OUTPT GERI PSYCH CLINIC	VA C/L	VA NEUROLOGY	VA 1H INPT GERIPSYCH + GRAND RDS & DIDACTICS	VA C/L
FEB	AM	VA 1H INPT GERIPSYCH	VA C/L	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH
	PM	OUTPT GERI PSYCH CLINIC	VA C/L	VA NEUROLOGY	1H INPT GERIPSYCH + GRAND RDS & DIDACTICS	VA C/L
MARCH	AM	VA 1H INPT GERIPSYCH	VA C/L	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH
	PM	VA OUTPT GERI PSYCH CLINIC	VA C/L	VA NEUROLOGY	1H INPT GERIPSYCH + GRAND RDS & DIDACTICS	VA C/L
APRIL	AM	VA 1H INPT GERIPSYCH	VA GO TEAM (NH OUTREACH)	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH
	PM	VA OUTPT GERI PSYCH CLINIC	VA GO TEAM (NH OUTREACH)	VA NEUROLOGY	1H INPT GERIPSYCH + GRAND RDS & DIDACTICS	VA NURSING HOME (NLRVA)
MAY	AM	VA 1H INPT GERIPSYCH	VA GO TEAM (NH OUTREACH)	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH
	PM	VA OUTPT GERIPSYCH CLINIC	VA GO TEAM (NH OUTREACH)	VA NEUROLOGY	1H INPT GERI PSYCH + GRAND RDS & DIDACTICS	VA NURSING HOME (NLRVA)
JUN	AM	VA 1H INPT GERIPSYCH	VA GO TEAM (NH OUTREACH)	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH	VA 1H INPT GERIPSYCH
	PM	VA OUTPT GERI PSYCH CLINIC	VA GO TEAM (NH OUTREACH)	VA NEUROLOGY	1H INPT GERI PSYCH + GRAND RDS & DIDACTICS	VA NURSING HOME (NLRVA)

PRI/INPT = PRI INPATIENT GEROPSYCH

PRI/INPT PULUS ****

NOTE: WEDNESDAY AM WILL BE:

- 1. GERIATRIC MEDICINE GRAND ROUNDS 8-9 AM**
- 2. DIDACTICS 9-10AM EITHER INDIVIDUAL OR WITH GERIATRIC MEDICINE IF APPLICABLE**

- 3. 10-NOON PRI**

AHC/LTC = BENTON HEALTH CARE / LONG TERM CARE

SHC NEURO= UAMS/RIOA-SHC GERIATRIC NEUROLOGY

SHC GERI MEDICINE = UAMS/RIOA-SHC GERIATRIC NEUROLOGY

SHC DEMENTIA = UAMS/RIOA-SHC DEMENITA CLINIC

SHC PSYCH MED MGNT= UAMS/RIOA-SHC OUTPATIENT PSYCH MEDICATION MANGEMENT

HOSPICE – PALLIATIVE CARE = UAMS HOSPICE – PALLIATIVE CARE MONTH

VA 1H INPT GERIPSYCH= VA Inpatient Geriatric Psychiatry, 1H NLRVA

VA GO TEAM (NH OUTREACH)= VA Geriatric Outreach Team, various sites

VA C/L= VA Psychiatry Consultation/Liaison, LRVA

VA NEUROLOGY= VA Neurology, Dementia or Movement Disorder Clinic, LRVA or NLRVA

VA GERI MEDICINE= VA Geriatric Medicine Outpatient Clinic

VA NURSING HOME= VA Inpatient Nursing Home, NLRVA

VA HOSPICE- PALL= VA Palliative Care/ Hospice

Overview of Rotations - Clinical Services

UAMS / PRI (Psychiatric Research Institute) Inpatient Geriatric Psychiatry Unit.

- A. SITE: PRI (Psychiatric Research Institute) Geriatric Psychiatry Inpatient Unit at UAMS.
1. Required rotation
 2. Duration of training: ½ day per week; X 5 days, for 5 months for Clinical Pathway
½ day per week; X 4 days, for 5 months for Research Pathway
 3. Part Time: 50% of rotation time at UAMS, for 5 months for Clinical Pathway
40% of rotation time at UAMS, for 5 months for Research Pathway.
- B. FACULTY STAFFING: one full time geriatric psychiatrist, with certification / added qualifications in geriatric psychiatry
- C. EDUCATIONAL ACTIVITIES:
1. Individual Case Discussions: including daily rounds and discussion with various members of the treatment team; approximate 5 hours / week; geriatric psychiatry residents (fellows) are supervised in the medical and psychiatric management of patients hospitalized on a geriatric psychiatry inpatient unit and case loads are monitored and controlled for both breadth and variety of experience; faculty are always available for consultation.
 2. directly observed interviews with feedback; approximate 2 hours / week
 3. observation of management of treatment team and discussion; approximate one hour / week
 4. observation of management of family conferences; approximately one hour / week
 5. one hour / week in didactics with geriatric medicine fellows
 6. one hour / week geriatric medicine grand rounds
 7. one hour / week of individual supervision
 8. daily attending review of notes, orders, etc.
- D. CLINICAL POPULATION: The population hospitalized on this unit is approximately 57% females and 43% males and have ranged in age from 65 years to 95 years of age. The population consists of approximately 82% Caucasian, 16% African American, and 2% Hispanic. The population carries a variety of psychiatric diagnosis, including: depression, bipolar disorder, schizophrenia, schizoaffective disorder, and a variety of dementias. Their psychiatric illnesses are further complicated by a variety of medical co-morbidities. The population is from a variety of socioeconomic strata, along with being from a mixture of ethnic and cultural strata. The clinical population is drawn from referrals from a variety of specialty services from UAMS (University) Hospital (teaching hospital), from a variety of outpatient clinics including geriatric medicine, a number of community long term care (nursing homes) institutions, and a tertiary level ER. Also, there are referrals from throughout the state.
- E. RESIDENT CASE LOAD / RESPONSIBILITY: The UAMS geriatric psychiatry inpatient unit is an 8-10 bed unit; and averages 6-8 patients / day. The geriatric psychiatry resident (fellow) will work assume primary responsibility for care of assigned patients and will be expected to function in a senior level of responsibility, with the attending providing daily supervision and oversight. The geriatric psychiatry resident (fellow) is expected to gradually increase the number of patients they can manage on a day to day basis, as the rotation progresses. The geriatric psychiatry resident (fellow) will be responsible for management of the weekly treatment team for their patients, which develops and revises a master treatment plan for each of their patients. Furthermore, they are responsible for management of family conferences for their patients, and relaying information to patients

and involved family members, Additionally, the geriatric psychiatry resident (fellow) is responsible for coordination of care with other health care providers.

F. SCHEDULED SUPERVISION:

1. one hour / week of individual supervision; the geriatric psychiatry resident (fellow) will spend one hour per week of individual supervision with the attending on the inpatient service (UAMS / PRI geriatric psychiatry unit).
2. supervision of daily clinical rounds
3. supervision of weekly treatment team meetings

G. OTHER ROTATORS: Potentially, there could be: an advanced level medical student, or an advanced level general psychiatry resident, geriatric medicine fellow, or APN student on the rotation. It is the attending's responsibility to limit acceptance of the number of rotators at any one time to ensure that all rotators are afforded the opportunity to an optimal educational experience

H. OTHER PERTINENT INFO: During this rotation, the geriatric psychiatry resident (fellow) is involved in geriatric patients undergoing ECT; this individuals are usually inpatients; they are expected to participate in evaluation of the ECT patient, consent of the ECT patient, ECT treatments, and management afterwards.

AHC (Arkansas Health Center) / LTC (Long Term Care = Nursing Home)

A. SITE: AHC / BENTON, ARKANSAS

1. Required Rotation
2. Duration of Training; ½ day per week; for 5 month
3. Part Time: 10% of rotation time at UAMS, for 5 months

B. FACULTY STAFFING: The geriatric psychiatry resident (fellow) interacts with one of 2 psychiatrists at AHC. The first one is Dr. L. Miller, who is board certified in general psychiatry, with added qualifications in geriatric psychiatry. Dr. Miller will be overseeing the rotation. Dr. Miller is the Medical Director of the Arkansas Division of Behavioral Health Services, which has the oversight responsibility for the Arkansas Health Center. Additionally, he holds a full time faculty position in the Department of Psychiatry at UAMS. The second psychiatrist is Dr. Stanley Crawford, who will be providing fill in assistance, when Dr. Miller is not available. Dr. Crawford has practiced geriatric psychiatry exclusively for the last 15 plus years. For the last five years he has primarily worked in long term care facilities and is considered an expert in the long term care arena.

C. EDUCATIONAL ACTIVITIES:

1. The geriatric psychiatry resident (fellow) is expected to provide psychiatric consultation and follow-ups in a long term care facility; consultations requested by the patients primary physician. The geriatric psychiatry resident's (fellow's) caseload is closely monitored to control the number and variety of experiences. The consultations assigned to the resident are selected to provide a variety of: diagnosis, age, sex, ethnicity, and psychosocial needs.
2. The geriatric psychiatry resident (fellow) is included in monthly staff meeting at the facility, which includes a variety of AHC staff (psychiatrists, psychologists, medical physician, etc) to discuss how the facility is functioning; goal to identify any potential problems and formulate a plan to address.

D. CLINICAL POPULATION: AHC is a campus run by the Division of Behavioral Services for the state of Arkansas. The total census for the AHC campus is currently 272 residents; composed of 46% females and 54% males. The population is 43% Caucasian, 55.5%

African American, <1% Hispanic, and <1% American Indian. Seventy-five percent of the population is 65 years of age or older. There is a wide variety of psychiatric diagnoses represented by this population, including psychotic disorders, anxiety disorders, mood disorders, somatoform disorders, various personality disorders, and mental retardation. Residents of the facility have a number of medical co-morbidities, including heart disease, various cancers, respiratory disease, neurological diseases (Huntington disease, Parkinson's disease, multiple sclerosis), traumatic brain injuries, and movement disorders (including chronic tardive dyskinesia). Psychiatric services provided at this location include psychiatric consultation / liaison (CL) services for the assistance with identifying and managing various psychiatric symptoms and behaviors, psychopharmacologic management, management of behaviors secondary to medical co-morbidities with behavioral interventions, individual and group therapy, and family education / therapy.

The AHC campus is composed of two main buildings. One building houses the chronically mentally ill who are unable to live outside of an institutional setting. The second building is a long term care unit for the difficult to place seniors in need of nursing home care. Usually there is some type of behavioral problem involved in placement at this facility. The psychiatric resident primarily spends their time on the long term care unit, addressing and following various psychiatric behaviors and needs. This exposes the resident to various dementias and organic brain pathology, which manifests in a number of different behaviors and psychiatric symptoms. There may also be an occasion for the resident to follow a few of the residents in the building for the chronically mentally ill, who are 65 years of age or older.

- E. **RESIDENT CASE LOAD / RESPONSIBILITY:** An average caseload for the geriatric psychiatry resident (fellow) consists of one new consult per week with 1-3 follow-ups per week. The geriatric psychiatry resident (fellow) is expected to function at a senior level of responsibility, in management of assigned patients. In this role, the geriatric psychiatry resident (fellow) is given the responsibility of independently evaluating the patient, obtaining needed collateral information, working with various treatment team members, communicating with various staff and family, and formulating diagnosis and treatment recommendations; including diagnostic studies, medications, non-pharmacologic behavioral management recommendations, etc. The geriatric psychiatry attending is available to the resident for consultation and assistance.
- F. **SCHEDULED SUPERVISION:** The attending oversees the caseload to ensure the geriatric psychiatry resident (fellow) has the opportunity to see an adequate number and variety of patients. The geriatric psychiatry attending / faculty will be on the AHC campus and available to the resident the day of the rotation, either in person or by phone. The attending / faculty will be responsible for monitoring the geriatric psychiatry resident (fellow) and providing appropriate feedback and assistance as needed, and for identifying good learning experiences.
- G. **OTHER ROTATORS:** No other rotators, from other services or programs share the same patient population, for this rotation.
- H. **OTHER PERTINENT INFO:** This rotation provides the resident an excellent opportunity to follow identified seniors on a long term basis (5 months) and to become familiar with regulations pertinent to the long term care setting. The geriatric psychiatry resident (fellow) is primarily seeing long term care (nursing home) patients. However, the geriatric psychiatry resident (fellow) is also in a unique position to see chronically mental ill seniors

who are permanently institutionalized. This opportunity should add to the overall richness of the rotation.

UAMS Senior Health Clinic (SHC): GERIATRIC OUTPATIENT NEUROLOGY

- A. SITE: UAMS/SHC (UAMS Senior Health Clinic); OUTPATIENT CLINIC
 - 1. Required Rotation
 - 2. Duration of Training: ½ day each week; for 5 months
 - 3. Part Time: 10% of rotation time at UAMS, for 5 months
- B. FACULTY STAFFING: one part time ABPN board certified neurologist
- C. EDUCATIONAL ACTIVITIES: The geriatric psychiatry resident (fellow) is involved and assists with **neurological** consultation at UAMS Senior Health Clinic; referred by providers of UAMS Senior Health Clinic

This experience provides the resident an opportunity to perfect their skills in assessment and management of neurological symptoms and diseases that manifest in the senior population.

- D. CLINICAL POPULATION: This clinic sees 22,000+ visits each year, with 5,000 – 6,000 individual patients. The demographics are approximately 60% female and 40% male. The ethnic mix is approximately 65% Caucasian, 33% African American, and 2% other. More than 5% of the population is 65 years of age or older. The pay mix is predominately Medicare, Medicaid, or other commercial insurances; less than 1% is self pay.
- E. RESIDENT CASE LOAD / RESPONSIBILITY: The geriatric psychiatry resident (fellow) is expected to participate in evaluation of new neurological consults and follow-up visits, with the neurologist who provides consultation to the UAMS SHC. The resident is working with the neurological attending; they will not be functioning independently.
- F. SCHEDULED SUPERVISION: During this rotation, the geriatric psychiatry resident (fellow) is supervised by the neurological attending, who is present in the clinic at the time of the visit. During the week at SHC, the geriatric psychiatric resident (fellow) will be provided one hour of individual supervision at the SHC with one of the two geriatric psychiatry attendings at SHC.
- G. OTHER ROTATORS: No other rotators are present for this rotation.
- H. OTHER PERTINENT INFO: This rotation provides the resident a unique opportunity to work with a neurologist, involved in evaluation and management of a variety of neurological diseases and symptoms common to the senior population.

UAMS SENIOR HEALTH CLINIC (SHC): GERIATRIC MEDICINE OUTPATIENT ROTATION:

- A. SITE: UAMS SHC (UAMS Senior Health Clinic); OUTPATIENT CLINIC
 - 1. Required Rotation
 - 2. Duration of Training: ½ day per week; for 5 months
 - 3. Part Time: 10% of rotation time at UAMS, for 5 months
- B. FACULTY STAFFING: geriatric medicine attendings; all who are active staff with the Department of Geriatric Medicine.

- C. **EDUCATIONAL ACTIVITIES:** This rotation allows the resident to perfect their medical skills under the supervision of the **geriatric medicine** facility. This rotation allows the geriatric psychiatry resident (fellow) to become familiar with geriatric syndromes and latest management recommendations of common illnesses and disease in a senior population.

The geriatric psychiatry resident (fellow) is given the option to spend one of those rotations each month (1/2 day each month) doing psychiatric consultations for the **geriatric medicine** attending involved in UAMS House Calls Programs. These consultations and follow-ups (new consults and follow-ups) work will be supervised by one of the two geriatric psychiatrists who work at SHC (Senior Health Center); if immediate assistance is needed, the attending will be available by phone, if not the attending will be available for in person consultation at Senior Health Clinic.

- D. **CLINICAL POPULATION:** The breadth of the clinical population is diverse. UAMS/RIOA-SHC houses the outpatient clinics for the Department of Geriatric Medicine at UAMS. This clinic sees 22,000+ visits each year, with 5,000 – 6,000 individual patients. The demographics are approximately 60% female and 40% male. The ethnic mix is approximately 65% Caucasian, 33% African American, and 2% other. More than 5% of the population is 65 years of age or older. The pay mix is predominately Medicare, Medicaid, or other commercial insurances; less than 1% is self pay.

- E. **RESIDENT CASE LOAD / RESPONSIBILITY:** The geriatric psychiatry resident (fellow) is expected to evaluate and manage patients under the supervision of a **geriatric medicine** attending. The geriatric medicine attending establishes the case load for the resident, with a goal of providing the resident with a variety of cases to provide a broad educational experience as possible. The geriatric medicine attending is responsible for monitoring the number and type of cases the resident is assigned, to ensure an appropriate learning experience.

- F. **SCHEDULED SUPERVISION:** During this rotation, the **geriatric medicine** attending is responsible for supervision of the resident; the attending is present in the Senior Health Clinic at the time of the visit and available to assist as needed. During the week at SHC, the geriatric psychiatry resident (fellow) will be provided one hour of individual supervision at the SHC with one of the two geriatric psychiatry attendings at SHC.

- G. **OTHER ROTATORS:** at times their patient population will be shared with geriatric medicine fellows and medical students.

- H. **OTHER PERTINENT INFO:** This rotation provides the geriatric psychiatry resident (fellow) with a unique opportunity to perfect their basic medical skills and to function in a treatment team, to provide the best care possible to the senior. In this clinic there is a multi disciplines available to assist with management of the patient: nursing, social work, psychology, dietary, Pharm D, and physicians of a variety of specialties working in the clinic.

UAMS SENIOR HEALTH CLINIC (SHC): DEMENTIA CLINIC:

- A. **SITE:** UAMS SHC (UAMS Senior Health Clinic); OUTPATIENT CLINIC
1. Required Rotation
 2. Duration of Training: ½ day per week; for 5 months
 3. Part Time: 10% of rotation time at UAMS, for 5 months

- B. **FACULTY STAFFING:** geriatric psychiatrist, geriatric medicine physician, social workers, and neurophysiologists
- C. **EDUCATIONAL ACTIVITIES:** The geriatric psychiatry resident /fellow participates in the evaluation and work-up of memory complaints, along with management of various **dementias**; including education and support of the family. Under the supervision of the geriatric psychiatry attending or the geriatric medicine attending, they will evaluate patients for complaints of memory, review various tests ordered as part of the work-up, and participate in treatment recommendations and family education.
- D. **CLINICAL POPULATION:** The breadth of the clinical population is diverse. UAMS/RIOA-SHC houses the outpatient clinics for the Department of Geriatric Medicine at UAMS. This clinic sees 22,000+ visits each year, with 5,000 – 6,000 individual patients. The demographics are approximately 60% female and 40% male. The ethnic mix is approximately 65% Caucasian, 33% African American, and 2% other. More than 5% of the population is 65 years of age or older. The pay mix is predominately Medicare, Medicaid, or other commercial insurances; less than 1% is self pay.

In addition to referrals from the geriatricians who practice in the SHC, the dementia clinic draws referrals from other outpatient clinics at UAMS and the local area. The goal of this clinic is to provide a referral site for the community and state for dementia evaluation. To accomplish this, a team is involved in the evaluation and management of the patient / family; all whom bring unique expertise to the process. After the evaluation of the patient, the treatment team meets together and review the work-up together, after which they arrive at a conscience diagnosis and treatment recommendations, which is relayed to the patient and family. Additionally, the patient and family is provided with education about their dementia / memory impairment and available support options will be identified for them.

- E. **RESIDENT CASE LOAD / RESPONSIBILITY:** The geriatric psychiatry resident (fellow) is expected to actively participate in the team evaluation and managing various dementias and education of the patient and family. The geriatric psychiatrist or geriatric medicine attending will supervise the resident during this rotation. It is the attending's responsibility to see that the resident is involved in with a variety of cases; to ensure an appropriate learning experience. The resident / fellow sees one new patient and 1-3 follow-up patients and families.
- F. **SCHEDULED SUPERVISION:** During this rotation the geriatric psychiatry resident (fellow) is supervised by the geriatric psychiatrist and/or geriatric medicine attending, who is present on site and available in person or by phone. During the week at SHC, the geriatric psychiatric resident (fellow) will be provided one hour of individual supervision at the SHC with one of the two geriatric psychiatry attendings at SHIC.
- G. **OTHER ROTATORS:** At various times, on the rotation, there is expected to be geriatric medicine fellows, medical students, and APN students. It is the attending psychiatrist or geriatrician's responsibility to ensure that during the rotation that each rotator has adequate exposure to the rotation to give them a good learning experience.
- H. **OTHER PERTINENT INFO:** This clinic, which occurs at the SHC is a unique clinic for the State of Arkansas. It involves a multi-discipline team evaluation and management of memory impairments / dementias that is offered not only to the geriatricians who practice at SHC, but also to referring physicians throughout the state and to individuals and family, who self refer. By including multiple disciplines (psychiatry, geriatric medicine, psychology, social work), we are able to offer a unique service to our medical community.

UAMS SENIOR HEALTH CLINIC (SHC): PSYCHIATRIC OUTPATIENT MEDICATION MANAGEMENT:

- A. SITE: UAMS/RIOA-SHC (UAMS Senior Health Clinic)
 - 1. Required Rotation
 - 2. Duration of Training: ½ day per week; for 5 months
 - 3. Part Time: 10% of rotation time at UAMS, for 5 months
- B. FACULTY STAFFING: One geriatric psychiatrist (Dr. Eads), who spends 50% of her time at SHC; full time with UAMS Department of Psychiatry. She is ABPN board certified in Geriatric Psychiatry
- C. EDUCATIONAL ACTIVITIES: This rotation's goal is to provide the geriatric psychiatry resident (fellow) with a longitudinal opportunity to engage in management of various psychotropic medications to the geriatric population. The geriatric psychiatry resident (fellow) provides psychiatric consultation services to the patient population of the SHC. This service includes new consultation requests. After the initial consultation the resident is expected to continue to follow the patient and to provide **psychotropic medication management** to the patient for the rest of the rotation. There is a variety of psychiatric diagnosis generated from the patient population at SHC, to include variety of mood disorder (depression and bipolar), psychotic disorders (including schizophrenia and schizoaffective), and anxiety disorders. Additionally, there is a psychotropic medication management of various behavioral issues associated with a variety of dementias. A number of the patients seen on the geriatric psychiatry inpatient unit, will also be enrolled in this clinic for outpatient care. This allows the geriatric psychiatry resident (fellow) involvement in patient care on a longitudinal basis and provides the resident with a continuity of care experience.

While seeing patients in this clinic, the geriatric psychiatry resident (fellow) is able to coordinate a variety of other disciplines (social work, psychology, Pharm D, dietary, etc) in patient care, as needed.

- D. CLINICAL POPULATION: The breadth of the clinical population is diverse. UAMS/RIOA-SHC houses the outpatient clinics for the Department of Geriatric Medicine at UAMS. This clinic sees 22,000+ visits each year, with 5,000 – 6,000 individual patients. The demographics are approximately 60% female and 40% male. The ethnic mix is approximately 65% Caucasian, 33% African American, and 2% other. More than (5% of the population is 65 years of age or older. The pay mix is predominately Medicare, Medicaid, or other commercial insurances; less than 1% is self pay.
- E. RESIDENT CASE LOAD / RESPONSIBILITY: During each clinic, the geriatric psychiatry resident (fellow) is expected to see one new patient evaluation and 1-2 follow up patient visits or to see 2-4 follow-up patient visits each clinic day. It is the attending's responsibility to monitor the cases they are involved in and to help ensure they are involved in the care of a variety of cases longitudinally.
- F. SCHEDULED SUPERVISION: The geriatric psychiatry resident (fellow) is scheduled for one hour per week of individual supervision with one of the two geriatric psychiatry attendings, who work in this clinic; mutual time to be arranged between the attending and geriatric psychiatry resident (fellow).
- G. OTHER ROTATORS: Potentially, there could be: an advanced level medical student, or an advanced level general psychiatry resident, geriatric medicine fellow, or APN student on the rotation. It is the attending's responsibility to limit acceptance of the number of rotators at

any one time to ensure that all rotators are afforded the opportunity to an optimal educational experience.

- H. OTHER PERTINENT INFO: The goal of this rotation is to provide the geriatric psychiatry resident (fellow) with longitudinal outpatient psychotropic medication management experience to the resident. In this clinic, patients are referred for psychiatric hospitalization on the UAMS geriatric psychiatry unit. This gives the resident a potential opportunity to be involved in the care of the patient before hospitalization, during hospitalization, and after hospitalization when they return to the SHC for future outpatient psychotropic medication management.

UAMS HOSPICE – PALLIATIVE CARE ROTATION (OFF SERVICE ROTATION):

- A. SITE: UAMS PALLIATIVE CARE / HOSPICE DIVISION, with experiences at a variety of venues utilized by the Division, including: (a) UAMS Hospital, (b) Arkansas Hospice, Inc, inpatient & outpatient venues (c) Hospice Home Care, Inc. or Arkansas Hospice, Inc.; inpatient and outpatient sites venues.
1. Required Rotation
 2. Duration of Training: 5 days / week for one month; (Monday – Friday approximately 8am to 1700 (5pm); no weekends or overnight care
 3. Full Time Rotation: Off service Rotation for ONE month
- B. FACULTY STAFFING: Faculty of UAMS Hospice – Palliative Care Division; Program Director for the rotation is Dr. Sarah Beth Harrington.
- C. EDUCATIONAL ACTIVITIES:
At UAMS, the rotating geriatric psychiatry resident (fellow) will review the rotation requirements and expectations with the supervising attending at the beginning of the rotation. The attending individualizes the rotation experience, based on level of education and experience of the geriatric psychiatry resident (fellow). The resident (fellow) is responsible for seeing consults, writing initial consult history and physical exam, and following the patient daily until the patient is discharged or the consult team signs off. The resident (fellow) rounds on all inpatient consults daily, with an attending physician. When the resident (fellow) is rotating with the Palliative Care team the resident (fellow) is responsible for admitting, writing orders on patients, and discharging patients from the service, with similar responsibilities as other inpatient medicine services. Rotating residents are expected to attend weekly interdisciplinary rounds. They are also expected to see patients one half-day / week in the UAMS Cancer Institute Pain Clinic. They will be precepted by the attending and are expected to write clinic notes in the patient's electronic chart (logician) to be cosigned by the attending.

The resident (fellows) follows the Palliative Care Attending and / or fellow on home hospice visits and inpatient hospice visits. The role and assignment is determined by the attending / palliative care fellow they are working with, and is determined by their experience and educational level.

During the time spent at Hospice Home Care or Arkansas Hospice the resident / fellow sees an average of 2-3 outpatients per day or 6-8 inpatients per day. They are accompanied by a Palliative Care Fellow and supervised by the hospice medical director or Hospice-Palliative care program director

- D. **CLINICAL POPULATION:** At all venues, there is a diverse patient population; male and female of all ages from adolescent to geriatric, representing most ethnic and racial backgrounds, from all social and economic groups. The attending is responsible for creating a rotation involving the geriatric population, for the resident (fellow). The patients seen on the palliative care service represent a wide spectrum of cancer and non-cancer diagnoses at various stages of illnesses.

At Hospice Home care the Outpatient census is approximately 30 patients on any given day and the inpatient census is approximately 8; 60-70% of the population falling within the geriatric age range.

At Arkansas Hospice, the outpatient census is approximately 120 patients on any given day and the inpatient census is approximately 10, with 60-70% of the population falling within the geriatric age range.

- E. **RESIDENT CASE LOAD / RESPONSIBILITY:** This will be determined by the Palliative care attending, responsible for the educational experience of the rotating resident (fellow).
- F. **SCHEDULED SUPERVISION:** During this off service rotation, individual supervision is provided by the faculty of UAMS Hospice-Palliative Care Division. At UAMS the resident / fellow is supervised by the Hospice-Palliative Care Attending. During their time at Hospice Home Care and Arkansas Hospice, they are accompanied by a Palliative Care Fellow and supervised by the hospice medical director or Hospice-Palliative care program director
- G. **OTHER ROTATORS:** Medical students and other resident from variety of specialties. It will be the Program Directors responsibility to see that the number of rotators do not exceed the Palliative Care's faculty ability to provide an excellent educational experience for the resident.
- H. **OTHER PERTINENT INFO:** This rotation will provide the resident with an excellent opportunity to understand hospice and palliative care in a variety of settings.

CAVHS INPATIENT GERIATRIC PSYCHIATRY:

- A. **SITE:** 1H Inpatient Geriatric Psychiatry at CAVHS (Central Arkansas Veterans Healthcare System)
- a. Required Rotation
 - b. Duration of Training: 6 months
 - c. Part Time: 40% time for 6months
- B. **FACULTY STAFFING:** One full-time geriatric psychiatrist.
- C. **EDUCATIONAL ACTIVITIES:** The resident serves on a multidisciplinary inpatient team on an intermediate-acuity geriatric psychiatry unit. Educational activities include case discussions on rounds (~5 hours per week), direct observed interviews with feedback (~2 hours per week), non-case-based didactic discussions/literature review (~1 hour per week), and a monthly journal club meeting.

- D. **CLINICAL POPULATION:** Geriatric patients (age 60 and up), drawn from the patient population at the Central Arkansas Veterans Healthcare System. It is almost entirely male. Racial demographics are ~80% Caucasian and ~20% African American. Diagnoses include dementia (~80%), depression (~40%), and late-life schizophrenia or bipolar illness (~20%). Note that there is a significant amount of comorbidity, most patients having both dementia and another mental health diagnosis. Treatment is primarily pharmacotherapy and milieu therapy. A small portion of the caseload is respite care, requiring little therapeutic intervention. Length of stay on this unit averages approximately 3 weeks

- E. **RESIDENT CASELOAD/RESPONSIBILITY:** Average case load is 8-12 patients for the entire team, which consists of the attending, the geriatric psychiatry resident (fellow), and 1 or 2 PGY II residents, as well as nursing and social work staff. The geriatric psychiatry resident (fellow) works in an “acting attending” role, in which members of the treatment team report to the directly to the fellow, who has the opportunity to make autonomous treatment decisions. The geriatric psychiatry resident (fellow) is also responsible for supervising the general psychiatry residents’ day-to-day clinical care of the patients and for providing education about geriatric psychiatry during rounds. The attending closely monitors these activities and all clinical decisions are subject to approval by the attending, who also steps in when needed for management of clinical issues beyond the expertise of the geriatric psychiatry resident (fellow). The geriatric psychiatry resident (fellow) on this service also answers sub-acute consults from other clinical services; this can be for collaborative care with the local nursing home units at the VA hospital, or to review cases on other units for appropriateness for transfer to 1H. There are 1-3 of these consults per week, which take an average of 1 hour each

- F. **SCHEDULED SUPERVISION:** Supervision occurs daily on clinical rounds and in a treatment team meeting afterwards consisting of the attending and all residents and fellows on the 1H rotation. The geriatric psychiatry resident (fellow) receive an additional hour of individual supervision per week.

- G. **OTHER ROTATORS:** Other trainees rotating on this service include 1-2 PGY II residents from the general psychiatry program. PGY IV residents from the general program have the option of doing an elective rotation on this service for one or more months. Fellows from geriatric medicine each do 1 month on 1H during the course of their fellowship.

- H. **OTHER PERTINENT INFO:** Geriatric psychiatry residents (fellows) on this rotation also participate in and lead family meetings. Some of our patients are treated with ECT, and when this occurs the resident is expected to participate in the ECT treatments. Geriatric psychiatry residents (fellows) may also provide supportive psychotherapy to patients admitted for mood disorders without cognitive dysfunction.

CAVHS COMMUNITY LONG TERM CARE (GO-Team):

- A. **SITE:** GO-Team, Nursing Home Outpatient Clinic, CAVHS (Central Arkansas Veterans Healthcare System)
 - a. Required Rotation
 - b. Duration of Training: 3 months
 - c. Part Time: 3 half-days for 3 months

- B. **FACULTY STAFFING:** One full-time geriatric psychiatrist.

- C. **EDUCATIONAL ACTIVITIES:** The geriatric psychiatry resident (fellow) serves on a multidisciplinary outpatient team that visits VA patients who reside in nursing homes. The GO-Team provides outpatient mental health care to patients who have limited ability to come directly to the VA for clinic visits.
- D. **CLINICAL POPULATION:** Geriatric patients (age 60 and up), drawn from the patient population at the Central Arkansas Veterans Healthcare System. These patients reside at nursing homes throughout the Central Arkansas VA catchment area, and the GO Team travels to see the patients on-site. The GO-Team consists of the fellow, a nurse (RN), and a clinical social worker. There are 60 patients currently enrolled in the program, located at 24 nursing home sites. The population is almost entirely male. Racial demographics are ~70% Caucasian and ~30% African American. Diagnoses include dementia (~80%), depression (~40%), and late-life schizophrenia or bipolar illness (~20%). Note that there is a significant amount of comorbidity, most patients having both dementia and another mental health diagnosis. Treatment is focused on maximization of function and quality of life through optimizing cognitive function and minimizing mood, psychotic, and anxiety symptoms. The primary treatment strategies are pharmacotherapy and recommendations for behavioral interventions in the nursing home. Patients on the GO Team roster are followed until they are no longer part of the CAVHS system, move out of the GO Team catchment area, or are deceased.
- E. **RESIDENT CASELOAD/RESPONSIBILITY:** Average case load is 4-12 patients for the entire team, per day, divided equally among the GO-Team members. Each patient is usually seen by one team member, though complicated cases may be visited by the entire team. Cases are divided among GO-Team members according to clinical need; those more likely to need medication interventions are assigned to the fellow. The geriatric psychiatry resident (fellow) will average 2-6 patients per day.
- F. **SCHEDULED SUPERVISION:** Primary supervision is delivered in post-hoc supervision on the following day, when the geriatric psychiatry resident (fellow) reviews cases with the attending. Often, evaluation occurs on the day of the visit, but treatment decisions are made the next day during supervision, and relayed via telephone to the nursing home. Although an attending is not present on-site, the attending is always available via telephone for urgent or acute questions.
- G. **OTHER ROTATORS:** There may be trainees from other programs participating in this rotation. PGY IV residents from the general program have the option of doing an elective rotation on this service for one or more months. Fellows from geriatric medicine may do 3-4 outings with the GO Team during the course of their fellowship. The flexible nature of the site visits allows for multiple fellows to participate without detracting from the experience. When there are other trainees present the fellow acts in a senior resident role and is expected to provide education to junior trainees.
- H. **OTHER PERTINENT INFO:** Clinical interventions with GO Team patients may extend beyond the day of the actual visit to the nursing home. Often the on-site assessment will uncover a need for laboratory testing, or there will be a medication change that may need to be followed-up in a week or so. Ongoing communication with the nursing home site can occur via telephone, and may lead to further interventions or even hospitalization on the 1H inpatient geriatric psychiatry unit.

CAVHS GEROPSYCH OUTPATIENT CLINIC THERAPY & MEDICATION MANAGEMENT:

- A. **SITE:** Mental Health Clinic, CAVHS (Central Arkansas Veterans Healthcare System)

- a. Required Rotation
 - b. Duration of Training: 6 months
 - c. Part Time: 1 half-day per week for 6 months
- B. FACULTY STAFFING: One full-time geriatric psychiatrist.
- C. EDUCATIONAL ACTIVITIES: The geriatric psychiatry resident (fellow) sees geriatric mental health clinic patients in the outpatient setting, for both initial evaluation and ongoing management.
- D. CLINICAL POPULATION: Geriatric patients (age 60 and up), drawn from the patient population at the Central Arkansas Veterans Healthcare System. It is almost entirely male. Racial demographics are ~70% Caucasian and ~30% African American. Diagnoses include dementia (~70%), depression (~40%), and late-life schizophrenia or bipolar illness (~20%). Note that there is a significant amount of comorbidity, most patients having both dementia and another mental health diagnosis. Treatment is primarily pharmacotherapy and supportive therapy. Special treatment methods available by referral include case management, individual or group psychotherapy, couples therapy, substance abuse treatment services, PTSD specialty clinic services, vocational rehabilitation, psychosocial rehabilitation services, and ECT. Geriatric psychiatry residents (fellows) on this rotation are expected to have one long-term psychotherapy case which will be seen on a weekly basis.
- E. RESIDENT CASELOAD/RESPONSIBILITY: Average case load is 2-3 return patients per and 1 new diagnostic evaluation per clinic day. Return visits are seen in a 30-minute clinic appointment slot, and diagnostic evaluations are seen in a 60-minute slot.
- F. SCHEDULED SUPERVISION: Supervision occurs during the clinic or shortly afterwards. The majority of cases seen during clinic are staffed by the attending while the patient is still present in clinic, and the attending has the option to see any patient in conjunction with the geriatric psychiatry resident (fellow). Stable patients may be seen by the resident alone and staffed later in the afternoon or on the following morning.
- G. OTHER ROTATORS: Other trainees rotating on this service include a third-year medical student, who may observe the fellow see patients or see patients separately from the fellow. There may be a geriatric medicine fellow, or a PGY-IV resident from the general psychiatry program on an elective rotation; this will occur less than 20% of the time. When there is another such trainee, cases will be carefully divided so as to not detract from the educational experience of the geriatric psychiatry resident (fellow).
- H. OTHER PERTINENT INFO: Geriatric psychiatry residents (fellow) on this rotation are available to outpatients by telephone to discuss side effects and response to interventions initiated during clinic appointments.

CAVHS GERIATRIC PSYCHIATRY ACUTE AND SUBACUTE CONSULTATION - LIAISON SERVICE:

- A. SITE: VA CONSULTATION - LIAISON Team at CAVHS (Central Arkansas Veterans Healthcare System)
 - a. Required Rotation
 - b. Duration of Training: 3 months
 - c. Part Time: 3 half-days per week for 6 months
- B. FACULTY STAFFING: One full-time psychosomatic psychiatrist.

- C. **EDUCATIONAL ACTIVITIES:** The geriatric psychiatry resident (fellow) sees consults in the acute medical setting at the CAVHS hospital (where the acute medical and surgical inpatient units are located) and in the sub-acute sitting at CAVHS. The geriatric psychiatry resident (fellow) works in conjunction with the general psychiatry consultation/liaison (C/L) team in the acute sitting, which is part of the general psychiatry residency training program; the geriatric psychiatry resident (fellow) sees new consults and also act in a “consulting to the consultant” role, being available for extra input on geriatric cases being managed by general residents.
- D. **CLINICAL POPULATION:** Geriatric patients (age 60 and up), drawn from the patient population on the consultation-liaison service at the hospital. It is almost entirely male. Racial demographics are ~60% Caucasian and ~40% African American. Diagnoses include delirium (~50%), dementia (~50%), depression (~30%), late-life schizophrenia or bipolar illness (~20%), and substance abuse (~20%). Note that there is a significant amount of comorbidity, most patients having some combination of delirium, dementia, and another mental health diagnosis. Treatment is primarily pharmacotherapy, supportive therapy, and recommendations to the primary medical team for behavioral management of patients with delirium or dementia.
- E. **RESIDENT CASELOAD/RESPONSIBILITY:** Average case load is 4-6 patients at time. The geriatric psychiatry resident (Fellow) sees an average of 1-2 new consults each half-day they are on service, and may follow these patients for some or all of the acute hospitalization.
- F. **SCHEDULED SUPERVISION:** Supervision occurs during rounds on the Consultation – Liaison service (~1 hour per day) and in individual discussion with the Consultation - Liaison attending after rounds (~15-30 minutes per day). A geriatric psychiatry faculty member is available by telephone to discuss aspects of geriatric psychiatry beyond the expertise of the Consultation – Liaison attending (~30 minutes per week).
- G. **OTHER ROTATORS:** Other trainees rotating on this service include third-year medical students on their psychiatry clerkships and PGY-II general psychiatry residents on their Consultation - Liaison rotations. The geriatric psychiatry resident (fellow) will be preferentially referred new geriatric consults on the days present on the Consultation – Liaison service. In addition, education of medical students and junior residents is considered part of the geriatric psychiatry resident’s (fellow’s) responsibility on this service and is one of the ways geriatric psychiatry resident (fellow) develop skill as educators and team leaders.
- H. **OTHER PERTINENT INFO:** Geriatric psychiatry residents (fellows) on this rotation are not available on site every day of the week. When not present, the general psychiatry residents on the Consultation – Liaison team will cover the geriatric psychiatry’s (fellow’s) patients, but the geriatric psychiatry resident (fellow) will be expected to be available by telephone during normal business hours to answer questions about management of these cases. In addition, the geriatric psychiatry resident (fellow) will also be available during this time for questions to facilitate the management of other geriatric patients on the Consultation – Liaison team. The geriatric psychiatry resident (fellow) will not be expected to manage emergent issues on the Consultation - Liaison team when not on site at CAVHS.

CAVHS OUTPATIENT NEUROLOGY CLINIC (MOVEMENT DISORDERS):

- A. **SITE:** Outpatient Neurology Clinic at CAVHS (Central Arkansas Veterans Healthcare System)
 - 1. Required Rotation:

2. Duration of Training: 3 months
 3. Part time: one half day per week for 3 months
- B. FACULTY STAFFING: one full time neurologist; faculty CAVHS Neurology
- C. EDUCATIONAL ACTIVITIES: The fellow sees patients in the CAVHS outpatient neurology movement disorders subspecialty clinic, under the supervision of the neurology attending. This rotation includes both new assessments and work-ups, referred to the outpatient specialty clinic. Educational activity is primarily in discussion of clinical cases, supplemented with a discussion of assigned readings.
- D. CLINICAL POPULATION: The patient's time in this clinic is assigned to geriatric patients enrolled in the CAVHS outpatient clinic. This is a predominately male population, which is composed of approximately 65% Caucasians and 35% African – Americans. The primary diagnosis is Parkinson's disease (70%), with additional diagnoses including spasticity, dystonia, chorea, athetosis, and tremor.
- E. RESIDENT CASELOAD / RESPONSIBILITY: The resident / fellow will see 4-6 cases per day, at 30 minutes per case.
- F. SCHEDULED SUPERVISION: There will be supervision via staffing with the neurology attending, during the clinic. Each case is discussed with the attending, who subsequently sees the patient with the resident / fellow before final treatment decisions are made.
- G. OTHER ROTATORS: Neurology residents may be present during in the same clinic, but they will have their own caseload.
- H. OTHER PERTINENT INFO: This rotations provides exposure to variety of neurological movement disorders, common encountered in the geriatric population.

Electroconvulsive Therapy (ECT):

UAMS: At UAMS the ECT service is run by Greg Cook, . Dr. Lou Ann Eads fills in at times. The resident / fellow will with work with Dr. Jeff Clothier and Dr. Lou Ann Eads to evaluate and participate in ECT treatments administered to seniors. The PRI attending will adjust their time, when appropriate to allow the resident / fellow to be involved in ECT being administered to senior population.

CAVHS: At CAVHS the resident / fellow will work with Dr. Erica Hiatt, who runs the ECT service at CAVHS. They will be involved in the evaluation and treatment administered to seniors. The 1H inpatient attending will adjust their time, when appropriate to allow the resident / fellow to be involved in this activity.

SITE SPECIFIC GOALS & OBJECTIVES:

AHC / BENTON, ARKANSAS

ROTATION: AHC (ARKANSAS HEALTH CARE) GERIATRIC PSYCHIATRY

LONG TERM CARE / NURSING HOME

ATTENDING: LAWRENCE MILLER, MD

LOCATION: BENTON, ARKANSAS

GOALS AND OBJECTIVES

1. Develop competency in the assessment and management of common psychiatric diagnoses associated with geriatric patients who reside in a long term care setting; especially depression, psychosis, dementia, and delirium (**medical knowledge, patient care**).
2. Develop competency in the management of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older individuals who reside in a long term care setting, and understand how care of these illnesses changes through the lifespan (**medical knowledge, patient care**).
3. Understand the etiology and neurobiology of dementia, delirium, various mood disorders, various psychotic disorders, and various anxiety disorders in the senior population, using required readings as well as self-guided study based on cases the patient is involved in at the long term care facility (**medical knowledge, practice-based learning**).
4. Understand the importance of using a multi-disciplinary team approach to management of mental health issues in older patients (e.g. input from social work, nursing, occupational therapy, recreation therapy, dietary, etc), and the role of the physician on this team as both physician and team leader (**systems-based practice, communication, professionalism**).
5. Develop competency in communicating with patients and families / caregivers in order: to obtain pertinent information from the patient, to obtain pertinent collateral information, to coordinate care, to convey medical recommendations, to identify needs, to coordinate available resources, etc. Also, to lead family meetings and steer treatment planning (**systems-based practice, communication, professionalism**).
6. Develop an understanding of the federal guidelines, including OBRA regulations which govern the care of patients in a long term care setting and demonstrate the ability to care for patients within these guidelines. (**systems-based practice, patient care, practice-based learning**).
7. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses, and should be able to serve as an effective leader of the multi-disciplinary team by the end of the rotation (**practice-based learning, systems-based practice, professionalism, patient care**).

UAMS CAMPUS

ROTATION: UAMS PRI INPATIENT GERIATRIC PSYCHIATRY

6 NORTH PRI

ATTENDING: LOU ANN EADS, MD

LOCATION: UAMS/LITTLE ROCK, ARKANSAS

GOALS AND OBJECTIVES

1. Develop competency in the assessment and management of common psychiatric diagnoses associated with geriatric patients, especially depression, dementia, and delirium (**medical knowledge, patient care**).
2. Develop competency in the management of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older patients, and understand how care of these illnesses changes through the lifespan (**medical knowledge, patient care**).
3. Understand the etiology and neurobiology of dementia, delirium, mood disorders, psychotic disorders, and anxiety disorders in the senior population, using required readings as well as self-guided study based on cases admitted to the inpatient unit (**medical knowledge, practice-based learning**).
4. Understand the importance of using a multi-disciplinary team approach to management of mental health issues in older patients (e.g. input from social work, nursing, occupational therapy, recreation therapy, dietary, etc), and the role of the physician on this team as both physician and team leader (**systems-based practice, communication, professionalism**).
5. Develop competency in communicating with patients and families / caregivers in order: to obtain pertinent information from the patient, to obtain pertinent collateral information, to coordinate care, to convey medical recommendations, to identify needs, to coordinate available resources, and to steer treatment planning (**systems-based practice, communication, professionalism**).
6. Understand the role of a geriatric psychiatry unit, in the health care system, and be able to assess patients in a variety of settings (ER, medical hospital, outpatient medical and psychiatric clinics, etc) for appropriateness for admission / transfer to the PRI-6N unit (**systems-based practice, communication, practice-based learning**).
7. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses, and should be able to serve as an effective leader of the multi-disciplinary team by the end of the rotation (**practice-based learning, systems-based practice, professionalism, patient care**).

ROTATION: RIOA/SHC GERIATRIC NEUROLOGY

OUTPATIENT GERIATRIC NEUROLOGY

ATTENDING: JAN SULLIVAN, MD (neurologist for UAMS/RIOA-SHC)

LOCATION: UAMS, LITTLE ROCK, ARKANSAS

GOALS AND OBJECTIVES

1. Develop competency in the assessment and management of common neurological diagnoses associated with geriatric patients seen in an outpatient sitting (**medical knowledge, patient care**).
2. Understand the interplay of psychiatry and neurology in the disorders seen in this clinic (**medical knowledge, practice-based learning**).
3. Understand etiology and neurobiology of the common neurological disorders encountered in the outpatient sitting; understand how they emerge and progress throughout an individual's lifespan, using required readings as well as self-guided study based on cases seen in the outpatient clinic (**medical knowledge, practice-based learning**).
4. Understand the use of a multi-disciplinary team approach to management of neurological disorders in senior patients (e.g. input from social work, nursing, occupational therapy, etc) (**systems-based practice, communication, professionalism**).
5. Develop competency in communicating with patients and families / caregiver in order to: obtain pertinent information from patient, to obtain collateral information, to coordinate care, to convey medical recommendations, and to identify needs, and to coordinate available resources (**systems-based practice, communication, professionalism**).
6. Understand the role of a neurologist in the management of seniors, in an outpatient multi-disciplinary team sitting (**systems-based practice, communication, practice-based learning**).
7. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses. (**practice-based learning, systems-based practice, professionalism, patient care**).

ROTATION: RIOA – SHC GERIATRIC MEDICINE

OUTPATIENT GERIATRIC MEDICINE

ATTENDING: **Geriatric Medicine Attending; to be assigned.**

LOCATION: **UAMS/LITTLE ROCK, ARKANSAS**

GOALS AND OBJECTIVES

1. Develop competency in the assessment and management of common medical diagnoses and disorders found in the outpatient geriatric medicine population and understand how management of these diagnoses and disorders changes through the lifespan of the patient (**medical knowledge, patient care**).
2. Develop competency in the management of common geriatric syndromes (**medical knowledge, patient care**).
3. Understand the etiology and neurobiology of common disorders / diseases found in the geriatric population, using required readings as well as self-guided study based on cases seen in the geriatric medicine outpatient clinic. (**medical knowledge, practice-based learning**).
4. Understand the importance of using a multi-disciplinary team approach to management of medical issues in older patients (**systems-based practice, communication, professionalism**).
5. Develop competency in communicating with patients and families / caregivers in order: to obtain pertinent information from the patient, to obtain collateral information, to coordinate care, to convey medical recommendations, and to identify needs, and to coordinate appropriate resources (**systems-based practice, communication, professionalism**).
6. Understand the role of geriatric medicine in the multi-discipline treatment team, in an outpatient setting (**systems-based practice, communication, practice-based learning**).
7. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses. (**practice-based learning, systems-based practice, professionalism, patient care**).

ROTATION: DEMENTIA CLINIC

RIOA – SHC (PSYCHIATRY & GERIATRIC MEDICINE)

ATTENDING: LOU ANN EADS, MD (Psychiatry) and/or

Ann Riggs, MD (Geriatric Medicine)

LOCATION: UAMS/LITTLE ROCK, ARKANSAS

GOALS AND OBJECTIVES

1. Develop competency as a member of a multi – disciplinary team, who is involved in the work-up / evaluation of various cognitive disorders / dementias. (**medical knowledge, patient care**).
2. Understand the etiology and neurobiology of various cognitive disorders, including various dementias, pseudo dementia of depression, cognitive disorder secondary to a variety of medical disorders such as: delirium, low B12 or thyroid disorders; using required readings as well as self-guided study based on cases admitted to the inpatient unit (**medical knowledge, practice-based learning**).
3. Understand the use of a multi-disciplinary team approach to evaluation and work-up of cognitive complaints in older patients (**systems-based practice, communication, professionalism**).
4. Develop competency in communicating with patients and families / caregiver in order: to obtain information from the patient, to obtain collateral information from other sources, to coordinate care, to convey medical recommendations, to identify needs, and to coordinate available resources (**systems-based practice, communication, professionalism**).
5. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses (**practice-based learning, systems-based practice, professionalism, patient care**).

ROTATION: OUTPATIENT MEDICATION MANAGEMENT

RIOA-SHC GERIATRIC PSYCHIATRY

ATTENDING: LOU ANN EADS, MD

LOCATION: UAMS/LITTLE ROCK, ARKANSAS

GOALS AND OBJECTIVES

1. Develop competency in the medication management of common psychiatric diagnoses / disorders associated with geriatric patients, especially depression, anxiety, and dementia(**medical knowledge, patient care**).
2. Develop competency in the management of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older patients, and understand how care of these illnesses changes through the lifespan (**medical knowledge, patient care**).
3. Understand the etiology and neurobiology of various mood disorder, psychotic disorders, anxiety disorders, and various dementias, using required readings as well as self-guided study based on cases admitted to the inpatient unit (**medical knowledge, practice-based learning**).
4. Understand the importance of using a multi-disciplinary team approach to management of mental health issues in older patients (**systems-based practice, communication, professionalism**).
5. Develop competency in communicating with patients and families/caregivers in order: to obtain pertinent information from the patient, to obtain collateral information from other sources, to coordinate care, to convey medical recommendations, to identify needs, and to coordinate available resources; with the assistance of a multi- disciplinary team (**systems-based practice, communication, professionalism**).
6. Understand the role of a geriatric psychiatrist in an outpatient sitting, as part of a multi-disciplinary team in the management of psychiatric needs for the senior population (**systems-based practice, communication, practice-based learning**).
7. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses (**practice-based learning, systems-based practice, professionalism, patient care**).

ROTATION: UAMS/HOSPICE-PALLIATIVE CARE (inpatient & outpatient)

University Hospital, Arkansas Hospice, Hospice Home care

ATTENDING: UAMS HOSPICE – PALLIATIVE CARE DIVISION

LOCATION: LITTLE ROCK, ARKANSAS

GOALS AND OBJECTIVES

1. Develop an understanding of the role of hospice and palliative care in the care of the senior population. (**medical knowledge, patient care**).
2. Develop an appreciation for end of life care choices made by families. (**medical knowledge, practice-based learning**).
3. Develop an understanding of pharmacology common in Hospice and Palliative care. (**medical knowledge, practice-based learning**).
4. Understand the use of a multi-disciplinary team approach to management of patients in hospice and palliative care. (**systems-based practice, communication, professionalism**).
5. Develop competency in communicating with patients and families / caregivers and other providers involved in hospice and palliative care. (**systems-based practice, communication, professionalism**).
6. Understand the role of an individual's belief in a higher power (God) and what happens after death and how this is addressed in a hospice-palliative care sitting. (**systems-based practice, communication, practice-based learning**).
7. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses. (**practice-based learning, systems-based practice, professionalism, patient care**).

CAVHS CAMPUS:

ROTATION: 1H INPATIENT GERIATRIC PSYCHIATRY
ATTENDING: LEWIS KRAIN, MD
TELEPHONE: 257-3146
MAIL SLOT: 116A/NLR
LOCATION: CENTRAL ARKANSAS VETERANS HEALTHCARE CENTER, NLR

GOALS AND OBJECTIVES

1. Develop competency in the assessment and management of common psychiatric diagnoses associated with geriatric patients, especially depression, dementia, and delirium (**medical knowledge, patient care**).
2. Develop competency in the management of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older patients, and understand how care of these illnesses changes through the lifespan (**medical knowledge, patient care**).
3. Understand the etiology and neurobiology of dementia and delirium, using required readings as well as self-guided study based on cases admitted to the inpatient unit (**medical knowledge, practice-based learning**).
4. Understand the importance of using a multi-disciplinary team approach to management of mental health issues in older patients (e.g. input from social work, nursing, occupational therapy, etc), and the role of the physician on this team as both physician and team leader (**systems-based practice, communication, professionalism**).
5. Develop competency in communicating with families in order to obtain collateral information and coordinate care. This includes the ability to use family meetings to obtain information, convey medical recommendations, and steer treatment planning (**systems-based practice, communication, professionalism**).
6. Understand the role of an intermediate care unit in the health care system, and be able to assess patients in acute settings (ER, medical hospital, acute psychiatric unit) for appropriateness for transfer to the 1H unit (**systems-based practice, communication, practice-based learning**).
7. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses, and should be able to serve as an effective leader of the multi-disciplinary team by the end of the rotation (**practice-based learning, systems-based practice, professionalism, patient care**).

ROTATION: VA OUTPATIENT GERIATRIC PSYCHIATRY CLINIC
ATTENDING: LEWIS KRAIN, MD
TELEPHONE: 257-3146
MAIL SLOT: 116A/NLR
LOCATION: CENTRAL ARKANSAS VETERANS HEALTHCARE CENTER, NLR

GOALS AND OBJECTIVES

1. Develop competency in the outpatient assessment and management of common psychiatric diagnoses associated with geriatric patients, especially depression, dementia, and delirium (**medical knowledge, patient care**).
2. Develop competency in the outpatient management of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older patients, and understand how care of these illnesses changes through the lifespan (**medical knowledge, patient care**).
3. Develop competency in collaborating outpatient care with other medical services, especially those involved with geriatrics such as Geriatric Medicine and Neurology. Understand how medical illnesses impact treatment of other medical conditions, and be able to identify and manage drug-drug interactions resulting from poly pharmacy and multiple providers (**medical knowledge, patient care, systems-based practice, communication, professionalism**).
4. Develop understanding of how to apply basic principles of psychotherapy to older patients, including compensating for sensory and cognitive deficits, specific stressors common in older patients, and the psychologic impact of illness and role transitions (**medical knowledge, patient care**).
5. Develop competency in application of specific psychotherapeutic techniques (Psychodynamic, cognitive behavioral, and supportive therapy) in the geriatric population. Understand how to refer patients to the most appropriate form of psychotherapy for each person (**medical knowledge, patient care, practice-based learning**).
6. Understand the legal concepts of competency and capacity, and be able to evaluate geriatric patients in the outpatient setting for their ability to make informed decisions about medical treatment and independent living. Be able to document this assessment in language that would be applicable in a legal setting and if necessary, be able to testify in court to support these findings (**Systems-based practice, communication, professionalism**).
7. Residents will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses, and should be able function in an independent manner by the end of the rotation (**practice-based learning, systems-based practice, professionalism, patient care**).

ROTATION: MENTAL HEALTH GERIATRIC OUTREACH TEAM (GO-Team)
ATTENDING: Joshua Woolley, MD
TELEPHONE: 257-3131
MAIL SLOT: 116A/NLR
LOCATION: CENTRAL ARKANSAS VETERANS HEALTHCARE CENTER, NLR

GOALS AND OBJECTIVES

1. Develop competency in the assessment and management of common psychiatric diagnoses associated with geriatric patients in the nursing home setting, especially depression, dementia, and delirium (**medical knowledge, patient care**).
2. Develop competency in the management of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older patients, and understand specific care needs of patients with these illnesses in the nursing home setting (**medical knowledge, patient care**).
3. Develop competency in the assessment of patients with acute behavioral changes in the nursing home setting, formulating differential diagnoses and treatment plans. Be able to follow these patients appropriately and adjust the treatment plans as needed (**medical knowledge, patient care, practice-based learning**).
4. Understand the impact of medical illness on behavioral stability of older patients. Be able to differentiate medical from psychiatric causes of acute behavior change, and use appropriate laboratory, imaging, and clinical resources to appropriately triage these patients (**medical knowledge, patient care, systems-based practice**).
5. Participate in a multi-disciplinary team to evaluate and treat nursing home patients (**systems-based practice, communication, professionalism**).
6. Develop competency in communicating with on-site physicians, nurses, and other clinical staff in order to obtain collateral information and coordinate care. (**systems-based practice, communication, professionalism**).
7. Fellows will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses, and should be able to serve as an effective leader of the multi-disciplinary team by the end of the rotation (**practice-based learning, systems-based practice, professionalism, patient care**).

ROTATION: VA NEUROLOGY MOVEMENT DISORDERS CLINIC

ATTENDING: STEVE METZER, MD

TELEPHONE: 257-1000

MAIL SLOT: 116A/NLR

LOCATION: CENTRAL ARKANSAS VETERANS HEALTHCARE CENTER, NLR

GOALS AND OBJECTIVES

1. Develop competency in the diagnosis of common neurologic movement disorders, including Parkinson's disease, Huntington's disease, dystonia, and others(**medical knowledge, patient care**).
2. Understand the pharmacology associated with movement disorders, including medications used to treat such disorders as well as medications that exacerbate them (**medical knowledge, patient care**).
3. Become familiar with the medical literature in movement disorders and apply that information to patients seen in the clinic (**medical knowledge, practice-based learning**).
4. Understand the role of the Movement Disorders clinic as a specialty clinic within the neurology clinic and the VA medical center, including communicating with referring physicians and coordinating patient care accordingly. (**systems-based practice, communication, professionalism**).

ROTATION: VA GERIATRIC PSYCHIATRY CONSULTATION SERVICE
ATTENDING: MARCUS WELLEN, MD
TELEPHONE: 257-1000
MAIL SLOT: 116A/NLR
LOCATION: CENTRAL ARKANSAS VETERANS HEALTHCARE CENTER, LR

GOALS AND OBJECTIVES

1. Develop competency in the assessment and management of common psychiatric diagnoses associated with geriatric patients in the acute medical setting, especially depression, dementia, and delirium (**medical knowledge, patient care**).
2. Develop competency in the management of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older patients in the acute medical setting, and understand how care of these illnesses changes through the lifespan (**medical knowledge, patient care**).
3. Understand the etiology and neurobiology of dementia and delirium, using required readings as well as self-guided study based on cases admitted to the inpatient unit (**medical knowledge, practice-based learning**).
4. Demonstrate competency in the assessment of suicidality of older patients in the acute medical setting (**patient care, interpersonal communication**).
5. Develop competency in communicating with families in order to obtain collateral information and coordinate care of patients in the acute medical setting. This includes the ability to use family meetings to obtain information, convey medical recommendations, and steer treatment planning (**systems-based practice, communication, professionalism**).
6. Understand the role of the psychiatry consultation/liaison service in an acute medical hospital, and be able to assess patients in this setting for appropriate disposition upon discharge (**systems-based practice, communication, practice-based learning**).
7. Fellows will be expected to apply the above goals and objectives with increasing autonomy as the rotation progresses, and should be able to serve as an effective leader of the multi-disciplinary team by the end of the rotation (**practice-based learning, systems-based practice, professionalism, patient care**).

SCHOLARLY ACTIVITIES FOR GERIATRIC PSYCHIATRY FELLOWSHIP:

The Geriatric Psychiatry Fellowship at UAMS/CAVHS has been created as primarily as clinical fellowship. Scholarly activities are an essential and required portion of the fellowship, as outlined by the ACGME. Below is a two branched pathway, to meet the needs of Geriatric Psychiatry Fellows.

Below are the expectations of all fellows involved in the one year fellowship program in Geriatric Psychiatry at UAMS/CAVHS.

1. ONE year clinical fellowship scholarly activities requirements:

Fellows are **expected** to participate in the following scholarly activities. They will be assigned to an attending, whose job will be to guide them through these expectations.

- a. Learn the research methodologies related to geriatric psychiatry, including biostatistics, clinical epidemiology, medical information, information sciences, decision analysis, critical literature review, research design, cross-sectional and longitudinal methods. The scholarly activity / research attending will work with them to develop an understanding of the above items.
- b. Integrate and apply current psychiatric scientific knowledge to clinical decision making (i.e. evidence-based medicine), during their clinical rotations, with the assistance of the attending supervising the specific rotation.
- c. Present critical appraisal of scientific literature on a geriatric psychiatry a topic of interest at one of the departmental (psychiatry) grand rounds.
- d. Lead at least 6 Geriatric Psychiatry Journal Clubs and to critically review at least one journal article every month in the journal club, they are able to attend.

Fellows are encouraged to participate in ongoing research activities at various fellowship training sites. (UAMS, CAVHS). The scholarly activity / research attending will work with the fellow to help identify activities of interest available on the two campuses. The attending will help guide and encourage them to present their work for scholarly review.

- a. They will be encouraged to submit their scholarly work for presentation at annual AAGP (American Association of Geriatric Psychiatry), AGS (American Geriatric Society, etc) or other forum or for publication as appropriate. The scholarly activity / research attending will work with the resident to help them identify the appropriate venue.

The fellow and scholarly activity / research attending will establish a mutual time they can meet, to accomplish the above criteria.

For those fellows who desire more research exposure, during their one year clinical fellowship in Geriatric Psychiatry, the following guidelines have been developed.

2. ONE year clinical fellowship (with emphasis on research) the requirements are as follows:

Fellows are **expected** to participate in the following activities.

- a. Learn the research methodologies related to geriatric psychiatry, including biostatistics, clinical epidemiology, medical information, information sciences, decision analysis, critical literature review, research design, cross-sectional and longitudinal methods. The scholarly activity / research attending will work with them to develop an understanding of the above items.
- b. Integrate and apply current psychiatric scientific knowledge to clinical decision making (i.e. evidence-based medicine), during their clinical rotations, with the assistance of the attending supervising the specific rotation.
- c. Present critical appraisal of scientific literature on a geriatric psychiatry a topic of interest, at one of the departmental (psychiatry) grand rounds.
- d. Lead at least 6 Geriatric Psychiatry Journal Clubs and to critically review at least one journal article every month in the journal club, they are able to attend.
- e. They will work with the scholarly activity / research attending to work on the publication of a case study or literature review article. They will be expected to have the case study or literature review submitted to a peer review journal by the end of their one year fellowship.
- f. The scholarly activity / research attending will work with and supervise all activities and will encourage them to present their work at appropriate national meetings; i.e. AAGP (American Association of Geriatric Psychiatry), AGS (Association Geriatric Society), etc

The fellow and scholarly activity / research attending will establish a mutually agreeable time to meet, to accomplish the above activities and will have ½ day/week blocked on their schedule to devote to work on the case study and/or review article.

Currently, our program at UAMS/CAVHS is set up as a one year clinical fellowship. Fellowships in Geriatric Psychiatry that prepare one for a research career are **2-year fellowships**. In those fellowships, the fellows are required to develop a grant proposal with a mentor locally or elsewhere in the country. Also, they frequently take part in the Geriatric Summer Research Institute which consist of a one-week boot camp in research training, that gets them in touch with eminent researchers there and get critical feedback on their ideas; they have a curriculum of didactics for the expectations listed above to help them meet those expectations.

For fellows interested in pursuing a true research tract, they will need to pursue a 2nd year of training, which we are not currently able to provide. The scholarly activity / research attending will help guide them through identifying appropriate places to pursue this; i.e. the attending will guide the fellow in finding a 2nd year Geriatric Psychiatry fellowship program, that offers research in an area they are interested in.

Evaluations

All templates for evaluations are found in Appendix III

Faculty Evaluation of Residents

The attending for each rotation will review the goals and objectives with the resident at the start of the rotation and they will sign an acknowledgement form that this occurred. The form will be returned to the Program Coordinator, to be included in the resident / fellow's permanent folder.

Faculty will also evaluate the resident / fellow's performance at mid point and at end of each rotation and discuss this with the resident / fellow. Below are copies of the evaluations forms for each rotation.

Resident/Fellow Evaluation of Faculty and Program (non-anonymous)

The fellow will be asked to complete an evaluation for the rotation, at the completion of the rotation; it is NOT anonymous. The evaluation will be reviewed by either the program director or the assistant program director. Then it is given to the program coordinator to comply into a summary for review during the ANNUAL FACULTY / REC MEETING. The fellow is made aware that these are not anonymous, due to the number of residents in the fellowship. They will be used to evaluate each rotation on an annual basis and to make improvements or changes as needed.

Program Director Evaluation

The Program director meets with the resident / fellow quarterly to review their progress and provide guidance. The resident / fellow is encouraged to contact the program director at any time, if there are concerns or difficulty they have not been able to resolve with their rotation attending. Below is the quarterly review template the program director completes.

The resident/fellow will complete a self-reflection evaluation form before each quarterly review reflecting upon level of functioning within the fellowship, strengths, weaknesses, and plan for improvement as well as an opportunity to express optional feedback.

Anonymous Evaluation Method

At the end of the rotation, the resident / fellow is asked to evaluate the attending faculty, anonymously. Additionally, at the end of the fellowship year, the fellow is asked to anonymously evaluate the fellowship program, overall.

Anonymous evaluations for the UAMS faculty will be turned in to the Assistant Program Director, who is at CAVHS. The evaluations will be reviewed by the Assistant Program Director and any acute concerns will be addressed. After the faculty evaluations are reviewed by the Assistant Program Director, they will be given to the Program Coordinator to comply into anonymous report for individual faculty review, in a 3 year cycle.

Anonymous evaluations for the CAVHS faculty will be turned in to the Program Director at UAMS. The evaluations will be reviewed by the program director and any acute concerns will be addressed. After the faculty evaluations are reviewed by the Program Director, they will be given to the Program Coordinator to comply into anonymous report for individual faculty review, in a 3 year cycle.

Since this fellowship is composed of one person / year. It is NOT possible to provide yearly anonymous feedback to faculty, for one year at a time. Therefore, the program coordinator will combine comments for the 3 most recent years and submit them (three years of evaluations) to appropriate faculty on a yearly basis.

Summative Evaluation

A summative evaluation is completed by the program director upon successful completion of all rotations

360 Evaluations (Multi-rater evaluations)

Location:

1. Patients assigned to resident / fellow on the inpatient geriatric psychiatry unit at UAMS/PRI
2. Patients assigned to resident / fellow on the inpatient geriatric psychiatry unit at CAVHS/ 1H in NLR

Raters / Evaluators:

1. Nursing Staff of Inpatient Unit (UAMS /CAVHS)
2. Social Workers for unit (UAMS / CAVHS)

For each patient assigned to the resident / fellow during their time on the inpatient geriatric psychiatry units, a 360 evaluation will be completed after the patient is discharged from the unit. After discharge the following individuals will be asked to complete the evaluations: 1. primary nurse who is primarily assigned to the care of that patient, and 2. social worker assigned to the patient. After the evaluation is completed, it will be returned to the program director for review and then included in the resident / fellow's permanent file.

SKILLS AND COMPETENCIES TO BE MASTERED UPON COMPLETION OF FELLOWSHIP;

The resident/fellow is expected to have mastered the following skills and competencies, upon completion of the geriatric fellowship. Successful completion of each of the required rotations is evidence of mastery of these skills and competencies.

1. Ability to identify, diagnosis, and manage a variety of dementia presentations.
2. Ability to manage a mental health disorders commonly seen in the senior population
3. Ability to practice in a variety of venues: inpatient, outpatient, and long term care.
4. Ability to act in a consultation and liaison role to other providers, in the management of dementia and mental health disorders common to the senior population.
5. Refinement of psychotropic management in the senior population.

POLICIES:

Geriatric Psychiatry Residency/Fellowship Program

Fatigue

The Geriatric Psychiatry residency/fellowship program is committed to preventing and counteracting fatigue's potential negative effects on patient care and learning in this training program. Both faculty and residents are required to complete an educational program about sleep loss and fatigue. Residents are also required to complete a Web CT module, SAFER (Sleep, Alertness, and Fatigue Education in Residency), as well. The program director and supervising faculty monitor the demands of individual rotations and call and make scheduling adjustments as necessary to mitigate excessive service demands and /or fatigue. The GMEC pamphlet on fatigue education is distributed to residents annually (at start of year), to educate them on the signs and symptoms of fatigue.

In the event a resident experiences fatigue severe enough to interfere with his/her ability to function normally or to impair patient care or safety, the resident, another resident or a faculty member will contact the program director. If the program director is not available, the report may go to the faculty member in charge of the rotation, or the director of resident education at that facility:

1. UAMS = Dr. Ben Guise or Dr. Lou Ann Eads
2. CAVHS = Dr. Lewis Krain or Dr. Mark Worley
3. AHC = Dr. Larry Miller

At UAMS, the resident/fellow will nap in the PRI call room until they can return to their clinical duties or safely drive home. At CAVHS, the faculty attending or program director will locate a room to nap in, until the resident/fellow can return to their clinical duties or safely drive home. At AHC, the faculty member or program director will locate a room to nap in, until the resident/fellow can return to clinical duties or safely drive home. The faculty member or program director who receives the original report of resident fatigue will notify the chief resident who will arrange coverage if needed. The chief resident will also report the incident to the program director by telephone or e-mail, if the program director was not involved in the original report.

In the event a resident experiences recurrent problems with sleepiness/fatigue, the program director will refer the resident for medical evaluation or counseling as appropriate.

Resident/Fellow Effects of Leaves of Absence

In accordance with the UAMS COM GME Committee Policy on Leave for Residents the following describes the effect of leave on completion of training in the Geriatric Psychiatry residency/fellowship program.

Effect of Leave on Completion of Training

Geriatric Psychiatry resident physicians are in the unique position of having a role as students and employees. Although brief periods of leave can usually be accommodated, extended absences from the residency (fellowship) program for any reason may adversely affect both the resident's completion of the educational program on schedule and the program's responsibilities for patient care, allocation of clinical teaching opportunities and funding for resident stipends. The resident must take into account these factors when requesting extended periods of leave from the program.

American Board of Psychiatry and Neurology - Minimum Requirements

B. Specific Training Requirements

Please Note: This is a brief summary of training requirements and not intended to be all inclusive. Read the current *Information for Applicants* publication for all requirements for Initial Certification in Geriatric Psychiatry.

Applicants for certification in geriatric psychiatry must be certified by the Board in general psychiatry by February 1 prior to the examination administration. All applicants other than those initially admitted during the "grandfathering period" are required to submit documentation of successful completion of one year of ACGME-accredited fellowship training in geriatric psychiatry that did not begin before the time general residency training in psychiatry, including time spent in combined training programs, was completed. The exposure to geriatric psychiatry given to psychiatry residents as part of their basic psychiatry curriculum does not count toward the one year of training. All licensing and training requirements must be met by June 30 of the year prior to the examination.

The required one year of specialized training in geriatric psychiatry may be completed on a part-time basis as long as it is not less than half time; credit is not given for periods of training lasting less than one year except under special circumstances that must be approved by the ABPN Credentials Committee. In such cases, it is the responsibility of the applicant to provide detailed documentation from the respective training directors including the exact dates (month/day/year to month/day/year) and outlining training content, duties, and responsibilities. Each case is considered on an individual basis.

For complete details of ABPN latest requirements, please refer to their website at: www.abpn.com

REAPPOINTMENT & PROMOTION:

Criteria and Processes for Academic Actions of Reappointment, Evaluation, Promotion, and other Disciplinary Actions

In compliance with the UAMS COM GME Committee policy on Evaluation and Promotion, the following guidelines apply:

Reappointment

Educational appointments to the Geriatric Psychiatry residency/fellowship program are for a term not exceeding one year. The resident agreement of appointment, which outlines the general responsibilities for the College of Medicine and for the resident, is signed at the beginning of each term of appointment. Renewal of the resident/fellow agreement of appointment for an additional term of education is the decision of the Program Director and the Department Chair.

It is the intent of the Geriatric Psychiatry program to develop physicians clinically competent in the field of Geriatric Psychiatry. Physicians completing the program will be eligible for certification by the American Board of Psychiatry and Neurology (ABPN) with an ultimate goal of a 100% pass rate on this examination.

Clinical competence requires:

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
2. **Medical Knowledge** about established and evolving biomedical, clinical, and epidemiological and social-behavioral sciences and the application of this knowledge to patient care.
3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and continuous improvement in patient care based on self-evaluation and life-long learning.
4. **Interpersonal and Communication Skills** that result in effective exchange of information with patients, their families, and other health professionals.
5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities and an adherence to ethical principles.
6. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Evaluation and Promotion

NOTE: ALL EVALUATION FORMS PERTAINING TO THE RESIDENTS SHOULD BE LABELED WITH THE FOLLOWING “Confidential Peer Review Document”:

During the residency/fellowship period, the above elements of clinical competence will be assessed in writing, at the end of a one month rotation or at the midpoint and again at the end of a rotation that runs for greater than one month, by direct faculty supervisors with subsequent review by the Program Director. Evaluations by peer resident physicians, patients, nursing staff and other paramedical personnel may be included at less frequent intervals. A resident will meet with the Program Director or other designee such as the assigned faculty advisor, quarterly to review results of evaluations, in-service scores, clinical exercises, and the 360s. A summary of the evaluations will be reviewed and signed by the resident/fellow. The evaluations will be maintained in confidential files and only available to authorized personnel. Upon request, the resident may review his/her evaluation file at any time during the year.

Reappointment and promotion to a subsequent year of training require satisfactory ratings on these evaluations.

A resident receiving 1 unsatisfactory evaluation during the year will be immediately reviewed by the Program Director or Resident Peer Review Committee and written recommendations made to him/her may include:

1. specific corrective actions
2. repeating a rotation
3. psychological counseling
4. academic warning status or probation
5. suspension or dismissal, if prior corrective action, academic warning and/or probation have been unsuccessful.

In instances where a resident’s agreement will not be renewed, or when a resident will not be promoted to the next level of training, the program director will provide the resident with a written notice of intent no later than four months prior to the end of the residents’ current agreement. If the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, the program director will provide the resident with as much written notice of the intent not to renew or not to promote as circumstances will reasonably allow, prior to the end of the agreement.

The resident may appeal an unsatisfactory evaluation by submitting a written request to appear before the department’s Resident Evaluation Committee in a meeting called by the Program Director. The Committee reviews a summary of the deficiencies of the resident/fellow, and the resident/fellow has the opportunity to explain or refute the unsatisfactory evaluation. After review, the decision of this Committee is final.

At the completion of the residency/fellowship program the Program Director prepares a final evaluation of the clinical competence of the resident. This evaluation stipulates the degree to which the resident has mastered each component of clinical competence – patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. In this evaluation the Program Director verifies that the resident/fellow “has demonstrated competence in Geriatric Psychiatry to enter practice without direct supervision”. This evaluation remains in the program’s files to substantiate future judgments in hospital credentialing, board certification, agency licensing, and in the actions of other bodies.

Academic and Other Disciplinary Actions (in accordance with UAMS COM GME Policy on Disciplinary Actions)

Academic Warning Status:

The resident / fellow will be placed on Academic Warning status, if their performance is felt to be less than satisfactory at the end of a rotation, by the rotation attending. This status is to allow the resident / fellow to engage in a remediation plan agree upon by the attending and program director.

Academic and Other Disciplinary Actions (Probation, Suspension and Dismissal)

Definitions

Probation: a trial period in which a resident is permitted to redeem academic performance or behavioral conduct that does not meet the standard of the program.

Suspension: a period of time in which a resident is not allowed to take part in all or some of the activities of the program. Time spent on suspension may not be counted toward the completion of program requirements.

Dismissal: the condition in which a resident is directed to leave the residency program, with no award of credit for the current year, termination of the resident's Agreement of Appointment, and termination of all association the University of Arkansas for Medical Sciences College of Medicine and its participating teaching hospitals.

Policy

Each Program Director, in consultation with the Departmental Chairperson and Departmental Education Committee, must implement written criteria and processes for academic and other disciplinary actions within the program including, but not limited to, probation, suspension and dismissal from the residency program. The specific actions of probation, suspension, and dismissal must follow the guidelines listed below. The particular administrative action imposed shall be based on individual circumstances and will not necessarily follow the sequential order in which they are described below. A resident involved in any of the actions of probation, suspension, dismissal has the right to appeal according to the GMEC Policy, 1.410, Adjudication of Resident Grievances.

Procedure

Probation

1. A resident may be placed on probation by a Program Director for reasons including, but not limited to any of the following:
 - a) failure to meet the performance standards of an individual rotation;
 - b) failure to meet the performance standards of the program;
 - c) failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions
 - d) misconduct that infringes on the principles and guidelines set forth by the training program;
 - e) documented and recurrent failure to complete medical records in a timely and appropriate manner;
 - f) when reasonably documented professional misconduct or ethical charges are brought against a resident which bear on his/her fitness to participate in the training program.

2. When a resident is placed on probation, the Program Director shall notify the resident in writing in a timely manner, usually within a week of the notification of probation. The written statement of probation will include a length of time in which the resident must correct the deficiency or problem, the specific remedial steps and the consequences of non-compliance with the remediation.
3. Based upon a resident's compliance with the remedial steps and other performance during probation, a resident may be:
 - a) continued on probation;
 - b) removed from probation;
 - c) placed on suspension; or
 - d) dismissed from the residency program.

Suspension

1. A resident may be suspended from a residency program for reasons including, but not limited, to any of the following:
 - a) failure to meet the requirements of probation;
 - b) failure to meet the performance standards of the program;
 - c) failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions;
 - d) misconduct that infringes on the principles and guidelines set forth by the training program;
 - e) documented and recurrent failure to complete medical records in a timely and appropriate manner;
 - f) when reasonably documented professional misconduct or ethical charges are brought against a resident which bear on his/her fitness to participate in the training program;
 - g) when reasonably documented legal charges have been brought against a resident which bear on his/her fitness to participate in the training program;
 - h) if a resident is deemed an immediate danger to patients, himself or herself or to others;
 - i) if a resident fails to comply with the medical licensure laws of the State of Arkansas.
2. When a resident is suspended, the Program Director shall notify the resident with a written statement of suspension to include:
 - a) reasons for the action;
 - b) appropriate measures to assure satisfactory resolution of the problem(s);
 - c) activities of the program in which the resident may and may not participate;
 - d) the date the suspension becomes effective;
 - e) consequences of non-compliance with the terms of the suspension;
 - f) whether or not the resident is required to spend additional time in training to compensate for the period of suspension and be eligible for certification for a full training year.

A copy of the statement of suspension shall be forwarded to the Associate Dean for Graduate Medical Education and the Director of Housestaff Records.
3. During the suspension, the resident will be placed on "administrative leave", with or without pay as appropriate depending on the circumstances.
4. At any time during or after the suspension, resident may be:
 - a) reinstated with no qualifications;
 - b) reinstated on probation;
 - c) continued on suspension; or

- d) dismissed from the program.

Dismissal

1. Dismissal from a residency program may occur for reasons including, but not limited to, any of the following:
 - a) failure to meet the performance standards of the program;
 - b) failure to comply with the policies and procedures of the GME Committee, the UAMS Medical Center, or the participating institutions;
 - c) illegal conduct;
 - d) unethical conduct;
 - e) performance and behavior which compromise the welfare and of patients, self, or others;
 - f) failure to comply with the medical licensure laws of the State of Arkansas;
 - g) inability of the resident to pass the requisite examinations for licensure to practice medicine in the United States, if required by the individual residency program.
2. The Program Director shall contact the Associate Dean for GME and provide written documentation which led to the proposed action.
3. When performance or conduct is considered sufficiently unsatisfactory that dismissal is being considered, the Program Director shall notify the resident with a written statement to include:
 - a) reasons for the proposed action,
 - b) the appropriate measures and timeframe for satisfactory resolution of the problem(s).
4. If the situation is not improved within the timeframe, the resident will be dismissed.
5. Immediate dismissal can occur at any time without prior notification in instances of gross misconduct including, but not limited to theft of money or property; physical violence directed at an employee, visitor or patient; use of, or being under the influence of alcohol or controlled substances while on duty, patient endangerment, and/or illegal conduct.
6. When a resident is dismissed, the Program Director shall provide the resident with a written letter of dismissal stating the reason for the action and the date the dismissal becomes effective. A copy of this letter shall be forwarded to the Associate Dean for GME and the Director of Housestaff Records.

Resident/Fellow Eligibility, Selection and Appointment

In accordance with the UAMS COM GME Committee Policy on Recruitment and Appointment the following describes the eligibility requirements, the selection criteria and the procedure for appointment to the Geriatric Psychiatry program.

The Geriatric Psychiatry residency/fellowship program uses both objective and subjective criteria to select applicants. The Program Director and Departmental Chairperson are responsible for selection and appointment of residents/fellows to the program. The application process meets all requirements of the Equal Employment Opportunity and the Americans with Disability Acts and does not discriminate with regard to sex, race, age, religion, color, national origin, disability or veteran's status. The criteria and processes for resident/fellow eligibility, selection and appointment follow:

ELIGIBILITY

All applicants must meet the following eligibility requirements:

1. Ability to carry out the duties as required of the Geriatric Psychiatry program.
2. Proficient in the English language to include reading printed and cursive English, writing (printing) English text, understanding spoken English on conversational and medical topics, speaking English on conversational and medical topics as determined by the program director and/or selection committee.
3. Meet **one** of the following qualifications (these are ACGME eligibility criteria):
 - a. Graduate of a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME).
 - b. Graduate of a college of osteopathic medicine in the United States or Canada accredited by the American Osteopathic Association (AOA).
 - c. Graduate of medical school outside the United States who has completed a Fifth Pathway program provided by an LCME-accredited medical school.
 - d. A graduate who holds a full and unrestricted license to practice medicine in a US licensing jurisdiction
 - e. Graduate of a medical school outside the United States or Canada with the following qualifications:
 1. A currently valid certificate from the Education Committee for Foreign Medical Graduates (ECFMG), or
 2. a full and unrestricted license to practice medicine in a US licensing jurisdiction
4. Completion of USMLE, STEP I, II, and III.
5. The ability to reside continuously in the U.S. for the length of training.
6. Successfully completed a ACGME General Psychiatry Program

APPLICATION PROCESS

1. Applicants should contact Lou Ann Eads, MD (program director) at 501-526-8601 or eadslouann@uams.edu or the program coordinator Ashley Lavender at 501-526-8159 lavenderashleya@uams.edu to receive information about the application.

2. Program Applicants must submit the following:
 - a. current CV
 - b. letter of recommendation from your training director to include your date of general psychiatry program completion or anticipated date of completion and current standing in the program.
 - c. Two additional letters of recommendation
 - d. Copy of medical school Transcript
 - e. Copy of USMLE Scores; must have completed USMLE I, II, AND III and be eligible to be licensed in the state of Arkansas
 - f. Foreign Medical Graduates must submit a copy of their ECFMG certificate and a copy of current visa status.
 - g. A personal statement regarding your interest in the field of Geriatric Psychiatry. In this statement, please include your vision of your involvement in the field of Geriatric Psychiatry, after completion of the fellowship.
3. Applications are received by mail on a daily basis and reviewed for eligibility and completion by the program director or coordinator. All application materials must be received before the director will review and before an applicant is invited for an interview.
4. An applicant invited for an interview will receive in writing and/or will sign an attestation that he/she has seen the terms, conditions and benefits of appointment (and employment) including financial support, vacation, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the resident and their family, and conditions under which living quarters, meals and laundry or the equivalents are provided. Applicants can access this information through the UAMS Resident Handbook at www.uams.edu/gme/toc.htm Applicants must also complete a self-disclosure form listing all convictions, guilty pleas, and pleas of no contest (or nolo contendere) to any felony, misdemeanor or any offense other than a minor traffic violation. This form must be signed and returned to the program director or coordinator by the date the interview is conducted.

SELECTION

1. Once an applicant has been found to meet minimal selection criteria, the program director or coordinator contacts him/her by mail, e-mail, or telephone to schedule an interview.
2. The interview consists of one full day of one to one interviews with faculty members and tours.
3. Current residents/fellows and faculty who interact with the applicant complete a written evaluation form to assess communication skills, clinical performance (if applicable), personal qualities, and personal statement.
4. Criteria for selection include
 - A. Review and confirmation of eligibility requirements
 - B. Performance on standardized medical tests
 - C. Overall academic performance in medical school
 - D. Recent clinical training or experience
 - E. Demonstrated ability to choose goals and complete the tasks necessary to achieve those goals
 - F. Maturity and emotional stability
 - G. Honesty, integrity and reliability

- H. Lack of history of drug or alcohol abuse
 - I. Motivation to pursue a career in the specialty of Geriatric Psychiatry
 - J. Prior research and publication experience
 - K. Verbal and written communication skills
 - L. Letters of recommendation from faculty
 - M. Program Director's letter of recommendation
 - N. Medical school transcript
 - O. The ability to reside continuously in the US for the length of the training
5. Following the interview, the Program Selection Committee, composed of Geriatric Psychiatry faculty, reviews the applicant's file and written interview evaluations and ranks the applicant based on the criteria above.
 6. The Program Selection Committee will meet and discuss all candidates who were interviewed, and rank those that are felt to be appropriate for our Geriatric Psychiatry residency / fellowship. Then the Program director will contact those candidates, in the order they were ranked, to offer them the position (our program only has one position/year). If none of the interviewees are felt to be appropriate for our program, then the Selection Committee is free to not select anyone for the upcoming year.

APPOINTMENT/REGISTRATION

Upon verification by the Program Director that the applicant has met eligibility requirements, completed the application process and been selected according to established criteria, the applicant will begin the process of appointment and registration with the College of Medicine Housestaff office. The Housestaff office will send out a packet in April with instructions and documents that will be required to be returned before the applicant is appointed. An applicant is considered fully appointed and registered only after all of the requested documents have been completed and returned to the Director of Housestaff Records. Once the Director of Housestaff Records has received all the documents, the applicant is registered in the payroll system to receive a stipend and may begin the residency/fellowship program. The final step to appointment is mandatory attendance at Housestaff Orientation which occurs mid to late June.

A complete list of documentation required can be found in the GME handbook.

Supervision

The program will supervise residents:

- to ensure the provision of safe and effective patient care,
- to ensure that the educational needs of the residents are met,
- to allow for progressive responsibility appropriate to the residents' level of education, competence and experience, and
- according to specific supervision requirements in the Program Requirements.

In compliance with the UAMS COM GME Committee policy on Resident Supervision, the following guidelines are followed for supervision of residents:

1. Qualified faculty physicians supervise all patient care at each participating site and their schedules are structured so that adequate supervision is available at all times.
2. Rapid, reliable systems for communication with supervisory physicians are available.
3. Attending faculty physician supervision is provided appropriate to the skill level of the residents/fellows on the service/rotations.
4. Residents/fellows have progressive responsibility according to their level of education, competence and experience.
5. Specific responsibilities for patient care are included in the written description of each service/rotation; this information is reviewed with the resident/fellow at the beginning of the service/rotation. In general, the chief or senior level resident/fellow oversees the lower level resident/fellow and intern. The faculty physician oversees the entire team.
6. On-call responsibilities and supervision is documented by the call schedules and is reviewed with the resident/fellow at the beginning of each service/rotation or if/when there is a change in the schedule.
7. The following procedure is followed to address fatigue of the resident/fellow:
 - a. The program director or designee is contacted and arranges for the backup person to relieve the resident/fellow.
 - b. The program director or designee determines when the resident/fellow should return to the education program.
 - c. The program director or designee notifies the attending faculty physician about these arrangements.

Due Process and Addressing Resident Concerns

At times various issues resulting from miscommunication, stress, or inappropriate behavior may arise. In compliance with the UAMS COM GME Committee Policy on Addressing Concerns in a Confidential and Protected Manner, the resident should follow these guidelines to raise and resolve issues of concern in a confidential manner:

Procedure for raising concerns in a confidential and protected manner

If the issue is of such a nature that it cannot be discussed at the program level or the resident desires additional discussion, the resident should follow the following procedure:

- 1) The resident contacts either the Associate Dean for GME or a member of the Resident Council.
- 2) If the resident wishes assistance from the Resident Council, the following steps should be followed:
 - a) The resident should contact at least two members of the Resident Council to schedule a meeting to discuss the problem confidentially.
 - b) The Resident Council members will meet with the resident and offer advice on how to resolve or handle the problem and if further steps are necessary. Based on the discussion and advice at this meeting, the resident may resolve the problem, and no further action is necessary.
 - c) If the resident's problem cannot be resolved or is of such a nature that further information is needed, the Resident Council members should discuss the problem with the Associate Dean for GME or the GMEC Chair.
 - d) In order to ensure easy access to Resident Council members, they are posted in the Resident Handbook on the GME website
- 3) The procedure for resolution will vary depending on the type of issue:
 - a) For issues related to general work environment, the Associate Dean for GME or Resident Council may discuss the issue and make recommendations for resolution through the GMEC.
 - b) Issues related to disciplinary action will be addressed according to the procedure outlined in the GMEC policy on Academic and Other Disciplinary Actions (Probation, Suspension and Dismissal).
 - c) Issues related to maltreatment will be addressed according to the procedure outlined in the GMEC policy on Appropriate Treatment of Residents in an Educational Setting.
 - d) Should a resident believe that a rule, procedure, or policy has been applied to him/her in an unfair or inequitable manner or that he/she has been the subject of unfair or improper treatment, the resident should refer to the GMEC policy on Adjudication of Resident Complaints and Grievances.

Discussions and recommendations by the Resident Council and/or the GMEC are confidential to the extent authorized by law and handled in a manner to protect the resident

Duty Hours, Work Environment, and Moonlighting

In compliance with the UAMS COM GME Committee policies on duty hours/work environment and moonlighting and considering that the care of the patient and educational clinical duties are of the highest priority, the following guidelines apply:

Duty Hours

1. Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
2. Residents are provided one day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
3. In order to ensure adequate time for rest and personal activities, a 10-hour time period is provided between daily duty periods and after in-house call.

On-Call Activities

The goal of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period.

1. **In-house call:**
 - a. Occurs no more frequently than every third night, averaged over a four-week period.
 - b. On psychiatry rotations, in-house call will occur no more frequently than every fourth night, averaged over a four week period.
 - c. Does not exceed 24 consecutive hours of continuous on-site duty. However, 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 care.
 - d. No new patients, defined as any patient not on the resident's service prior to the present 24-hour continuous duty period, may be accepted after 24 hours of continuous duty.
2. **At-home call (pager call):**
 - a. The frequency of at-home call is not subject to the every third night limitation.
 - b. Residents taking at-home call are provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period.
 - c. When residents are called into the hospital from home, the hours spent in-house are counted toward the 80-hour limit.
 - d. The Program Director and the teaching faculty will monitor the demands of at-home call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

The resident is expected to be on duty during normal working hours, as established by each rotation, Monday through Friday. Additional duty hours include on-call duties. Night, weekend and holiday call schedules are formulated by the chief resident and depend on the specific educational rotation. Residents must be available by telephone or pager while on-call. Specific call schedules and responsibilities are delineated in the written goals/objectives of each rotation, which are reviewed with the resident at the beginning of the rotation.

GERIATRIC PSYCHIATRY FELLOWS do not have any call responsibilities. There is NO on call responsibility for the PGY-5 resident / fellow; they are scheduled to work Monday - Friday only. They are not expected to provide any coverage after hours, on weekends, or holidays. They are expected to do part of their scholarly activity and required reading after hours, as a result.

Work Environment

1. **Meals:** food is available for those residents who provide 12 consecutive hours of in-house call.
2. **Call rooms:** call rooms are provided for all residents who take in-house call.
3. **Ancillary support:** adequate ancillary support for patient care is provided. Except in unusual circumstances, providing ancillary support is not the resident's responsibility except for specific educational objectives or as necessary for patient care. This is defined as, but not limited to, the following: drawing blood, obtaining EKGs, transporting patients, securing medical records, securing test results, completing forms to order tests and studies, monitoring patients after procedures.

Moonlighting

External moonlighting is not permitted at this program. A variety of internal moonlighting options are available. Internal moonlighting is defined as clinical work at a facility with an affiliation with UAMS, and for which there is some level of supervision from a UAMS attending. Because internal moonlighting opportunities vary over time, they will not be listed here; the chief resident will inform residents of available internal moonlighting opportunities and implement all necessary scheduling.

In order to be eligible for internal moonlighting, residents must meet all program requirements for their PGY level, including attendance at didactics/grand rounds and compliance with administrative responsibilities such as keeping up with charting, etc. Internal moonlighting cannot interfere with a resident's ability to function on required rotations, and time spent moonlighting counts towards ACGME limits on duty hours.

The office of the Residency Training Director maintains the right to remove a resident from internal moonlighting opportunities should there be evidence, in the opinion of the Director or Assistant Director of Residency Training, that internal moonlighting interferes with educational training or with clinical or administrative responsibilities.

UAMS POLICY CRIMINAL BACKGROUND CHECKS:

IV. Criminal Background Checks

All candidates for residency positions will be notified upon invitation for interview (or during telephone interview if an in-person interview will not be held) that all appointments to residency positions are contingent upon successful completion of a criminal background check. This notification will include a representative sample of unfavorable information that might prevent appointment as a UAMS Resident. The notification document will be a institutional notification that is approved by the UAMS GME Committee. Candidates must complete and return to the program coordinator or program director a self-disclosure form listing all convictions, guilty pleas, pleas of no contest (or nolo contendere) to any felony, misdemeanor or any offense other than a minor traffic violation by the date of interview. Candidates will be encouraged to confidentially discuss any issues that might prevent appointment with the program director prior to acceptance of an interview, acceptance of appointment or entry of the Rank Order List.

- A. Upon notification of match or selection of appointment, candidates will receive an electronic consent for criminal background check.
- B. Background checks will be obtained, and results reviewed by a designated member of the institutional GME office.
- C. Program Directors and the UAMS-COM Director of Housestaff Records will be notified of all candidates who have completed the background check without potentially unfavorable information.
- D. If potentially unfavorable information is revealed on the background check, the Program Director and DIO will be notified. After consultation with the DIO, the Program Director will notify the candidate of the potentially unfavorable information. The candidate will have the opportunity to submit additional information to address the potentially unfavorable information, within fourteen business days of notification
- E. After consultation with the DIO and review of any information submitted by the candidate to address the potentially unfavorable information, the Program Director will determine if the appointment will be honored or withdrawn.
- F. A candidate whose offer of appointment has been withdrawn because of criminal background check information may request reconsideration, in writing and with any relevant supporting documentation, by the Executive Associate Dean for Academic Affairs. The request must be submitted to the Executive Associate Dean for Academic Affairs within five business days of notification of the decision of the Program Director
 - 1.) The Executive Associate Dean for Academic Affairs will review the matter and will notify the candidate that the decision of the Program Director is upheld or reversed within fifteen business days of receiving the request for reconsideration
 - 2.) Solely at his discretion, the Executive Associate Dean for Academic Affairs may convene a panel of faculty members and at least one current resident to assist him in reaching a decision.
 - 3.) There is no requirement for a hearing
 - 4.) The decision of the Executive Associate Dean for Academic Affairs is final.

General Information

Contractual Agreement

House staff appointments are for a period not exceeding one year. A house staff agreement outlining the general mutual responsibility of the College of Medicine and house staff member is signed at the beginning of the term of service and is in effect for the full term of service. Please see the Appendix I for a sample contract.

ID Badges

Each house officer will be furnished with an ID badge.

Holidays

Official UAMS holidays are:

- New Year's Day (January 1)
- Martin Luther King Day (third Monday in January)
- Presidents' Day
- Memorial Day (fourth Monday in May)
- Independence Day (July 4)
- Labor Day (first Monday in September)
- Veteran's Day (November 11)
- Thanksgiving Day (fourth Thursday in November)
- Christmas Eve (December 24)
- Christmas Day (December 25)

Leave

Professional Leave

Time spent attending meetings or taking Board examinations or other examinations will not be counted as vacation if the activity is sanctioned by the home department.

Three factors govern the circumstances under which a trip to attend a professional meeting will be approved or disapproved (Leave requests must be signed by the resident's immediate supervisor(s), and the Director of the Forensic Residency Program **prior** to attending a professional meeting): (1) whether adequate coverage is maintained for patient care responsibilities, (2) the availability of travel funds, and (3) the training value of the meeting the resident proposes to attend. Forms are available in the Education Office

If you are traveling on departmental business which will require reimbursement from the department, please tell the Education Office your departure and return dates, hotel information, etc., **BEFORE** you begin your trip. Upon return, all **ORIGINAL RECEIPTS** must be submitted to the Education Office. Failure to follow the above procedures could result in no reimbursement from the department.

Sick Leave

If you cannot come to work due to illness, notify the attending physician as well as the Office of Education. If you have a planned medical leave or appointment, a standard leave form should be submitted prior to the leave for planning purposes.

Residents have 12 days of sick leave (including weekend days) for medical reasons during each year of training. The sick leave cannot be "carried over". Sick leave in excess of 12 days requires special review by the Associate Dean and Program Director.

Vacation

Residents receive 21 days (15 work days plus weekend days) of paid vacation each year. This cannot be "carried over" from one year to the next.

Effect of Leave on Completion of Training

Resident physicians are in the unique position of having a role as students and employees. Although brief periods of leave can usually be accommodated, extended absences from the residency (fellowship) program for any reason may adversely affect both the resident's completion of the educational program on schedule and the program's responsibilities for patient care, allocation of clinical teaching opportunities and funding for resident stipends. Most specialty boards specify a minimum number of weeks of education (or training) that must be completed for a resident to receive credit for the educational (or training) time. The resident must take into account these factors when requesting extended periods of leave from the program.

Library

The UAMS Library is housed in the Education II Building and occupies space on three levels with the Audio-Visual Library on the fifth floor. The library contains 38,000 books and regularly receives approximately 108 journals related to the behavioral sciences, 1,619 medical journals, and 57 neurology journals. Available databases include MEDLINE, PsycINFO, and CURRENT CONTENTS/CLINICAL MEDICINE, among several others.

A small library is located on the first floor of Building 170 at the Ft. Roots (NLR) V.A.; computer search facilities are available free of charge.

The Department of Psychiatry houses a small library of key textbooks and journals in the Psychiatry Administration building. In addition, the department's audio-visual library contains over 700 psychiatry-related audio cassettes and videotapes.

Mailboxes

Mailboxes are located in the Education Office. You are expected to retrieve your mail at least weekly.

Pagers

If a resident is issued a pager by the Department, the resident accepts full responsibility for the pager. If the pager is lost, the resident may be expected to reimburse the Department.

Parking

UAMS – All members of the house staff are granted parking privileges in the parking deck. A card key to operate the parking gate can be obtained from the Traffic Office (686-5856).

CAVHS – Parking stickers can be obtained from the CAVHS Traffic Office. The resident's ID card, should be programmed to allow admittance into appropriate parking lots.

Pay Schedules

House staff members are paid monthly. Effective April 1, 2012, all UAMS employees are required to participate in the Direct Deposit of earnings into any financial institution cooperating under the regional Automated Clearing House agreement. UAMS requires Direct Deposit for its employees through the Office of Human Resources (“OHR”) and Finance Department/Payroll. For a list of banks that can be used visit the OHR website: <http://uams.edu/ohr/>

Professional Liability Insurance

Each house staff physician is provided professional liability insurance when on official duty. Forms for the insurance are available in the House Staff Office. Additional coverage may be obtained from the insurance carrier. Moonlighting is not covered by residency liability insurance.

Resident Participation in Nondepartmental Activities/ Public Service

When engaged in non-remunerative activities in which a resident might be reasonably perceived by the public to represent UAMS or the Department of Psychiatry, advance clearance from the Residency Director is required.

Resident Benefits

For complete information on the terms, conditions, and benefits of employment, go to <http://medicine.uams.edu/current-residents/resident-handbook/benefits-2/>.

Suicide by a Patient

The following are **UAMS** guidelines for management:

- 1) Remember that death of the patient does not necessarily end the therapist's interaction with the patient's family, and further contact with the family should be discussed with the supervisor.
- 2) The supervisor(s), the Residency Director and the head of the service (if different from the supervisor) should be notified immediately – at any time of the day or night.
- 3) The University attorney and the malpractice insurance company defense attorney should be consulted by the UAMS faculty member involved.
- 4) The Chief Resident should be notified by either the resident or the Residency Training Director, unless the Residency Director deems this inappropriate for some reason.

5) A chart review should be arranged, generally within 24 hours, involving the resident, the attending on the service, the supervisor, the residency training director, chairman, and any other staff with close involvement.

6) The hospital administrator should be notified.

Website

The address to access our department's website is: <http://psychiatry.uams.edu/> .

This site contains information on our faculty, residency programs, calendar of events, and other items of interest.

Appendix I – Sample Resident Contract

University of Arkansas for Medical Sciences
Little Rock, Arkansas

RESIDENT AGREEMENT of APPOINTMENT

Agreement made this _____ day of _____, 2012 by and between the University of Arkansas for the University of Arkansas for Medical Sciences (“UAMS”) and Dr. _____ (“Resident”).

In consideration of the promises, conditions, and undertakings hereinafter contained, the parties agree as follows;

- I. Resident is hereby appointed to a position as Resident (PGY _____) in _____ for a period beginning _____ and ending _____ . UAMS, through this appointment, agrees to provide:
1. Supervised instruction and experience in keeping with the standards established by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties with the understanding that the hours of duty and the content of the educational phase of the residency, including the duration and sequence of assignments to clinical, laboratory or ambulatory care facilities are determined by the Program Director. In addition, the Program Director will determine the length and scheduling of vacation periods. Information concerning vacation time will be made available to the resident at the beginning of the academic year.
 2. A total of five (5) laboratory coats during the entire training period; no laundry services are provided.
 3. Food and call rooms while performing in-house call;
 4. Professional liability insurance coverage and legal defense protection against awards, including “tail coverage”, will be provided in an amount and with coverage to be determined by UAMS for acts or omissions of the Resident in the scope and course of his or her duties hereunder and the provisions applicable to such coverage are contained in the insurance contract;
 5. A stipend of \$ _____ for the year of this contract; For returning residents, failure to complete Annual GME Survey and/or web based courses could revert stipend to last year’s value.
 6. A. Medical, Dental, Basic Life, and Basic Long Term Disability insurance coverage as described in the UAMS Office of Human Resources Benefits for Housestaff document included with this agreement. Medical Insurance takes effect the first day of the training program, provided the Resident submits the required enrollment forms to Human Resources within their first 31 days of initial appointment to the training program.
B. Basic Housestaff Long Term Disability insurance coverage. The Resident shall participate and shall enroll at the time of registration and appointment to the training program.
 7. Professional, parental, and sick leave as specified in the policies of the Graduate Medical Education Committee and contained in the College of Medicine Resident Handbook;
 8. Access to counseling, medical, and psychological support services in accordance with the provisions of, and subject to the limitations of, the UAMS Medical Benefit Plan, the UAMS Employee Assistance Program, and the UAMS Employee Health/Student Preventive Health Services. Questions concerning such services should be directed to the Program Director, the Associate Dean for Graduate Medical Education of the College of Medicine or the UAMS Office of Human Resources.
 9. A certificate for the appropriate period of satisfactory Residency performance;
 10. The Resident will be accorded due process consistent with applicable policies and procedures of UAMS, the College of Medicine and the Department in which the Resident is appointed. These policies and procedures include: grievance, promotion/non-promotion, work environment, and harassment are included with this agreement.
- II. The Resident, through this appointment, agrees or understands:
1. That this appointment is conditioned upon successfully passing a pre-employment drug screen in accordance with the UAMS Drug Testing Policy (Policy 3.1.14). Further, initial appointments are conditioned upon completion of a satisfactory criminal background check and authorization by the relevant residency program. In cases where employment may have been initiated prior to the criminal background check, the University reserves the right to determine the residents’ suitability for continued employment.
 2. To accept the provisions described above and set forth hereinafter;
 3. To complete and return all forms in the registration packet prior to the appointment period;

4. To comply with all terms and conditions of appointment and all policies of UAMS, the College of Medicine, the Graduate Medical Education Committee and any facility or department to which Resident is assigned or in which Resident is working. All policies of the Graduate Medical Education Committee contained in the College of Medicine Resident Handbook, including the policies on physician impairment and substance abuse, evaluation and promotion, duty hours, moonlighting, other professional activities outside the program, sick leave, vacation, parental leave, accommodation for disabilities, are included with this agreement;
5. To comply with the College of Medicine's and the program's duty hour policies and accurately report duty hours;
6. To complete all medical records according to the Rules and Regulations of the participating hospitals;
7. To complete the Annual Graduate Medical Education Survey and assigned web-based educational modules;
8. To participate in providing appropriate medical care for all assigned patients;
9. Not to accept fees from patients;
10. Not to engage in employment outside the residency program without the written approval of the Program Director.
11. That this agreement may be terminated for cause in accordance with the procedures set out in the policies of the Graduate Medical Education Committee of the College of Medicine as may be changed or supplemented from time to time by the Graduate Medical Education Committee. Any such changes or supplements during the period of this agreement shall become effective when promulgated or adopted by the Graduate Medical Education Committee and when notice thereof has been furnished the Resident;
12. That he/she is free of any conflicting obligation(s) during the period of appointment;
13. That the appointment herein is for the period indicated and on the terms and conditions set forth hereinabove and any subsequent appointment for additional periods of residency education are wholly within the discretion of the Program Director and/or the Chairman of the resident's program. In the event Resident is not to be appointed for a subsequent period, Resident will be furnished written notice of non-reappointment at least four (4) months prior to the expiration of the period of this appointment, provided, however, that in no event shall the failure to furnish such notice operate to extend this appointment or to confer any rights upon the resident to a subsequent appointment.
14. To conduct himself/herself in accordance with the laws and regulations that applies to compliance matters and to report any information of possible wrongdoings, errors or violations of the law to the FGP compliance Officer.

III. Licensure. Resident represents that he or she has been awarded the M.D. degree and has completed, or will complete, the requirements for licensure in Arkansas. If Resident is unable to affirm the foregoing, reasons therefore are stated in a written attachment to this Agreement.

IV. Entire Agreement – Arkansas Law Controls. This Agreement is executed in the State of Arkansas and shall be interpreted in accordance with Arkansas law. This agreement shall not be amended, changed or modified except by an Agreement in writing signed by all parties.

IN WITNESS WHEREOF, the parties have executed this agreement on the date and year first above written.

UNIVERSITY OF ARKANSAS FOR THE
UNIVERSITY OF ARKANSAS FOR
MEDICAL SCIENCES

RESIDENT

Dean for Graduate Medical Education
Date: _____

Resident
Date: _____

Residency Program Director
Date: _____

Appendix II - Didactics Schedule 2012 – 2013

SCHEDULED SEMINARS AND CONFERENCES

Listed below are all scheduled seminars and didactic courses **attended by residents**

II. SCHEDULED SEMINARS AND CONFERENCES:

1. THEORY OF AGING

- a. Required
- b. Jina Lewallen, LCSW
- c. Lecture Description: The current scientific understanding of aging and longevity, including theories of aging, epidemiology and natural history of aging, and diseases of the aged. This includes specific knowledge of: the effects of biologic aging on human physiology with emphasis on altered pharmacokinetics, pharmacodynamics, and sensory acuity in the elderly; the differences and gradations between normal and abnormal age changes with particular reference to such areas as memory and cognition, affective stability, personality and behavioral patterns, and sexuality.
- d. Geriatric medicine fellows
- e. Single one hour lecture

2. LONG TERM CARE (LTC) ENVIRONMENT

- a. Required
- b. Ann Riggs, MD; Geriatric Medicine
- c. Lecture Description: LTC guidelines (federal and state/Arkansas); job of LTC medical director; management of patents in LTC; explanation of MDS required in LTC
- d. Geriatric medicine fellows
- e. Single one hour lecture

3. LONG TERM CARE (LTC) GUIDELINES

- a. Required
- b. Lou Ann Eads, MD and/or LTC Pharmacist
- c. Lecture Description: federal and state legislation governing prescription of psychotropic drugs in LTC
- d. Geriatric medicine fellows
- e. Single one hour lecture

4. BEHAVIORAL PROBLEMS IN LONG TERM CARE (LTC) / PHARMACOLOGICAL MANAGEMENT

- a. Required
- b. Lou Ann Eads, MD; psychiatry
- c. Lecture Description: pharmacological management of behavioral problems in LTC; including management of disturbances often seen in the elderly, including: agitation, wandering, changes in sleep patterns, and aggressiveness.
- d. Geriatric medicine fellows
- e. Single one hour lecture

5. BEHAVIORAL PROBLEMS IN LONG TERM CARE (LTC) / NON-PHARMACOLOGICAL MANAGEMENT

- a. Required
- b. Panel led by Lou Ann Eads, MD, psychiatry; including: Carol Coleman-Kennedy, LTC psych APN, and head nurse of the geropsych unit at PRI

- c. Lecture Description: Non-pharmacological Management of behavioral problems in LTC; including management of disturbances often seen in the elderly such as agitation, wandering, changes in sleep patterns, and aggressiveness.
- d. Geriatric medicine fellows
- e. Single one hour lecture

6. LIFE CHANGES:

- a. Required
- b. Mark Krain (PhD); UALR, Dept Gerontology
- c. Lecture Description: Understanding of successful and maladaptive responses to stressors frequently encountered in older adults such as retirement, widowhood, role changes, interpersonal and health status losses, financial reverses, environmental relocations, and dependency.
- d. Geriatric medicine fellows
- e. Single one hour lecture

7. CULTURAL AND ETHNIC ISSUES IN GERIATRIC POPULATION:

- a. Required
- b. Cobbie Bernard, LMSW
- c. Lecture Description: The relevance of cultural and ethnic differences, and the special problems of disadvantaged minority groups, as these bear upon distinguishing and treating abnormal and maladaptive clinical changes as well as the use of psychosocial support services.
- d. Geriatric medicine fellows
- e. one hour lecture

8. CAREGIVER ISSUES:

- a. Required
- b. Sandra Sanders, LCSW
- c. Lecture Description: Recognition of the stressful impact of psychiatric illnesses, medical illnesses, and dementia on caregivers. Attention should be placed on the appropriate guidance of and protection of caregivers as well as the assessment of their emotional and physical state and ability to function.
- d. Geriatric medicine fellows
- e. Single one hour lecture

9. ELDER ABUSE:

- a. Required
- b. Cobbie Bernard, LMSW and/or APS (Adult Protective Service) representative
- c. Lecture Description: Recognition and assessment of elder abuse and appropriate intervention strategies.
- d. Geriatric medicine fellow
- e. Single one hour lecture

10. COMMUNITY RESOURCES:

- a. Required
- b. Sandra Sanders, LCSW
- c. Lecture Description: The appropriate use of community or home health services, respite care, and the use of and need for institutional long term care.
- d. Geriatric medicine fellows
- e. Single one hour lecture

11. GERIATRIC PHARMACOLOGY:

- a. Required
- b. Lisa Hutchison; Pharm D
- c. Lecture Description: Pharmacologic alterations associated with aging, including changes in pharmacokinetics, pharmacodynamics, drug interactions, appropriate medication management and strategies to recognize and correct medication noncompliance. Attention should be given to the psychiatric manifestations of iatrogenic influences such as the multiple medications frequently taken by the elderly
- d. Geriatric medicine fellow
- e. Single one hour lecture

12. BAD GERIATRIC DRUGS:

- a. Required
- b. Melanie Pilcher, Pharm D
- c. Lecture Description: OTC medications, herbal medications, anticholinergic medications, Beers criteria
- d. Geriatric medicine fellow
- e. Single one hour lecture

13. DRIVING:

- a. Required
- b. Shelia Cassidy, PhD Psychology and/or OT driving instructor
- c. Lecture Description: driving evaluations, warning signs of problems, reporting to state driving control.
- d. Geriatric medicine fellows
- e. Single one hour lectures

14. MEDICARE / MEDICAID:

- a. required
- b. Larry Miller, MD psychiatry or Mark Krain (PhD) UALR gerontology
- c. Lecture Description: The current economic aspects of supporting services, including but not limited to Title III of the Older Americans Act, Medicare, Medicaid, and cost containment; explanation of Medicare and Medicaid
- d. Geriatric medicine fellow
- e. Single one hour lecture

15. LEGAL ISSUES:

- a. Required
- b. Ben Guise, MD or Albert Kittrell, MD, forensic psychiatrists
- c. Lecture Description: capacity vs. competence; how to evaluate capacity, informed consent, and holds
- d. Geriatric medicine fellows
- e. Single one hour lecture

16. LEGAL ESSENTIALS FOR SENIORS:

- a. Required
- b. Kemal Kutait, UAMS/risk management or community elder law attorney
- c. Lecture Description: power of attorney, guardianship, wills, surrogate decision maker
- d. Geriatric medicine fellow
- e. Single one hour lecture

17. ETHICS:

- a. Required
- b. Chris Hackler (PhD) or other staff of UAMS Ethics Department
- c. Lecture Description: withholding medical treatment and right to die
- d. Geriatric medicine fellows
- e. Single one hour lecture

18. ALZHEIMER DISEASE / DEMENTIA

- a. Required
- b. Ann Riggs, MD; geriatric Medicine
- c. Lecture Description: Alzheimer Disease / Dementia; to include diagnoses, course, pathology, etc.
- d. Geriatric medicine fellows
- e. Single one hour lecture

19. NON-ALZHEIMER DEMENTIAS

- a. Required
- b. Lou Ann Eads, MD, psychiatry
- c. Lecture Description: Vascular Dementias, Frontal lobar Dementias, Parkinson Dementia, including Lewy Body Dementia.
- d. Geriatric medicine fellow
- e. Single one hour lecture

20. DEMENTIA DRUGS:

- a. Required
- b. Pharm Liem, MD; geriatric medicine
- c. Lecture Description: cholinesterase inhibitors, namenda, etc.
- d. Geriatric medicine fellows
- e. Single one hour lecture.

21. Neuropsychological Testing:

- a. Required
- b. Normand Begnoche, PhD Psychology
- c. Lecture Description: when to refer for testing, what to expect from testing, how to interrupt test results, etc.
- d. Geriatric medicine fellows
- e. Single one hour lecture

CAVHS LECTURES

22. Introduction to Psychotherapy in the Older Patient

- a. Required
- b. Lewis Krain, MD
- c. Lecture Description: Introduction to principles of psychotherapy in the geriatric population. Includes review of literature documenting efficacy and an outline of unique challenges to psychotherapy in this population. Discussion will also include guidelines for deciding what kind of psychotherapy is appropriate for individual patients.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture

23. Geriatric Psychotherapy

- a. Required
- b. Grace Aikman PhD
- c. Lecture Description: A review of applications of psychotherapy for the older population. Includes a discussion of common conflicts and issues facing older patient. Specific techniques focus on supportive therapy, grief therapy, and cognitive behavioral therapy, including modifications for optimizing treatment for the older population.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Two one-hour lectures

24. Geriatric Psychodynamic Psychotherapy

- a. Required
- b. Wendy Batdorf, PhD
- c. Lecture Description: A review of psychodynamic theory as applied to the geriatric population, including late-life developmental and adjustment. Emphasis on use of dynamic work to improve quality of life, doctor-patient relationships, and treatment planning.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture

25. Behavioral Planning

- a. Required
- b. Wendy Batdorf, PhD
- c. Lecture Description: Review of principles behavioral planning as applied to patients with dementia. Will include reward paradigms in both inpatient and outpatient settings, with a focus on reducing violence and maximizing participation in activities.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective
- e. Single one hour lecture

26. Interdisciplinary Teamwork in Geriatric Psychiatry

- a. Required
- b. Lewis Krain, MD
- c. Lecture Description: Discussion of formal and informal administrative leadership of the mental health care team, in both the inpatient and outpatient setting. Includes constructing multidisciplinary treatment plans, communicating these plans to patient and family, and making appropriate referrals and consultations outside the team. Also includes a discussion of professionalism and ethics in a team leadership role.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture

27. Research Methods in Geriatric Psychiatry

- a. Required
- b. Dinesh Mittal, MD
- c. Lecture Description: Discussion research methodologies as applied to geriatric psychiatry, including biostatistics, clinical epidemiology, medical informatics, decision

analysis, critical literature review, and research design (including cross-sectional and longitudinal methods).

- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Two one-hour lectures

28. Scholarly Work in Geriatric Psychiatry

- a. Required
- b. Dinesh Mittal, MD
- c. Lecture Description: Introduction of the requirement for scholarly work in the geriatric psychiatry fellowship. Includes available resources and mentors for the fellow's scholarly project .
- d. None.
- e. Single one hour lecture

29. Fatigue and Physician Impairment

- a. Required
- b. Shanna Palmer, MD
- c. Lecture Description: Review of the literature on physician impairment, including fatigue, substance abuse, and mental health issues. Includes guidelines on avoiding these impairments, as well as on-campus resources in the event aid is needed for dealing with these impairments during the fellowship.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture

30. Medical Comorbidity in the Practice of Geriatric Psychiatry

- a. Required
- b. Lewis Krain, MD
- c. Lecture Description: Guidelines for managing comorbid illness in the geriatric psychiatry population, especially dementia and depression. Includes common drug interactions, medications which may have psychiatric side effects, and medical complications of common psychotropics. Will also include guidelines for use of laboratory and radiologic tests.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Two one hour lectures

31. Mood Disorders in the Geriatric Population

- a. Required
- b. Lewis Krain, MD
- c. Lecture Description: Review of the diagnosis and treatment of mood disorders in the older population. Includes analysis of the current literature on depression and bipolar disorder in late life. Emphasis on aspects of treatment that vary from standard treatment of mood disorders in the non-geriatric population. Also includes review of pertinent laboratory and imaging tests, as well as the indications and side effects of medications used to treat mood disorders.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture.

32. Anxiety Disorders in the Geriatric Population

- a. Required
- b. Lewis Krain, MD
- c. Lecture Description: Review of the diagnosis and treatment of anxiety disorders in the older population. Includes analysis of the current literature on GAD, panic disorder, and PTSD in late life. Emphasis on aspects of treatment that vary from standard treatment in the non-geriatric population. Also includes review of pertinent laboratory and imaging tests, as well as the indications and side effects of medications used to treat anxiety disorders in geriatric patients. .
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture.

33. Psychotic Disorders in the Geriatric Population

- a. Required
- b. Lewis Krain, MD
- c. Lecture Description: Review of the diagnosis and treatment of psychotic disorders in the older population. Includes analysis of the current literature on schizophrenia and schizoaffective disorders in late life. Emphasis on assessment of new-onset psychosis in older patients. Also includes review of pertinent laboratory and imaging tests, as well as the indications and side effects of medications used to treat psychotic disorders in older patients.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture.

34. Substance Abuse Disorders in the Geriatric Population

- a. Required
- b. Lewis Krain, MD
- c. Lecture Description: Review of the diagnosis and treatment of substance abuse disorders in the older population. Includes analysis of the current literature on alcohol and nicotine use in late life. Emphasis on aspects of treatment that vary from standard treatment in the younger population. Also includes review of pertinent laboratory and imaging tests, as well as the indications and side effects of medications used to treat substance abuse disorders in the older population.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture.

35. Personality Disorders in the Geriatric Population

- a. Required
- b. Lewis Krain, MD
- c. Lecture Description: Review of the diagnosis and treatment of personality disorders in the older population. Includes analysis of the current literature on evolution of personality disorders throughout the lifespan. Emphasis on how medical illness, grief, and social change impact personality disorders. Also includes review of pertinent laboratory and imaging tests, as well as the indications and side effects of medications used to treat personality disorders in the older population.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture.

36. Sleep and Sleep Disorders

- a. Required
- b. Lewis Krain, MD
- c. Lecture Description: Review of changes in sleep patterns in older patients and common sleep disorders. Includes the impact of sleep apnea on both medical and psychiatric illness, use of hypnotics in the older population, and CBT for sleep.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture.

37. Sex and Sexuality in Late Life

- a. Required
- b. Lewis Krain, MD
- c. Lecture Description: Review of normal sexuality in late life, and the impact of medical and psychiatric illness on sexual function. Includes discussion of medication-induced sexual dysfunction and treatment options. Also includes discussion of abnormal sexual behavior in patients with dementia, and potential treatments.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Single one hour lecture.

38. Difficult Case Discussions

- a. Required
- b. Panel discussion with Lewis Krain, MD, Dinesh Mittal, MD, Monica Shotwell, MD, and Robert Ebert, MD
- c. Lecture Description: Discussion of the assessment, diagnosis, and treatment of difficult cases as encountered by the fellow on clinical rotations. This is an open-format round-table interaction with several attending, to give the fellow a chance to discuss complicated cases and see how several different attending approach them.
- d. May include PGY-IV residents from the general residency on a geriatric psychiatry elective.
- e. Three to four one hour lectures

39. MONTHLY JOURNAL CLUB

- a. Required
- b. Fellow to lead the club
- c. Monthly review and discussion of pertinent journal articles
- d. general psychiatry residents on geriatric psychiatry rotation
- e. 30-45 min, once per month throughout the fellowship

40. CASE CONFERENCES

- a. Required
- b. Geriatric Psychiatry Resident to present or lead discussion of geriatric case presented at CAVHS clinical difficult case conference approximately once every three months, during their 6 months at CAVHS.
- c. Discussion of management of difficult geriatric psychiatry case
- d. psychiatry faculty, residents, medical students
- e. One hour case conference, 2-3 times during the fellow's time on the VA 6-month block

EVALUATIONS: APPENDIX III
Goals and Objectives Review

Faculty Evaluation of Residents: The attending for each rotation will review the goals and objectives with the resident at the start of the rotation and they will sign an acknowledgement form that this occurred. The form will be returned to the Program Coordinator, to be included in the resident / fellow's permanent folder. Below is a copy of the form.

GOALS AND OBJECTIVES DOCUMENT:
START OF ROTATION

I MET WITH MY ATTENDING AT THE BEGINNING OF THIS ROTATION. THE PURPOSE WAS TO REVIEW THE GOALS AND OBJECTIVES FOR THE ROTATION, ALONG WITH A DISCUSSION OF EXPECTATIONS FOR THIS ROTATION.

ROTATION NAME: _____

ROTATION LOCATION: _____

ROTATION DATES: _____

FELLOW NAME / PRINTED: _____

FELLOW SIGNATURE AND DATE:

ATTENDING NAME / PRINTED: _____

ATTENDING SIGNATURE AND DATE:

PLEASE RETURN THIS SIGNED DOCUMENT TO THE PROGRAM DIRECTOR, WITHIN A WEEK OF STARTING THE ROTATION.

SAMPLE: Supervisor Evaluation of Fellow

Check one

Mid Term Evaluation: _____ **End Of Rotation Evaluation:** _____

Fellow: _____

Rotation: **AHC / LONG TERM CARE**

Faculty: _____

Date: _____

Medical Knowledge

1. The fellow demonstrated understanding of the etiology of common psychiatric diagnoses associated with geriatric patients who reside in a long term care sitting; especially depression, dementia, and delirium.

Evaluation: Chart Review

Teaching Method: Didactics

Mid and end of rotation evaluations

Case presentations and reviews

Unsatisfactory		Needs Improvement		Satisfactory		Very Satisfactory		Outstanding	
----------------	--	-------------------	--	--------------	--	-------------------	--	-------------	--

2. The fellow demonstrated understanding of the etiology of chronic mental illnesses (e.g. schizophrenia, bipolar disorder, etc) in older individuals who reside in a long term care sitting,

Evaluation: Chart Review

Teaching Method: Didactics

Attending Critique

Case presentations and reviews

Mid and end of rotation evaluations

Unsatisfactory		Needs Improvement		Satisfactory		Very Satisfactory		Outstanding	
----------------	--	-------------------	--	--------------	--	-------------------	--	-------------	--

3. The fellow demonstrated understanding of how care of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older patients changes through the lifespan.

Evaluation: Chart Review

Teaching Method: Didactics

Attending Critique

Case presentations and reviews

Mid and end of rotation evaluations

Unsatisfactory		Needs Improvement		Satisfactory		Very Satisfactory		Outstanding	
----------------	--	-------------------	--	--------------	--	-------------------	--	-------------	--

Comments:

Patient Care

1. The fellow demonstrated competency in the assessment and management of common psychiatric diagnoses associated with geriatric patients in a long term care sitting; especially depression, dementia, and delirium.

Evaluation: Chart Review

Teaching Method: Didactics

Mid and end of rotation evaluations

Case presentations and reviews

Unsatisfactory		Needs Improvement		Satisfactory		Very Satisfactory		Outstanding	
----------------	--	-------------------	--	--------------	--	-------------------	--	-------------	--

2. The fellow demonstrated competency in the management of chronic mental illnesses (e.g. schizophrenia, bipolar disorder) in older patients who reside in a long term care sitting.

Evaluation: Chart Review

Teaching Method: Didactics

Attending Critique

Case presentations and reviews

Mid and end of rotation evaluations

Unsatisfactory		Needs Improvement		Satisfactory		Very Satisfactory		Outstanding	
----------------	--	-------------------	--	--------------	--	-------------------	--	-------------	--

Comments:

Systems Based Practice

1. The fellow demonstrated understanding of the role of a long term care sitting, in the health care system, and be able to assess the psychiatric needs of patients in such a sitting and to identify patients in this sitting who would benefit from referral to an inpatient gero-psych unit for acute management.

Evaluation: Observation

Teaching Method: Modeling

Mid and end of rotation

Supervisor critique

evaluations

Unsatisfactory		Needs Improvement		Satisfactory		Very Satisfactory		Outstanding	
----------------	--	-------------------	--	--------------	--	-------------------	--	-------------	--

Comments:

Practice Based Learning

1. The fellow demonstrated understanding of OBRA Regulations and other federal and state regulations governing the care of individuals in a long term care sitting.

Evaluation: Attending Critique

Teaching Method: Didactics

Mid and end of rotation

Planning with treatment team members

evaluations

Unsatisfactory		Needs Improvement		Satisfactory		Very Satisfactory		Outstanding	
----------------	--	-------------------	--	--------------	--	-------------------	--	-------------	--

2. The fellow was able to apply rotation goals and objectives with increasing autonomy as the rotation progresses, and was able to serve as an effective leader of the multi-disciplinary team by the end of the rotation.

Evaluation: Observation

Teaching Method: Modeling

Mid and end of rotation

Supervisor critique

evaluations

Unsatisfactory		Needs Improvement		Satisfactory		Very Satisfactory		Outstanding	
----------------	--	-------------------	--	--------------	--	-------------------	--	-------------	--

Comments:

Overall Comments:

NOTE:

1. After completion of the evaluation, the supervisor and fellow should review and discuss the evaluation together.
2. After review of the evaluation together, both the supervisor and fellow should sign and date the evaluation.
3. The completed evaluation should be forwarded to the Program Director at UAMS, to review for any acute concerns
4. After review by the program director, it is given the Program Coordinator, to be placed into the fellow's permanent file.
5. The completed evaluation should be returned to the Program Director within **one week** of completion of the midterm evaluation or within **one week** of completion of the rotation.

Supervisor Signature _____ Date _____

Fellow Signature _____ Date _____

PROGRAM DIRECTOR EVALUATION: The Program director meets with the resident / fellow quarterly to review their progress and provide guidance. The resident / fellow is encouraged to contact the program director at any time, if there are concerns or difficulty they have not been able to resolve with their rotation attending. Below is the quarterly review template the program director completes.

QUARTERLY REVIEW:
CHECK QUARTER BEING REVIEWED.

FIRST QUARTER (JULY, AUGUST, SEPTEMBER) _____

SECOND QUARTER (OCTOBER, NOVEMBER, DECEMBER) _____

THIRD QUARTER (JANUARY, FEBRUARY, MARCH) _____

FOURTH QUARTER (APRIL, MAY, JUNE) _____

REVIEW OF ROTATIONS: _____

REVIEW OF PROGRESS IN FELLOWSHIP: _____

IDENTIFIED DIFFICULTY / NEED IMPROVEMENT: _____

REVIEW OF PATIENT LOG / WEEKLY DUTY HOURS: _____

Patient population / diagnosis: _____

Duty hours per week within ACGME limits _____

MOONLIGHTING: _____

DISCUSSION OF SCHOLARLY ACTIVITY: _____

DISCUSSION OF PLANS AFTER COMPLETION OF FELLOWSHIP: _____

**REMINDER TO CONTACT ABPN AT COMPLETION OF FELLOWSHIP, TO
DECLARE INTENT TO SIT FOR GERIATRIC FELLOWSHIP BOARDS, WHEN
ELIGIBLE.** _____

MISC: _____

Overall Comments: _____

PROGRAM DIRECTOR / DATE: _____

FELLOW / DATE: _____

Below is a template of the summative template that is completed by the program director upon completion of all rotations.

SUMMATIVE EVALUATION:

DATE:

Final Evaluation of **RESIDENT/FELLOW**:

RESIDENT/FELLOW, has successfully completed **her/his** training in our ACGME-accredited Geriatric Psychiatry Fellowship Training Program at the University of Arkansas for Medical Sciences (UAMS). **RESIDENT/FELLOW** entered our program on **DATE** and successfully completed all training on **DATE**. There is no documented evidence of unethical or unprofessional behavior, nor any serious question regarding **RESIDENT/FELLOW**'s clinical competence. I verify that **she/he** has demonstrated sufficient professional ability to be able to practice competently and independently without supervision. **She/he** has satisfactorily demonstrated competence in each of the six ACGME competency areas.

PROGRAM DIRECTOR

Resident Fellow Self Reflection Evaluation

Name:		Date:		Year in Training:	
FELLOWSHIP Requirements:		Months Completed		Additional Program Requirements:	
UAMS/PRI INPATIENT	5 months			SCHOLARLY ACTIVITY / RESEARCH	
UAMS/SHC OUTPATIENT	5 months			TEACHING	
LTC AT AHC / BENTON	5 months			Patient Log completed	
UAMS HOSPICE-PALLIATIVE CARE	1 month			Lecture Attendance	
CAVHS INPATIENT	6 months			Evaluations completed	
CAVHS THERAPY	3 months				
CAVHS OUTPATIENT	3 months			PRITE (if applicable)	%tile
CAVHS LTC	3 months			Psychiatry (at PGY Level)	
CAVHS NEUROLOGY	3 months			Neurology (at PGY Level)	

1. Are you functioning at a level commensurate with your year of training? **Y or N** (circle one)

2. What are you doing well in this program?

3. What do you need to work on in this program?

4. How do you plan to address these issues?

5. General Comments:

_____ Date: _____
Residency Training Director Signature

_____ Date: _____
Resident/Fellow Signature

Resident Evaluation of Individual Rotations: (NOT ANONYMOUS)
COMPLETED AT END OF EACH ROTATION.

Instructions

This evaluation form has been designed to provide a rapid and accurate assessment of clinical experience. This evaluation will be reviewed and discussed in the annual evaluation of the program; at the annual faculty meeting. The goal of this exercise is to strive for the highest quality of programming in our geriatric psychiatry fellowship. Your honest and constructive feedback is valued and much appreciated. Please work with his to help in our ongoing desire to improve the program. **NOTE: This evaluation is reviewed annually. In a one person fellowship it is not anonymous. If you have concerns that you feel should be anonymous please discussed them with either the program director or assistant program director.**

NOT ANONYMOUS / REVIEWED AT ANNUAL FACULTY & REC MEETING OF GERIATIRC PSYCHIATRY PROGRAM.

Rotation Evaluation.

1. Rotation is appropriate to resident's level. Was the rotation experience appropriate for the level of the resident in terms of subject matter, prerequisites [e.g., required level of knowledge, maturity (in terms of professional identity, leadership, role requirements with professional staff), and capability of functioning dependently/independently].
2. Rotation provided pertinent educational experience. The educational benefit of the rotation was appropriate to the needs of a geriatric psychiatrist in training -- neither too specialized nor too superficial.
3. Extent of clinical responsibilities was sufficient to provide an adequate educational experience. The patient population/ work load was sufficient to provide an adequate base of clinical experience in terms of number of patients and diversity of patient population (e.g., demographics and psychopathology).
4. Clinical responsibilities were adequately limited to provide an educational opportunity. The clinical responsibilities of the rotation were limited such that an educational opportunity was provided in terms of having an adequate amount of time to review pertinent literature, to seek supervision, and to utilize present educational examples. It should be noted that part of the educational experience is training in time management and efficient management of clinical responsibilities. Therefore, provision of adequate time is not necessarily synonymous with allowing leisurely execution of duties.
6. Structure of rotation and demands of clinical duties allowed attending adequate time for teaching/supervision. The rotation structure allowed the attending adequate time to provide educational instruction and supervision.

ROTATION EVALUATION

1. Rotation is appropriate to resident's level. (check one)

unsatisfactory	needs to improve	satisfactory	very satisfactory	Outstanding

N/A = if question is not applicable to rotation

COMMENTS:

2. Rotation provided pertinent educational experience.

unsatisfactory	needs to improve	satisfactory	very satisfactory	Outstanding

N/A = if question is not applicable to rotation

COMMENTS:

3. Extent of clinical responsibilities were sufficient to provide an adequate educational experience.

unsatisfactory	needs to improve	satisfactory	very satisfactory	Outstanding

N/A = if question is not applicable to rotation

COMMENTS:

4. Clinical responsibilities were adequately limited to provide an educational opportunity.

unsatisfactory	needs to improve	satisfactory	very satisfactory	Outstanding

N/A = if question is not applicable to rotation

COMMENTS:

5. Structure of rotation and demands of clinical duties allowed attending adequate time for teaching/supervision.

unsatisfactory	needs to improve	satisfactory	very satisfactory	Outstanding

N/A = if question is not applicable to rotation

COMMENTS:

6. Recommendations for next year:

FELLOW / DATE: _____

PLEASE COMPLETE THIS FORM AND RETURN TO THE PROGRAM DIRECTOR. WE WELCOME YOUR EVALUATION AND RECOMMENDATIONS. THESE WILL BE REVIEWED AT THE ANNUAL FACULTY & REC MEETING, WITH A GOAL OF PROGRAM IMPROVEMENT. THANK YOU FOR YOUR TIME.

ANONYMOUS RESIDENT RATING

Site: _____

Supervisor: _____

1 one of the worst -- in the lower 20%ile	2 below average	3 average -- between the 35th & 65th %ile	4 above average (but not in top 20%ile)	5 top 20%
---	--------------------	--	---	--------------

Please especially comment on any extreme ratings (1 or 5).

1. Compared to other sites, the overall learning experience was:

1 2 3 4 5

Comments:

2. Educational time (quality and quantity) spent with faculty was:

1 2 3 4 5

Comments:

3. The educational experience provided by the patient population was:

1 2 3 4 5

Comments:

4. Supervision of your work (patient care and nonclinical matters) was:

1 2 3 4 5

Comments:

5. This rotation provided stimulation for me to learn on my own as well as on the spot:

1 2 3 4 5

Comments:

6. My primary supervisor's teaching was:

1 2 3 4 5

Comments:

7. Did I have a total of at least 1 hour average individual supervision on site per week?

Yes No

8. My work-related stress level at this site compared to other sites was:

1 high (highest 20%)	2 above average	3 average	4 below average	5 low (lowest 20%)
----------------------------	--------------------	--------------	--------------------	--------------------------

ANONYMOUS RESIDENT RATING

RESIDENCY PROGRAM (not any individual faculty member)

1 seldom	2 only sometimes	3 often	4 usually	5 very nearly always
-------------	---------------------	------------	--------------	----------------------------

Please especially comment on any extreme ratings (1 or 5).

1. Does it seem that the residency has fairness as a goal?

1 2 3 4 5

Comments:

2. Are you treated with respect in the residency?

1 2 3 4 5

Comments:

3. Is the ratio of work to education proportioned in a way to encourage your professional development?

1 2 3 4 5

Comments:

4. Do you feel free to ask questions about the residency and/or UAMS policies?

1 2 3 4 5

Comments:

5. Do you feel the evaluations residents complete are considered in residency planning?

1 2 3 4 5

Comments:

6. Are you being taught what you need to know?

360 Multi-Rater Evaluation of Resident

Evaluator:

Subject:

Status:

Rotation:

Program:

To provide an effective residency experience, it is important to systematically evaluate residents' professional performance from a variety of perspectives (eg. patient, attending doctor, nurse, other health care professional, peer and self). Your feedback is critical to understanding how residents develop professional skills, and how residency programs can be made more effective. In particular, your written comments will serve to extend the information that you provide on the checklist. Your comments and feedback are completely anonymous and confidential.

Please take a few minutes to respond to the following, **360 Comprehensive Multi-Rater Evaluation**, which measures five of the six ACGME competencies. Base your responses on how you think the resident **generally performed** his or her duties over the past rotation.

THIS RESIDENT GENERALLY:

INTERPERSONAL AND COMMUNICATION SKILLS

- | | | | | | | |
|---|-----------------------|-----------------------|----------------------------|-----------------------|-----------------------|-----------------------|
| 1) Is frank with patients, provides truthful and upfront information as appropriate | Strongly Agree | Agree | Neither Agree Nor Disagree | Disagree | Strongly Disagree | Do Not Know |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2) Encourages the patient to ask questions | Strongly Agree | Agree | Neither Agree Nor Disagree | Disagree | Strongly Disagree | Do Not Know |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3) Communicates well with referring and consulting physicians | Strongly Agree | Agree | Neither Agree Nor Disagree | Disagree | Strongly Disagree | Do Not Know |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4) Communicates well with other residents on the team | Strongly Agree | Agree | Neither Agree Nor Disagree | Disagree | Strongly Disagree | Do Not Know |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5) Effectively handles demanding interpersonal situations | Strongly Agree | Agree | Neither Agree Nor Disagree | Disagree | Strongly Disagree | Do Not Know |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

	<input type="checkbox"/>	<input type="checkbox"/>	Disagree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------	----------	--------------------------	--------------------------	--------------------------

6) Shows interest in each patient as a person

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRACTICE-BASED LEARNING AND IMPROVEMENT

7) Responds to feedback receptively

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8) Uses scientific evidence in medical decision making

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9) Is adept at using information technology

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10) Acknowledges the limits of own medical knowledge as appropriate

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11) Demonstrates change in practice as a result of new information

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12) Demonstrates willingness to share knowledge and information in teaching others	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROFESSIONALISM

13) Maintains confidentiality	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14) Manages time well	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15) Dresses appropriately for work	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16) Makes ethically sound judgments regarding patient care	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17) Respects the roles of health care staff in patient care	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18) Demonstrates altruism in putting patient care above personal issues or desires	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19) Responds to requests, including pages, in a helpful and prompt manner	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20) Keeps medical records in an accurate and timely manner	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYSTEMS-BASED PRACTICE

21) Advocates for quality patient care and optimal patient care systems	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22) Uses consultations and referrals appropriately	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23) Understands the relationship of the clinical specialty to the larger healthcare system	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24) Practices cost effective care	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25) Advocates for patient safety

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT CARE

26) Gathers essential and accurate information about patients

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27) Develops and carries out appropriate management plans

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28) Adequately counsels and educates patients and their families

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29) Displays sensitivity and individualizes care for diverse populations

Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30) Considers the impact of the patient's condition and treatment on the quality of the patient's life

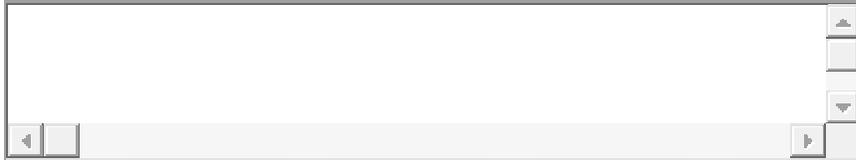
Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Do Not Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31) During the past year, I have worked with this resident

Less than 1 Month	1-6 Months	More than 6 Months
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments extend and explain the numerical ratings on the survey. Comments also provide more specific information for resident feedback.

32) Comments:



33) I am a (an):

Attending
Physician



Nurse



Resident Evaluating
Another Resident



Other Healthcare
Provider

