

Warren Alpert School of Medicine
Brown University

Department of Psychiatry & Human Behavior

*Geriatric Psychiatry
Fellowship Training Program
Manual*



BROWN
Alpert Medical School

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I. INTRODUCTION

A. WELCOME

We are very excited to welcome you to the Geriatric Psychiatry Fellowship Training Program at Brown University and believe you have made a great decision in pursuing further training which will undoubtedly serve you well in your career.

We have designed this fellowship with the expectation that it be a comprehensive educational and clinical experience first and foremost.

This manual is intended to be a ‘live document’ to be updated and improved upon throughout the year as needs are identified. You should feel free to contribute to this process and discuss ideas with the program directors.

B. GOALS AND OBJECTIVES

The program must integrate the following ACGME **Educational Goals and Objectives (ACGME Competencies)**:

Patient Care and Procedural Skills

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

- establishing rapport with all geriatric patients;
- Demonstrate competency in diagnosing and treating psychiatric disturbances that occur among the elderly population including adjustment disorders, affective disorders, delirium, dementia, iatrogenesis, late- onset psychoses, medical presentations of of psychiatric disorders, personality disorders, sexual disorders, sleep disorders, substance-related disorders, and psychiatric disorders that began in earlier life
 - Performing the mental status examination that takes into account the special needs of elderly patients, including structured cognitive assessment, community and environmental assessment, family and caregiver assessment, medical assessment and functional assessment
 - Short-term and long-term diagnostic and treatment planning by using the appropriate synthesis of clinical findings and historical as well as current information acquired from the patient and/or relevant others, including family members, caregivers and or other healthcare professionals
 - The selection and use the clinical laboratory tests, radiologic and other imaging procedures, and polysomnography graphic electrophysiologic and neuropsychologic tests
 - Recognizing and managing psychiatric comorbid disorders, including dementia and depression, as well as agitation, wandering, changes in sleep patterns and aggressiveness
 - This must include competence in the ongoing monitoring of changes in mental and physical health status and medical regimens
 - Recognizing the stressful impact of psychiatric illness on caregivers, assessing their emotional state and ability to function and providing guidance and protection to caregivers
 - Recognizing assessing elder abuse and providing appropriate interventions

- Managing the care of elderly patients with emotional or behavioral disorders, using age appropriate modifications and techniques and goals and applying the various psychotherapies with individual, group, and family focuses and behavioral strategies.
- Fellows must be able to competently perform all medical, diagnostic and surgical procedures considered essential for the area practice

Medical Knowledge

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

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

- biological and psychosocial aspects of normal aging, psychiatric impact of acute and chronic, physical illnesses, and biological and psychosocial aspects of the pathology of primary psychiatric disturbances beginning in or continuing into older age
- current scientific understanding of aging and longevity, including theories of aging, epidemiology and natural history of aging, and diseases of elderly patients, to include
- effects of biologic aging on human physiology with emphasis on altered pharmacokinetics, pharmacodynamics, and sensory acuity in elderly patients
- differences and gradations between normal and abnormal age-related changes with particular reference to memory and cognition, affective stability, personality and behavioral patterns, sleep, and sexuality; and,
- successful and maladaptive responses to stressors frequently encountered in elderly patients, including retirement, death of a spouse, role changes, interpersonal and health status losses, financial difficulties, environmental relocations, and increased dependency
- relevance of cultural and ethnic differences, and the special problems of disadvantaged minority groups, as these relate to mental illness in elderly patients;
- epidemiology, diagnosis, and treatment of all major psychiatric disorders seen in elderly patients
- American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the fellow and the patient including the dynamics of differences in cultural identity, values and preferences, and power ethical and legal issues especially pertinent to geriatric psychiatry, including competence, capacity, guardianship, right to refuse treatment, wills, advance directives, informed consent, elder abuse, the withholding of medical treatments, and federal legislative guidelines governing psychotropic drug prescription in nursing homes and other settings;
- Indications, side effects, and therapeutic limitations of psychoactive drugs and the pharmacologic alterations associated with aging including changes pharmacokinetics, pharmacodynamics and drug interactions. Appropriate medication management and strategies recognize and correct medication noncompliance and psychiatric manifestations iatrogenic influences. Applications and limitations of behavioral and therapeutic strategies and physical

restraints. Appropriate use of the application of electroconvulsive therapy and or other nonpharmacologic somatic therapies in elderly patients.

- Appropriate use of psychodynamic understanding of developmental problems, conflict, and adjustment difficulties in elderly patients which may complicate the clinical presentation and influence the physician-patient relationship for treatment planning.
- Appropriate use of psychotherapy is applied to elderly patients including individual group and family therapies.
- current economic aspects of supporting services and practice management, including Title III of the Older Americans Act, Medicare, Medicaid, and cost containment
- research methodologies related to geriatric psychiatry, including biostatistics, clinical epidemiology, medical information sciences, decision analysis, critical literature review, and research design (including cross-sectional and longitudinal methods).

Practice-based Learning and Improvement

Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

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

- Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; and,
- Demonstrate administrative and teaching skills in the subspecialty.

Interpersonal and Communication Skills

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

Professionalism

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

- Demonstrate sensitivity and responsiveness to diverse patients, including but not limited to sex, age, culture, race, religion, disabilities, and sexual orientation.
- Demonstrate competence in recognizing and appropriately addressing biases in themselves, others, and the health care delivery system.
- Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows must demonstrate proficiency in diagnosis and treatment of all major psychiatric disorders seen in elderly patients, including adjustment disorders, affective disorders, anxiety disorders, delirium, dementia, iatrogenic cysts, late onset psychoses, medical presentations of psychiatric disorders, personality disorders, sexual disorders, sleep disorders, substance related disorders and continuation of psychiatric illnesses that began earlier in life

- Fellows must demonstrate proficiency in performing mental status examination that takes into account the special needs elderly patients, including structured cognitive assessment, community environment assessment, family and caregiver assessment, medical assessment, and functional assessment.
- Fellows must demonstrate proficiency in short-term and long-term diagnostic and treatment planning by using appropriate synthesis of clinical findings and historical as well as current information acquired from the patient and/or relevant others, including family members, caregivers, and or other healthcare professionals.
- Fellows must demonstrate proficiency in selection and use of clinical laboratory tests, radiologic and other imaging procedures, and polysomnographic electrophysiologic and neuropsychologic tests.
- Fellows must demonstrate proficiency in recognizing and managing psychiatric comorbid disorders, including dementia and depression as well as agitation, wandering, changes in sleep patterns, and aggressiveness..
- This must include competence in the ongoing monitoring of changes in mental and physical health status and medical regimens.
- Fellows must demonstrate proficiency in recognizing the stressful impact of psychiatric illness on caregivers, assessing the emotional state and ability to function, and providing guidance and protection to caregivers.
- Fellows must demonstrate competence in recognizing and assessing elder abuse, and providing appropriate interventions.
- Fellows must demonstrate proficiency in managing the care of elderly patients with emotional or behavioral disorders, using age appropriate modifications and techniques and goals and applying various psychotherapies and behavioral strategies.

Systems-based Practice

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

- Demonstrate facilitative skills necessary to enhance the care of psychiatric disturbances among the physically ill through cooperative interaction with other physicians and allied health professionals.
- Demonstrate competence in effectively working with discharge planning personnel and personnel in aftercare facilities

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C. CONTACTS

- Laura Stanton, M.D., Program Director (lstanton1@lifespan.org)
- Gulham Surti, M.D. Associate Program Director (gsurti@butler.org)
- Ema N. Costa, Program Coordinator (ecosta@butler.org or ema.costa@Lifespan.org)
- Geriatric Psychiatry Fellowship Office Telephone: (401) 455-6421 or (401) 606-4362
 - Fax: (401) 455-6566 or (401) 444-3492

Updated June 8, 2018

- The Miriam Hospital Outpatient Psychiatry office 401-793-4301

See attached excel sheet for full contact list.

D. SUPERVISORS

1. Burock, Jeffrey
2. Boykin, Brittney
3. De-Filio, Julio
4. Friedman, Joseph
5. Halt, Amy
6. Honeyman, Brian
7. Ingraham James
8. Jiminez-Madeio, Carolina
9. Lawrence, Caitlin
10. Mendelsohn, Debbie
11. Murphy, Emily
12. Riddel, Meghan
13. Ruf, Barbara
14. Salloway, Stephen
15. Smulever, Romina
16. Stanton, Laura
17. Vogner, Lydia

II. FELLOWSHIP STRUCTURE

A. SCHEDULES

BLOCK SCHEDULE (EXAMPLE) Geriatric Psychiatry Fellowship

Monthly Blocks

July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
BH	BH	BH	Kent	Kent/ TMH	TMH	RIH	TMH	BH	VAMC	VAMC	VAMC/ TMH

Weekly Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
8AM-12PM	clinical	clinical	clinical	Didactics	clinical
12PM-1PM					Memory Disorder Clinic Conference
1PM-5PM	clinical	Longitudinal outpatient clinic	clinical	clinical	clinical

NOTES:

1. Sites: RIH - Rhode Island Hospital and Lifespan Ambulatory Clinics, TMH - The Miriam Hospital and Lifespan Ambulatory Clinics, BH- Butler Hospital, Kent- Kent Hospital and Kent Ambulatory Clinics, VAMC- Veteran's Medical Center and homebased care.
2. The Kent Rotation will be 6 weeks in length
3. The VA rotation will be 4 weeks in length
4. The Longitudinal Clinic takes place at TMH throughout the year. This clinic will be at TMH every Tuesday afternoon from 1-5pm.
5. On the 1st Tuesday of every month the fellow doing the VAMC longitudinal clinic will rotate on The Memory Disorders clinic with Dr. Lawrence for 6 months.
6. The Memory Disorder Clinic Team Conference occurs every Friday at Butler Hospital with Steve Salloway, MD.
7. Didactics occur every Thursday morning at The Harwood Center of the VAMC. These didactics will be integrated with geriatric medicine, palliative care and consult- liaison psychiatry.
8. The VAMC longitudinal clinic will occur all day on Fridays for a 6 month block with Dr. Jiminez.
9. Conferences and other educational opportunities will be provided and included in the work day variably, some required (R) and others optional (O), and include, but are not limited to: Medicine Grand Rounds (O), Neurology Grand Rounds (O), Psychiatry Grand Rounds (R), Neurology Noon Conference (O), Memory Disorders Team Noon Conference (R) and the Consultation-Liaison Psychiatry Case Conference (O).

ROTATION SPECIFICS

Specific Sites of Rotations will be determined closer to each block depending on attending availability and clinic schedules.

1. The Butler Hospital Rotation will include:
 - a. Lippitt 1 Geriatric Inpatient Unit with Amy Halt, MD
 - b. The Memory Disorders Clinic with Steve Salloway, MD, Meghan Riddle, MD
 - c. The Movement Disorders Clinic with Joe Friedman, MD
 - d. TMS with Linda Carpenter, MD
2. The Kent Hospital Rotation will include:
 - a. Acute Care for Elders (ACE) unit with Ana Fulton, MD
 - b. Palliative Medicine inpatient and outpatient Team with John Honeyman, MD
3. The Miriam Hospital Rotation will include:
 - a. Consult- Liaison Psychiatry with Jeff Burock, MD and Barbara Ruf, MD
 - b. Psycho-Oncology with Laura Stanton, MD
 - c. Nursing Home Consults with Romina Smulever, MD, Emily Murphy, MD, Brittney Boykin, MD, Debbie Mendelsohn, PCNS
 - d. The Outpatient Longitudinal Clinic with be supervised by Laura Stanton, MD
4. The Rhode Island Hospital Rotation will include:
 - a. Inpatient Geriatric Unit with Caitlin Lawrence, MD
 - b. Memory Disorders with Jon Drake, MD
 - c. Integrated Care, Memory Disorders Aryan Fotros, MD and Caitlin Lawrence, MD
 - d. Neuropathology with John Donahue, MD
 - e. Neuropsychology with Geoff Tremont, Phd and Seth Margolis, PhD
 - f. Neuroradiology with Jerome Boxerman, MD
5. The VA Rotation will include:
 - a. Geriatric Medicine and home based health care with Lidia Vogner, MD
 - b. Consult- Liaison with Jamey Ingraham, MD
 - c. The Geriatric Psychiatry Clinic, Carolina Jimizez, MS

B. EXPECTED SKILLS AND COURSE DESCRIPTIONS

Expected Skills and Competencies (ACGME Core Competencies) are expected to be met in all clinical rotations as outlined below:

Educational Goals and Objectives (ACGME Competencies):

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- Short-term and long-term diagnostic and treatment planning by using the appropriate synthesis of clinical findings and historical as well as current information acquired from the patient and/or relevant others, including family members, caregivers and or other healthcare professionals
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Medical Knowledge

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Updated June 8, 2018

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- current scientific understanding of aging and longevity, including theories of aging, epidemiology and natural history of aging, and diseases of elderly patients, to include
- effects of biologic aging on human physiology with emphasis on altered pharmacokinetics, pharmacodynamics, and sensory acuity in elderly patients
- differences and gradations between normal and abnormal age-related changes with particular reference to memory and cognition, affective stability, personality and behavioral patterns, sleep, and sexuality; and,
- successful and maladaptive responses to stressors frequently encountered in elderly patients, including retirement, death of a spouse, role changes, interpersonal and health status losses, financial difficulties, environmental relocations, and increased dependency
- relevance of cultural and ethnic differences, and the special problems of disadvantaged minority groups, as these relate to mental illness in elderly patients;
- epidemiology, diagnosis, and treatment of all major psychiatric disorders seen in elderly patients
- American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the fellow and the patient including the dynamics of differences in cultural identity, values and preferences, and power ethical and legal issues especially pertinent to geriatric psychiatry, including competence, capacity, guardianship, right to refuse treatment, wills, advance directives, informed consent, elder abuse, the withholding of medical treatments, and federal legislative guidelines governing psychotropic drug prescription in nursing homes and other settings;
- current economic aspects of supporting services and practice management, including Title III of the Older Americans Act, Medicare, Medicaid, and cost containment
- research methodologies related to geriatric psychiatry, including biostatistics, clinical epidemiology, medical information sciences, decision analysis, critical literature review, and research design (including cross-sectional and longitudinal methods).

Practice-based Learning and Improvement

Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and

assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

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

- Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; and,
- Demonstrate administrative and teaching skills in the subspecialty.

Interpersonal and Communication Skills

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

Fellows must:

- Demonstrate competence in effective formal and informal administrative leadership in the mental health care team
- Demonstrate competence in effectively communicating treatment plans to the patient and family
- Demonstrate competence in making appropriate referrals to and obtaining consultations from other health care specialists.
- Demonstrate competence in providing consultations
- Demonstrate competence in interviewing socio-culturally diverse patients and families in an effective manner which may include those with limited English proficiency, health literacy, and vision/sight and hearing.

Professionalism

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

- Demonstrate sensitivity and responsiveness to diverse patients, including but not limited to sex, age, culture, race, religion, disabilities, and sexual orientation.
- Demonstrate competence in recognizing and appropriately addressing biases in themselves, others, and the health care delivery system.

Systems-based Practice

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

- Demonstrate facilitative skills necessary to enhance the care of psychiatric disturbances among the physically ill through cooperative interaction with other physicians and allied health professionals.
- Demonstrate competence in effectively working with discharge planning personnel and personnel in aftercare facilities.

Butler Hospital Inpatient Rotation

Overview/Description of Rotation:

Updated June 8, 2018

Geriatric inpatient psychiatry rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents gain knowledge, skills and practice in the care of geriatric psychiatric patients in an acute inpatient setting. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

General Information:

- Chief of Service: Amy Halt, MD
- Fellowship Coordinator: Ema Costa 455-6421
- Faculty: Amy Halt, MD

Address: Butler Hospital, 345 Blackstone Blvd, The Lippitt Unit

Topics/Teaching Methods and Materials Used During This Rotation

- Based upon patient population cared for by team over the course of the rotation and are drawn from a variety of teaching services within the hospital.
- Family Assessments and interventions
 - Rehabilitation Services
 - Community services and level of care determination
- Cases selected for presentation

Principle Teaching Methods:

- Attending rounds
- multidisciplinary team meetings
- Weekly seminars
- Guided literature reviews

Educational materials provided/referred to Fellows:

- Reading: Each attending and Fellow are expected to utilize current medical literature in the planning of therapeutic and diagnostic interventions.
- Computer-assisted educational materials: All house staff have access to full-text literature search and retrieval capacity through the hospitals' computer networks. Terminals are located on all floors and in common service office.
- Fellows are given articles as part of their weekly morning seminar series and by faculty on service.

Butler Hospital Movement Disorders Rotation:

Overview/Description of Rotation:

objectives: to learn how to diagnose parkinsonian disorders, and gain expertise in identifying and treating the manifold behavioral problems that occur in Parkinson's disease, dementia with Lewy bodies and related neurodegenerative disorders; to recognize and treat the chronic movement disorders caused by neuroleptic drugs and other psychiatric medications that also may induce movement disorders; to recognize and assess Huntington's disease.

Course: the fellows will spend the duration of their clinics in the movement disorders program under the direct supervision of either Dr. Friedman or Dr. Gopalakrishnan, and, after some time spent shadowing, will see patients on their own, then presenting the patient to the attending neurologist. Readings will be assigned as pertinent to the patients seen in clinic.

General Information:

Address: Movement Disorders Program

Butler Hospital

345 Blackstone Blvd.

- Program Coordinator: Sandy Edmonds; 455-6669 or email semond@butler.org
- Chief of Service: Joseph Friedman, MD
- Faculty: Joseph H. Friedman, MD and Bijou Gopalakrishnan, MD

Topics/Teaching Methods and Materials Used During This Rotation

- Based upon patient population cared for by team over the course of the rotation and are drawn from a variety of teaching services within the hospital.
- Cases selected for presentation

Principle Teaching Methods:

- Direct Attending Supervision
- Weekly readings
- Guided literature reviews

Educational materials provided/referred to Fellows:

- Reading: Each attending and Fellow are expected to utilize current medical literature in the planning of therapeutic and diagnostic interventions.
- Computer-assisted educational materials: All house staff have access to full-text literature search and retrieval capacity through the hospitals' computer networks. Terminals are located on all floors and in common service office.

Butler Hospital Memory Disorders Clinic Rotation:

The geriatric psychiatry rotation in the Brown General Psychiatry Residency constitutes an elective training experience during which residents gain knowledge, skills and practice in the evaluation, diagnosis, and care of geriatric psychiatric patients with a focus on those with neurocognitive disorders. The rotation requires a high degree of organization, efficiency and communication skills, as well as a strong commitment to compassion and

professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

Description of Rotation

This rotation is a 1-month rotation in the Memory and Aging Program and Outpatient Geriatric Psychiatry clinic at Butler Hospital which takes place during the fellowship year. The rotation allows fellows to develop important diagnostic, treatment, and other skills in a specialty geriatric environment, specifically with evaluations of neurocognitive disorders and assessing, diagnosing and treating dementia. Residents have the opportunity to become familiar with latest in therapeutics, diagnosis, neuroimaging and plasma biomarkers, and research trials for Alzheimer’s disease. It also allows residents to begin to become comfortable with the care and management of elderly patients. Residents evaluate and treat geriatric patients and have specific supervision with a geriatric psychiatry supervisor who has subspecialty boards in this area.

I. GENERAL INFORMATION

Name of Rotation	Geriatric Psychiatry and Memory & Aging Elective
Unit Chiefs	
Contact Information	Meghan Riddle, MD (Butler Hospital)
Residency Coordinator	Fellowship Coordinator, Ema Costa

II. FACULTY

Meghan Riddle, MD

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

Topics to be covered are based upon:

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

Principal teaching methods:

- Attending supervision, working alongside APPs

Educational materials provided/referred to residents:

- **Reading:** Each attending and resident is expected to utilize current literature regarding assessment and treatment of patients.
- **Computer-assisted educational materials:** All residents have access to full-text literature search and retrieval capacity through the hospitals’ computer networks.
- **Other:** Residents are provided additional supervision by faculty on service and will have interaction with faculty from Neurology and Neuropsychology

IV. SPECIFIC AREAS & EXPECTATIONS

Residents are expected to regularly review relevant:

- Neuroimaging studies
- Laboratory test results

- Neuropsychological testing results
- Interagencies from nursing homes, reports from primary care physicians, caregivers, and other subspecialty physicians

Residents will see approximately 2-3 new neurocognitive evaluations weekly with the interdisciplinary team. Residents will be responsible for 6-8 geriatric psychiatry outpatients weekly and 4-6 Memory & Aging clinic patients weekly. All residents have 1 hour of scheduled supervision per week. Additional supervision is available on a daily basis.

Residents are supervised in the evaluation and management of older patients on psychiatric and neurocognitive issues.

The Butler Hospital Memory & Aging Program (MAP) is a worldwide leader in Alzheimer's Disease (AD) research. Since 1997, the program has played a major role in advancing the study and treatment of AD and dementia. Over 20+ years, it has amassed a history of excellence in clinical care, training, and cutting-edge research aimed at developing new and better ways to detect, treat, and someday even prevent Alzheimer's. The program works hand in hand with health care providers, community groups, other research organizations, and everyday people with normal memory or some degree of memory loss who are willing to participate in the research needed to bring an end to Alzheimer's disease.

Residents will have the opportunity to learn and engage with research and clinical participants across some of the landmark clinical trials and efforts: **A4 Study**: a treatment aimed at preventing the onset of Alzheimer's; | **LEADS Study**: MAP joined with 14 other AD research centers around the U.S. to establish an early-onset AD clinical trial network to study Early Onset Alzheimer's Disease. **IDEAS Study**: The results of this landmark trial, conducted in part at MAP, show that amyloid PET scan imaging improves the diagnosis and management of AD. **ARIAS Study**: to test the use of simple and painless retinal scanning as a tool for diagnosing Alzheimer's, which could help clinicians detect the disease two decades or more before symptoms. | **U.S. POINTER Study**: MAP becomes one of just 5 sites across the nation for this landmark study focused on how healthy lifestyle changes might reduce risk of cognitive decline. **AHEAD Study**: treatment with lecanemab, a monoclonal antibody, aimed at preventing Alzheimer's disease. **Aducanumab Clinical Care**: Aducanumab is the first FDA approved disease modifying treatment for AD, and MAP is currently clinically managing 20+ patients with this monthly infusion.

Diagnoses include the full spectrum of psychiatric disorders, including Alzheimer's disease and other dementias, severe depression and other mood and anxiety disorders. In addition, there are patients who have neurological and neuropsychiatric problems as a result of head injuries, strokes, Parkinson's disease and multiple sclerosis.

This rotation allows residents to develop important diagnostic, treatment, and other skills in an outpatient subspecialty setting. It allows residents to work more independently in a supervised clinical setting and to assume increasing responsibility for older adults. Residents evaluate and treat geriatric outpatients and have specific supervision with a geriatric psychiatry supervisor who has subspecialty boards in this area. Residents also build their team leadership skills working closely with an interdisciplinary team of nurse practitioners, Neurologists, Neuropsychologists, post-doctoral students, administration and other members of MAP faculty.

V. EVALUATIONS

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

VI. RESPONSIBILITIES OF ATTENDING ON ROTATION

- Faculty will oversee the care of the patients in the resident's caseload assigned to that particular supervisor.

VII. RESPONSIBILITY OF RESIDENT ON ROTATION

- Resident is responsible for evaluation, treatment, and disposition of geriatric psychiatric outpatients
- Resident is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Resident is responsible for family and patient communication.
- Resident is responsible for discussing the case with his or her supervisor, other health care professionals involved with the patient and the patient's family, as dictated by the circumstances.
- Resident is responsible for written or dictated evaluations of all patients assessed and followed.
- Resident must attend weekly educational experiences that are site and rotation-specific.
- Resident will submit an online evaluation of the attending upon completion of the rotation.

VIII. SCHEDULE DURING THIS ROTATION

Grand Rounds	Neurology Grand Rounds, every Wednesday 8:00 – 9:00 AM; DPHB 1 st Wednesday of each month, 11:00, Ray Hall, Butler Hospital Campus
Dementia Case Conference	Fridays, 12:00 – 1:00 PM
Memory & Aging Clinic	Tuesday AM, Wednesday AM, Thursday AM (new evals) and PM, Friday AM
Geriatric Psychiatry Clinic	Tuesday/Wednesday 1:00 – 5:00 PM
Recurrent Meetings	Research Operations/Internal Investigator meeting; Aducanumab and Research recruitment meetings; Monthly RI Advisory Council Meetings, and opportunity to attend our Outreach and Recruitment Initiatives

IX. GENERAL EDUCATIONAL OBJECTIVES

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

- Assess geriatric patients and implement treatment for individuals with psychiatric and/or neurocognitive illness
- Develop important diagnostic and treatment skills in an outpatient setting
- Have both a theoretical and practical understanding of geriatric psychopharmacology
- Recommend laboratory/imaging tests

- Prepare and present case presentations
- Develop an appreciation for cost-efficient care, and proper utilization of resources
- Work in a coordinated fashion with other treatment providers
- Recognize and treat chronic and recent onset primary psychiatric illness in the context of multiple co-morbid conditions, which frequently characterize the late life adult
- Understand the etiology, diagnosis, and management of dementia in elders.
- Distinguish among the various types of dementia in older persons.
- Understand the impact of dementia on elderly patients.
- Understand the latest developments of research for Alzheimer's dementia and the role of amyloid testing, neuroimaging and plasma biomarkers and disease modifying treatments
- Understand the various factors, which influence the use of psychopharmacologic agents in the aged and the role of drug interactions
- Distinguish between normative and pathological neurological changes in the aging process
- Be sensitive to the normative stresses of late life as they interact with the various personality styles in the aging person and the changes in psychotherapeutic technique which are most helpful in working with older patients

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

Competency/Description		
1. Patient Care	Goals and Objectives	Evaluation Method
<p>➤ Resident must be able to provide care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</p>	<ul style="list-style-type: none"> - Residents will prepare and present case presentations - Residents will develop the ability to communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families - Residents will learn to gather essential and accurate information about their patients - Residents will learn to make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment - Residents will learn to develop and carry out a patient management plan - Residents will learn to counsel and educate patients and their families - Residents will work with health care professionals, including those from other disciplines, to provide patient-focused care - Residents will use information technology to support patient care decisions 	<ul style="list-style-type: none"> ○ Residents are evaluated by their supervisors
2. Medical Knowledge	Goals and Objectives	Evaluation Method
<p>➤ Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.</p>	<ul style="list-style-type: none"> - Residents will demonstrate an investigatory and analytic thinking approach to clinical situations - Residents will know and apply the basic and clinically supportive sciences which are appropriate to their discipline - Residents will learn to generate a differential diagnosis and unique treatment plan for each patient encounter - Residents will learn to effectively communicate their investigatory and analytic thinking approach via written notes and presentations to supervisors and other health care professionals - Residents will keep abreast of new scientific knowledge, which is obtained via didactic sessions, Grand Rounds, critical review of scientific literature, computer and web-based resources - Residents will actively participate in seminars 	<ul style="list-style-type: none"> ○ Feedback of presentations will be provided by supervisors
3. Interpersonal and	Goals and Objectives	Evaluation Method

Communication Skills		
<p>➤ Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates.</p>	<ul style="list-style-type: none"> - Residents will create and sustain a therapeutic and ethically sound relationship with patients - Residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information - Residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries. - Residents will write clearly and legibly when hand-writing instructions or other information for patients/families - Residents written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable 	<ul style="list-style-type: none"> ○ Residents are evaluated by their supervisors
4. Professionalism	Goals and Objectives	Evaluation Method
<p>➤ Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</p>	<ul style="list-style-type: none"> - Residents will demonstrate their responsibility to patient care by: (1) Responding to communication from patients and health professionals in a timely manner, (2) Establishing and communicating back-up arrangements, including how to seek emergent and urgent care when necessary, (3) Using medical records for appropriate documentation of the course of illness and its treatment , (4) Providing coverage if unavailable, (for example, when out of town or on vacation), (5) Coordinating care with other members of the medical and/or multidisciplinary team, (6) Providing for continuity of care, including appropriate consultation, transfer, or referral if necessary - Residents will demonstrate ethical behavior, integrity, honesty, compassion, and confidentiality in the delivery of care, including matters of informed consent/assent, professional conduct, and conflict of interest - Residents will demonstrate respect, sensitivity and responsiveness for and to patients and their families, and their colleagues as persons, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations. - Residents will demonstrate understanding of and 	<ul style="list-style-type: none"> ○ Attendings will evaluate residents

	<p>sensitivity to end of life care and issues regarding provision of care</p> <ul style="list-style-type: none"> - Residents will review their professional conduct and remediate when appropriate - Residents will make reasonable efforts to act as advocates for their patients. - Residents will truthfully report medical errors of their own to their attending, or Risk Management and to follow hospital protocols in the face of errors. Residents will encourage and facilitate reporting of medical error on the part of professional colleagues - Residents will seek professional help for personal impairments that may compromise patient care; will assist impaired colleagues to obtain professional help; and will take responsibility for interceding to protect patient safety when impaired colleagues do not respond appropriately to their own duties in this regard - Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice - Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family - Residents will create and sustain a therapeutic and ethically sound relationship with patients 	
5. Practice-Based Learning and Improvement	Goals and Objectives	Evaluation Method
<p>➤ Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.</p>	<ul style="list-style-type: none"> - At the end of this rotation, the resident should be able to identify gaps in knowledge based upon experience, introspective awareness, and feedback for the year. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice. - The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into 	<ul style="list-style-type: none"> ○ Day to day knowledge base evaluated by feedback on diagnoses, and both psychopharmacologic and psychotherapeutic treatment approaches

	<p>their strengths and weaknesses.</p> <ul style="list-style-type: none"> - The resident should be able to obtain scientific literature, appraise quality, and assimilate data through the use of up to date resources to improve their practice and care of patients' health problems. - The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed. - The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist - The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients - The resident is expected to take a proactive and interactive approach to enhancing their knowledge. The resident is expected to "think out loud", ask for clarification and guidance, and actively seek input on their practice and knowledge base from their mentors. - The resident will facilitate the learning of students and other health care professionals 	
6. Systems-Based Practice	Goals and Objectives	Evaluation Method
<p>➤ Resident must demonstrate an awareness of and responsiveness to a larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals.</p>	<ul style="list-style-type: none"> - The resident will learn to practice cost-effective health care and resource allocation that does not compromise quality of care - The resident will learn how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance - The resident will learn how to work other health care providers to develop and coordinate a care plan for their patients - The resident will be familiar with the presence and influences of alternative and complimentary therapies, and its use in their populations and patients - The resident will learn about a variety of insurances and how they affect patient referrals and prescriptions. They will learn the legal rights of the uninsured and will work with the appropriate services to assist patients who are under- or un-insured - The resident will learn how to interact and advocate effectively with other physicians, ancillary caregivers, community agencies, landlords, and insurance companies etc. via spoken and written 	<ul style="list-style-type: none"> ○ Evaluations from supervisors

	<p>communications when it effects the health of their patients</p> <ul style="list-style-type: none"> - The resident will learn about the various community resources available for patients and will work with case managers and social workers to enable patients to access these resources 	
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XI. OTHER IMPORTANT INFORMATION FOR RESIDENT DURING THIS ROTATION

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

Butler Hospital Neuromodulation Rotation:

The Kent Hospital Geriatric and Palliative Medicine Rotation

I. Rotation Objectives:

- a. Evaluate and Manage geriatric syndromes (delirium, dementia, falls, insomnia, osteoporosis, urinary incontinence, functional status (IADLs/ADLs), pain management
- b. Detect unsafe polypharmacy and reduce pill burden (Familiarize self with 2019 Beer’s Criteria and deprescribing.org website or app)
- c. Understand the differences between normal cognitive changes associated with aging vs mild cognitive impairment vs dementia syndrome
- d. Learn how to run organized family meetings and navigate complex social dynamics
- e. Explore different factors to help with prognostication in different disease trajectories
- f. Improve skills in complex symptom management including pain, nausea, delirium etc
- g. Demonstrate ability to work with an interdisciplinary team and navigate patient transitions across various care settings
- h. Understand the Age-Friend Health Systems 4Ms framework and how integrates into caring for older adults

TEAM: We are available on Care Threads

CLINICAL SETTINGS:

On 1st Day of Rotation please meet at 9am in GME center room

Inpatient consults: Kent (Floor Consult Services for Geriatrics and Palliative) & Kent Acute Care for Elders (ACE) unit 4NW rm 486-492

Outpatient consults: Care New England Primary Care for Older Adults: 215 Toll Gate Rd, Suite 104, Warwick, RI 02886, 921-7290

Contacts:

Geriatrics:

Dr. Michael Ross,

Dr. Ana Tuya Fulton,

Mary-Beth Welesko RNP,

Rachel Roach RNP,

Leyda Urugutia SW,

Kim Jones OT,

Shannon Levesque PharmD

Palliative:

Dr. Brian Honeyman,

Kate Baccari PA,

Karen Pendelton RNP

Administrator Assistant: Justine Belanger (Jbelanger@CareNE.org) please contact for any scheduling issues

General Schedule: 3 weeks of Geriatric Medicine / 3 weeks of Palliative Care

II. Rotation Objectives:

- a. Evaluate and Manage geriatric syndromes (delirium, dementia, falls, insomnia, osteoporosis, urinary incontinence, functional status (IADLs/ADLs), pain management
- b. Detect unsafe polypharmacy and reduce pill burden (Familiarize self with 2019 Beer's Criteria and deprescribing.org website or app)
- c. Understand the differences between normal cognitive changes associated with aging vs mild cognitive impairment vs dementia syndrome
- d. Learn how to run organized family meetings and navigate complex social dynamics
- e. Explore different factors to help with prognostication in different disease trajectories
- f. Improve skills in complex symptom management including pain, nausea, delirium etc
- g. Demonstrate ability to work with an interdisciplinary team and navigate patient transitions across various care settings
- h. Understand the Age-Friend Health Systems 4Ms framework and how integrates into caring for older adults

III. AVAILABLE APPLICATIONS TO DOWNLOAD TO SMARTPHONE:

[GeriPal Share Point website](#): Shared articles and EBM journals located here.

- a. Useful Apps: Geriatric At Your Fingertips; AGS Geriatric Evaluation Management Tools, iGeriatrics (includes Updated Beers Criteria), FastFacts

Updated June 8, 2018

- b. Deprescribing.org has an application called *IAM Medical Guidelines*
- c. Alzheimer's Association has an application called *Alzheimer's Disease Pocket Guide*

The Miriam Hospital Longitudinal Clinic Rotation

Overview/Description of Rotation:

Geriatric inpatient psychiatry rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents gain knowledge, skills and practice in the care of geriatric psychiatric patients in an outpatient setting. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

General Information: address: 164 Summit Avenue, Fain 2B; 401-793-4300

- Chief of Service: Laura Stanton, MD
- Service Administrator: Elizabeth Johnston

- Faculty: Emily Murphy, MD and Brittney Boykin, MD
- Front Desk Staff: Nelia Andrade (nandrade2@lifespan.org) PH: 401-793-4301 Fax: 401-793-4312

Topics/Teaching Methods and Materials Used During This Rotation

- Based upon patient population cared for by team over the course of the rotation and are drawn from a variety of teaching services within the hospital.
- Family Assessments and interventions
- Rehabilitation Services
- Community services and level of care determination
- Cases selected for presentation

Principle Teaching Methods:

- Attending rounds
- multidisciplinary team meetings
- Weekly seminars
- Guided literature reviews

Educational materials provided/referred to Fellows:

- Reading: Each Attending and Fellow are expected to utilize current medical literature in the planning of therapeutic and diagnostic interventions.
- Computer-assisted educational materials: All house staff have access to full-text literature search and retrieval capacity through the hospitals' computer networks. Terminals are located on all floors and in common service office.
- Fellows are given articles as part of their weekly morning seminar series and by faculty on service.

Miriam Hospital Consultation Liaison Psychiatry Rotation**Overview/Description of Rotation:**

Consultation liaison psychiatry at Miriam Hospital, an academic community hospital, constitutes an important Fellow training experience. There, the Fellow spends 3 months, over their fellowship year, performing psychiatric consults to geriatric patients with a focus on general medical, ICU and emergency room settings. The Miriam Hospital consult service offers a robust caseload of geriatrics patients with comorbid HIV, Hepatitis C, and Hematology/Oncology illness, given proximity to specialty ambulatory clinics.

I. Core Areas:

1. Psychiatric assessment and consultation
2. Legal issues
3. Ethical issues
4. Psychological response to illness

II. SYMPTOMS AND DISORDERS

5. Delirium
6. Dementia
7. Aggression and violence
8. Depression
9. Suicidality
10. Psychosis, mania, catatonia
11. Anxiety disorders
12. Somatization and somatoform disorders
13. Deceptive disorders: factitious and malingering
14. Eating disorders
15. Sleep disorders
16. Sexual disorders
17. Substance use disorders

General Information: Address: The Miriam Hospital,

- Chief of Service: Jeffrey Burock, MD
- Service Administrator: Victoria Horsfield RN and Lindsay Bucci RN

- Fellowship Coordinator: Ema Costa 455-6421
- Faculty: Jeffrey Burock, MD, Barbara Ruf MD
- Address: The Miriam Hospital, 164 Summit Avenue, Fain 2B

Topics/Teaching Methods and Materials Used During This Rotation

- Based upon patient population cared for by team over the course of the rotation and are drawn from a variety of teaching services within the hospital.
- Consultation liaison multidisciplinary team meetings (held daily)
- Cases selected for presentation

Principle Teaching Methods:

- Attending rounds
- Consultation liaison team meetings
- Weekly seminars
- Guided literature reviews

Educational materials provided/referred to Fellows:

- Reading: Each attending and Fellow are expected to utilize current medical literature in the planning of therapeutic and diagnostic interventions.
- Computer-assisted educational materials: All house staff have access to full-text literature search and retrieval capacity through the hospitals' computer networks. Terminals are located on all floors and in common service office.
- Fellows are given articles as part of their weekly morning seminar series and by faculty on service.

Nursing Home Psychiatry Rotation:

Overview:

The nursing home psychiatry rotation in the Brown University geriatric psychiatry fellowship constitutes a core training experience during which residents were to perform cognitive consultation 10 none psychiatric medical personnel regarding psychiatric and behavioral problems in elderly nursing home patients. The rotation requires a high degree of organization and efficiency as well as a strong commitment to professionalism. This latter quality is a "value which should guide residents in making steps to take on the behalf of their patients as well as their own education.

Description of Rotation:

Residents are provided with several half days per week of nursing home psychiatry for 4-year divided into different rotations. Nursing homes are through the Miriam Hospital geriatric psychiatry consultation service and and several different locations throughout the state. Each resident's assignments are scheduled in order to give the relevant clinical experience in all areas of nursing home psychiatry. Faculty experienced a nursing home consultation with added qualifications in geriatric psychiatry to provide supervision and a psychiatric evaluation and management geriatric patients consulted in the nursing home.

Faculty: Laura Stanton, MD, Emily Murphy, MD Brittany Murphy, MD, Jeff Brock, MD, Jyllian Rogers, NP, Debbie Mendelson, PCNS

Specific Areas and Expectations:

Fellows are expected to regularly review relevant:

Nursing home records
Neuroimaging studies
Laboratory test results
communication with nursing home staff

In addition to providing diagnostic evaluations, fellows will provide recommendations regarding behavioral and psychopharmacological management. Residents are expected to apply cost-effective care measures and principles to the care of the patient. Fellows are expected to communicate as needed with nursing staff and primary care physicians

The VAMC Geriatric Assessment and Treatment Clinic

Overview/ Description: Geriatric inpatient psychiatry rotation in the Brown University Geriatric Psychiatry Fellowship constitutes a core training experience during which residents gain knowledge, skills and practice in the care of geriatric psychiatric patients in an outpatient setting. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism. This latter quality is a core value, which should guide residents in decision-making about which steps to take on behalf their patients, as well as their own education.

General Information on the VAMC:

Supervisors:

-Carolina Jimenez Madiedo (for general supervision and Friday assessments)

x15869; office located on 3A (room 325A); email: carolina.jimenezmadiedo@va.gov

-Syed Raza (for Thurs afternoon assessments)

x13259; office located on 3B (room 396B); email: syed.raza2@va.gov

-Jamey Ingraham (for Tues morning consults)

X13291; office located on 3B (388A); email: james.ingraham@va.gov

Topics/Teaching Methods and Materials Used During This Rotation

- Based upon patient population cared for by team over the course of the rotation and are drawn from a variety of teaching services within the hospital.
- Family Assessments and interventions
- Rehabilitation Services
- Community services and level of care determination
- Cases selected for presentation

Principle Teaching Methods:

- clinical supervision and discussion

- Guided literature reviews

Educational materials provided/referred to Fellows:

- Reading: Each Attending and Fellow are expected to utilize current medical literature in the planning of therapeutic and diagnostic interventions.
- Computer-assisted educational materials: All house staff have access to full-text literature search and retrieval capacity through the hospitals' computer networks. Terminals are located on all floors and in common service office.
- Fellows are given articles as part of their weekly morning seminar series and by faculty on service.

The VAMC Geriatric Medicine and Homecare Rotation:

Supervisor: Lidia Vognar, MD

III. ADMINISTRATION

A. GENERAL MEDICAL EDUCATION COMMITTEE (GMEC)

The Geriatric Fellowship Training Program is governed by the General Psychiatry departmental graduate medical education committee (GMEC). The GMEC:

- Plans, develops and implements all significant features of the residency program;
- Determines curriculum goals and objectives; and
- Evaluates the curriculum, the teaching staff and the fellows.

The GMEC also serves in an advisory capacity to the Program Director and Chairman of the Department regarding other educational issues. Membership is comprised of stakeholders representing the faculty, fellows and institutions which contribute to the residency and fellowship programs.

The GMEC of the Department of Psychiatry also reviews at least annually the Consultation-Liaison Psychiatry Fellowship Training Program.

B. CLINICAL COMPETENCY COMMITTEE (CCC)

The program director must appoint the Clinical Competency Committee. At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. The program director may appoint additional members of the Clinical Competency Committee. These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows in patient care and other health care settings.

The Clinical Competency Committee should:

- Review all fellow evaluations semi-annually.
- Prepare and ensure the reporting of Milestones evaluations of each fellow semi-annually to ACGME.
- Advise the program director regarding fellow progress, including promotion, remediation, and dismissal.

C. PROGRAM EVALUATION COMMITTEE (PEC)

The program director must appoint the Program Evaluation Committee. The Program Evaluation Committee:

- Must be composed of at least two program faculty members and should include at least one fellow;
- Must have a written description of its responsibilities; and,
- Should participate actively in:
 - Planning, developing, implementing, and evaluating educational activities of the program;
 - Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
 - Addressing areas of non-compliance with ACGME standards; and,
 - Reviewing the program annually using evaluations of faculty, fellows, and others, as specified below.

The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. The program must monitor and track each of the following areas:

- Fellow performance;
- Faculty development;
- Progress on the previous year's action plan(s); and,
- Program goals and objectives as well as program effectiveness in achieving them.
 - At least one fellow representative and all faculty members should participate in these reviews.

The PEC must prepare a written plan of action to document initiatives to improve performance, as well as delineate how they will be measured and monitored.

- The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

At least 80% of the program's eligible graduates from the preceding six years should have taken the ABPN certifying examination in Geriatric Psychiatry.

At least 80% of the program's graduates from the preceding six years who have taken the ABPN certifying examination for Geriatric Psychiatry for the first time must pass.

IV. EDUCATION

A. EDUCATIONAL PROGRAM: DETAILED SKILLS AND COMPETENCIES (Milestones)

Geriatric psychiatry focuses on prevention, diagnosis, evaluation, and treatment of psychiatric mental disorders, and signs and symptoms seen in older adult 50 patients. An educational program in geriatric psychiatry must be organized to 51 provide professional knowledge, skills, and opportunities to develop competency through a well-supervised clinical experience. At the completion of the 12-month training program, fellows will be able to demonstrate the following competencies as outlined in the Geriatric Milestones:

1. **Patient Care (PC)**
2. **Medical Knowledge (MK)**
3. **Practice Based Learning and Improvement (PBLI)**

4. **Interpersonal and Communication Skills (ICS)**
5. **Professionalism (PROF)**
6. **Systems Based Practice (SBP)**

1. **Patient Care (PC)**

General Expectations:

The fellow will:

- a. Complete comprehensive psychiatry consultations for geriatric patients who are hospitalized on medical units, inpatient psychiatric units and the outpatient setting.
- b. Provide diagnostic formulation and treatment planning with a focus on biological and psychosocial contributors and management principles.
- c. Serve in the psychiatry liaison role alongside multidisciplinary services, including transplantation and palliative care medicine teams.

Detailed Skills and Competencies:

PC1 – Psychiatric Evaluation:

- a. Interviewing Skills or Psychotherapeutic Interventions: The fellow will integrate interpersonal skills and knowledge base to sensitively and efficiently gather comprehensive and relevant data; verbally intervene to increase patients' comfort, collaboration, or insight; approach sensitive topics (e.g., lethality, trauma, substance use) with respect and poise.
- b. Assessment and Diagnosis: The fellow will assimilate data from interviews and examinations to accurately recognize relevant problems and likely diagnoses, including consideration of general medical conditions that impact affective, behavioral, and cognitive presentations. Fellows must demonstrate proficiency in conducting psychiatric evaluations and management involving:
 - Psychiatric complications of aging
 - Psychiatric complications of medical treatments
 - Typical and atypical presentations of psychiatric disorders due to medical, neurological, and surgical illnesses;
 - Acute and chronic pain;
 - Delirium, dementia, and psychiatric disorders due to medical illness;
 - Somatoform disorders;
 - Palliative care and end-of-life issues;
 - Issues in adjusting to the emotional stresses of medical illness;
 - The assessment of acute decision making capacity issues;
 - Suicidality and other high risk behaviors in the outpatient or inpatient setting

PC2 – Psychiatric Formulation and Differential Diagnosis:

The fellow will address most relevant biological and psychosocial contributions to patients' acute and chronic conditions; weigh risks and benefits of all likely interventions; justify levels of care based on patients' safety and levels of functioning.

PC3 – Treatment Planning and Management:

The fellow will formulate comprehensive treatment plans that address the consultation questions posed by primary teams and any additional psychiatric needs of patients seen; maintain flexibility in treatment planning to match the needs of patients and other treatment providers; gain specific comfort with guiding treatment planning for agitation, trauma-based syndromes, and substance withdrawal states.

PC4 – Psychotherapy:

The fellow will provide customized bedside therapies (e.g., supportive psychotherapy, relaxation and mindfulness) for patients with chronic medical illness and/or prolonged medical hospitalizations, whenever appropriate; develop therapeutic alliances with patients while maintaining professional boundaries.

PC5 – Somatic Therapies:

The fellow will effectively implement somatic treatments for psychiatric conditions in the geriatric population, keeping in mind psychopharmacological principles, drug-drug interactions, and associated approaches to drug monitoring; choose and titrate medications safely; formulate plans for treatment resistance; explore alternate treatment options, including augmentation and ECT; identify and manage adverse reactions appropriately.

2. Medical Knowledge (MK)

General Expectations:

The fellow will:

- a. Demonstrate knowledge of diagnostic schema, pathophysiology, and differential diagnosis for psychiatric syndromes that are seen commonly in the geriatric population.
- b. Develop an appreciation for the relevance of neural anatomy and physiology to psychiatric presentations (e.g., agitation associated with dementia, traumatic brain injury, movement disorders).
- c. Demonstrate a comprehensive knowledge of somatic and psychotherapeutic treatments.

Detailed Skills and Competencies:

MK1 – Development through Later Life:

The fellow will gain knowledge of developmental series across all developmental domains and later life development. through later life. The fellow will gain knowledge of pathological and environmental influences on later in life. The fellow will gain knowledge of the impact of life events, functional change, and general medical health on later life.

MK2 – Psychopathology:

Includes presentation of psychiatric disorders in diverse older populations (e.g., different cultures, families, genders, sexual orientation, ethnicity, etc.)

The fellow will demonstrate knowledge to identify and treat psychiatric conditions in a variety of treatment settings. The fellow will gain knowledge to assess risk and determine level of care. The fellow will gain knowledge regarding the interface of geriatric psychiatry and other clinical disciplines

MK3 – Treatment and Management:

. The fellow will demonstrate knowledge of somatic therapy, nonpharmacological therapies, and clinical settings of care.

MK4 – Psychotherapy:

The fellow will demonstrate knowledge of various psychotherapeutic interventions associated with Geriatric Psychiatry (e.g., motivational interviewing, cognitive behavioral therapy), including limits and appropriate use; understand how to tailor psychotherapeutic interventions to patients' diagnoses, psychosocial strengths and stressors, levels of functioning, readiness for change, personal preferences, and access to resources.

SBP1 – Patient Safety and The Health Care team:

The fellow will demonstrate knowledge of medical errors and improvement in activities, communication and patient safety: As well as regulatory and educational activities related to patient safety

SBP2: Resource management:

The fellow will appreciate the costs of care and balance the best interests of the patient and family with the availability of resources.

3. **SBP3: Community Based care.** The fellow will incorporate support and self-help groups, community based programs, and appropriately referred to recovery and rehabilitation programs.
4. **SBP4: Consultation to non psychiatric medical providers and non medical systems.** The fellow will provide integrated care for geriatric psychiatric patients through collaboration with other physicians and advanced level practitioners. The fellow will provide care as a consultant and collaborator with other medical specialties and engaged in specific consultative activities.

5.

6. Practice-Based Learning and Improvement (PBLI)

General Expectations:

The fellow will:

- a. Assimilate scientific literature to improve knowledge and patient care.
- b. Integrate experiential knowledge, clinical feedback, and mentorship for self-development.
- c. Refine teaching and supervisory skills.

Detailed Skills and Competencies:

PBLI1 – Development and Execution of Life-Long Learning through Self-Evaluation, including Critical Evaluation of Research and Clinical Evidence:

The fellow will engage in self-assessment and self-improvement. The fellow will incorporate evidence into clinical practice. The fellow will recognize mistakes and learn quickly from them; remain open to constructive criticism and integrate supervision well; outline and target educational goals; demonstrate an understanding of various modalities of research; seek studies that improve general knowledge and facilitate provision of evidence-based clinical practice.

PBLI2 – Teaching:

The fellow will develop as a teacher and engage in observable teaching skills. The fellow will supervise students and fellows using a combination of bedside supervision, formal instruction, and

modeling behaviors; provide education to general medical and surgical teams and ancillary staff regarding neuropsychiatric phenomena associated with patient care in the general hospital setting.

7. Interpersonal and Communication Skills (ICS)

General Expectations:

The fellow will:

- a. Represent a psychiatry consultation service in interactions with primary psychiatric teams and ancillary staff.
- b. Coordinate psychiatric care with other providers and family members in an empathic and collaborative manner.
- c. Provide comprehensive communication and documentation of clinical interactions and impressions.

Detailed Skills and Competencies:

ICS1 – Relationship Development and Conflict Management with Patients, Families, Colleagues, and Members of the Healthcare Team:

- a. Patient Relationships: The fellow will establish therapeutic alliances based on empathy and collaboration; support and set limits with patients appropriately; educate patients and families about diagnosis and treatment options; handle conflict gracefully.
- b. Work Relationships: The fellow will integrate perspectives from various disciplines to develop a multidimensional view of patients; contribute to a team with flexibility and lead with poise; inspire mutual respect and collaboration with other health care providers and ancillary staff; coordinate care between various providers and function within multidisciplinary medical teams to provide psychiatric expertise. The fellow will engage in team based care.
- c. Conflict management: The fellow will recognize different philosophies within and between different disciplines and care provision

ICS2 – Information Sharing and Record Keeping:

Accurate and effective communication with the healthcare team. Maintain effective communication patients. Maintain professional boundaries and communication

8. Professionalism (PROF)

General Expectations:

The fellow will:

- a. Display ethical and respectful behaviors during interactions with patients, families, and coworkers.
- b. Maintain accountability and commitment to patient care.
- c. Contribute to a clinical team as guided by work ethic, reliability, and responsibility.

Detailed Skills and Competencies:

PROF1 – Compassion, Integrity, Respect for Others, Sensitivity to Diverse Patient Populations, Adherence to Ethical Principles:

- a. Respect and Compassion: The fellow will value patients' and staff members' dignity and individuality, including respect for age, gender, ethnicity, culture, religion, disabilities, individual value systems, and sexual orientation.
- b. Ethics: The fellow will behave in a manner that conforms to AMA and APA codes of ethics; maintain appropriate boundaries; respect patient confidentiality; avoid acting out negative counter-transference towards patients; provide honest communications with patients, coworkers, and the health care system.

PROF2 – Accountability to Self, Patients, Colleagues, and the Profession:

The fellow will carry out duties reliably; maintain work ethic with commitment to clinical excellence; assure continuity of care by adequate notification of absences, arrangements for coverage, and coordination of care between caregivers.

9. System-Based Practices (SBP)

General Expectations:

The fellow will:

- a. Identify and manage challenges to patient safety when treating acute psychiatric conditions in the general medical setting.
- b. Make use of local, regional, and national resources available to patients in order to guide thoughtful treatment planning for harm prevention.
- c. Identify barriers to care and approaches to overcoming them.

Detailed Skills and Competencies:

SBP1 – Patient Safety and the Healthcare Team:

The fellow will understand institutional operations designed to maintain patient and provider safety; collaborate with other providers to review treatment planning in an effort to reduce errors; provide medical staff with education on maintaining safety of acutely suicidal or homicidal patients.

SBP2 – Resource Management:

The fellow will recognize and manage variability in provision of patient care based on organization of a clinic, unit, hospital, or healthcare delivery system; predict and manage logistical barriers, including financial limitations, to provision of longitudinal psychiatric care.

SBP3 – Community Based Care:

The fellow will identify and refer to appropriate psychosocial supports (e.g., grief counseling groups, case management services), self-help groups, and recovery programs in the general medical setting and in the community.

SBP4 – Consultation to Non-Psychiatric Medical Providers and Non-Medical Systems:

The fellow will provide effective and efficient psychiatric consultation within an interdisciplinary medical system, including medical and surgical providers, nursing staff, aides, social workers, and case managers; understand the structure of various medical teams, including interfacing between fellow services, hospitalist services, physician extenders, and other interdisciplinary teams.

SUPERVISION

In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.

Each fellow must have a minimum of two hours of faculty preceptorship weekly, one of which must be one-to-one preceptorship and one of which hour may be group preceptorship. Please see more details in the policies section below under supervision.

B. DIDACTICS

Educational sessions should include journal club, critical incident conferences, weekly didactic seminars, and teaching patient rounds. Fellows must attend at least 90% of all required didactic components of the programs. Attendance by fellows and faculty members should be documented.

Formal didactics will take place weekly at the Harwood Center. Some lecture will be available via zoom. Didactics will be in conjunction with Geriatric Medicine and Palliative Medicine with our geriatric medicine and palliative medicine faculty. 10am didactic will be specific to geriatric psychiatry. The fellow will be expected to present in scheduled journal club presentations, case presentations and discussion as well. The fellow will also present a Quality Improvement Project.

The Didactic schedule will be given to the fellow at the start of the academic year.

Fellows are required to attend a minimum of 70% of their seminars. This requirement meets the new ACGME Psychiatry guidelines.

- Documentation of attendance is secured by each resident signing to attest to their attendance during the scheduled seminar and completing the seminar evaluation form. Copies of the attendance logs and evaluations are kept in the geriatric psychiatry fellowship office.
- Resident attendance is reviewed at each semi-annual meeting with the Geriatric Psychiatry Fellowship Directors.

- Failure to meet the 70% threshold or misrepresenting attendance will constitute grounds for initiating the Guidelines for Resident Evaluation and may jeopardize the resident's standing in the fellowship.
- For the purpose of calculating percent attendance, eligible seminars (the denominator) do not include lectures given during the following: Butler Hospital PAS and approved vacation, conference or sick leave.

C. OTHER SEMINARS, CONFERENCES AND MEETINGS

a. Journal Club (J. article collection)

Every month an article will be selected for discussion. The fellow will be expected to have read the article and be prepared to present it.

b. Psychiatry: Department of Psychiatry & Human Behavior Academic Grand Rounds (currently offered virtually)

Monthly (Wednesday)

Ray Hall Conference Center, Butler Hospital

11:00 AM – 12:30 PM

c. Medicine Grand Rounds (Tuesday)

To include grand rounds and other selected talks of interest that may be available throughout the year.

George Auditorium, Rhode Island Hospital

8:00 – 9:00 AM

d. Medicine Noon Conference

Jane Brown

12:00 – 1:00 PM

e. Neurology Grand Rounds (Wednesday)

To include grand rounds and other selected talks of interest that may be available throughout the year.

George Auditorium, Rhode Island Hospital

8:00 – 9:30 AM

f. Neurology Noon Conference

APC 5, Neurology Conference Room

12:00 – 1:00 PM

g. PM Quarterly Case Conference Consult-Liaison Psychiatry (Friday)

Interesting cases to be presented every quarter for discussion.

The fellow will be expected to present twice throughout the year.

Rhode Island Hospital, PDR123

12:00 – 1:00 PM

h. Ethics Meetings

When applicable in complex cases.

i. Root Cause Analysis, Critical Incident Meetings

When applicable in relevant cases.

j. Geriatric Medicine (Thursdays)

For selected topics
Rhode Island Hospital,
8:00 – 10:00 AM

k. Forensic Psychiatry Didactics (Tuesday/Wednesday)

For selected topics
Selected locations
Selected times

l. Addiction Medicine (Selected Day of Week)

For selected topics.
Selected locations
Selected times

D. TEACHING

Fellows will have the opportunity to obtain teaching experience through direct clinical care at the bedside (always supported by an attending physician, clinically and pedagogically), case presentations, and didactics among others.

Our department, and the consultation service specifically, provides training and supervision at various times for a variety of learners including medical students, PA students, psychiatry fellows, neurology fellows, consult liaison psychiatry fellows, geriatric medicine fellows, graduate psychology interns, and clinical social work interns.

E. SCHOLARLY ACTIVITY/ ACADEMIC PROJECT

Fellows may participate in developing new knowledge or evaluating research findings. This can be done by participating in a research project, preparing a poster to present at the APM, or writing a review article among others. Appropriate guidance, support and mentorship will be provided as needed.

F. QUALITY IMPROVEMENT AND PATIENT SAFETY

Fellows are expected to participate in a quality improvement process or a patient safety initiative. The goal is to demonstrate an understanding of the process and to be able to learn how to identify and address issues on their own.

V. EVALUATION

A. FELLOW PERFORMANCE EVALUATIONS

Formative Evaluation

The faculty must evaluate fellow performance in a timely manner. The program must:

- Provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones;
- Use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,
- Provide each fellow with documented semiannual evaluation of performance with feedback.

The evaluation must include review and discussion with each fellow of his or her completion of all required components at the time of the evaluation of the program, evaluations of clinical and didactic work by supervisors and teachers, and patient log documenting all clinical experiences.

Summative Evaluation

The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program.

The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must:

- Become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy;
- Document the fellow's performance during their education; and,
- Verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.

The final evaluation of each fellow must document proficiency in all required competency-based outcomes that include: Patient Care (PC), Medical Knowledge (MK), Practice Based Learning and Improvement (PBLI), Interpersonal and Communication Skills (ICS), Professionalism (PROF), and Systems Based Practice (SBP), and overall pertinent comments.

B. MILESTONES

The Milestones are designed only for use in evaluation of fellows in the context of their participation in ACGME- accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the fellow in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context. Fellow will be provided with ACGME Milestones at the beginning of the academic year.

The Geriatric Psychiatry Milestones will be used by attending faculty members to evaluate fellows on a regular basis at the completion of each inpatient rotation, as well as for the ambulatory/ longitudinal component of the fellowship program. They also constitute the core of how fellows are evaluated in the

semiannual and summative evaluations. The fellow will be provided with a copy of the ACGME milestones for geriatric psychiatry.

PC1 — Geriatric Psychiatric Evaluation and Differential Diagnosis: Geriatric specific interview skills, including use of collateral information and functional assessment as indicated. Neurocognitive assessment. Organization and summary of findings and generation of differential diagnosis

PC2 —Geriatric Therapeutic Modalities:. Somatic therapies, psychotherapies, behavioral and environmental interventions.

PC3 —Treatment Planning and Management:. Participates in the development, management, and periodic review of interprofessional treatment plans. Manages geriatric patient safety issues. Evaluates and manages if issues regarding: Self-determination and decisional capacity.

MK1 — Development Through Later Life: Knowledge of developmental theories across all developmental domains and later life development. Knowledge of pathological and environmental influences on later life. Knowledge of the impact of life events, functional change, and general medical health on later life.

MK2 — Psychopathology: Includes presentation of psychiatric disorders and diverse older adult populations (e.g., different cultures, families, genders, sexual orientation, ethnicity). Knowledge to identify and treat psychiatric conditions in a variety of treatment settings. Knowledge to assess risk and determine level of care. Knowledge regarding the interface of geriatric psychiatry and other clinical disciplines

MK3 — Treatment and Management:

- A. Ethics and legal issues
- B. Models of consultation and collaborative care
- C. Issues in diverse populations (e.g., cultural, ethnic, developmental, gender, sexual orientation)

SBP1 — Patient Safety and the Health Care Team

- A. Medical errors and quality improvement activities
- B. Communication and patient safety
- C. Regulatory and educational activities related to patient safety

SBP2 — Resource Management: costs of care and resource selection

SBP3 — Community-based Care: community-based programs; self-help groups, including 12-step approaches; medical, psychiatric, and substance abuse recovery/rehabilitation programs

SBP4 — Consultation to Health Care Systems

PBLI1 — Lifelong Learning

- A. Self-assessment and self-improvement
- B. Use of evidence-based medical knowledge

PBLI2 — Teaching

- A. Development as a teacher

- B. Observable teaching skills

PROF1 — Compassion, Integrity, and Respect

- A. Compassion for others, self-reflection, sensitivity to diverse patient populations
- B. Adherence to ethical principles

PROF2 — Accountability to Self, Patients, Colleagues, and Profession

- A. Work balance and fatigue management
- B. Professional behavior and participation in professional community

ICS1 — Relationship Development and Conflict Management

- A. Relationship with patients
- B. Conflict management with patients, families, colleagues, and members of the health care team

ICS2 — Information Sharing and Record Keeping

- A. Accurate documentation and effective communication with health care team and patients
- B. Maintaining professional boundaries

C. ATTENDING PHYSICIAN EVALUATIONS BY FELLOW

At least annually, the program must evaluate faculty performance as it relates to the educational program. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

Fellows will be required to submit evaluations providing feedback on their supervising attending physicians at the conclusion of each block. This includes evaluation on medical knowledge, patient care, practice based learning and improvement, professionalism, systems based practice, availability, and teaching skills.

D. PROGRAM EVALUATION BY FELLOW

The program, through the PEC (see above under administration), must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation.

The PEC must prepare a written plan of action to document initiatives to improve performance, as well as delineate how they will be measured and monitored.

E. DIDACTICS

Fellows will be required to submit brief evaluations on the core didactics provided for continuous review and improvement purposes. This will include evaluation of the presentation and the speaker.

F. CASE LOGS

Each fellow must maintain a patient log documenting all clinical experiences. The program director will review these regularly to ensure that the fellow has exposure to an appropriate breadth of clinical problems

VI. POLICIES and Benefits

A. BENEFITS

Health Insurance:

Blue Cross Healthmate Coast to Coast PPO

BlueChip HMO

No Coverage Option – Employees covered under another health plan may opt out and receive money back on a bi-weekly basis.

Dental Insurance:

Blue Cross Dental - High Plan or Standard Plan (Fellows & Post Doc Fellows only)

Note: All health and dental deductions are pre-tax. For employees' share of premium see rate chart.

No Coverage Option – Employees covered under another dental plan may opt out and receive money back on a biweekly basis. Effective 07-01-05, Psychology Interns are not eligible for dental coverage.

Employee Life and AD&D Insurance:

This is a core benefit, but with the CNE Flex Plan, you can choose the level of protection you and your family need.

Dependent Life Insurance:

You may purchase Dependent Life Insurance for your spouse and/or children by payroll deductions.

Long Term Disability Insurance:

This is a core benefit, but with the CNE Flex Plan, you can choose the level of protection that is right for you.

Dependent Care Assistance:

This program allows employees to use pre-tax dollars to pay for dependent care expenses.

Health Care Reimbursement:

This program allows employees to use pre-tax dollars to pay for medical expenses not covered by insurance.

Pharmacy Mail Order Service:

Employees enrolled in the Medical Insurance Plans can take advantage of a mail order prescription service. A maximum of up to a 3 month supply of drugs for 1 co-payment of most medications can be ordered and sent directly to your home generally within 48 hours of receiving the order.

Health and Wellness:

All benefit eligible employees, their spouses and dependents are encouraged to take advantage of the free Flex for Life programs and resources available through the Care New England Wellness Centers and other locations. Whether you're at home, at work or visiting one of the Wellness Centers, our comprehensive Employee Wellness Benefit is a resource to help you address many health related concerns such as weight loss, exercise and nutrition, smoking cessation, and risk reduction for disease. Continued program expansion will include an offering of new health services and improved access through a wider network of host locations and vendors.

Fitness Benefit:

All benefit eligible employees can save money when they join Healthtrax, the fitness facility located at each of the Wellness Centers. Membership fees can be conveniently deducted from employee's paychecks.

Voluntary Benefits

MetLife Auto and Home Insurance: Special group rates and discounts help you save up to 10% on your auto insurance alone. Plus, you can count on convenient payment options, including payroll / checking account deduction, outstanding customer service, a Guaranteed Repair Program, and valuable coverages for all of your personal property and liability insurance needs.

Veterinary Pet Insurance: With veterinary pet insurance, you can stop worrying about the ever-increasing costs of caring for your pets, because your pets will be covered for more than 6,400 medical problems and conditions, subject to policy terms and conditions.

MetLaw: Provides you, your spouse and eligible dependents with fully covered legal services from experienced attorneys at a low monthly group rate. Coverage includes preparation of wills, living trusts and powers of attorney, court appearances, mortgage document review, real estate matters and much more.

Aflac through Aflac Insurance Company,

Personal Cancer Protector Plan: When a covered individual is diagnosed with cancer, this plan provides benefits directly to you for hospital confinement, radiation and chemotherapy, surgery, among others, over and above what your health plan pays. Aflac also pays benefits for outpatient treatment.

Personal Recovery Plus Plan: Aflac's Personal Recovery Plus plan pays a benefit when a covered individual is first diagnosed as having a covered life-threatening health event such as heart attack, bypass surgery or stroke. Coverage includes benefits for hospital confinement, continuing care, and continuation of coverage. For more information concerning the Aflac benefits, call our rep. Steve Phillips at 401-487-8447.

Long Term Care Insurance – Offered through UNUM. Long term care is defined as the type of care received either at home or in a facility (i.e. nursing homes, assisted living facilities) when someone needs assistance with activities of daily living, or suffers severe cognitive impairment, due to an accident, an illness or advancing age. Long term care insurance is an **optional** insurance available to employees, spouses and family members.

403b/Tax-Sheltered Annuity Account:

Allows you to save additional monies toward retirement with a Pre-Tax Retirement program provided by one of the following three companies: Transamerica, Tiaa/Cref, Voya (formerly ING) Fidelity.

College Bound 529 Plan:

Allows you to save money for higher education expenses through payroll deduction. Fund is administered by Alliance Capital.

Vacation, Sick & Holiday Time Off:

Please refer to your program office for details regarding Vacation, Sick, Holidays, Bereavement Leave, Jury Duty and Military Leave policies.

Parking: Free

B. VACATION, SICK TIME, SNOW POLICY AND LEAVE OF ABSENCE

VACATION TIME OFF

Vacation allocation for fellows employed through Butler Hospital is based on weekdays only. Vacation time is not accrued, but is based on the fellow's academic year beginning July 1st of each year. Fellows are urged to carefully plan out their vacations for the entire year at the start of the academic year so they can use all of the allowed vacation time.

Fellows are allowed up to 4 weeks off throughout the year, inclusive of time off for conference. Only one week can be taken at a time unless there are exigent circumstances and with approval of the program director. Vacation time off must be requested in advance and approved by the site director.

SICK TIME/BEREAVEMENT LEAVE

All extended sick time or leave must be requested in advance from the fellowship training director. The fellow must also file a written leave request as soon as possible. Sick leave in excess of five working days requires a physician note.

All fellows are eligible for up to 3 days of Bereavement Leave over and above all other leave allowances. Bereavement Leave is awarded upon the death of a close relative (parents, grandparents, grandchild, sister, brother, spouse/partner, children, mother/father in law, foster parent or child, or legal guardian) for the purposes of funeral responsibilities.

EXTENDED LEAVE OF ABSENCE

Fellows should discuss all requests for Leave of Absence, whether medical, family or personal, with the Program Director at the earliest possible opportunity. Such requests should be documented in the fellow's file along with final arrangements. The Program Director will notify the Butler Human Resource Office of the leave at the earliest opportunity. The Program Director, with support from the Human Resources office, will advise the Fellow of any impact of the leave time on satisfying the completion of the requirements for training and board eligibility, and any impact of the leave time on pay and employee benefits. The granting of a leave of absence or other time away from the training program does not relieve the Fellow of the obligation to complete all program-specific reappointment requirements.

Extended Leave Specifics

During the fellowship training, absence due to sickness, the birth of a child or family leave for greater than 20 consecutive work days (4 work weeks) is considered extended leave. When extended leave can be anticipated fellows are requested to consult with the training directors to coordinate the absence with their educational needs and requirements.

Snow Policy

- 1) Fellows who are scheduled to be on call before, during or after a weather emergency must plan ahead to make sure that they are present for their shift. This may mean coming to the hospital early or staying with someone who lives closer to the hospital.
- 2) Residents must contact their supervisor and/or Department Head before the start of his/her regular shift, informing them of the reason for being tardy, and when s/he expects to report to work.
- 3) If a person is going to be absent, s/he must contact the supervisor or Department Head at least one half hour before the start of a regular shift, or in accordance with specific department protocol.
- 4) Residents who are absent for two consecutive days without notifying the hospital will be considered as voluntarily abandoning their job.
- 5) Frequent lateness or absence may be cause for discipline and discharge
- 6) In the event of a storm or other community catastrophe, it is expected that residents will make every effort to report to work. Even though all departments are not directly related to patient care, a resident may be needed at such times to assist in other departments where the service must not be disrupted.
- 7) Because of the difficulty in evaluating individual circumstances, the Fellowship Program's procedure in regard to payment is as follows:
 - a. Residents who do not report for work on any day of a storm or other community catastrophe will be charged with a vacation day.
 - b. Residents who are dismissed early by the Hospital because of storms will receive payment for the full day.
 - c. Unless on sick leave, an employee may not call in sick on the day of a storm or other community catastrophe and receive payment for the day.

C. DUTY HOURS

Duty Hours are defined as time spent on all clinical academic activities related to the fellowship program, including patient care at all duty sites (inpatient, outpatient, and in the Emergency Department), administrative duties related to patient care, the provision for transfer of patient care, and include time spent in the hospital during on-call activities, as well as program scheduled activities such as conferences and on site meetings. Duty hours do not include reading and preparation time spent away from the duty site.

1. Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting unless the ACGME and the GMEC have granted an exception to that policy.
2. Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
3. Duty periods of PGY-2 house staff and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
4. Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. It is essential, however, for patient safety and fellow education that effective transitions in care occur. PGY-2 and above trainees may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
5. In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the fellow must:
 - a. Appropriately hand over the care of all other patients to the team responsible for their continuing care.
 - b. Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
 - c. The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.
6. Consultation-Liaison Psychiatry fellows who are at a minimum at a PGY-5 level are defined by the Psychiatry RC to be in the final years of education and must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
 - a. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. There are no circumstances under which trainees in the final years of education may stay on duty with fewer than eight hours off.
7. Fellows must not be scheduled for more than six consecutive nights of night float.
8. PGY-2 trainees and above must be scheduled for in-house call no more frequently than every-third-night when averaged over a four-week period.

9. Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
 - a. Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.
10. In addition to the GMEC process for monitoring duty hours, the fellowship program will include fellow monthly reporting of duty hours.
11. Moonlighting is permitted in accordance with the Institutional Policies on Moonlighting Activities.

D. SUPERVISION

PURPOSE:

To establish a formal supervision that fosters education and facilitates safe care of patients. The program policy must be consistent with the institutional supervision policy and requirements as outlined in the ACGME’s Institutional Requirements and Common Program Requirements that apply to each program.

I. Introduction

The Fellowship Program is committed to:

1. Providing safe and effective medical care to our patients.
2. Providing care within a superior and safe training program which is compliant with ACGME requirements.
3. Providing appropriate levels of supervision to promote progressive autonomy of trainees that is consistent with institutional policies.
4. Providing mechanisms by which fellows can report inadequate supervision in a protected manner that is free from reprisal.

Definitions of Supervision

To ensure oversight of trainee supervision and progressive responsibility, the following classification of supervision levels must be used:

1. Direct Supervision – the supervising physician is physically present with the fellow and patient.
2. Indirect Supervision with direct supervision *immediately* available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision
3. Indirect supervision with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by telephone and/or electronic modalities, and is available to provide direct supervision.

4. Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

II. Policy

1. Each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care.
 - a. This information should be available to all members of the health care team, as well as patients.
 - b. Fellows and faculty members should inform patients of their respective roles in each patient's care.
2. The fellowship program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.
3. Progressive responsibility, conditional independence, and a supervisory role in patient care are delegated to each fellow by the program director and faculty members, based on an evaluation of each individual fellow's abilities.
4. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.
5. Evaluation is guided by specific national standards-based criteria, where available, including (but not limited to) milestones designated for Consultation-Liaison Psychiatry.
6. Faculty members functioning as supervising physicians are expected to delegate portions of care to fellows, based on the needs of the patient and the skills of the trainees.
7. Fellows should serve in a supervisory role of junior trainees in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.
8. Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
9. Each fellow must notify an appropriate supervisor when he/she is unable to carry out clinical responsibility in a timely fashion for any reason (e.g., illness, fatigue, lack of experience or knowledge, clinical workload).
10. In the following circumstances, each fellow must notify a supervising attending:
 - a. Death
 - b. Transfer to ICU or higher level of care; other significant change in patient status
 - c. Change of code status or withdrawal of care
 - d. Medical error or near miss event
 - e. Excessive clinical volume compromising ability to provide safe care

III. Procedures

The descriptions below outline specific supervision responsibilities and practices for each major component of the training program.

Inpatient services:

Attending faculty physicians will provide indirect supervision, with direct supervision *immediately* available to fellows at all times.

Outpatient Services:

Attending faculty physicians will provide indirect supervision, with direct supervision *immediately* available to fellows at all times.

On-call and Weekends/After Hours:

N/A.

Emergency Room consults:

Attending faculty physicians will provide indirect supervision, with direct supervision *immediately* available to fellows at all times.

Research:

If applicable, supervision will be provided on an individual basis by an assigned advisor

Other sites:

Attending faculty physicians will provide indirect supervision, with direct supervision *immediately* available to fellows at all times.

Unique circumstances:

As they arise, but supervision will always be available.

E. MOONLIGHTING

1. Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.
2. Time spent by fellows in Paid on call, Internal and External Moonlighting (as defined above) must be counted towards the 80-hour Weekly Duty Hours requirement.
3. The Program Director is responsible for providing written permission for all paid on call and moonlighting activities and for monitoring the effect of these activities on performance. Monitoring must include the effect of Paid on Call, Internal Moonlighting and External Moonlighting on sleep and fatigue.
4. Fellows must not be required to engage in Paid on Call, Internal Moonlighting or External Moonlighting.
5. J1 visa holders are excluded from participating in Internal and External Moonlighting activities in accordance with the Federal Regulations Governing Exchange Visitor Physician: "Visa sponsorship authorizes a specific training activity and associated financial compensation. Federal Regulations do not permit activity and/or financial compensation outside of the defined parameters of the training program."
6. H1B visa holders may engage in Paid on Call, Internal and External Moonlighting activities, however, restrictions may apply. It is the individual visa holder's responsibility to ensure compliance with immigration laws.

In order to participate in Paid on Call, Internal Moonlighting and External Moonlighting, the following issues must be addressed:

1. Licensure requirements

- Paid on Call is allowed under the Limited Medical Registration (“limited license”) provided by CNE for trainees in GME programs, as the duties are consistent with the training program requirements.
- Internal Moonlighting is not allowed under the Limited Medical Registration (limited license).
- In order to participate in Internal Moonlighting, the fellow requires a full medical license from the State of Rhode Island.
- External Moonlighting activities are not covered by the Limited Medical Registration provided by CNE for trainees.
- In order to participate in External Moonlighting, the fellow must have a full medical license and must obtain an individual DEA number; the assigned DEA number(s) for the trainee designated by any of the CNE Operating Units cannot be used in moonlighting activities in non-CNE facilities.

2. Malpractice:

- The Trainee Malpractice Program extends malpractice coverage to fellows for their program responsibilities.
- The Trainee Malpractice Program extends malpractice coverage to fellows for Program Director approved Paid on Call.
- The Trainee Malpractice Program extends malpractice coverage to fellows for Internal Moonlighting once the following conditions have been met:
- Compensation for internal moonlighting activities is paid by a CNE affiliate’s payroll. Note: if compensation is not through a CNE affiliate payroll, then the fellow should seek malpractice coverage from the employer hiring them for their moonlighting services.
- The fellow applies for permission in writing from the Program Director and the Program Director approves the activity in writing.
- Appropriate licensure is obtained.
- The Trainee Malpractice Program does NOT cover any External Moonlighting activities. Fellows are responsible for obtaining independent malpractice insurance coverage for External Moonlighting activities.

3. Approval/Monitoring:

The Program Director must:

- Provide written approval for an individual fellow to participate in Paid on Call, Internal Moonlighting or External Moonlighting, prior to participation. The attached Moonlighting Request Form may be used as a model for the application and approval process. A written application must be completed and filed in the trainee’s administrative file.
- Monitor and document the impact of these activities on the individual fellow’s performance to assure that factors such as sleep deprivation and fatigue are not contributing to diminished learning or performance, or detracting from patient safety.
- If approval is withdrawn the Program Director must notify the DIO in writing.
- Monitor and document the nature of the clinical activity and the number of hours worked by all fellows participating in Paid on Call, Internal Moonlighting or External

Moonlighting. All time spent in Paid on Call, Internal Moonlighting and/or External Moonlighting must be included in the 80-hour work week limit.

F. FATIGUE AWARENESS AND MITIGATION

The program must:

- Educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;
- Educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,
- Adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

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

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

G. PROFESSIONALISM AND APPEARANCE

Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

- Assurance of the safety and welfare of patients entrusted to their care;
- Provision of patient- and family-centered care;
- Assurance of their fitness for duty;
- Management of their time before, during, and after clinical assignments;
- Recognition of impairment, including illness and fatigue, in themselves and in their peers;
- Attention to lifelong learning;
- The monitoring of their patient care performance improvement indicators; and,
- Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

A professional appearance is expected at all times. This includes professional attire, to include a regularly laundered white coat, as well as proper grooming and hygiene that excludes the use of excessive makeup and perfumes.

H. SOCIAL MEDIA

Purpose

The purpose of this policy is to provide consistent standards for the use of social media outlets, both those hosted by Care New England and its operating units, as well personal sites or other non-CNE outlets where the employee's affiliation is known, identified or presumed.

Definition

Social media is defined as the online technologies and practices used to share opinions, insights, experiences, and perspectives. Social media can take many different forms, including text, images, audio, and video. Social media typically uses technologies such as blogs, message boards and podcasts to allow users to interact.

Policy

This policy and these procedures apply to all staff of CNE and its member organizations. CNE and its member organizations expect that the use of social media by employees will meet certain basic standards and be subject to the restrictions set forth in this policy.

Privacy

Use of any social media (e.g. Twitter, Facebook) that includes any information that is related to any current or former patients or families (named or not named) is considered a violation of Care New England's confidentiality policy and the procedures governing such violations will be followed. Any employee who becomes aware of such uses of work related health information or other confidential organizational information is expected to inform his/her supervisor or the Privacy Officer.

Corporate Compliance

All information published on social media outlets supported by CNE or any member organization must comply with all local, state and federal laws. Users must agree not to infringe upon or otherwise impair, interfere with or violate any copyright or trademark laws, or other intellectual property rights of another. Any user who violates this commitment will be responsible for all liability and other claims resulting from such violation and shall indemnify and hold harmless CNE and its member organizations from any costs, expenses or liability that might be asserted or imposed upon it or any of its officers, agents, or affiliates as a result of this violation.

Advertising/Promotion

Social media outlets are for informational, educational or intellectual presentation without direct advertising or solicitation (for financial gain) other than for organizational purposes. CNE sponsored social media outlets may not be used to promote any non-CNE-affiliated products or services, except through approved links to other sites that are provided for informational purposes. The use of CNE sponsored social media outlets for the promotion of CNE-affiliated products and services must be approved by CNE Marketing. The use of CNE sponsored social media outlets for the purpose of generating and/or promoting academic research must be approved by the Institutional Review Board of the member organization.

Enforcement

Care New England and its member organizations consider any violation of this policy and procedures to be a serious offense that can be the basis for loss of network access and/or other disciplinary action including discharge from employment, removal of medical privileges and/or legal prosecution. Violators are subject to disciplinary action up to, and including, termination of employment.

Best Practices/Code of Ethics

While personal use of such new media is limited at work, our organization acknowledges that these vehicles are part of the communications mix which enables effective information exchange and conversation about our programs and services.

Below are suggested best practices for the use of social media:

- Use a personal email address and not your CNE address as your primary means of identification. Just as you would not use CNE affiliates' stationery for personal purposes, you should not use your CNE e-mail address or any of CNE's electronic resources to blog or to post personal views.
- Treat fellow employees, customers and competitors with respect and professionalism.
- Do not blog, post or make inappropriate comments. If your blog, Internet posting or social networking activities are clearly not appropriate as an employee or representative of a CNE affiliate (i.e., not consistent with the mission, vision and values of CNE, or would negatively impact our brand or reputation), you should not refer to CNE or its affiliated organizations in the posting. If you are about to publish something that makes you the slightest bit uncomfortable, review these guidelines. If you are still unsure, and it concerns CNE affiliates' business interests or health care operations, feel free to discuss with your manager or your Human Resources Representative.
- Be mindful that what you write will remain part of the public discussion for a long time. Care New England staff are personally responsible for opinions shared.
- Try to resolve work-related disputes at work. You are more likely to resolve complaints about work by speaking directly with your co-workers, supervisor or other management-level personnel than by posting complaints in a blog. If you, nonetheless, decide to post complaints or criticism, avoid doing so in a way that is defamatory or damaging to CNE or any of CNE's employees.
- Ensure accuracy and, when possible, link to credible sources that can validate information.
- Take responsibility for errors correct them quickly.
- Employees are advised to set a "privacy" setting such that third parties cannot view CNE's customers and vendors who are included on an employee's social network.
- Do not post on any social media site (whether hosted by CNE and its operating units or otherwise) any material or information that:
 - Violates the privacy rights of another CNE employee, or current or former patient of CNE;
 - Intentionally or inadvertently discloses any CNE trade secret or confidential business information of CNE or any affiliated business entity, or CNE's customers, suppliers or vendors;

- Comments on the future business performance, business plans or prospects of CNE or any affiliated business entity;
- Disparages the competitors, customers, suppliers, or employees or current or former patients of CNE or any affiliated business entity;
- Includes copyrighted materials or other intellectual property of someone other than the employee;
- Constitutes the unauthorized use of trademarks, logos and other branding symbols;
- Uses or displays the logo, graphics, or trademarks of the Company or any affiliated business entity
- Displays false or misleading information about the Company, any affiliated business entity, employee, supplier, or customer;
- Displays any information that violates any other CNE policy;
- Displays any content that purports to represent the position, viewpoint, statements, opinions, or conclusions of CNE of any affiliated business entity, employee, supplier or customer; or
- Violates any law, such as laws that prohibit defamation, harassment, discrimination and retaliation.

The intent of this policy is not to restrict the flow of useful and appropriate information or to prohibit protected concerted activities, but to minimize the risk to CNE, its employees, current and former patients and families, and CNE’s affiliated entities, customers, suppliers and vendors.

I. LICENSURE

All fellows, at the time of matriculation into the fellowship program, are expected to have active, full and unrestricted:

- Rhode Island medical license,
- Rhode Island controlled substance license, and
- DEA license

The fellow is also expected to have successfully passed Step 3 of the USMLE.

J. GRIEVANCES

Policy statement

As the sponsoring institution for the general psychiatry and fellowship training programs in psychiatry, Butler hospital offer as this policy in an effort to strengthen communication and to develop a sound working relationship. There will be no reprisal in any way or at any time against a training for exercising his/her right to follow the grievance procedure.

Purpose statement

While every effort has been made to provide all trainees have equitable wages, benefits and working conditions, questions and concerns can arise. The procedure outlined below is designed to assure that questions at a trainee has about the job or policies are answered promptly and equitably. Questions about academic standing and promotion are covered not covered here.

Scope statement

All trainees are covered by this policy. This policy covers trainee grievances on all rotations and clinical assignments without regard to the location.

Procedure

When a trainee has questions about job or policies, he/she should first see supervising attending. He supervising attending will either answer the question directly or obtain additional information from the appropriate source. In either case, questions will be giving serious consideration and answered within two working days. If the answer received still believes question or if the trainee feels unable to discuss the problem with the supervising attending, the trainee shell contact the program director. If the trainee is not satisfied with the discussion with a training director he/she she'll write down the question or problem and send it or take it to the director of medical education/Designated Institutional Official (Dr. Pat Recupero) along with a request to see the DIO who will review the problem with the trainee within 3 working days. The DIO will be concern or question with appropriate hospital representatives as well as the program director. The trainee may be present during discussion with the program director. The trainee will receive a wouldn't reply with 5 additional working days. An information copy will be forwarded to the program director. If the trainee is still not satisfied with the outcome, he/she should request that DIO forward the written statement to the fellow of Butler Hospital; the DIO will arrange a meeting with the program director, the president, the DIO and the trainee. The trainee is encouraged to present additional information at this meeting if any. The president's decision will be given in writing within 7 days and will be final. When the problem has been resolved, it will be in one to three ways. It may be in the trainee's favor, not in favor, or any compromise. Whatever the decision, it is important that all concerned accept the decision in good grace. It is also important that anyone with a problem should follow this procedure. Never feel it is useless to have a request given fair consideration.

K. SEXUAL HARASSMENT

Brown is committed to promoting a safe, welcoming and inclusive campus culture. It is the responsibility of every member of the Brown University community to foster this type of environment. This requires our community to be able to identify and address prohibited conduct. Prohibited conduct under our Title IX policy includes gender and sexual harassment, sexual violence, relationship and interpersonal violence, and stalking. This type of conduct will not be tolerated.

(<https://www.brown.edu/about/administration/title-ix/index.php?q=policy>)

Updated June 8, 2018