NATIONAL CAPITAL CONSORTIUM MILITARY PSYCHIATRY RESIDENCY

AY 2020-2021 HANDBOOK

Reviewed: 14 April 2021

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# THE NCC PSYCHIATRY PROGRAM

## PROGRAM MISSION

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Background

Mission statements explain what we do, our purpose. Without them, our efforts may be disorganized or counterproductive; with it, all involved individuals understand what we are working to accomplish. This creates a sense of shared vision leading to a shared identity and unity of effort. No matter what your role within the Program, you should attempt to understand how you serve the mission and how you can do so better.

MISSION

*To develop and transform a diverse group of medical students into military officers and physician-scholars who are equipped with knowledge, skills and attitudes as experts in psychiatry, prepared to serve the military, veterans, and the community as healers, and to enable medical readiness of their commanders and military units.*

## PROGRAM AIMS

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Resident and Faculty Wellness

* Promote diversity and create a professional, equitable, respectful, and civil environment that is free from discrimination
* Enable a work climate informed by the Job Characteristics Model (JCM) that emphasizes autonomy and timely feedback
* Support one another in accomplishing goals and performing and living at our highest potential

Leadership

* Integrate mentorship, sponsorship and coaching starting in intern year
* Apply leadership and management skills via *Leading Change* curriculum
* Provide Military unique curriculum including Combat and Operational Stress Course, Traumatic Event Management, and Supervisor Courses, etc. that prepares future Military medical leaders

Clinical Care

* Provide access to diverse patient population across the greater DC area
* Enable autonomy and provide choices in self-directed experiential learning

Scholarship

* Create learning climate to encourage curiosity and critical thinking
* Advance knowledge to reduce military mental health burden and improve military readiness

Education

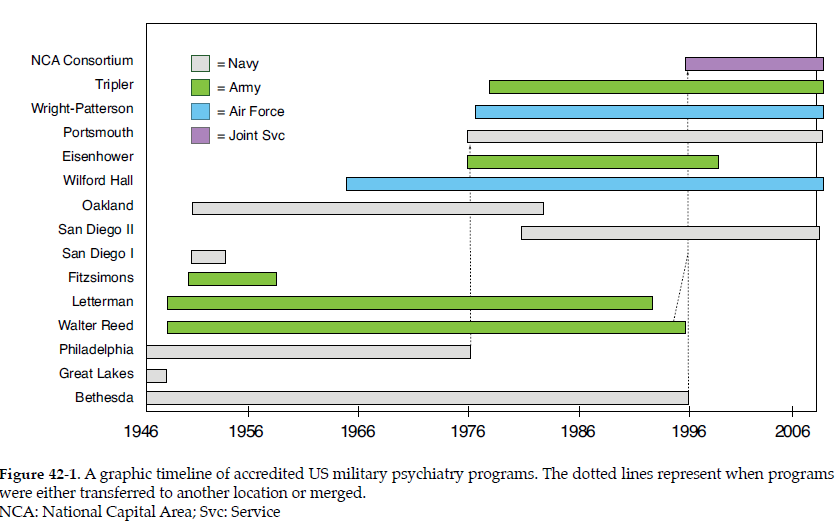
* Organize and create curriculum based on Self-Directed Learning and Adult Learning Theories and Principles to improve -knowledge and skill retention
* Develop faculty in order to support organizational and residency mission and aims

## PROGRAM HISTORY

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* 1946 and 1948 mark the founding of the first Navy and Army psychiatry programs, which are the foundation of our current program
* In addition to being the oldest program for any Service, it is the first and remains the only joint program.





## RESIDENCY OVERVIEW

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Compilation

* 49 Psychiatry Residents (2020-2021)
  1. 13 PGY-1s
  2. 15 PGY-2s
  3. 12 PGY-3s
  4. 9 PGY-4s
* 2 to 3 Medicine-Psychiatry Combined Residents per year
* 173 Faculty

Population served

* Wounded Warriors
* Active Duty
* Retired service members
* Veterans (VA rotation)
* Community members (outside rotations)
* Family Members
* Foreign military and dignitaries
* Congress members and Supreme Court judges
* The President of United States

## ADMIN RESOURCES FOR RESIDENTS

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* Residency Website
  1. <https://www.nccpsychiatry.com>
  2. This resident-maintained site serves as unofficial guidance provided by other residents to help access key information anywhere, anytime
* Psychiatry Residency Handbook
  1. Reviewed and updated yearly ensuring current policies help achieve desired end-states including maximizing resident and faculty autonomy, mastery, and purpose
* DBH SharePoint
  1. <https://www.wrnmmc.intranet.capmed.mil/BehavioralHealth/SitePages/HOME.aspx>
  2. Bookmarking this page for easy access is recommended
* National Capital Consortium GME
  1. Handbook: <https://www.wrnmmc.intranet.capmed.mil/EducationTrainingResearch/GraduateDentalMedicalEducationDept/SiteAssets/SitePages/Home/NCC%20GME%20Administrative%20Handbook.pdf>
  2. SharePoint site: <https://www.wrnmmc.intranet.capmed.mil/EducationTrainingResearch/GraduateDentalMedicalEducationDept/SitePages/Home.aspx>

## KEY PERSONNEL AND ROLE DESCRIPTIONS

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Hold down CTRL and click on a position below to see its description and the individual(s) filling the role:

PROGRAM DIRECTOR

ASSOCIATE PROGRAM DIRECTORS (APDs)

FACULTY

PROGRAM COORDINATORS (PCs)

CHIEF RESIDENTS (CHIEFS)

DEPUTY CHIEF RESIDENTS

CLINICAL COMPETENCY COMMITTEEs (CCCs)

POLICY AND EDUCATION COMMITTEE (PEC)

RECRUITMENT CHAIRS

ACADEMIC CHAIRS

SECRETARY

TREASURER

DIVERSITY AND INCLUSION CHAIR

TRADITIONS AND MORALE CHAIRS

CALL CHIEFS

KNOWLEDGE MANAGEMENT CHAIR

[GRAND ROUNDS CHAIR](#_1pxezwc)

CLASS REPRESENTATIVES

[INTERN ORIENTATION CHAIR](#_2p2csry)

[HAIL AND FAREWELL BANQUET CHAIR](#_147n2zr)

### PROGRAM DIRECTOR

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MAJ Rohul Amin, MD, FAPA, FACP: [Rohul.amin.mil@mail.mil](mailto:Rohul.amin.mil@mail.mil); 301-400-1924

Dr. Amin is board certified in Internal Medicine and Psychiatry. Dr. Amin hearened his medical degree at America’s medical school (Uniformed Services University) in Bethesda, Maryland. He then completed residency in internal medicine and psychiatry at Walter Reed National Militayr medical Center, Bethesda, Maryland. He is now the program director for the National Capital Consortium – Psychiatry Residency Program.

Role Description

* Authority and accountability for the overall program
* The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care

### ASSOCIATE PROGRAM DIRECTORS (APDs)

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(Return to Key Personnel and Role Descriptions)

APD WRNMMC: LCDR John Burger, MD: [john.m.burger6.mil@mail.mil](mailto:john.m.burger6.mil@mail.mil)

APD FBCH: Dr. Elizabeth Greene MD, FAPA: [Elizabeth.a.greene22.civ@mail.mil](mailto:Elizabeth.a.greene22.civ@mail.mil)

APD USUHS: LtCol Alvi Azad, DO, FAPA: [alvi.a.azad.mil@mail.mil](mailto:alvi.a.azad.mil@mail.mil)

Role Description

* Supports and advises the Program Director in all matters as determined by the Program Director
* Leads projects and initiatives as determined by the Director
* Available to take on the role of acting Director as needed

### FACULTY

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* Faculty members teach residents how to care for patients
* They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning
* Faculty members ensure that patients receive the level of care expected from a specialist in the field
* Faculty members provide appropriate levels of supervision to promote patient safety
* Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves

### PROGRAM COORDINATORS (PCs)

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(Return to Key Personnel and Role Descriptions)

Ms. Veronica Lopez: [Veronica.b.lopez2.civ@mail.mil](mailto:Veronica.b.lopez2.civ@mail.mil)

Ms. Jennifer Ramaekers: [Jennifer.l.ramaekers.civ@mail.mil](mailto:Jennifer.l.ramaekers.civ@mail.mil)

Role Description

Program Coordinators manage the day-to-day operations and administrative requirements of the program and serve as an important liaison with learners, faculty and other staff members, the NCC, and the ACGME and ABPN. These individuals work hard to ensure that you are able to do your work. We expect you to be immediately responsive to them and to do what they request of you. They are here to help and both are very open to working with you as needed. We take non-compliance with their requests and instructions very seriously. Please respect them and thank them for the help they provide you!

### CHIEF RESIDENTS (CHIEFS)

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(Return to Key Personnel and Role Descriptions)

CPT Vanessa Freeman: [vanessa.e.freeman2.mil@mail.mil](mailto:vanessa.e.freeman2.mil@mail.mil)

LT Julia Jacobs: [julia.f.jacobs2.mil@mail.mil](mailto:julia.f.jacobs2.mil@mail.mil)

Role Description

### DEPUTY CHIEF RESIDENTS

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(Return to Key Personnel and Role Descriptions)

CPT Andrew Johnson: [andrew.m.johnson157.mil@mail.mil](mailto:andrew.m.johnson157.mil@mail.mil)

LT Thanh Nguyen: [thanh.t.nguyen51.mil@mail.mil](mailto:thanh.t.nguyen51.mil@mail.mil)

Role Description

### CLINICAL COMPETENCY COMMITTEEs (CCCs)

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PGY-1 CCC Members

Dr. John Burger – Chair

PGY-2 CCC Members

Dr. Michelle Hornbaker-Park – Chair

PGY-3 CCC Members

Dr. Elizabeth Green – Chair

PGY-4 CCC Members

Dr. Alvi Azad – Chair

Committee Description

A CCC is the Accreditation Council for Graduate Medical Education (ACGME)’s “required body comprising three or more members of the active teaching faculty who is advisory to the program director and reviews the progress of all residents in the program.”

* Source: ACGME CCC Guidebook with description from ACGME Core Requirements: <https://www.acgme.org/Portals/0/ACGMEClinicalCompetencyCommitteeGuidebook.pdf>

### POLICY AND EDUCATION COMMITTEE (PEC)

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PEC Members

Dr. Rohul Amin – Chair

DBH

Education Department Chair

Clinical Competency Committee Chairs

APDs

CAPS Department Chair

PCLS Service Chief

7W Service Chief

Chief Residents

Deputy Chief Residents

Committee Description

ACGME programs must have a Program Evaluation Committee (PEC) appointed by the program director that functions in compliance with both the common program and program specific requirements. The goal of the PEC is to oversee curriculum development and program evaluations for its respective graduate medical education training program.

Each PEC must be composed of at least two program faculty members and one resident or clinical fellow from the program. Faculty members may include physicians and non-physicians from the core program or required rotations in other specialties that teach and evaluate the program’s residents.

The committee’s responsibilities are to:

* Plan, develop, implement, and evaluate educational activities of the program;
* Review and make recommendations for revision of competency based curriculum goals and objectives;
* Address areas of non-compliance with ACGME standards;
* Review the program annually using evaluations of faculty, residents, and others;
* Document a formal, systematic evaluation of the curriculum at least annually and render a written Annual Program Evaluation (APE), which must be submitted to the GMEC annually in the Annual Program Director Update;

### RECRUITMENT CHAIRS

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(Return to Key Personnel and Role Descriptions)

CPT Katrina Wachter: [katrina.l.wachter.mil@mail.mil](mailto:katrina.l.wachter.mil@mail.mil)

LT Matthew Heller: [matthew.s.heller4.mil@mail.mil](mailto:matthew.s.heller4.mil@mail.mil)

Role Description

### ACADEMIC CHAIRS

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(Return to Key Personnel and Role Descriptions)

CPT Francis Ridge: [francis.o.ridge2.mil@mail.mil](mailto:francis.o.ridge2.mil@mail.mil)

CPT Jane Ma: [jane.ma.mil@mail.mil](mailto:jane.ma.mil@mail.mil)

Role Description

### SECRETARY

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(Return to Key Personnel and Role Descriptions)

CPT Chelsea Younghans: [chelsea.r.younghans.mil@mail.mil](mailto:chelsea.r.younghans.mil@mail.mil)

Role Description

### TREASURER

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(Return to Key Personnel and Role Descriptions)

CPT Isioma “Miracle” Amayo: [isioma.d.amayo.mil@mail.mil](mailto:isioma.d.amayo.mil@mail.mil)

Role Description

### DIVERSITY AND INCLUSION CHAIR

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(Return to Key Personnel and Role Descriptions)

LT Alana Connell: [alana.m.connell.mil@mail.mil](mailto:alana.m.connell.mil@mail.mil)

Role Description

### TRADITIONS AND MORALE CHAIRS

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(Return to Key Personnel and Role Descriptions)

CPT Anna Defrancesco: [anna.c.defrancesco.mil@mail.mil](mailto:anna.c.defrancesco.mil@mail.mil)

CPT Omin Kwon: [omin.kwon.mil@mail.mil](mailto:omin.kwon.mil@mail.mil)

Role Description

### CALL CHIEFS

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(Return to Key Personnel and Role Descriptions)

PGY-1/PGY-2 call: LT Meghan Quinn: [meghan.e.quinn5.mil@mail.mil](mailto:meghan.e.quinn5.mil@mail.mil)

PGY-3/PGY-3 call: CPT Christopher Willis: [christopher.d.willis36.mil@mail.mil](mailto:christopher.d.willis36.mil@mail.mil)

Role Description

The call chiefs are responsible for organizing and publishing the call schedule for each PGY class each academic year. Prior to the beginning of the academic year, the call chiefs work with each class to formulate a schedule for the entire academic year. Once this schedule is completed, it is published to Amion, where it is easily accessible to the residents and staff. The call chiefs will also collect the call schedule for the staff psychiatrists and include this in the published call schedule. Throughout the academic year, the call chiefs will update the call schedule as needed. When scheduling conflicts arise during the academic year, residents should first discuss conflicts/discrepancies with the respective call chief. Some examples of scheduling conflicts include unexpected leave (emergency leave, medical leave) or changes made to the academic year block schedule.

### KNOWLEDGE MANAGEMENT OFFICER

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CPT Kellin Mair: [kellin.k.mair.mil@mail.mil](mailto:kellin.k.mair.mil@mail.mil)

Role Description

### GRAND ROUNDS CHAIR

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CPT Steven Nemcek: [steven.p.nemcek.mil@mail.mil](mailto:steven.p.nemcek.mil@mail.mil)

Role Description

### CLASS REPRESENTATIVES

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PGY-1

PGY-2 – CPT Marcus Hunt: [marcus.j.hunt.mil@mail.mil](mailto:marcus.j.hunt.mil@mail.mil)

PGY-3

PGY-4

Role Description

### INTERN ORIENTATION CHAIR

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(Return to Key Personnel and Role Descriptions)

2020

CPT Andrew Johnson: [andrew.m.johnson157.mil@mail.mil](mailto:andrew.m.johnson157.mil@mail.mil)

LT Thanh Nguyen: [thanh.t.nguyen51.mil@mail.mil](mailto:thanh.t.nguyen51.mil@mail.mil)

2021

CPT Katrina Wachter: [katrina.l.wachter.mil@mail.mil](mailto:katrina.l.wachter.mil@mail.mil)

LT Matthew Heller: [matthew.s.heller4.mil@mail.mil](mailto:matthew.s.heller4.mil@mail.mil)

Role Description

### HAIL AND FAREWELL BANQUET CHAIR

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2020

LT Lan-Anh Tran: [lan.a.tran.mil@mail.mil](mailto:lan.a.tran.mil@mail.mil)

Role Description

## RESIDENT’S RIGHTS

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### Safety

* Residents will take all possible efforts to ensure their own, other staff’s, community, and patients safety
* Clinical information needed by others to ensure continuation of this safety should be given, especially involving mandating reporting and at transitions of care including but not limited to on call work
* Report any hazards or health concerns as soon as possible

### Process Improvements and Research

* Residents will report areas that may be improved to their leadership and provide specific examples and suggestions when possible
* If an area of improvement may possibly impact patient safety, a patient safety report should be submitted and leadership notified to allow more immediate remedy
* Residents are encouraged to participate in process improvement and research to help improve our practices or the knowledge of their fields. Such projects must be approved by the PD and requests should be routed via e-mail

### Terminating Therapy with Patients

* If a patient is considered clinically to be inappropriate for therapy, care may be terminated and providers will make reasonable accommodations to not abandon that patient but give them appropriate resources and notify appropriate command or other elements (at a minimum, the primary care provider) of the termination of care
* Care may be terminated in the following situations or as per approval by the Clinical Leader
  + Not engaging in treatment (no show, not performing work required, etcetera)
  + The patient is disruptive or violent
  + The patient is disrespectful or verbally offensive toward staff or others
* Documentation of the above will be made in the electronic health record

### Personal Cell Phone or E-mail Use with Patients or Other Staff

* Staff are recommended to not provide patients with personal cell phone numbers or e-mail addresses to prevent potential safety issues with missed communications or delayed responses
* The right to provide this to patients resides with the staff. The understanding must be held that the patient may contact the provider at inconvenient times or when the provider is not accessible. The message that the provider has should include to call 9-1-1 or go to the Emergency Department if there are concerns about safety
* Staff must provide means of emergency communication to clinic leadership that may be used to instantly reach them if needed in emergency situations
* Social media use with other staff shall remain professional at all times and not interfere with clinical work
* Social media contact may not be maintained with patients

### Privacy

* Staff shall respect professional and ethical requirements, which protect the patient's right to privacy. Cases shall only be discussed as clinically appropriate discussions. These discussions should never occur in front of patients or non-involved staff
* To ensure appropriate disclosures, follow site, state, and federal laws as well as professional guidance, including performing mandatory reporting
* There will be no tolerance of any infractions, and disregard of these policies may result in disciplinary measures.
* Files and records shall be off-limits at all times to non-staff members. There shall be no exceptions to this rule
* Communications including sensitive or protected health information shall be encrypted

### Physical Spaces

* Clean and neat spaces fostering a positive work environment

### Formal and Informal Counselling

* Supervision includes feedback to improve residents’ ability to achieve their potential and to hold them accountable for deviations from what is acceptable with the hope they will remedy the noted issue(s).
* Such feedback may be issued in formal (written) or informal (verbal) settings

### Recusing Oneself for Particular Evaluations or Treatments

* We make choices for the good of the military and good of the service member, and those can seemingly or really compete. For example, we decide if someone can stay in or not at every appointment.
* Residents may be asked to evaluate fellow residents or otherwise find themselves in situations that pose questions about appropriateness.
* Instead of a black and white policy, residents are empowered to consider each case and recuse themselves if appropriate after discussion with a supervisor.
* When a provider holds multiple roles with a patient, the provider may check for a conflict between guiding principles for these differing roles by performing an American Psychological Association ethical standard 3.06 check by asking five questions:
  + Is there a chance of loss of effectiveness of the professional? If yes, then stop. If no, then proceed to the next step
  + Is there a chance of loss of objectivity of the professional? If yes, then stop. If no, then proceed to the next step
  + Is there a chance of loss of competence of the professional? If yes, then stop. If no, then proceed to the next step
  + Is there a chance of risk of exploitation of the client? If yes, then stop. If no, then proceed to the next step
  + Is there a chance of risk of harm of the client? If yes, then stop. If no, then proceed.
* Always feel free to consult with a colleague and speak with a supervisor to determine the client's best interests and to identify any ethical blind spots.

## RESIDENT’S RESPONSIBILITIES

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### Schedule Changes

* Each resident is responsible for alerting the appropriate scheduling coordinator and supervisor of any changes in his/her schedule. This includes late arrivals or absences.

### Workplace Behavior

* The Residency strives to make this a great place to work and a setting where all residents feel happy (or at least satisfied) to come to work and feel that they are contributing to something important and positive alongside a dedicated and professional staff. We need to ensure our overall culture is not one of cynicism, burdensomeness, and feeling like independent "cogs" in a pointless machine but rather one of hope, gratitude, and thankfulness among a unified team making a difference
* We enculture our work environment every day through our collegiality, professionalism, and work ethic. Most staff work hard and build a positive environment; however, there will remain a vocal and troubled minority who are going to be harder to motivate
* As we attempt to improve our morale and working environment, we are going to note behavior counter to that goal, especially as people are held accountable and struggle with internalizing constructive feedback, which they perceive as threats that lead unconsciously or not to retaliation or disruptive behavior
* Please attempt to discuss with your peers and other staff recommendations for improved communications and performance in a respectful and collegial manner that helps us all achieve our potential; we all have weaknesses that we can work on with honest, constructive criticism
* If you note disruptive behavior that is not professional, this should not be tolerated. Please ask the staff to stop and e-mail the PD, APD, Chiefs, or Deputy Chiefs and your clinical supervisor. This allows leadership to provide feedback and hold people appropriately accountable appropriately. Include:
  + Date and time of the incident;
  + Names of all parties involved;
  + If the behavior affected or involved a patient in any way, the name and medical record number of the patient;
  + Circumstances that precipitated the incident;
  + A factual description of the questionable behavior;
  + Consequences, if any, of the disruptive behavior as it relates to patient care or operation of the facility;
  + Any action taken to try to remedy the situation;
  + Any witnesses to the event.

This is perhaps our most important pursuit to create an enduring, positive environment for all our staff and patients

### Productivity

* All residents will be expected to work assigned hours
* All residents are expected to take lunch as appropriate to their schedules
* Productivity may be discussed with staff as appropriate, but the focus will be on safe and quality care that is reasonable

### Dress Code

* Appropriate clothing will be worn at all times and during clinical duties as per rotation dress codes

### Hospital and Service Specific Rules

* All residents must follow hospital and Service specific rules
* Follow SOPs and consult with leadership when issues arise or to bring up areas of concern or questions
* If you do not know how to proceed, take the time to review relevant sections of the SOP or speak with clinical or Program leaders

### Wellness

* Residents shall maintain their own wellness and alert leadership as needed when their wellness is jeopardized or when illness or distress may impact patient care
* If you become ill or injured, report this to your supervisor as soon as possible
* We operate in drug-free workplaces with staff presenting unimpaired because of illness or substance

### Feedback

* You will be expected to know much upon graduation. These courses are pivotal to ensure you do. If that isn’t happening, please give feedback to help improve these courses moving forward. Teachers are often grateful for feedback. To give feedback, go to…

### Training

* Complete all training requirements on-time or as quickly as possible
* All civilian staff will attend the Cultural Competency Course as soon as possible after checking in
* All staff members must complete site-specific and Service-specific mandated training

### Interactions with Others

* Be an effective communicator as per TEAMSTEPPS principles
* Treat all patients and staff with dignity and respect
* Be professional demonstrating integrity, collegiality, fairness, and commitment to performing at your best possible level
* Communication should be objective, honest, and professional with all
* Disputes with staff or patients should be handled respectfully and professionally. Such communications should occur in person or over the phone, but may occur via e-mail if there is no alternative. If issues arise or disagreement ensues, involve leadership as needed
* Communications will be in English in the workplace

### Business Practices

* Honestly report hours worked and perform those hours in accordance with your position description or statement of work
* Work the schedule approved by the Department Head and Director in consultation with the Clinic Manager
* Complete all documentation as per the SOP on that subject
* Ensure 30 hours a week of clinical care and protect time outside of that use time for work appropriately (templates will be formed to ensure providers have a minimum of 30 hours of direct patient care a week including no-shows and cancellations)
* Alert leadership about scheduling issues as soon as possible
* Schedule changes will be made in writing to the Clinic Manger or Division Officer and must be approved

### Documentation

* Complete notes, including attending signatures, within 3 days (as soon as possible if safety concerns exist)
* Notes should be checked for errors, should not include out of date copy and pasted or unverified information unless denoted
  + Inaccurate documentation or documentation that is placed in the wrong chart should be expunged by contacting the patient administration HIPAA office
* Notes should be clear and concise conveying accurately what transpired, what the assessment was, and what the plan was and what actions were taken
* Fitness for duty should be clearly delineated and accurate
* Write records understanding they may be reviewed by the patient or for legal reasons in the future. The current policy is that records may be released without review to patients from the Patient Administration Department.

# WELLNESS

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Background

We should be proud of directly supporting our country and those that are ready to fight for our freedom, but their well-being is made possible by our own health. More explicitly, our mission accomplishment is made possible by residents and faculty who themselves strive to maintain their own psychological and physical health, even in the face of significant challenges. In doing so, we build healthy habits for ourselves, model for our patients and those around us how we should handle life’s challenges, and may help others gain confidence to seek help when it’s needed. Difficulties arise for us all, and it is more in how we handle them that we are defined than their occurrence.

Topics to explore:

[KEEPING YOURSELF RESILIENT](#_2grqrue)

[WHERE TO REACH OUT WHEN YOU NEED SOME HELP](#_vx1227)

[COMPLETE RESOURCE LISTING](#_3fwokq0)

[MINDFULNESS APPS](#_3fwokq0)

[LEAVE POLICY](#_4f1mdlm)

[FATIGUE MANAGEMENT](#_2u6wntf)

[POST-PATIENT SUICIDE](#_19c6y18)

[FIFTH WEDNESDAYS](#_111kx3o)

[PSYCHIATRY AND THE GOOD LIFE](#_3l18frh)

[TRAINING PSYCHOTHERAPY](#_206ipza)

## KEEPING YOURSELF RESILIENT

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For any number of reasons, our own self-care can easily become compromised in stressful times and situations. If we don’t take time to care for ourselves, we can’t support the people around us who rely on us. Here are some reminders and guides for Caring for You

* *Create a routine*. Routines and patterns and healthy habits provide your mind with a much needed anchor. They help us create predictability. Learn more [here](https://www.blurtitout.org/2018/11/08/mental-health-benefits-routine/).
* *Keep a Gratitude Journal*. An increasing amount of [evidence](https://positivepsychology.com/benefits-of-gratitude/) shows that the simple practice of gratitude (think, glass half full vs half empty) can significantly improve your personal well-being (physical and emotional). Journaling isn’t for you? Here are [5 easy ways to grow your gratitude](https://www.hprc-online.org/total-force-fitness/hope-those-covid-19-frontline/additional-resources/ways-grow-your-gratitude).
* *Practice mindfulness/meditation*. The evidence is clear that meditation improves health, happiness, and success. Check out these [20 positive effects of meditation](https://www.psychologytoday.com/us/blog/feeling-it/201309/20-scientific-reasons-start-meditating-today) - all backed by research. Some examples of available apps are [below](#_3fwokq0).
* *Maintain an exercise routine.* The [NSA Bethesda Fitness Center](https://www.navymwrbethesda.com/programs/69a501a7-7905-4a5c-a331-c1fb1ef99723) has group classes and lots of equipment and space. If you haven’t been there yet, you should check it out. If you prefer to work out alone or at home, you can also check out a [YouTube at-home work out](https://www.pastemagazine.com/health/fitness/the-10-best-fitness-youtube-channels/#fitness-blender) or [download an app](https://www.glamour.com/story/best-free-workout-apps) to get started. Better yet, find a friend to keep you motivated.
* *Spend time outside*. Try to spend time [in nature](https://www.pnas.org/content/112/28/8567.abstract) and/or even just [in the sun](https://www.destress.com/daily-life/outside/the-effects-of-sunshine-on-stress/) to help manage stress. The trails on NSAB can be a quick option or go for a local [hike](https://bethesdamagazine.com/bethesda-beat/news/6-great-hikes-near-bethesda-and-beyond/), run, or bike on the [Capital Crescent Trail](https://www.cctrail.org/), [Bethesda Trolley Trail](https://www.traillink.com/trail/bethesda-trolley-trail/), or the [Rock Creek Trails](https://www.montgomeryparks.org/parks-and-trails/rock-creek-stream-valley-park/rock-creek-hiker-biker-trail/).
* *Prioritize sleep*. Be proactive to [ensure restful sleep](https://www.stress.org/stress-and-sleep-how-to-master-stress-and-enjoy-restful-sleep-instantly).
* *Take a break.* We all need time to recharge, especially when we are in stressful situations or times. Ensure you have a daily aspect of rest, but also take leave to store up our wellness reserve. The [Residency Leave Policy](#_4f1mdlm) explains more.
* *Connect with others*: Meet up with friends and family. If they’re not local, try virtually with Google Hangouts, Zoom, or FaceTime. If you need help with an issue, talk with a friend or family member. There are multiple [resources available to you](#_vx1227).
* *Eat healthfully.*
* Check out some [free military apps](https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Operations/Clinical-Support-Division/Connected-Health/mHealth-Clinical-Integration) to help you maintain your resilience.

## WHERE TO REACH OUT WHEN YOU NEED SOME HELP

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Anxiety and depression can affect anyone. Getting help is a sign strength. Getting help early is a sign of wisdom. There are [numerous resources available to you](#_3fwokq0). When you need help, here are some key ones:

* Your PD, APDs, Chiefs, and colleagues. We truly believe in working through difficulty together.
* USU Counseling Center (<https://www.usuhs.edu/fam/university-counseling-center>)
  + Self-referral therapy and psychiatry appointments (
  + No AHLTA documentation
* Integrative Health and Wellness Service (301-295-0105)
  + Self-referral short term therapy options that focuses on building on existing strengths, can utilize modalities such as mindfulness and meditation.
  + Does document in AHLTA
* Chaplain Services (walk in 0730-1600 Bldg 85T, 301-295-1510, 24 hour pager 202-668-0000)
  + Self-referral support for times of stress.
  + No AHLTA documentation
* Provider Wellness Committee (contact the PWC Chair)
  + Self-referral support for providers at WRNMMC who feel they may have a condition that may impair their ability to optimally provide care.
* Military One Source (<https://www.militaryonesource.mil/>)
  + Self-referral to civilian providers for free short term therapy (typically up to 12 sessions) for active duty members and their families. They also provide marital/family therapy.
  + No ALTHA documentation
* Crisis Text Line (text the word HOME to 741-741)
  + A confidential free texting hotline who can help you problem solve your crisis.
* National Suicide Prevention Lifeline (1-800-273-TALK (8255))
  + The Lifeline provides 24/7, free and confidential support for people in distress and crisis resources for you or your loved ones along with best practices for professionals.

A NOTE ON ACCESS: You can and should always seek care in times of crisis; there is help here for you! Programs are required to allow you to go to doctor’s appointments and have historically been very supportive of you engaging in any and all resources that you need.

## AN ALPHABETICAL LISTING OF RESOURCES

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Here is a quick listing with details for each numbered item immediately following:

1. Addiction Treatment Services
2. Adult Outpatient Behavioral Health Clinic
3. Coalition of Service Members Against Destructive Decisions
4. Combined Managed Equal Opportunity Program
5. Comprehensive Soldier & Family Fitness
6. Emergency Medicine Department
7. Emergency Monetary Relief
8. Family Advocacy Program
9. Fitness Center
10. Fleet and Family Support Center
11. Gratitude and Acts of Kindness
12. Integrated Health & Wellness Services, Mind-Body Medicine
13. Junior Officer Council
14. Leadership Academy
15. Military & Family Life Consultants
16. Military OneSource
17. Mobile Apps (National Center for Telehealth & Technology)
18. MWR Bethesda
19. National Suicide Prevention Lifeline
20. Occupational Health
21. Our People Foundation: Be the Change
22. Outpatient Nutrition Services
23. Pastoral Care
24. Pathway to Excellence
25. Peer Support Program
26. Provider Wellness Committee
27. Public Health/Preventive Medicine
28. Resiliency & Psychological Health
29. Sexual Assault Prevention & Response
30. SMART-R (for GME trainees only)
31. STEPS Forward
32. Three Good Things
33. USO Warrior and Family Center at Bethesda
34. Workplace Violence Prevention Program
35. WRB Facility Dog Program
36. **Addiction Treatment Services-** (WRB, Bldg 7, Floor 4, 301-400-1298) Provide substance-related education, evaluation and outpatient and intensive outpatient treatment individually and in groups, and can coordinate higher acuity ca re when needed. Available to TRICARE beneficiaries, and individuals may be referred or self-refer.
37. **Adult Outpatient Behavioral Health Clinic** (WRB, Bldg 19, Floor 6, 301-295-0500/301-319-6592) A multidisciplinary clinic providing a range of services to adults seeking change, healing, and care. Comprehensive treatment includes evaluation, medication management, and individual, couples and group therapy. Services are provided using various therapy modalities, and are provided by a staff of psychiatrists, clinical psychologists, licensed clinical social workers, nurse practitioners, pastoral counselors and trainees. Available to TRICARE beneficiaries.
38. **Coalition of Service Members Against Destructive Decisions** Providing a support system of peers, while encouraging positive behaviors among service members and providing education on the impacts of bad behaviors. Serves as a resource for service members to support good decision making and leadership development, and fostering a culture of mentorship, leadership and camaraderie to support mission accomplishment. Provides service members within the command and community involvement opportunities and morale building events. Meetings occur the 1st and 3rd Mondays of every month at 1100 hrs in Bldg 19, 4th Floor, Canyon Conference Room 4238.
39. **Combined Managed Equal Opportunity Program** (WRB, Hotline 301-642-4035, <https://www.wrnmmc.intranet.capmed.mil/Programs/CMEO/SitePages/Home.aspx>) Responsible for conducting command climate surveys. Contribute to readiness by supporting and improving DoD civilian equal employment opportunity (EEO) and military equal opportunity (MEO) goals and objectives. Promote positive command morale and quality of life by providing an environment in which personnel can perform to their maximum ability, unimpeded by institutional or individual biases based on federally-protected statuses. Provide training on non-discrimination, anti-harassment, and anti-bullying, facilitating conflict resolution at the lowest appropriate level, provide guidance on resolution strategies and advise service members on formal grievance/redress procedures. Separate military branches also have links to additional branch-specific information and resources, which can be found by including the name of a specific uniformed service and "EEO" in an internet search. See "Equal Employment Opportunity Manager" for information related to federal civilian EEO support available.
40. **Comprehensive Soldier** & **Family Fitness** (<http://csf2.army.mil/>) Designed to build resilience and enhance performance of soldiers, their families, and Army civilians. Provides hands-on training and self-development tools to enhance coping with adversity and help people perform better in stressful situations and thrive in life. Additional resources available for soldiers, their families, and Army civilians are available at ArmyFitOne (<https://armyfit.army.mil>). Army Community Service is available in Bldg 62, 2nd Floor, office 2020, where soldiers and their families, and Army civilians can request resiliency training, team building training, and for volunteer opportunities available.
41. **Emergency Medicine Department** (WRB, Bldg 9A, Floor 1, 301-295-4810) Serves patients with serious injuries or illnesses, and patients needing urgent or emergency medical care, including behavioral health emergencies.
42. **Emergency Monetary Relief** Emergency monetary relief can be requested by military members when unexpected emergencies arise and there is a short-term financial need. Army Emergency Relief (AER) is located in Bldg 62, 2nd Floor, Office 2022 (301-400-1994, <https://www.aerhq.org/>). Navy-Marine Corps Relief Society can be reached in Bldg 11, 151 Floor, Office 118 (301-295-1207, <http://www.nmcrs.org/>). Air Force members can request emergency relief through the Air Force Aid Society (<https://www.afas.org> or at Air Force Base Airman & Family Readiness Centers). Coast Guard Mutual Assistance is available to members of the Coast Guard (800-881-2462, <http://www.cgmahq.org/>). American Red Cross Services to the Armed Forces are also available (877-272-7337).
43. **Family Advocacy Program** (WRB, Bldg 11, Floor 1, Rm 111, 301-319-4087, after hrs 301-312-5531, [usn.bethesda.nsabethesdamd.list.NNMC-FFSC@mail.mil](mailto:usn.bethesda.nsabethesdamd.list.NNMC-FFSC@mail.mil)) Provides a variety of intervention and treatment models to meet the needs of families in reference to child and spouse abuse concerns. The program is designed to address the prevention, identification, reporting, intervention, treatment, and follow-up of child and spouse maltreatment. Victims of domestic violence can work with victim advocates for confidential assistance, safety planning, and referrals to military and civilian support services. Services are available to all, with priority placement available to military families or intimate partners. The Sexual Assault Prevention and Response (SAPR) Program's primary goals are to prevent sexual assault from happening in our community and to support victims when an assault is reported. The SAPR program services are confidential and available 24/7.
44. **Fitness Center** (WRB, Bldg 17, Floor 1, 301-295-2450, [www.navymwrbethesda.com](http://www.navymwrbethesda.com)) Indoor facility has running track, basketball court, racquetball court, volleyball court, pool, cardio and weight equipment, stretching and abdominal training area, spinning studio, and locker rooms. Available free to service members and federal civilians, and available to contractors for a small fee. Group classes have included BodyPump, BodyFlow, BodyCombat, spinning, yoga, boot camp and water aerobics, and are free for active duty and $3 per class for other patrons. Outdoor trails are free for anyone with base access.
45. **Fleet and Family Support Center** (NSA/WRB, Bldg 11, Floor 1, Room 111, 301-319-4087) Available to civilian staff and service members (active duty, retirees, reservists, guard) and families from all branches of service. Offers free programs and services including individual and group clinical counseling, family advocacy, financial planning, crisis response, information and referral, new parent support, transition and employment services, and education on topics such as interpersonal relations, self-esteem, anger management, stress management, conflict resolution, team building, parenting, and suicide awareness.
46. **Gratitude and Acts of Kindness** Empirical evidence suggests that experiencing gratitude and demonstrating kindness can positively affect wellbeing. One study found that writing a gratitude letter and giving it to the person for whom gratitude was felt created a notable increase in happiness and decrease in depression that lasted a month (Seligman, Steen, Park, and Peterson, 2005). Demonstrating kindness towards others was found to have a similar effect, as suggested by another study in which people doing a kind act experienced five to seven hours of positive emotion, and receivers experienced three to four hours of positive emotion (Pressman, Kraft, and Cross, 2015).
47. **Integrated Health** & **Wellness Services, Mind-Body Medicine** - Medical Home (WRB, Bldg 19, Floor 2, 301-295-0105) Focuses on mind-body interactions and how emotional, mental, social and spiritual factors can affect health. Therapists teach scientifically-validated techniques that enhance capacity for self-care, self-awareness, and stress reduction. No referral necessary, and TRICARE beneficiaries may schedule an individual session by calling 301-295-0105. Classes are open to all staff, and are typically held in the America Building or Fitness Center, although non-active duty are charged a small fee for classes at the Fitness Center. Classes include topics such as "Dealing with Difficult People," " Insomnia," "Mind-Body Resiliency Skills," "Mindfulness," "Procrastinate No More," "Take Shape: Weight & Wellness," "Anger Management," and "Train Your Brain for Happiness and Well-Being." See intranet or contact them directly for information on upcoming classes and how to register. Leadership interested in requesting mind-body self-care skills trainings for their staff can contact the MindBody Medicine Program Coordinator (301-319-4960). A relaxation experience is also available to everyone, with zero-gravity chairs and relaxing music, on Mondays from 1100-1400 hrs in America Building, 151 Floor, Shore Conference Room.
48. **Junior Officer Council** (JOC) Provides opportunities for career development through mentorship, leadership and stewardship by fostering an environment supporting personal and professional growth for junior officers across all Services. Meets monthly on the second Thursday in Bldg 5, room 2019 at 1500 hrs.
49. **Leadership Academy** WRB course taught by subject matter experts to develop healthcare professionals into innovative leaders. Available to staff in leadership positions and to up-and-coming leaders throughout the Command. The course is designed to build competency in effective leadership, quality improvement, personnel management and career track progression, the patient experience, resources available to support leaders, topics unique to 2l51 century healthcare, and business optimization. To learn more or register to participate in Leadership Academy, visit <https://www.wrnmmc.intranet.capmed.mil/EducationTrainingResearch/HEAT/SitePages/Leadership%20Academy.aspx>.
50. **Military** & **Family Life Consultants** (For Adults: 301-456-6134/202-536-8081; For Children/Youth: 301-456-4316) Licensed clinical counselors available to military members (active duty, guard, reserve, veterans) and their families to help by providing information and support for relationships, stress management, grief, family dynamics, and healthy coping skills. Capabilities include non-medical counseling, call centers, financial counseling, and referral services. Also provide education necessary to thrive in the face of challenges unique to the military lifestyle. Deliver behavioral health services in flexible formats, including onsite, telephonically, or online.
51. **Military OneSource** ([www.militaryonesource.com](http://www.militaryonesource.com), 800-342-9647) Comprehensive information and support resource for military members (active duty, retired, medically discharged), their families, survivors, and, to a more limited degree, others within the military community at large. Available 24/7 to help military families adjust to frequent moves, deployments and separations from loved ones. Provides free non-medical counseling in person, by telephone, via secure chat or by secure video session. Services also include online webinars, call center consultations, language translation services for documents and telephone interpretation, tax consultation and filing services, health and wellness coaching, financial counseling and legal support, and educational and employment resources.
52. **Mobile Apps** (National Center for Telehealth & Technology)
    1. **BREATHE2RELAX** (stress management t hrough deep-breathing)
    2. **DREAM EZ** (can help diffuse nightmares)
    3. **LIFEARMOR** (self-assessments & learn about PTSD, anger, depression, etc.)
    4. **MINDFULNESS COACH** (practice mindful meditation & live in the present)
    5. **POSITIVE ACTIVITY JACKPOT** (activity to improve mood/thinking)
    6. **TACTICAL BREATHER** (breathing to manage stress response)
53. **MWR** Bethesda ([www.navymwrbethesda.com](http://www.navymwrbethesda.com)) Provides staff with a program of off-duty leisure activities that contribute to quality of life. Their website also contains information about childcare options, a liaison for local schools, intramural sports and other fitness opportunities, food vendors on base, installation lodging, recreational opportunities, and available support services. Additionally, the MWR Tickets and Travel office provides a military discount on tickets to many events, local theme parks and other attractions, and is located in Bldg 2, Floor 1 near the Main Street Food Court in Room 1448 (301-295-0434).
54. **National Suicide Prevention Lifeline** ([www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org), 800-273-TALK) A national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. Committed to improving crisis services and advancing suicide prevention by empowering individuals, advancing professional best practices, and building awareness.
55. **Occupational Health** (WRB, Bldg 7, Floor 2, 301-295-0786) Serves employees with medical surveillance, certification exams, treatment and referral of occupational injuries and illnesses, work area consultations, occupational illness and injury case management, occupational audiology services, clinical consultative services, prevention and health promotion.
56. **Our People Foundation: Be the Change** Our People Foundation is the Command-wide Strategic Plan platform charged with developing, encouraging and supporting WRB staff. All staff members are invited to volunteer, with supervisory approval, in support of initiatives underway to benefit our staff. To learn more about current initiatives and get involved, please attend the monthly committee meeting held the first Thursday of each month, 1130-1230, in Bldg 9, Executive Conference Room 0301.
57. **Outpatient Nutrition Services** (NSA/WRB, Bldg 7, Floor 3, at North Elevators, 301-295-4065) The "Better Body Better Life" Healthy Weight Program is open to all staff, and is held Wednesdays 1500-1630, Thursdays 0800-0930, and Fridays 1300-1430; call to register. Individual consultations with a registered dietitian or exercise physiologist are also available to TRICARE beneficiaries.
58. **Pastoral Care** (WRB, Bldg 8, Floor 1, Room 1329D, 301-295-1510) Fully confidential spiritual support available to active duty and federal civilian staff. Services include pastoral counseling with 100% confidentiality, and pastoral education on topics such as spiritual resiliency, suicide awareness, interpersonal stress, and grief. Duty chaplain can be reached after hours by calling the Command Duty Office at 301-295-4611, and selecting option 4 to have the chaplain paged.
59. **Pathway to Excellence** (P2E) WRB Directorate of Nursing adopted Pathway to Excellence standards as a commitment to being an organization that promotes and sustains a safe, positive and healthy work environment. This is a designation from the American Nurses Credentialing Center that recognizes medical facilities who integrate Pathway to Excellence standards into operating policies, procedures and management practices. Teams of nurses contribute to shared decision-making, well-being, professional development, quality, safety, and leadership to contribute to an overall positive practice environment. Nurses Command-wide may participate in events sponsored by Pathway to Excellence, which are advertised on the intranet banner or by other means.
60. **Peer Support Program** This program is slated to rollout summer of 2018, and coordinates peer support for healthcare providers that is tailored to address the provider's needs, whether from an adverse medical event, compassion fatigue, vicarious trauma or burnout. Peer supporters are trained quarterly on how to provide respectful, non-judgmental, discrete and effective caring support. Providers from all disciplines may volunteer to become a trained peer supporter, and may request peer support, by contacting Healthcare Resolutions at 301-295-5434.
61. **Provider Wellness Committee** (<https://www.wrnmmc.intranet.capmed.mil/cos/ecoms/pwc/SitePages/Home.aspx>) Promotes the wellbeing of healthcare providers by assisting them with identifying and getting treatment for conditions that may impair the ability to safely provide patient care as well as recommend alteration or limitation of clinical practice duties to facilitate treatment and recovery.
62. **Public Health/Preventive Medicine** (WRB, Bldg 7, Floor 5, 301-400-0075/202-352-1596) Protects and improves health through education, promotion of healthy lifestyles, research for disease and injury prevention, and assuring conditions in which people can be healthy.
63. **Resiliency** & **Psychological Health** ([dha.bethesda.ncr-medical.mesg.wrnm-resiliency@mail.mil](mailto:dha.bethesda.ncr-medical.mesg.wrnm-resiliency@mail.mil), WRB, Bldg 7, Floor 5, Room 5307, 301-400-1974) Provide one-on-one resilience coaching to any WRB staff, and encounters are not documented in medical records given they do not involve clinica l evaluation or treatment; rather, they focus on exploring challenges associated with current stressors, coping strategies being used and adaptive strategies to consider. Can also provide support at the team or unit level, such as facilitating discussions of common reactions to stress or traumatic events, pitfalls to avoid, adaptive coping strategies, and available resources for support. Also offer unit climate assessments and training on a variety of topics, including “Stress Management and Relaxation," “Building a Resilient Team," and “Conflict Resolution," among others. Mobile relaxation stations with zerogravity chairs can also be set up for a day within a specific unit upon request.
64. **Sexual Assault Prevention** & **Response** (WRB, Bldg 2, Floor 3, Rm 3268, 301-319-4087/afterhours 301-442-2053) 24/7 Victim Advocate Helpline 301-442-8225; DoD Safe Helpline Victim Assistance 877-995-5247, [www.safehelpline.org](http://www.safehelpline.org), or text 55247.
65. **SMART-R** (stress management/resiliency training specifically for GME trainees during orientation or otherwise) Program developed by the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital and Harvard medical School. Incoming GME trainees receive the 6-hour training during orientation. Some residents and GME staff have been trained up as SMART-R trainers.
66. **STEPS Forward (**[**www.stepsforward.org**](http://www.stepsforward.org)**)** American Medical Association's innovative website designed to support physicians and their staff to thrive in the current health care environment. STEPS Forward contains a variety of information and free CME professional well-being training modules on topics such as 11lmproving Physician Resiliency," “Preventing Resident and Fellow Burnout," "Preventing Physician Burnout," “Preventing Physician Distress and Suicide," and “Creating the Organizational Foundation for Joy in Medicine." The site also provides physicians the opportunity to anonymously take 1-3 minute “Mini Burnout Survey" to see how their workplace stress impact compares against other local physicians in the same field of medicine ([www.stepsforward.org/modules/physicianburnout-survey](http://www.stepsforward.org/modules/physicianburnout-survey)).
67. **Three Good Things** This is an empirically-supported wellness strategy developed by J. Bryan Sexton, PhD, an associate professor and director of the Patient Safety Center for the Duke University Health System. He developed and tested this intervention, called "The Three Good Things," which involves participants reflecting on three positive things that happened to them during the day, after which they briefly allow themselves to experience the related positive emotion (e.g., joy, gratitude, serenity, interest, hope, pride, amusement, inspiration, awe, love). Participants may then share their good things or consider good things others have identified. Research suggests that reflecting on three good things nightly for one week is comparable to benefits from a selective serotonin reuptake inhibitor on reducing depression (Seligman, Steen, Park, and Petersen, 2005).
68. **USO Warrior and Family Center at Bethesda** (WRB, Bldg 83, 4565 Taylor Road, 240-552-9350) The USO mission is to strengthen America's service members by kee ping them connected to family, home and country, throughout their service to the nation. USO is run by volunteers and sustained by charitable contributions of Americans united in a commitment to support service members. Hours of operation are 0600 to 2200 daily. Specific events and programs available can be found on the website (<https://metro.uso.org/bethesda>).
69. **Workplace Violence Prevention Program** ([www.capmed.mil/EmployeeServices/WVP/SitePages/Home.aspx](http://www.capmed.mil/EmployeeServices/WVP/SitePages/Home.aspx)) Provides coordination of resources that prevent and respond to workplace violence within the Defense Health Agency National Capital Region Medical Directorate. Service include education of leadership on workplace violence and prevention, connection with programs addressing work-life balance and wellness, consultation on the evaluation and prevention of workplace violence, and response to workplace violence incidents. Seeks to empower leadership, management, employees and contractors in reporting workplace violence to create a healthy and safe workplace. Staff members are encouraged to report workplace violence incidents, and incident forms and contact information for site POCs can be found on the program website. An immediate crisis should be reported to Base Police at 301-295-1246 or 777. Questions about the Workplace Violence Prevention Program can be directed to the Program Manager at 301-319-3817.
70. **WRB Facility Dog Program** Staff can request a visit from one of the facility dogs to enhance unit morale and provide an opportunity to relax and decompress. Facility dog visits can be requested by calling 301-319-4447 or 301-295-7895.

***NOTE: Resource listing does not constitute any formal endorsement by the Department of the Army/Navy/Air Force, Department of Defense or U.S. Government. This list provides a sampling of possible resources, and is not an exhaustive list of all available services for all***

***employees.***

## MINDFULLNESS APPS

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For wherever and whenever use, here are a number of helpful apps:

* List of [free mental health apps](https://ncgwg.org/wp-content/uploads/2018/04/Resources_-Apps-for-Veterans.pdf) for Veterans and Active Duty
* Calm (Available at [Android](https://play.google.com/store/apps/details?id=com.calm.android&hl=en_US) [Apple](https://apps.apple.com/us/app/calm/id571800810)) - “Sleep more. Stress Less. Live better.”
* [HeadSpace](https://www.headspace.com/) prioritizes providing authentic expertise in meditation infused by the science of meditation.
* The [Five Ways to Wellbeing](https://mentalhealthpartnerships.com/resource/five-ways-to-wellbeing-app/) app helps people improve their well-being through everyday activities

## LEAVE POLICY

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Background

One of the keys to wellness is taking time to rest and rejuvenate oneself and maintain the important relationships and meaning one has outside of work, as that often helps us maintain the meaning inside of work. MAJ Amin favors maximizing leave with the loosest interpretation of the NCC leave policy, which places specific limits. Non-psychiatric rotations may be more restrictive.

Military Leave

Each month, a Service member receives 2.5 days of leave. Leave is accumulated over time. Leave greater than 60 days cannot be maintained and must be used or lost prior to the next fiscal year start (1 October). Military leave is completely separate from ABPN leave regulations. The below is primarily focused on leave from an ABPN and programmatic standpoint. For military Service leave, please speak with a mentor or unit leadership.

NCC Policy

Accrual of annual leave is fixed by Uniformed Service regulations and excess accrual may result in loss of leave. The following policies for trainees hold unless in conflict with the program requirements:

* PGY-1: During the first year, a trainee may be granted up to 14 days of leave.
  + 14 business days (if a day missed is not a working day; e.g., weekends or holidays on most rotations, the day does not count toward the total 14 days). More than one week in a 4 week block must receive prior approval.
* PGY-2 and beyond: During the second and subsequent years, a trainee may be granted up to 30 days of annual leave.
  + 30 business days (if a day missed is not a working day; e.g., weekends or holidays on most rotations, the day does not count toward the total 14 days). More than one week in a 4 week block must receive prior approval.

ABPN recommendations

The ABPN requires that all programs allow **a minimum of four weeks** of leave time (including vacation, sick time, maternity/paternity leave, etc.) during training per year. These four weeks should be averaged over the four-year training period. Leave or vacation time may NOT be used to reduce the total amount of required residency training or to make up deficiencies in training. **Programs must allow a minimum of 6 weeks of time away from training for purposes of parental, caregiver, and medical leave at least once during training, without exhausting all other allowed time away from training and without extending training.** Within ABPN and ACGME policy guidelines, it is up to the program director and the program clinical competency committee to determine whether a given resident has met training requirements or must extend their period of training.

Coverage

Residents on non-elective rotations are required to find a peer to cover them and are encouraged to do so on electives. This is an expected responsibility. We do not want abandoned posts.

Psychiatry Program Policy for PGY1-4

* The Program must abide by the above NCC rules; however, the below are the limits placed by the Program based on ABPN guidance. NCC rules supersede the below.
* Annual (regular) leave:
  + Each PGY year, a trainee is allowed up to 30 days of leave. Only training days (weekends excluded) are counted towards these 30 days. Example: A trainee takes leave from Monday thru Sunday on a rotation without duty days on the weekend. It is counted as 5 days away from training because Sat and Sun are non-training days.
  + No leave is authorized during medicine wards or medical ICU, outside emergency.
  + No more than 5 training days may be missed from a typical 4-week rotation block. Exceptions such as longer OCONUS leave must be approved by the program director.
  + All trainees are required to get approval from clinical supervisors before submitting their leave for approval.
* Medical Leave of absence: includes any medical conditions or parental leave
  + A total of 6-week parental leave is authorized over the course of the entirety of the residency that will not result in training extension. This permitted 6-week period may be taken all at once or in smaller chunks. This will not count towards the annual leave.
  + Maternity leave: Up-to 12 weeks of maternity leave is authorized IAW military Service policies. Only training days (weekends excluded) will result in training extension.
    - Examples:
      * First pregnancy during the residency: The trainee takes a total of 12-week maternity leave. She uses the 6-week, one-time allowance. The remaining 6 weeks equate to 30 days of training days. Therefore, the trainee is extended by 30 days. If the trainee misses any required training such as medicine, geriatrics, neurology etc., she will need to make that up during her remaining training.
      * Second pregnancy during the residency: Having expended the 6-week allowance, this trainee is already extended by 30 days from her prior pregnancy. If she takes 12-week maternity leave, this will equate to 60 days of training days and extension. Now, the trainee is 90-days off-cycle (30 day extension from pregnancy #1 and 60 day extension from pregnancy #2). 90 day lead is the maximum before a trainee is unable to take their ABPN boards that year i.e. the trainee must graduate by 30 September in order to be eligible to take the boards.
  + Paternity leave: The trainee may take the maximum paternity leave authorized by their military Service. Based on the 6-week parental leave allowance, this leave will not result in training extension, as long as the cumulative parental leave taken by the individual does not go over the 6-weeks over their entire residency training. Any additional missed days for paternity leave beyond 6-weeks will result in training extension by counting training days missed, excluding non-working days (e.g., weekends and holidays).
  + Other medical leave of absence: Up to 6-week of leave over the course of the residency is authorized without any training extension. Any leave beyond this will result in training extension based on training days missed from the program i.e. weekends are excluded.
* Administrative absence from training: a trainee who may not be able to train due to administrative issues such as failed physical fitness or body weight, losing security clearance, or any other administrative or legal reason will be extended 1:1 for each missed day of training and weekends will be included. This type of absence is treated like a “pause” on training rather than being on leave. Therefore, the trainee resume where they’d left off prior to the leave. The 6-week allowance by ABPN/ABMS does not apply to this.

Trainees may use the online calculator location at <https://www.timeanddate.com/date/dateadd.html> to determine their training extension.

## FATIGUE MANAGEMENT

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Background

Fatigue decreases judgement and attention, which can lead to tragic consequences. We mandate that residents and faculty be sufficiently rested to safely perform their duties and prevent accidents.

What to do if you are too tired

**Per the ACGME CLER Brief:**

* Fatigued providers can place patients at risk for medical errors and also jeopardize their own health (e.g. car accidents, burnout, etc.).
* Fatigue management is about both patient safety and provider well-being.
* “Fatigue” can also be a precursor to burnout or a marker for depression.
* Many factors can contribute to fatigue beyond total hours worked, including task or mental overload due to high-volume or high-acuity patient activity, circadian rhythm disruption, chronic sleep deficit, and non-work-related activities.

**What to do if you feel fatigued:**

1. Residents who are sufficiently fatigued to potentially impair their ability to perform should transfer clinical responsibilities to another resident or attending.
2. Notify your team and direct supervisor (e.g. resident, attending physician) that you are experiencing fatigue. Please communicate with your team about your fatigue level frequently so proactive steps may be taken to prevent fatigue from impairing patient safety.
3. Notify the Chief Residents that you are expecting significant fatigue, including plan (e.g. nap in call room, leave after clinical duties are finished and prior to sign out to sleep, late arrival) and when you expect you will be ready to return to work
4. If you feel too fatigued to safely travel home, call rooms are available:
   1. Room 7060🡪 7061 and 7059
5. If for any reason, a resident feels too fatigued to work but is uncomfortable approaching their team or their supervisor, they should reach out directly to the chief residents, an associate program director or the program director to help mitigate the situation and ensure resident well-being and patient safety.

**Additional Resources:**

* **ACGME CLER Brief:** <https://www.acgme.org/Portals/0/PDFs/CLER/CLER_Issue_Brief_FATIGUE_FINAL.pdf>
* **LIFE Curriculum:** 24 minute video about resident fatigue <http://med.stanford.edu/gme/duke_life/fatigue.html>
* **The SAFER Training PowerPoint** is a set of slides by the American Academy of Sleep Medicine for medical residents on recognizing and managing fatigue.
* This **Video on Residency Fatigue and Alertness** in Our Educational System by Dr. Kingman Strohl is a 40 minute talk on the scientific, educational and legal issues of impairment of residents: <https://www.youtube.com/watch?v=E9-JZ7umaRU>

**ACGME Program Requirements for fatigue management:**

<https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf>

VI.D.1. Programs must:

* VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)
* VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, (Core)
* VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)
* VI.D.2. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)
* VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)

## POST-PATIENT SUICIDE

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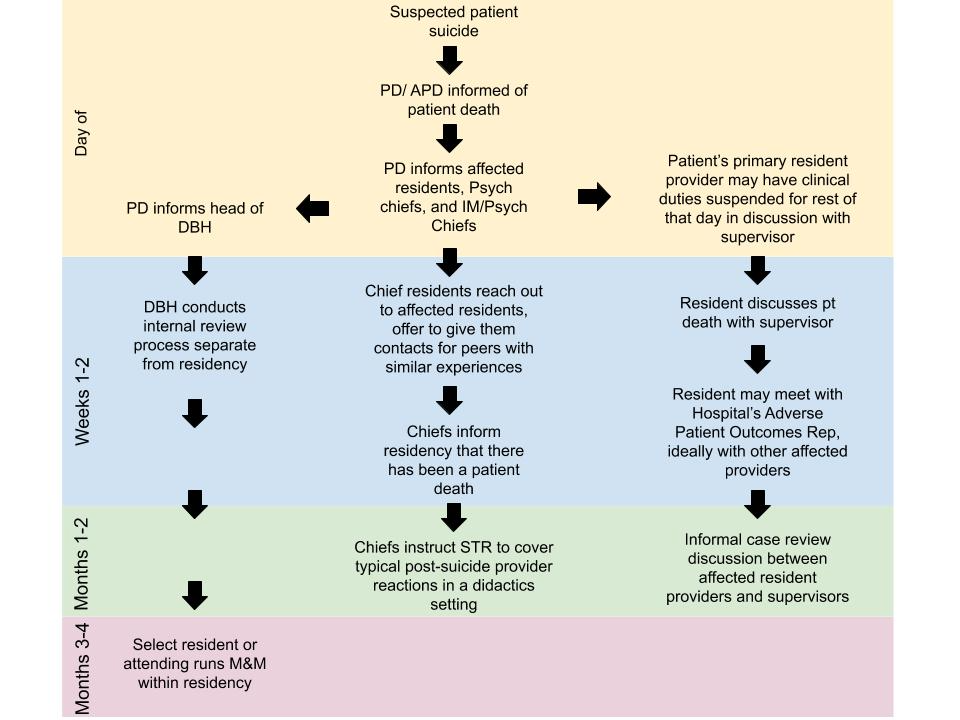
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Background

* Suicides are tragic but possible eventualities despite the best care possible
* Patients remain autonomous beings with the ability to make decisions we wish they did not and negatively impact many, including their providers
* As a residency, we are proud of the help we provide, but we must realize that tragic events sometimes occur despite our efforts. We need to support each other during such times

Default Process

* At any point, affected residents can **opt out** of the below default process.



Notification of Leadership

* If you hear about a suicide, please notify a PD or APD and your clinical supervisor
* Refraining from spreading this information beyond leadership will prevent an affected staff member from hearing in a less than ideal manner and also respects that staff members ability to remain anonymous in subsequent events
* Leaders will make every effort to immediately notify the affected staff

Affected Resident Notification

* After a suicide, the residents involved will be notified as soon as possible by appropriate leadership
  + If multiple residents are involved, individual notifications will be the presumed default
  + The guiding principle will be notifying residents that were the most involved to the least involved and most recently involved to most distantly involved as much as possible
  + Delays should not be made in notification
  + Available and appropriate information will be shared with the residents along with resources

Supporting Affected Residents

* Involved and affected residents most directly impacted may:
  + Have any remaining patient care or other responsibilities for that day cancelled with other staff covering necessary duties
  + Remain at work to complete administrative duties;
  + Take sick leave for the remainder of the day, if approved by appropriate leadership;
  + Seek counselling available at work; or
  + Continue patient care
    - While residents with direct patient care are recommended to take time to process their emotions before resuming patient care, the decision to do so will be at their discretion unless they seem impaired
  + Be offered to be put in touch with residents/fellows with similar experiences
* Counselling and support may be received by Fleet and Family Counselling, the Chaplains Office, the Social Work Department, or supervisors/peers as appropriate and able
  + Where able, supervisors will contact the above resources and present their availability to the involved residents
  + If multiple residents are involved, resources may be arranged to be available at a time and date of supervisors’ choosing with time afforded for affected residents to receive counselling

Notification of Others

* Predominantly involved residents will be afforded the opportunity to make decisions about how much information is released about their involvement in the case
  + The presumption is that they will not be named or otherwise identified
  + Uninvolved residents are encouraged not to identify involved staff in order to respect their wish to remain anonymous

Review of Care

* There are two separate review processes
  + 1) A staff member will be identified by the Director for Behavioral Health to review the electronic medical record to ensure that the national standards of care were met
    - This step will occur after every suicide and may occur for other events at the discretion of the Director or Department Chief
    - This information will be disseminated at the discretion of the Director to those they deem needing to know
  + 2) A review will be made in order to present the case as an opportunity to evaluate best practices, seek lessons learned as a system, and to improve future care
    - Guidelines will be provided at these presentations to focus on lessons learned and possible improvements and to remain respectful
    - Individual providers will not be made to defend their actions and no blame is to be projected toward any named or implied individual, although discussions of areas for improvement and standards of care may be expected to occur
    - Primary involved residents whose interactions with the patient may be highlighted in the presentation may make several decisions regarding this process
      * They may choose to remain anonymous throughout this process including in the presentation itself as much as is practicable
      * They do not have to participate or attend such presentations
      * They may be afforded opportunities to add comments at designated parts of the presentation
      * Primary providers and staff, as determined by their supervisors, will be afforded the opportunity to review the above presentation and speak to the person reviewing the case prior to the presentation
        + The goal of this is to allow them to understand the process and what is going to be presented as well as provide amplify information not found in the electronic medical chart
        + These staff may choose to not be involved at all with the review or presentation, at their discretion
* Any process improvements will be applied for future care

DODSER

* BUMED Instruction 6520.2 states that "Suicides and suicide-related behavior shall be reported as per reference (b). The Department of Defense Suicide Event Report (DoDSER) shall be completed for all suicide attempts [and suicides per NAVADMIN 122/09] by Active and Reserve Component Service members, as determined by competent medical authority, within 30 days of medical evaluation."
* OPNAV INST 1720.4A states that “Suicide attempt DoDSERs shall be completed by the military medical provider at the facility responsible for the member's psychological assessment or (if assessment occurs at a civilian facility) by the Military Treatment Facility (MTF) responsible for the TRICARE referral or by the RC command medical representative (for RC not on active duty)."

## FIFTH WEDNESDAYS

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## PSYCHIATRY AND THE GOOD LIFE

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## TRAINING PSYCHOTHERAPY

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Background:

The instrument of therapy is our own ability to navigate the psyche of others and to help them heal and grow. As with all instruments, the precision and accuracy is important both in correctly interpreting inputs and in providing the correct intervention. To this end, training psychotherapy is a dedicated time to help explore, understand, and work to improve cognitive biases or personal issues that may impede your therapy work with patients, which is a critical part of our profession. This is not intended as a treatment, as if you are ill-equipped, but to solidify and strengthen your abilities. This is a significant financial investment in your abilities, and we intend for all trainees to participate, but the program is strictly voluntary.

Confidentiality:

These sessions are strictly confidential. Program leaders know who the training psychotherapists are to ensure they are able to be compensated for their work; however, we do not reach out to them to request information or to speak about you. These sessions are not placed in AHLTA and records are kept per the clinicians’ typical practice. They likely will give you confidentiality statements regarding mandatory state reporting requirements (i.e., safety requirements).

Limits:

You may only use providers contracted with DBH. You are authorized 100 sessions. Current DBH guidance requires prior approval for more than once a week. If you use a non-contracted provider, go over 100 sessions, or have sessions more than once a week without prior approval, you are financially responsible for those sessions.

Timing:

Given the structured framework of your PGY-3 year, this is an ideal time to build a weekly appointment into your schedule. We recommend contacting a therapist late in your PGY-2 year to setup a start time that works for you and your training psychotherapists.

Approved Providers:

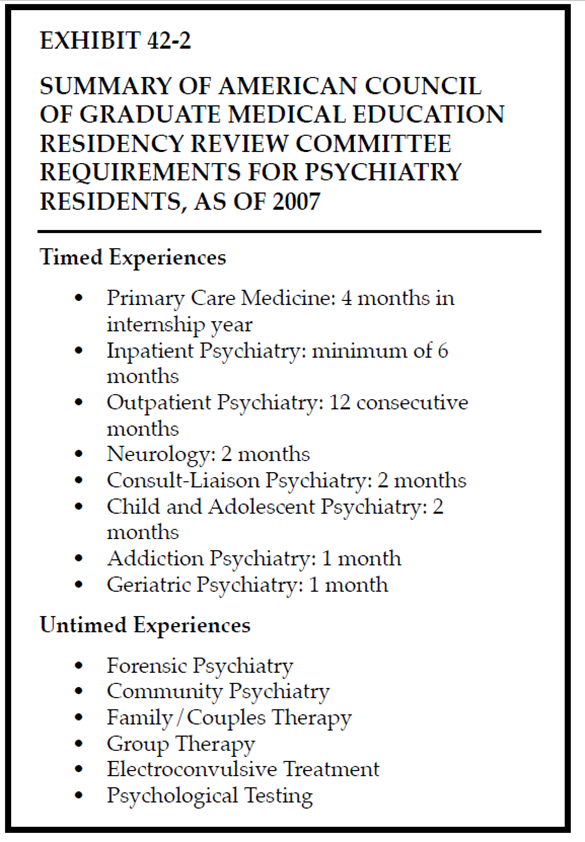
A list of approved providers may be found at: [INPUT SITE HERE]

# GRADUATION AND CERTIFICATION REQUIREMENTS

## ACGME REQUIREMENTS

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* The American College of Graduate Medical Education governs residencies. They publish requirements for each residency through a specialty-specific Residency Review Committee.
* Specific requirements of the Psychiatry RRC include:
  1. The educational program in psychiatry must be 48 months in length
  2. Managing and treating patients using both **brief** and **long-term** supportive, psychodynamic, and cognitive-behavioral psychotherapies.



* Further Program Requirements can be found at: <https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_Psychiatry_2019.pdf?ver=2019-08-26-134127-827>

## ABPN REQUIREMENTS

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* Be a graduate of an accredited medical school
* Complete all training in either a U.S. program accredited by the ACGME or approved by the ABPN
* Have an active, full, unrestricted medical license
* Have satisfactorily completed the Board’s specialized training requirements
* Apply online and submit an application through ABPN Physician Folios
* For more information, visit <https://www.abpn.com/faqs/>

ABPN Training Requirements

* All applicants seeking certification in psychiatry must successfully complete three clinical skills evaluations (CSVs)
* The ABPN Psychiatry Core Competencies, which are the specialized training requirements, can be found at: <https://www.abpn.com/wp-content/uploads/2015/02/2011_core_P_MREE.pdf> (this site is a reference for rotation and didactic objectives below)

PRITE

* To assess personal strengths and weaknesses in knowledge to allow focused study
* To gauge likelihood of passing ABPN Board exams at the end of graduation

## MILITARY SPECIFIC REQUIREMENTS

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The DoD has standardized what KSAs are required by specialty. The below are for psychiatry.

* Active Unrestricted License (Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO). Board Certified, or Eligible, by the American Board of Psychiatry and Neurology (ABPN). Fully privileged at Medical Treatment Facility (NMRTC) prior to deploying)
* Demonstrates knowledge of Combat and Operational Stress Reactions (COSR)
* Demonstrates proficiency of:
  1. Mental Health Triage
  2. Assessment, diagnosis, and treatment of psychiatric/psychological disorders
  3. Basic Life Support (BLS)
  4. Disaster mental health management for units, teams, and individuals
  5. Suicide risk assessment and mitigation planning of persons at risk for harm to self/others
  6. Short-term problem-focused and supportive psychotherapy
  7. Provide oversight of multidisciplinary behavioral health treatment team
  8. Coordination of mental health with primary care
  9. Command consultation and liaison
  10. Behavioral Health Unit Needs Assessment
  11. Assessing fitness for duty, suitability, and use of waivers in theater as appropriate
  12. Psychiatric medication management
  13. Crisis response and safety planning
  14. Identifying substance and intoxication
  15. Identifying Potentially Concussive Events (PCE) and Mild traumatic brain injury (mTBI)
  16. Describing processes and procedures of utilizing tele-behavioral health in theater
  17. Provide staff education, mentoring, supervision, and peer to peer support
  18. Disposition and evacuation of psychiatric casualties
* Demonstrates proficiency with: Triage, treatment, and management of chemical, biological, radiological, nuclear, and high-yield explosives (CBRNE) exposure

## NCC PSYCHIATRY SPECIFIC REQUIREMENTS

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* The above guidelines have been used to create the below requirements per year group
  1. Graduation requirements without a stipulated timing are listed under the PGY-4 year.
  2. Each year, the following are required:
     + 1 passing CSV (2 during PGY-4 year)
     + Minimum 70% didactic/conference attendance
     + Scholarly activity participation
     + Maintain and update ILP
* PGY-1
  1. 1 month Neurology (of the 2 required months, 1 month must be as a PGY1 or PGY2)
  2. 4 months inpatient Internal Medicine
* PGY-2
  1. There are no stipulated PGY-2 rotations
* PGY-3
  1. 12 months outpatient psychiatry including the following cases:
     + Pharmacotherapy
     + Cognitive therapy
     + Long term individual psychotherapy
     + Group Psychotherapy
     + Family therapy
     + Couples therapy
  + Obtain DEA license
* PGY-4
  1. Minimum Required Rotations for Graduation (not captured elsewhere)
     + 48 months Total
     + 1 month Neurology (of the 2 required months, this accounts for the other)
     + 6 months inpatient Psychiatry (no more than 16 months)
     + 2 months CL Psychiatry
     + 1 Senior Teaching Resident (STR)
     + 1 month Geriatric
     + 1 month Addictions
     + 2 months Child (1 month via the 1/2 day in CAPS over a year (24 days))
       - Child/adolescent evaluation (six cases)
       - Grade school/latency evaluation (one case)
* Other
  1. 1 Grand Rounds presentation
  2. 1 QI/PI project
  + Evaluation of forensic issues (sometime during residency) including 1 706 Evaluation
  + Emergency psychiatry exposure (sometime during residency)
  + Community psychiatry exposure (sometime during residency)

## CLINICAL SKILLS EVALUATIONS (CSVs)

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General Guidance

* APBN guidance is found at <https://www.abpn.com/wp-content/uploads/2015/01/CSE-Psychiatry-2017.pdf>
* Three successful evaluations with three different patients are required
* Upload completed CSV evaluation forms into MedHub once completed

Patient Selection

* The patients must be unknown to the physician; the physician must not have seen or examined the patient previously
* Translators are not acceptable

What Is Being Assessed

* The ABPN requires that physicians demonstrate mastery of the following three components of the core competencies:
  1. Physician-patient relationship
  2. Psychiatric interview, including mental status examination
  3. Case presentation
* All three competency components are to be assessed in the context of a patient evaluation that is conducted in the presence of a psychiatrist currently certified in psychiatry by the ABPN. (Videotaped interactions, simulated/standardized patients, or live video streaming cannot be used as the basis for the evaluation)

Evaluators

* At least two of the evaluations must be conducted by different ABPN-certified psychiatrists
* Clinical Competency Committee Members are required to be ABPN-certified, so these lists can serve as eligible faculty

Timing

* In-residency evaluations may be administered at any time during residency training
* Verification of successful completion of the clinical skills evaluations must be submitted to the ABPN by July 31 of the year of the examination

Evaluation Forms

* Evaluations must be completed on ABPN-approved forms
  1. Psych CSV v1: <https://www.abpn.com/wp-content/uploads/2015/01/ABPN_CSV_form_v1.pdf>
  2. Psych CSV v2: <https://www.abpn.com/wp-content/uploads/2015/01/ABPN_CSV_form_v2.pdf>

Passing Criteria

* The individual evaluator will determine if the physician performed acceptably on each of the three competency components. An acceptable score is required for all three components to be overall passable. Regardless of when during training a resident takes the evaluation, the standard for acceptable performance is that of a competent practicing psychiatrist
  1. Physician-Patient Relationship: The physician must develop rapport with the patient, respond appropriately to the patient, and follow cues presented by the patient.
  2. Psychiatric Interview: The physician must obtain sufficient data for formulating an acceptable differential diagnosis; obtain psychiatric, medical, family, and social histories; screen for suicidal and homicidal ideation; use open- and close-ended questions as appropriate; and perform an adequate mental status examination.
  3. Case Presentation: The physician must present an organized and accurate history and an organized and accurate summary of the mental status findings.

Overall Attempts and Required Completions

* A physician may take each of these clinical skills evaluations multiple times
* Multiple attempts do not affect the physician’s admissibility to the ABPN certification examination

Prior to approval of an application for certification, the ABPN requires attestation of successful completion of three clinical skills evaluations from the residency program director. Documentation must include a statement that the physician performed acceptably on three clinical skills evaluations, and must include the full names of the ABPN- certified evaluators and the exact dates of the evaluations. The uploaded evaluation form in MedHub will be part of a resident’s training file and will be used for this purpose

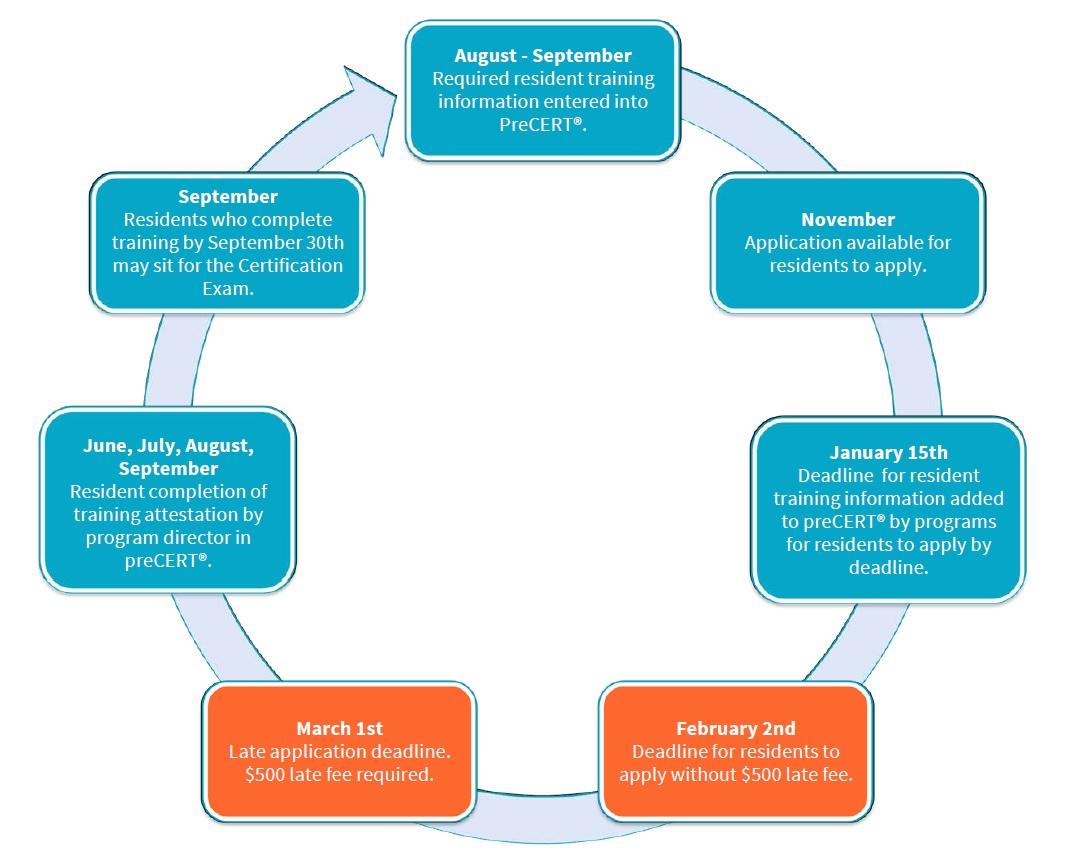
## BOARD EXAMS

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Background

Licensing and privileging entities require continuing medical education after obtaining initial privileges for good reason, as the pace of changes within the medical field are rapid and sometimes transformative. For this reason, the Department takes this seriously and although this is responsibility of each individual provider, it will strive to provide relevant and up-to-date information to aid in this endeavor. Staff should feel comfortable bringing up requests for specific topics and helping when able bring in relevant resources they are familiar with as approved by the Department leadership

Timeline for Applications for Specialty Certification



## STATE LICENSING

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The following is a paraphrased e-mail from one of the interns to their class.

As you may already be aware, Navy interns need to apply for an unrestricted medical license upon completion of PGY1 year. Army residents need to do so by the end of PGY2 year. For current interns, the process can be started, but it cannot be completed until after graduation in June.

It is up to each individual to select the state in which they want to apply for a license. To work at an MTF, you can practice with an unrestricted license from any state. The only caveat to be aware of when applying is that you cannot apply for a license in a state that requires 2 years of PGY training or that requires completion of residency. In addition, the state license cannot be a military-specific license, which is limited.

The other determining factor is cost. Applications vary in cost state to state. Some states require both application fees and licensing fees. Please see below for a spreadsheet compiled by an intern at Tripler that compares cost and training requirements. Please use this as a starting point; you should visit each state’s individual website to verify their application process and fees. You can also look at the Federation of State Medical Boards (FSMB) website (https://www.fsmb.org/step-3/state-licensure/#AZ) to review the training requirements and find each state medical board’s website and contact information.

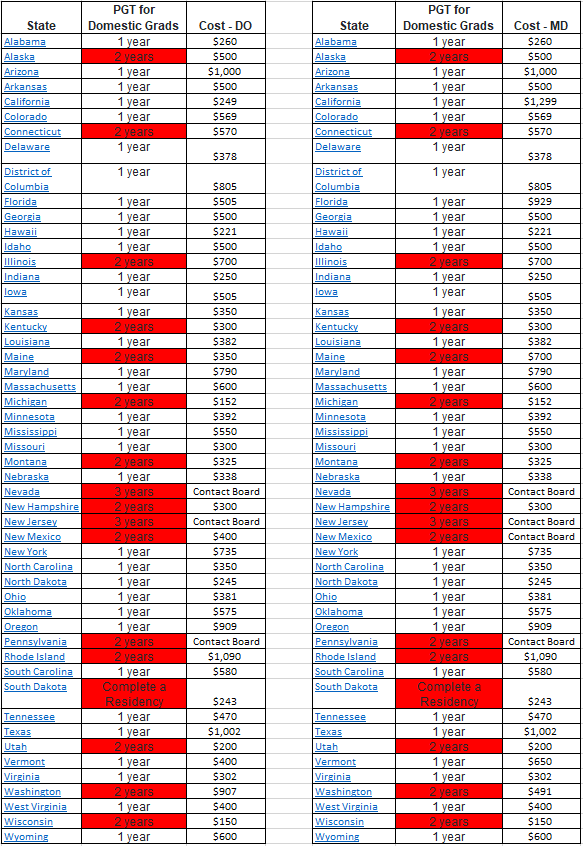
Another thing to keep in mind is that if you plan to moonlight as a GMO/FS/UMO, you will need a license for that state. This may be relevant for those going GMO who are already in correspondence with the detailer and have an idea about where they will be PCSing after this year.

You may also want to look into the IMLCC (Interstate Medical Licensure Compact), which streamlines the process to apply for licensure in multiple states (https://www.imlcc.org). There are 29 states plus DC that currently participate in this Compact. In order to apply, you must first hold an unrestricted medical license in a state that is part of the Compact.

If you have no idea where to start, Virginia has been a consistently popular choice in past years due to low price and proximity.

Lastly, after completion of licensing process, trainees should email Mr. Harvey in GME for submission to CCQAS (credentialing database) and subsequent application for a DEA number.

Please reach out with any questions!



## DEA LICENSING

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## GOVERNMENT TRAVEL CARDS AND DEFENSE TRAVEL SYSTEM

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[**https://www.nccpsychiatry.com/gtcc**](https://www.nccpsychiatry.com/gtcc)Follow the steps at this website.

**10 Steps to Obtaining your GTCC:**

1.      Please review the below attachment (**GTCC Application Presentation**) for applying. Then go to the website: www.citimanager.com/login



 2.      Select: (Under New Users): **Apply For Card**

3.      Select: Invitation Pass Code then click Continue

4.      Please use the following link and passcode to apply.

Passcode:  **WRNMMC**

The Inviter’s Email Address is:  [**karin.m.pollock.civ@mail.mil**](mailto:karin.m.pollock.civ@mail.mil)

**5.      Fill in all required blanks**

6.      Enter your supervisor’s email address for APPROVER1: **Program Director (**[**rohul.amin.mil@mail.mil**](mailto:rohul.amin.mil@mail.mil)**) (301-400-1924)**

7.      **Fill in all required blanks**

8.      Then **load the SoU and Travel 101 Certificate (good for 3 years) into the application**

To upload the **SoU and Travel 101 Certificate** within the application click on **View Account Documents** (at the bottom of the last page of the application next to the word submit)

\*\*\*\*If you fail to load the SoU and the training certificate into the application or list anyone in the travel office as approver1 then the application will be rejected requesting correction.

 9.      You will receive your card in the mail **(Please look out for a white envelope in the mail for government credit card). It will look inconspicuous and very generic (like spam mail).**

10.  Once you have received your governmentCredit Card:

        Call the number on the back of the card to confirm receipt and to **activate the card**.

        **You must let the travel office and Program Coordinator know when you have received your GTCC.**

        DTS office will need the following information in order to update your DTS profile:

1. **GTCC Number**
2. **GTCC Expiration Date**

\*\*\*\*\*\*\*If the card simply needs to be transferred under Walter Reed then you will email the SoU, training certificate, your full SSN  and GTCC card number with the expiration date to the travel office in an encrypted email.  You will need to let the travel office know in the body of the email that you have a GTCC that needs to be transferred under Walter Reed.

 If there are any questions or assistance is needed, please contact Ms. Lopez or Ms. Pollock (information below).

Karin Pollock

Defense Travel Office

Walter Reed National Military Medical Center Bethesda

(301)295-5132

[karin.m.pollock.civ@mail.mil](mailto:karin.m.pollock.civ@mail.mil)

To be added to the Defense Travel System (DTS), send Ms. Lopez the following:

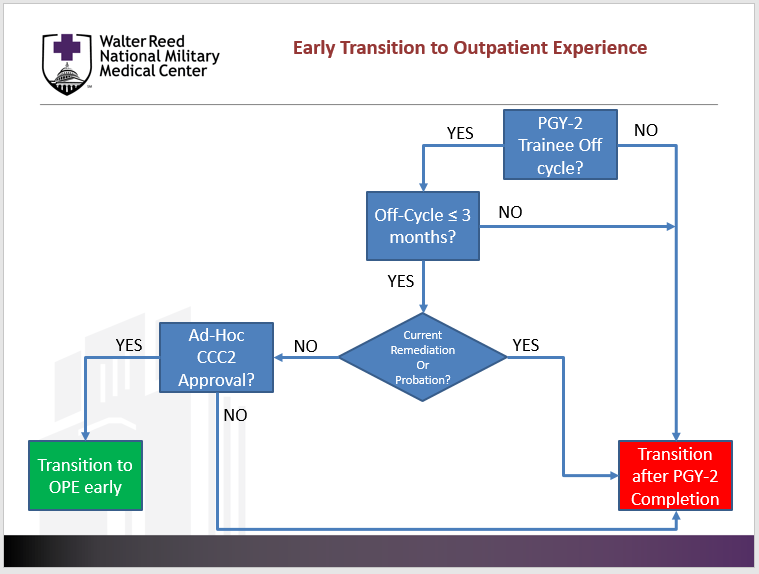


## PROGRESSION FROM PGY-2 to PGY-3 YEAR

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General Guidance

* Anyone delayed more than 3 months or for academic reasons who is currently on in-program remediation or academic probation needs to wait and then transition (those within a few days of 3 months may be allowed to progress)
* If individuals are off-cycle less than or equal to 3 months and the reason is something else or it is academic but they are no longer on academic probation or remediation, these cases will be discussed on an individual basis.
* The benefit of gaining all the relevant and sequenced orientations, didactics, and other training is considered alongside readiness for this level of autonomy.



# WEEKEND AND OVERNIGHT CALL

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Hold down CTRL and click on a rotation below to see its description:

[PGY-1 Call Requirements](#_2r0uhxc)

[PGY-2 Call Requirements](#_1664s55)

[PGY-3 Call Requirements](#_25b2l0r)

[PGY-4 Call Requirements](#_kgcv8k)

## PGY-1 CALL REQUIREMENTS

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([Return to Weekend and Overnight Call](#_4bvk7pj))

**Location:** PGY-1 resident call responsibilities are at Walter Reed National Military Medical Center (WRNMMC), covering the adult inpatient psychiatry unit (7W). Towards the end of PGY-1 year, PGY-1s will begin break-in call, where they take on the PGY-2 call responsibilities while the PGY-2 covers the inpatient unit for the PGY-1.

**Schedule**: PGY-1 call shifts are from 1530-2000 Monday-Friday, and from 0800-2000 Saturday, Sunday, and holidays. Monday-Friday call shifts are typically covered by the PGY-1s currently rotating on 7W. Both weekend days are covered by the same PGY-1 each weekend.

The call schedule for the residency is published on Amion. Login: NCCPsych

The call schedule includes the residents and attending faculty on-call, including proper contact information.

The call chiefs are responsible for publishing the call schedule before the beginning of the academic year, and update the schedule throughout the academic year.

**Duties**: During weekdays, the PGY-1 on-call is responsible for taking calls about current patients on the adult psychiatry unit at WRNMMC. This includes entering orders. If a patient is placed in restraints, the on-call PGY-1 will be summoned to evaluate the patient in-person in a timely manner and notify the on-call staff. The on-call PGY-1 is also responsible for entering admission orders and notifying the appropriate unit staff for admission to the adult psychiatry unit from outside hospitals after the PGY-2 has accepted the patient for transfer. They are responsible for completing the history and physical exam upon arrival of the patient to the unit and work collaboratively with the PGY-2 for admissions from the emergency department. During weekends and holidays, the PGY-1 is responsible for rounding and writing notes on all of the patients on the adult inpatient psychiatry unit and running a late morning group for patients on the inpatient unit to participate in.

## PGY-2 CALL REQUIREMENTS

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([Return to Weekend and Overnight Call](#_4bvk7pj))

**Location:** PGY-2 resident call responsibilities are at Walter Reed National Military Medical Center (WRNMMC), including the adult inpatient psychiatry unit (7W), neuropsychiatry unit (7E), and patients in the emergency department and on other medical/surgical units that have consulted psychiatry.

**Schedule**: PGY-2 call shifts are from 1500-2000 Monday-Thursday, 1500-0800 Friday, 0800-0800 Saturday, and 0800-2000 Sunday and holidays. Monday-Thursday shifts are typically covered by the PGY-2s currently rotating on 7W.

The call schedule for the residency is published on Amion. Login: NCCPsych

The call schedule includes the residents and attending faculty on-call, including proper contact information.

The call chiefs are responsible for publishing the call schedule before the beginning of the academic year, and update the schedule throughout the academic year.

**Duties**: During weekdays, the resident on-call is responsible for taking calls about current patients on 7E, as well as patients on other medical/surgical units that have consulted psychiatry. They respond to pages to see new patients in the emergency department and respond to new consults on medical/surgical units. The on-call resident is also responsible for taking calls to accept patients for admission to the adult psychiatry unit from outside hospitals. If the resident decides to admit a patient from an outside hospital, the resident is required to enter the appropriate admission orders and notify the appropriate unit staff and patient administration as well as complete the required history and physical if the PGY-1 is no longer in house. If the PGY-1 is in house, they are responsible for admitting transfer patients after they have been accepted by the PGY-2.

## PGY-3 CALL REQUIREMENTS

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PGY-3 and PGY-4 call requirements are the same, with the exception that during PGY-3, residents hold more call shifts than during the PGY-4 year. The responsibility is therefore shared between the PGY-3 and PGY-4 classes. The amount of call required by each resident is dependent on the size of his/her class each academic year. Historically, PGY-3 residents have been expected to fulfill approximately three weeks of call and PGY-4 residents have been expected to fulfill approximately one week of call.

**Location**: PGY-3 and PGY-4 resident call responsibilities are at Fort Belvoir Community Hospital (FBCH), including the adult inpatient psychiatry unit, adolescent inpatient psychiatry unit, and patients on other medical/surgical units that have consulted psychiatry.

**Schedule**: PGY-3 and PGY-4 call shifts are for one-week intervals, beginning on each Tuesday afternoon, and ending on the subsequent Tuesday morning. On weekdays, the resident is on home-call, meaning that the resident is not routinely expected to be physically present at FBCH. On weekends and holidays, the resident must be physically present in the mornings at FBCH to round on current patients, see newly admitted patients, enter orders, and enter proper progress notes/history and physicals as appropriate.

The call schedule for the residency is published on Amion. Login: NCCPsych

The call schedule includes the residents and attending faculty on-call, including proper contact information.

The call chiefs are responsible for publishing the call schedule before the beginning of the academic year, and update the schedule throughout the academic year.

**Duties**: During weekdays, the resident on-call is responsible for taking calls about current patients on the adult and adolescent psychiatry units at FBCH. This includes entering orders. If a patient is placed in restraints, the on-call resident will be summoned to evaluate the patient in-person in a timely manner. The on-call resident is also responsible taking calls to accept patients for admission to the adult and adolescent psychiatry units, both from the FBCH ER and from outside hospitals. If the resident decides to admit a patient, the resident is required to enter the appropriate admission orders and notify the appropriate unit staff and patient administration. During weekdays, the on-call resident is not expected to enter progress notes or history and physicals, as the regular day team will assess the patients daily. However, on weekends and holidays, the on-call resident is required to round on the adult and adolescent psychiatry inpatients and any necessary medical/surgical patients with psychiatry consultation requests.

## PGY-4 CALL REQUIREMENTS

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PGY-3 and PGY-4 call requirements are the same, with the exception that during PGY-3, residents hold more call shifts than during the PGY-4 year. The responsibility is therefore shared between the PGY-3 and PGY-4 classes. The amount of call required by each resident is dependent on the size of his/her class each academic year. Historically, PGY-3 residents have been expected to fulfill approximately three weeks of call and PGY-4 residents have been expected to fulfill approximately one week of call.

**Location**: PGY-3 and PGY-4 resident call responsibilities are at Fort Belvoir Community Hospital (FBCH), including the adult inpatient psychiatry unit, adolescent inpatient psychiatry unit, and patients on other medical/surgical units that have consulted psychiatry.

**Schedule**: PGY-3 and PGY-4 call shifts are for one-week intervals, beginning on each Tuesday afternoon, and ending on the subsequent Tuesday morning. On weekdays, the resident is on home-call, meaning that the resident is not routinely expected to be physically present at FBCH. On weekends and holidays, the resident must be physically present in the mornings at FBCH to round on current patients, see newly admitted patients, enter orders, and enter proper progress notes/history and physicals as appropriate.

The call schedule for the residency is published on Amion. Login: NCCPsych

The call schedule includes the residents and attending faculty on-call, including proper contact information.

The call chiefs are responsible for publishing the call schedule before the beginning of the academic year, and update the schedule throughout the academic year.

**Duties**: During weekdays, the resident on-call is responsible for taking calls about current patients on the adult and adolescent psychiatry units at FBCH. This includes entering orders. If a patient is placed in restraints, the on-call resident will be summoned to evaluate the patient in-person in a timely manner. The on-call resident is also responsible taking calls to accept patients for admission to the adult and adolescent psychiatry units, both from the FBCH ER and from outside hospitals. If the resident decides to admit a patient, the resident is required to enter the appropriate admission orders and notify the appropriate unit staff and patient administration. During weekdays, the on-call resident is not expected to enter progress notes or history and physicals, as the regular day team will assess the patients daily. However, on weekends and holidays, the on-call resident is required to round on the adult and adolescent psychiatry inpatients and any necessary medical/surgical patients with psychiatry consultation requests.

# ROTATIONS

## SAMPLE RESIDENT SCHEDULES

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PGY-1 Schedule

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Block** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** |
| **Site Rotation** | WR Medicine Wards | WR Medicine Wards | WR Medicine Wards | WR Medical Intensive Care Unit | WR Consult Liaison Psychiatry | WR Inpatient Psychiatry | WR Inpatient Psychiatry | FB Addiction Psychiatry | WR/Soldier’s Home Geriatric Psychiatry | DC VAMC Neurology | DC VAMC Neurology | WR Selective | WR Selective |
| **% Outpatient** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 20 | 20 | 100 | 0 | Varies | Varies |
| **% Inpatient** | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 80 | 80 | 0 | 100 | Varies | Varies |

PGY-2 Schedule

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Block** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** |
| **Site Rotation** | WR Partial Hospitalization Program | WR Partial Hospitalization Program | WR Inpatient Psychiatry | WR Inpatient Psychiatry | WR Inpatient Psychiatry | WR Night Float / Emergency Psychiatry | INOVA Consult Liaison Psychiatry | INOVA Consult Liaison Psychiatry | CNMC Adolescent Inpatient Psychiatry | NVMHI Community Psychiatry | NVMHI Community Psychiatry | WR Elective | WR Selective |
| **% Outpatient** | 100 | 100 | 0 | 0 | 0 | 50 | 50 | 50 | 0 | 100 | 100 | Varies | Varies |
| **% Inpatient** | 0 | 0 | 100 | 100 | 100 | 50 | 50 | 50 | 100 | 0 | 0 | Varies | Varies |

PGY-3 Schedule

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Block** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** |
| **Site Rotation** | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | WR/FB Outpatient Psychiatry | \*WR/FB Outpatient Child Psychiatry |
| **% Outpatient** | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| **% Inpatient** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

\*PGY-3s spend 4 days per week in the adult outpatient psychiatry clinic and a half-day a week in the child and adolescent outpatient psychiatry clinic (52 half-days = 26 full days = 1 block)

PGY-4 Schedule

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Block** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** |
| **Site Rotation** | \*WR Inpatient Psychiatry | WR Forensic Psychiatry | WR Inpatient Neuro-psychiatry | WR Consult Liaison Psychiatry | FB Inpatient Psychiatry | DC DMH Emergency Psychiatry | WR Elective | WR Elective | WR Elective | WR Elective | STR | WR Selective | WR Selective |
| **% Outpatient** | 0 | 0 | 0 | 0 | 0 | 0 | Varies | Varies | Varies | Varies | 50 | Varies | Varies |
| **% Inpatient** | 100 | 100 | 100 | 100 | 100 | 100 | Varies | Varies | Varies | Varies | 50 | Varies | Varies |

\* PGY-4s have a half day of outpatient clinic throughout the year

WR = Walter Reed National Military Medical Center (Primary Teaching Site)

FB = Fort Belvoir Community Hospital

DC VAMC = District of Columbia Veteran’s Administration Hospital

INOVA = INOVA Fairfax Hospital

NVMHI = Northern Virginia Mental Health Institute

CNMC = Children’s National Medical Center

DC DMH = District of Columbia Department of Mental Health (Comprehensive Psychiatric Emergency Program)

STR = Senior Teaching Resident

## ROTATION LISTS BY FACILITY

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Walter Reed National Military Medical Center

* Adult Partial Hospitalization (PGY2)
* Consult-Liaison Psychiatry (PGY-1, PGY-4, selective)
* Forensic Psychiatry (PGY-4, selective)
* Geriatric Psychiatry (PGY-1)
* Inpatient Neuropsychiatry (PGY-4, selective)
* Inpatient Psychiatry (PGY-1, PGY-2, PGY-4, selective)
* Medicine Inpatient Wards (PGY-1)
* Medicine Intensive Care Unit (PGY-1)
* Night Float / Emergency Psychiatry (PGY-2)
* Outpatient Addiction (selective)
* Outpatient Adult Psychiatry (PGY-3)
* Outpatient Child and Adolescent Psychiatry (PGY-3, selective)
* Pain Management (selective)
* Procedural Psychiatry (ECT, rTMS) (selective)
* Senior Teaching Resident (PGY-4)
* Sleep Disorders (selective)
* Other electives

Fort Belvoir Community Hospital

* Addiction Residential Treatment Facility (PGY-1, selective)
* Child/Adol Partial Hospitalization (selective)
* Inpatient Psychiatry (PGY-4, selective)
* Inpatient Child and Adolescent Psychiatry (selective)
* Outpatient Adult Psychiatry (PGY-3)
* Outpatient CAPS (PGY-3, selective)
* Other electives

INOVA Fairfax Hospital

* Consult-Liaison Psychiatry (PGY-2, selective)

Northern Virginia Mental Health Institute (NVMHI)

* Inpatient Psychiatry (PGY-2, selective)

Children’s National Medical Center (Washington DC)

* Inpatient Child Psychiatry (PGY-2)

Washington DC VA Hospital

* Consult Neurology (PGY-1, selective)
* Neurology Clinic (PGY-2, selective)
* Internal Medicine (PGY-1, selective)
* Inpatient Psychiatry (Selective)

DC DMH

* Emergency Psychiatry (PGY-4, selective)

## REQUIRED PGY-1 ROTATIONS

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Hold down CTRL and click on a rotation below to see its description:

[WRNMMC MEDICINE WARDS ROTATION](#_xvir7l)

[WRNMMC MICU ROTATION](#_3hv69ve)

[WRNMMC PGY-1 CONSULT LIAISON PSYCHIATRY ROTATION](#_1x0gk37)

[WRNMMC PGY-1 INPATIENT PSYCHIATRY ROTATION](#_4h042r0)

[FBCH ADDICTION PSYCHIATRY ROTATION](#_2w5ecyt)

[WRNMMC / SOLDIER’S HOME GERIATRIC PSYCHIATRY ROTATION](#_3vac5uf)

[DC VAMC NEUROLOGY ROTATION](#_3vac5uf)

[DC VAMC INPATIENT MEDICINE ROTATION](#_2afmg28)

### WRNMMC MEDICINE WARDS ROTATION

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([Return to Required PGY-1 Rotations](#_2iq8gzs))

What to do before arriving and when to do it by

* AHLTA, CHCS, and Essentris Access well before your first day
* Get sign-out on patients the night before from the intern who is leaving the service
* Get scrubs from the scrubs machine on the first floor with your scrubs card you got during in-processing, and a WR white coat from the Linens Dept. in the basement. White coats are on hangers organized by size and you’re supposed to sign them out; it’s the honor system. You return your white coat to another bin next to where you picked it up for laundering.

What to do when you first arrive

* Where to go: Go to the 5th Floor of Bldg. 10 and find your team room based on the color team you’re on (Red/Yellow in 5024, White/Blue in 5056). If you’re confused, going to Room 5155 is a good start (west elevators to 5th floor, first door around the corner to your left) and someone will help you find your team. All Team Rooms are in 5C (“5-center”).
* Badging / Orientation: There isn’t much of an orientation, more of a trial by fire. When you arrive at 0600 on your first day and get sign-out all of those patients are now your patients. Most residents (your team lead will be a medicine resident) will not initiate much guidance, but especially if you never rotated at Walter Reed on medicine as a medical student, it’s worth asking them for tips at least on how to pre-round efficiently given that Essentris and CHCS are confusing and their limits and quirks can easily make your work inefficient and feel overwhelming.
* What do you need to bring: something to write with, a stethoscope, +/- reflex hammer, a flexible and take-nothing-personally attitude

During the rotation

* Where to go: Your team room, day in, day out
* What to wear: Scrubs and fleece/white coat
* Day-to-day work explanation:
  + 0600-0615: Sign-out from Night float intern
  + 0615-0800: Pre-round/review VS, labs, imaging, consult notes, EKGs, check telemetry (*you must go to 3C in person for this no matter where the patient is located*)
  + 0800-1100: Rounds with attending
  + 1100-1200: Call New Consults/Order Labs/Change Meds/ Discharge Med Request
  + Noon Report (Psych on T/Th, Med on M/F), Psych Didactics on Wednesdays (*your resident/attending should allow you to always attend Psychiatry Didactics*)
  + 1300-1730: Daily Notes/Update Narrative Summary, Follow up Consult Recs/Update Sign-out
  + 1730: Sign-out
* What do you need to bring: as above
* Expected hours: 0600 – 1800 six days a week

Supervisor: Each team has an attending, a resident (Medicine or Med-Psych PGY-2 or PGY-3), two interns (from any specialty really), and +/- a sub-intern. Attendings are usually on for 2 straight weeks and your resident should be on for 2 – 4 weeks.

Important POCs: your resident

Leave policy for rotation: No leave on this rotation

Parking: your Walter Reed parking pass or the metro

Objectives: None explicitly outlined by GME (if they exist then they have not been readily shared with interns). In general, the focus at the intern level is understanding sick vs. not sick patients, interpreting findings and formulating basic treatment plans, and ensuring completion of all of the administrative tasks (and there are many) that are involved in caring for and, perhaps just as importantly, discharging a medicine patient from Walter Reed. Your attending or resident will likely have some chalk talks along the way and it’s always great to dive into UpToDate or the like for whatever issues your patients have. Your team will probably be grateful for the extra effort and expertise you can offer. The hours are long and the many administrative hoops and hurdles will most certainly challenge you, but never be afraid to ask your resident or attending (or even a psychiatry resident who’s been through it) for help!

### WRNMMC MICU ROTATION

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What to do before arriving and when to do it by

* Essentris and CHCS access, as with inpatient medicine
* Get sign-out on patients the night before from the intern who is leaving the service
* Get scrubs from the scrubs machine on the first floor with your scrubs card you got during in-processing, and a WR white coat from the Linens Dept. in the basement. White coats are on hangers organized by size and you’re supposed to sign them out; it’s the honor system. You return your white coat to another bin next to where you picked it up for laundering.
* You may want to check out COL Jessica Bunin’s very helpful trainee/generalist-level [YouTube videos](https://www.youtube.com/channel/UCaibk0qwIrOkzBoPeQqZ3FA) on critical care medicine to prepare for some of what you’ll see.
* **Brush up on your preferred strategy for reading chest x-rays and other imaging since you will be asked to do this in front of your whole team on day 1 (see Rads rounds below—not as bad as it sounds).**

What to do when you first arrive

* Where to go: The MICU (Medical Intensive Care Unit, as opposed to the SICU or the Surgical Intensive Care Unit) is somewhat puzzlingly located in a separate building from the medicine wards/main hospital. It is in Building 9, 4th Floor. The easiest way to access the MICU is by entering radiology from the side of the scrubs machine and walking deep into the radiology department until you find a set of elevators (this is confusing for everyone so please ask for directions if you need). If you’ve hit the Emergency Department, you’ve gone too far. Take the elevators to the fourth floor, turn right out of the elevators, and ask for the resident work room.
* Badging / Orientation: Similar to medicine wards, there is no formal orientation. Also similar to medicine wards, Essentris is not a helpful electronic health record, so ask your resident for tips on how to efficiently chart round on your patients.
* What do you need to bring: stethoscope and ensure that you have an N95 mask that fits you at the ready. See charge nurse for an N95 mask. Early in the pandemic, all trainees kept a brown paper bag in the work room with their N95, eye protection, and head covering in the case of a code blue. The MICU team (including interns) responds to code blues anywhere in the hospital and you will be expected to wear N95 and eye protection to any code.

During the rotation

* Where to go: as above
* What to wear: scrubs and a white coat
* Day-to-day work explanation:
  + 0600: arrive, get sign-out from night intern and resident, pre-round on your patients
  + 0700/0730: Rads rounds. This is where all of the new radiology studies, usually chest x-rays in the era of covid-19, are reviewed by the whole team together prior to rounds. Good news! The interns get to be the ones to read the imaging for the team. This is actually a low stakes opportunity to practice something you probably won’t do much more after intern year and most attendings and fellows are happy to help walk you through it at least the first couple days.
  + 0730/0800 – 1000/1100: Rounds. Interns present each patient in a system-by-system approach. Essentially you just read through the note updating the team with new labs and vent settings as applicable. With antibiotics, always say this is Day \_\_ of \_\_ (i.e. 6 of 7) of \_\_\_\_\_ (i.e. pip/tazo) for \_\_\_\_\_\_ (i.e. klebsiella pneumonia). Try to offer a plan for each system, i.e. “keep vent settings the same” or “increase PEEP”. It can’t hurt to try your hand at a plan. In fact, most attendings appreciate the effort. Then the fellow and attending will tell you and the team what is actually going to happen.
  + 1100 – 1400: Follow up on orders, consults, write notes, noon conference, call the patient’s family (especially important given new hospital limits on visitation).
  + 1400 – 1800: New admissions, transfers, maybe an intern can leave early.
  + 1730/1800: Sign-out
* What do you need to bring: as above
* Expected hours: 0600 – 1800 six days a week. If multiple interns on service, often someone goes home early.

Supervisor: your resident

Important POCs: your resident

Leave policy for rotation: No leave

Parking: your WR parking pass or metro

Objectives: Again, like medicine, no set objectives that are explicit. If you get through the work of each day and learn something along the way then pat yourself on the back. The first few days don’t worry if you don’t understand much of what is going on and how your patients are actually doing. That’s pretty normal especially if you never rotated in an ICU before. Some residents and fellows are very proactive teachers so don’t be shy about asking for topics that you might want to learn more about such as how to choose vent settings or manage DKA. A wonderful resource we also now have is Walter Reed’s own COL Jessica Bunin’s (Med-Psych trained intensivist) [YouTube channel](https://www.youtube.com/channel/UCaibk0qwIrOkzBoPeQqZ3FA) on common critical care issues and covid-19 critical care management.

### WRNMMC PGY-1 CONSULT LIAISON PSYCHIATRY ROTATION

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([Return to Required PGY-1 Rotations](#_2iq8gzs))

What to do before arriving and when to do it by

* Ensure you have access to the 7W doors as well as the doors connecting 7W and 7C. This can be done at the pass and security office currently located in Bldg. 10, 1st floor at the CDO desk.
* Join WB POD/PCLS service on Cureatr
* Make sure you have been N-95 fit tested prior to starting rotation

What to do when you first arrive

* Report first day no later than 0700 to: Walter Reed building 10, 7 Center. Take the East elevators to the 7th floor, turn left out of them (not left down social work wing), at the end of the hallway turn right.
* The resident room is the last door to the left before the double doors, room 7034 (code: 4217, it is Dr. Janke’s door # but backwards) this is where you will work and use computers.
* The conference room for sign out to the entire PCLS/geriatrics staff is next door, 7037 (code: 9307, office # to the left but backwards)
* Pager turn over from the POD is at 0700, preround (chart &/or in person) with table rounds occurring at 0800.
* During rounds you will present any changes to PCLS patients overnight, new consults, or send-outs (including their disposition plan). Be prepared with the one liner for each patient and the H&Ps for new consults overnight as they will likely ask you questions.
* You will also need to print off the patient list which can be found on the Shared Drive -> Behavioral health acute and outpatient services -> PCLS -> !PCLS Sign Out and Patient List.

During the rotation

* Monday through Friday will report to resident workroom in mornings at 0700 for signout from overnight, take time to pre-round/ chart review and then will have morning report next door.
* Throughout day will see old consults as needed, alternate taking new consults/ see ER cases with other residents, and write notes
* You will rotate with at least 1 other psychiatry intern that is on PCLS, and a 4th year psychiatry resident. Walter Reed Internal Medicine and TY interns rotate on the service for 2 weeks at a time and occasionally neurology interns rotate as well.
* You will see new consults and write a H&P (see template) for new consults, and a daily consult note (see template) for patients you are already following. Write the note as a Consolidated Consult note in Essentris and just copy and paste your note from Microsoft Word. Put PCLS as the title.
* You may carry 4 patients at a time and take 3 new consults in a day. If there continue to be new consults past this point, pass them off to the attending on duty (the attending schedule changes regularly).
* The pager is generally managed by the PGY4 to ensure even distribution of the workload. On Wednesday, the psychology interns hold the pager but all new consults come back to the residents/ students rotating on PCLS. You can work out the schedule with your fellow PCLS intern and the 4th year rotating on the service.
* Sign out is 1500 Monday through Friday. On Wednesdays there is no expectation to return for sign-out, and the PGY2 on short-float signs out at 1600. Sign out everything before leaving for didactics, update the patient list and staff cases with your attending.

PCLS Chief & Supervisor

* Dr. Hines
* Office – 301-319-8122

Uniform of the day:

* Monday through Friday: Scrubs are okay; otherwise it is uniform of the day (ACU’s and ASU’s on Fridays)

Important POCs

Leave policy for rotation

Please let the service chief know ahead of time; generally very easy to take leave on this rotation.

Parking

Objectives

### WRNMMC PGY-1 INPATIENT PSYCHIATRY ROTATION

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What to do before arriving and when to do it by

* Ensure you have access to the 7W doors as well as the doors connecting 7W and 7C. This can be done at the pass and security office currently located in Bldg. 10, 1st floor at the CDO desk.

What to do when you first arrive

* The resident room is located in the far back corner after entering the unit, room 7005. Passcode to the room is 7005\*. Sign out is at 0730.
* Dr. Williams will complete orientation likely on the first day of the rotation. An email will be sent out a few days prior with more information.

During the rotation

* 7W is located in Bldg 10, 7th floor. Take the West elevators to enter the unit. If you accidentally take the East elevators, cut across the courtyard to get to the unit doors.
* The Uniform of the Day is the appropriate attire for the rotation, with the exception of Fridays, where it is still ACUs/NWUs.
* There are two teams on 7W. Each team will carry a panel of patients admitted to the unit. Sign out occurs in the conference room (7004) at 0730 each morning, where patients admitted the previous night will be presented and nursing will give an update from the evening. After morning sign-out, which will sometimes include some teaching, teams will go back to the resident room and execute the plan of the day.
* Mondays and Thursdays are Treatment Planning Committee (TPC) days, where social work will sit in on interviews of the patients.
* Expect to have at least 2 command calls with the command of AD patients (one early in admission and one near discharge). These calls are do discuss how the service member has been doing, what the working diagnosis is, the prognosis, and current disposition plan. These calls are typically with the whole team and social work.
* Notes for the day must be opened by 1000, as they are Multi-D notes and need to be available for other staff to edit even if the patient has not been seen by the team yet.
* Helpful resources to have for this rotation include a pocket DSM-5 as well as Stahl’s Essential Psychopharmacology Prescriber’s Guide. Neither of these tools are required.
* Normal hours are 0715-1600. If on short float, prepare to be on the until 2000.

Supervisor

LCDR Williams if the department chief.

Dr. Hornbaker-Park and Dr. Nam are the team attendings.

Important POCs

All important POCs will be listed on the first page of sign out each day.

Leave policy for rotation

You may take a maximum of 1 week of leave during each month. Leave must be approved by LCDR Williams and a fellow intern must agree to cover the unit if there is a surge of patients that cannot be handled by the remaining members of the team. This intern will likely be someone on an selective.

Parking

Walter Reed Parking applies.

Objectives

LCDR Williams will go over objectives of the course on the first day during orientation.

### FBCH ADDICTION PSYCHIATRY ROTATION

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What to do before arriving and when to do it by

* Email or text Dr. Peter Armanas 410-627-9868 the week prior to introduce yourself and set up when and where to meet on your first day.
* No specific academic preparation required. However, it would be helpful to review those 11 criteria for substance use disorder, common addiction treatment medications, ASAM Levels of Care guidelines, and principles of Motivational Interviewing prior to starting.

What to do when you first arrive

* This rotation is at Fort Belvoir Community Hospital (FBCH) in Virginia, approximately a 30-minute drive from downtown DC without traffic. Give yourself plenty of time to get there. Google Maps to Fort Belvoir Community Hospital should get you there just fine. Park in Meadows Garage. When facing the main entrance this is the garage on the left. You will walk across the entire hospital to get to the River part of the building, which is on the opposite side from the Meadows Garage. The River part of the building has a garage, but if you park in it you may be towed.
* Orientation/badging should be taken care of during in-processing to FBCH that happened during intern orientation at the beginning of your year. Make sure to bring that FBCH badge from June orientation! Once you are on the rotation, Dr. Armanas should take you back to basement ID office to get you as much access as he has since you probably won't have access to outpatient Addiction Psychiatry clinic otherwise. If he doesn’t, just ask.

During the rotation

* Where to report: River Building, 2nd Floor, outpatient Addiction Psychiatry clinic. Facing the front of the building at the main entrance, River is all the way to the right, opposite where you parked. FBCH is kind of like Walter Reed in that outpatient clinics are just lumped together in giant open rooms throughout the hospital building so it can be helpful to ask for directions.
* What to wear: Uniform of the day on your first day, so Navy Type IIIs or Army ACUs, for example. Dr. Armanas will likely take you to the basement to get you some scrubs and a white coat in the first couple days. If he does not, you should ask him about getting scrubs.
* You will see mainly outpatient Addiction Psychiatry patients until the residential addiction program opens up again. You will also get consults from the hospital that are related to addiction or detox, including from 4N, the inpatient psychiatry unit (non-addiction-specific) that is operational during the pandemic. More than likely you won’t have an official office assigned to you so be flexible as you may be moving around day-to-day as space is available.
* What to bring: Bring something to take notes on and a good medication app like Epocrates.
* Expected hours: 0730/0800 - 1600/1700
* Special note about lunch: The hospital has a cafeteria with hot food on the 3rd floor more or less in the middle. Quality is comparable to Walter Reed but with fewer options. Dr. Armanas does not eat much during the day, so he may not take a break to eat or remember to offer you one. However, it is definitely ok to ask him for a break to eat lunch and he’ll have no problem.

Supervisor: Peter Armanas, DO, a graduate of WR Psychiatry Residency Program and native Marylander

Important POCs: Dr. Armanas as above

Leave policy for rotation: Leave is allowed. Just ask Dr. Armanas in advance as much as possible.

Parking: Meadows Garage. Free parking. No pass needed. See above for directions.

Objectives: These are not explicitly provided. However, feel free to come up with your own and share them with Dr. Armanas and he will likely be happy to help you meet them. Some ideas for objectives: 1) Learn to determine whether addiction patients require dual diagnosis treatment programs, ie for comorbid mood and substance use disorder vs. substance use treatment alone; 2) Improve understanding of commonly prescribed medications in Addiction Psychiatry, their side effects, contraindications, uses, and monitoring requirements; 3) Be able to safely administer Vivitrol (long-acting naltrexone injection); 4) Improve Motivational Interviewing skills and ability to assess readiness for change as it applies to Addiction Psychiatry.

### WRNMMC / SOLDIER’S HOME GERIATRIC PSYCHIATRY ROTATION

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What to do before arriving and when to do it by

* Ensure you have access to the 7W doors as well as the doors connecting 7W and 7C. This can be done at the pass and security office currently located in Bldg. 10, 1st floor at the CDO desk.
* Join WB POD/PCLS service on Cureatr
* Make sure you have been N-95 fit tested prior to starting rotation

What to do when you first arrive

* Report first day no later than 0700 to: Walter Reed building 10, 7 Center. Take the East elevators to the 7th floor, turn left out of them (not left down social work wing), at the end of the hallway turn right.
* The resident room is the last door to the left before the double doors, room 7034 (code: 4217, it is Dr. Janke’s door # but backwards) this is where you will work and use computers.
* The conference room for sign out to the entire PCLS/geriatrics staff is next door, 7037 (code: 9307, office # to the left but backwards)
* Pager turn over from the POD is at 0700, preround (chart &/or in person) with table rounds occurring at 0800.
* During rounds you will present any changes to PCLS patients overnight, new consults, or send-outs (including their disposition plan). Be prepared with the one liner for each patient and the H&Ps for new consults overnight as they will likely ask you questions.
* You will also need to print off the patient list which can be found on the Shared Drive -> Behavioral health acute and outpatient services -> PCLS -> !PCLS Sign Out and Patient List.

During the rotation

* Monday through Friday will report to resident workroom in mornings before 0715 for sign-out from overnight, and then will have morning report next door.
* Throughout day will see old consults as needed, alternate taking new consults with other residents, and write notes
* You will rotate with at least 1 other psychiatry intern that is on PCLS, and a 4th year psychiatry resident. Walter Reed Internal Medicine interns rotate on the service for 2 weeks at a time and occasionally neurology interns rotate as well.
* You will see any new consults on patients >65 y/o and write a H&P (see template) for new consults, and a daily consult note (see template) for patients you are already following. Write the note as a Consolidated Consult note in Essentris and just copy and paste your note from Microsoft Word. Put PCLS as the title.
* You may carry 4 patients at a time and take 3 new consults in a day. If there continue to be new consults past this point, pass them off to the attending on duty (the attending schedule will be listed on the whiteboard in the conference room where you sign out).
* You will also switch off holding the pager with the PCLS intern either in the morning or afternoon. You will not need to hold the pager Wednesday afternoons during didactics (either an attending or the psychology interns will take care of it). You can work out the schedule with your fellow PCLS intern and the 4th year rotating on the service.
* On Thursdays you are at the Armed Forces Retirement Home (during COVID this has been virtual – either telephonic or VTC) you will see new patients and write an H&P on them (due within 48H). You will also see follow-up patients and write a daily note using the previous note in AHLTA as a template. You can either email the note to your attending or have them show you how to put it directly into AHLTA.
* Plan to write up to 4 notes on patients you see that day. You may want to ask the attending ahead of time to let you know what patients he/she would like you to write notes on so you are not surprised at the end of the day.
* Sign out is 1500 Monday through Friday, with teaching occurring after sign out on Monday, Tuesday, and Friday.

Supervisor

* Dr. Ford
* Office – 301-400-2014

Important POCs

Dr. Hines – Chief, PCLS

Leave policy for rotation

Coordinate leave with Dr. Ford and Dr. Hines

Parking

Objectives

Uniform of the day:

* Scrubs or Uniform of the day
* Wear BDUs to AFRH

Any words of wisdom:

* Read the instructions on how to give a MOCA (it’s scripted)
* Know dosing for Aricept and Namenda, as well as common side effects
* Put a safety assessment in each of your notes
* Know DSM criteria for diagnoses of major/minor neurocognitive disorder
* Understand how dementia typically presents, its effects on the patient and their caregiver

### DC VAMC NEUROLOGY ROTATION

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([Return to Required PGY-1 Rotations](#_2iq8gzs))

What to do before arriving and when to do it by

* Complete fingerprinting at the VA prior to the rotation
* Complete online training

What to do when you first arrive

* Where to go: neuro work rook is 3rd floor take a left then immediate right after exciting the main staircase/ elevators, take the first right and at the end of the hallway the work room is on the left hand side. Code is 321 turn the handle to the R
* Badging / Orientation: Neuro senior resident will orient you upon arrival, you will need to visit the neuro office to check on the status of your paperwork to get your badge and access codes
* What do you need to bring: reflex hammer, stethoscope, extra work to do/study

During the rotation

* What to wear: business casual with Walter Reed white coat or psychiatry fleece
* Day-to-day work: chart check all old patients and any new consults from overnight. Then review patient list with team and decide who needs to be seen. Round on patients and then write notes.
* Expected hours: 0800-1600

Supervisor

-Dr. Lynn Kataria: [lynn.kataria@va.gov](mailto:lynn.kataria@va.gov)

Important POCs

-Deborah Taylor: can help with access problems

-Jacqueline Allmond: works in the dept office and will assist with paperwork

Neuro office number: 202-745-8000 ext. 58145

Leave policy for rotation

-You can take leave during this rotation if approved by Dr. Kataria

Parking:

-You can park in the visitor parking if you show your CAC card

-You can also, and may have to if parking is full, park at the soldier's home and take the shuttle

Recommended Texts:

-Lange Clinical Neurology (there is a reading schedule for this text posted in the neurology call room)

-Kaufman's Clinical Neurology for Psychiatrists

Objectives

### DC VAMC INPATIENT MEDICINE ROTATION

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What to do before arriving and when to do it by

* Complete fingerprinting at the VA prior to the rotation (at least 2 months prior, usually will have already done VA Neuro rotation in which case you already have your VA ID card). This process has to be completed to get an ID badge, which also logs you into the VA computers and printers. Ms. Lopez will usually be emailing you well in advance of your rotation to start this process.
* Complete online training (TMS)
* Contact the GW chief resident in charge of rotations (Ms. Lopez will be making that connection prior to your rotation) to coordinate your orientation with one of the GW chiefs, which is usually the Sunday night before your first day.

What to do when you first arrive

* Where to go: For orientation with the chief, follow directions of the chief to the Medicine resident office. They will assign you to a team and give you the room number and door code for your team room.
* Badging / Orientation: as above
* What do you need to bring: white coat and stethoscope; **lunch is provided most days**

During the rotation

* Where to go
* What to wear: For most attendings, business casual should work. Tie for men is optional. Bring your own white coat, aka borrow one from Walter Reed.
* Day-to-day work explanation:
  + 0645: sign-out from night interns (ask chief resident at orientation where exactly to show up for sign-out). You may want to arrive earlier to pre-round on your patients. And you may be getting new patients at morning sign-out.
  + 0700 – 0800: Pre-round on patients (expect 5 – 10 patients per intern; at least 2 patients will have complicated dispositions and require little day-to-day medical follow-up)
  + 0800 - 1000: Round with your attending. Some attendings do discovery rounds where you only do chart review prior to rounds and you wait to see your patients as a whole team.
  + 1000 – 1800: Notes, consults, noon didactics, disposition planning.
  + 1800: Sign-out to night intern
* What do you need to bring: as above
* Expected hours: 0645 – 1800

Supervisor: you will most likely be on a Walter Reed team with a Walter Reed resident

Important POCs: chief resident from GW, whom you will meet one night before you start (see above), as well as your WR resident team lead

Leave policy for rotation: probably not allowed

Parking: Officially per the VA, rotating residents are supposed to Park in the Soldiers and Sailors home a couple miles away and take the shuttle. In practice, this is not feasible with the medicine wards schedule and no one does it. Show your CAC at the gate to the VA (they check all IDs in the parking lot) and park in one of the small lots on the north side of the building. Do not park in the parking garage. Do not park in the valet parking area.

Objectives: None specified

Tips:

* The basement of the VA is its own little universe. There you’ll find the cafeteria, which has been newly renovated, the radiology department, and a convenience store, among other mysteries waiting for you. The food in the cafeteria is apparently a major improvement from pre-renovation days and isn’t bad for the occasional noon conference that doesn’t serve lunch. Starbucks is located on the main floor right at the entrance.
* Generally speaking, there is somewhat less nursing attention at the VA as compared to Walter Reed. This results in orders tending to need a bit more follow-up, especially activity orders such as out of bed to chair. Always verify with the nursing staff that these types of orders are being carried out. Vocera, the communication tool between staff, is the go-to for reaching your patient’s nursing team during the day, but in-person discussions always go a long way.

## REQUIRED PGY-2 ROTATIONS

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Hold down CTRL and click on a rotation below to see its description:

[WRNMMC PARTIAL HOSPITALIZATION ROTATION](#_39kk8xu)

[WRNMMC PGY-2 INPATIENT PSYCHIATRY ROTATION](#_1opuj5n)

[WRNMMC NIGHT FLOAT AND EMERGENCY PSYCHIATRY ROTATION](#_48pi1tg)

[INOVA FAIRFAX CONSULT LIAISON PSYCHIATRY ROTATION](#_2nusc19)

[CNMC ADOLESCENT INPATIENT PSYCHIATRY ROTATION](#_1302m92)

[NVMHI COMMUNITY PSYCHIATRY ROTATION](#_3mzq4wv)

### WRNMMC PARTIAL HOSPITALIZATION ROTATION

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What to do before arriving and when to do it by

* AHLTA access

What to do when you first arrive

* Where to go : Building 85T, can get to after exiting Bldg 19 by Gate 1 (North gate)
* Badging / Orientation: NP Thomas and/or Dr. Maria Agular
* Make sure to check with the IT services or DHA global service center 1-800-600-9332
* What do you need to bring: Navy Working Uniform or Army OCP

During the rotation

* Where to go: Building 85T, can get to after exiting Bldg 19 by Gate 1 (North gate)
* What to wear: Navy Working Uniform or Army OCP
* Day-to-day work explanation: you will see patient's in the morning with the attending providers and discuss the patient progress and any necessary changes to medications; after putting in a note
* PCS new patients have extensive intake interviews that go through their history before presenting the PCS program and goals of treatment
* What do you need to bring: Navy Working Uniform or Army OCP
* Expected hours: 07:00 till early afternoon (check with your attending for what work needs to be done after patients have been seen in the morning

Supervisor -varies

Important POCs- service chief, Dr. Maria Aguilar - [maria.e.aguilar2.mil@mail.mil](mailto:maria.e.aguilar2.mil@mail.mil)

NP Thomas -

Leave policy for rotation: check with the service chief, Dr. Maria Aguilar - maria.e.aguilar2.mil@mail.mil

Parking

Objectives

### WRNMMC PGY-2 INPATIENT PSYCHIATRY ROTATION

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What to do before arriving and when to do it by

* Ensure you have access to the 7W doors as well as the doors connecting 7W and 7C. This can be done at the pass and security office currently located in Bldg. 10, 1st floor at the CDO desk.

What to do when you first arrive

* The resident room is located in the far back corner after entering the unit, room 7005. Passcode to the room is 7005\*. Sign out is at 0730.
* Dr. Williams will complete orientation likely on the first day of the rotation. An email will be sent out a few days prior with more information.

During the rotation

* 7W is located in Bldg 10, 7th floor. Take the West elevators to enter the unit. If you accidentally take the East elevators, cut across the courtyard to get to the unit doors.
* The Uniform of the Day is the appropriate attire for the rotation, with the exception of Fridays, where it is still ACUs/NWUs.
* There are two teams on 7W. Each team will carry a panel of patients admitted to the unit. Sign out occurs in the conference room (7004) at 0730 each morning, where patients admitted the previous night will be presented and nursing will give an update from the evening. After morning sign-out, which will sometimes include some teaching, teams will go back to the resident room and execute the plan of the day.
* Mondays and Thursdays are Treatment Planning Committee (TPC) days, where social work will sit in on interviews of the patients.
* Expect to have at least 2 command calls with the command of AD patients (one early in admission and one near discharge). These calls are do discuss how the service member has been doing, what the working diagnosis is, the prognosis, and current disposition plan. These calls are typically with the whole team and social work.
* Notes for the day must be opened by 1000, as they are Multi-D notes and need to be available for other staff to edit even if the patient has not been seen by the team yet.
* Helpful resources to have for this rotation include a pocket DSM-5 as well as Stahl’s Essential Psychopharmacology Prescriber’s Guide. Neither of these tools are required.
* Normal hours are 0715-1600.
* On [Need PGY 2 input on day of the week] you will co-lead an interpersonal group with the other PGY-2's on the rotation. This group will be supervised by [Need PGY 2 input]. After the group the residents who led are expected to write Essentris group notes.

Supervisor

LCDR Williams if the department chief.

Dr. Hornbaker-Park and Dr. Nam are the team attendings.

Important POCs

All important POCs will be listed on the first page of sign out each day.

Leave policy for rotation

You may take a maximum of 1 week of leave during each month. Leave must be approved by LCDR Williams and a fellow intern must agree to cover the unit if there is a surge of patients that cannot be handled by the remaining members of the team. This intern will likely be someone on an selective.

Parking

Walter Reed Parking applies.

Objectives

LCDR Williams will go over objectives of the course on the first day during orientation.

### WRNMMC NIGHT FLOAT AND EMERGENCY PSYCHIATRY ROTATION

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What to do before arriving and when to do it by

* If you have been off site recently, make sure that you can still access AHLTA and Essentris
* Join WB POD/PCLS service on Cureatr
* The offgoing POD nightfloat should forward you a copy of the CCIR email so you know who needs to be copied each morning
* Make sure you have been N-95 fit tested prior to starting rotation

What to do when you first arrive

* The POD call room is also identified as GME 5 and is on the right side as you approach 7E. You typically get sign out from short float in the 7W resident work room
* Every class determines the time that short float stops seeing new consults on their own—this usually falls between 1900-1930. You still need to return the page even if the person taking over will be the one doing the evaluation.
* Most of us stop seeing new consults at 0600 so that we have time to prepare CCIR, update 7W sign out, etc.

During the rotation

* What to wear: scrubs and fleece/white coat
* Carry the PCLS pager and POD phone, as well as monitor the PCLS/POD cureatr account. Respond to pagers in a timely manner. You are allowed to defer patients to the day team if there is not a safety concern or urgent need for evaluation. The contact phone number for all staff on call should be in the POD phone. If it’s not, add it. Add yourself as well if you’re not in there already.
* Intoxicated patients can not be admitted to 7W until their ETOH is under 100—depending on ER volume they may want to admit the patient to medicine to detox and free up a bed or they may be okay with letting the patient sober up in the ED.
* What do you need to bring: clipboard is helpful to store different paperwork that you will need access to. Recommend carrying copies of Maryland Voluntary, Involuntary, and Adolescent admission paperwork, several copies of whatever template you use to take notes during interviews, MOCA/MMSE. You’ll slowly add to this as you find out what you rely on. You will need your stethoscope to do physical exams on any patients that you admit to 7W. Some people opt to flip their schedules and stay awake all night, others try to sleep if the ED/floor are not busy.
* Expected hours are 2000-0800 Sunday-Thursday
* Every morning by 0630 email the updated CCIR to the list of hospital staff. The CCIR should have EVERY patient contact once PCLS hands off the pager—even if it is just a phone call about a patient that doesn’t end up coming, it still needs to be documented. Check in with 7W nursing to get updated census numbers for Fort Belvoir before sending it off.
* Every morning at 0715 there is a conference call with department leadership where you review the CCIR. Read the updated census numbers for Walter Reed and the event numbers on the first page. On the second page, briefly review each patient—name, age, gender, military status/rank/duty station, presenting problem, and disposition. If they are active duty you MUST report their duty station or you will be asked about it. After you review all the patients you will be asked questions. Most of these questions are not things that you are supposed to know and reflect `the fact that the staff on this conference call do not take call at Walter Reed. PCLS staff will be standing next to you in the PCLS resident room during the call and can take over/redirect any questions that are out of your lane.
* Sign out to PCLS in the resident room at 0700. Have a copy of the CCIR to sign out any new patients for them. You are not responsible for updating the PCLS patient list.
* Sign out to 7W in the conference room at 0730. Print the 7W sign out when you are done updating it so its ready for the day team. You’re always going to need more copies than you think you will need.

Supervisor: staff on call (see Amion or 7W sign out for name and contact information). Amion also notes who the backup staff on call is in the event of an emergency. Every staff wants to be called for different things so clarify with them/with short float if they want calls on all patients or only send outs. B52/restraints/suicide attempts/elopements or other significant events must be reported on the CCIR and called in to the staff on call, as well as reported to 7W service chief.

Important POCs: LTC Shannon Ford, rotation supervisor/ PCLS (910-391-0787)—if there are C+L specific questions or you are having trouble reaching staff on call

LCDR Williams – questions re: admission criteria, events that occur on the ward, etc

Leave policy for rotation: **leave is not allowed on this rotation**

Parking: they do not ticket in the parking garages overnight, so you are free to park in patient parking in the eagle garage. Do not park in the NEX overnight

Objectives

### INOVA FAIRFAX CONSULT LIAISON PSYCHIATRY ROTATION

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([Return to Required PGY-2 Rotations](#_pkwqa1))

What to do before arriving and when to do it by

* Pre-arrival paperwork (can generally be done one month out)
  + In order to begin the IFMC credentialing process, use the link below to access the GME Website and locate the required credentialing paperwork. <https://www.inova.org/education/gme/resident-requirements>
  + As soon as you complete these documents, please submit them to the GME Office by fax to 703-776-7850 or email to [GMECredentialing@inova.org](mailto:GMECredentialing@inova.org).
* Make sure to communicate with Ms. Lopez/Ramaekers about an active Virginia Medical License.
* Epic Training Will Also need to be done prior to arrival.
  + In order to get this, you will need to complete the pre-arrival paperwork above first. They will subsequently send you an e-mail on instructions on the epic training. Remember to save the certificates and send them in as a system of redundancy.
  + Trainings to be completed (<http://www.healthstream.com/hlc/inova>) – Provider ID will be provided to you via e-mail
    - EpicCare Resident/Fellow Training
    - 2020 Annual Education for Acute Care Clinical Staff
    - Equal Access: Language and Disability Services

What to do when you first arrive

* Plan to be in the office by 0830h.
* Wear business casual. White coat required. When you enter the building, either have Dr. Vyas vouch for you to come in or just let the front know you’re here on your first day (written during pandemic time frame). Have your Epic Login at the ready (should’ve acquired this during the training).
* Park in the Grey or Blue parking garage. Find a map [here](https://www.inova.org/locations/inova-fairfax-medical-campus/plan-your-visit/maps-directions-parking). They will give you a voucher so you can leave without paying but after you get your badge, you can park in the Employee Garage.
* On your first day, your first stop will be to check in with the GME office on Monday, May 4th. The office opens at 8am. They will then direct you to the office of Safety and Security which will set up your parking and badge access. Get your badge.
* Then you will be directed to the Psychiatry Chairman’s office. This is the Orange Building (surgical building). Just follow the signs that have orange backgrounds.

During the rotation

* Where: You will arrive at the psychiatry department in the orange building every day with a start time of 0830h. The door to the office will be unlocked by Dr. Vyas by 0815h so unfortunately if you come a bit earlier, just grab a cup of coffee.
* You will be in business casual attire (no tie necessary) with a white coat – no exceptions.
* The fellow you’re working with should’ve shared their patient list with you and you will be reviewing the charts prior to table rounding about the patients. There may be new consults over night or over the weekend so keep your eyes open for this.
* For any follow-up or new consult, the fellow will ultimately always need to see them. A redundant system but this is what you’re working with. You will really be dividing the work load of the patient list with your fellow so this is usually the first plan of attack. On Monday and Fridays at 1300h, you will be rounding on the patients, generally new ones or interesting ones that have active problems that are ongoing.
* Consults will roll through the door from 0815h to 1630h. Generally if within the last half hour and lower acuity, they can be deferred to the following day with the exception of Friday evenings. You will do every Friday evening consults right up to 1630h.
* You will leave at 1630h unless otherwise permitted by your fellow.

Important POCs

Mariam Hashimi (GME Credentials Manager)

703-776-2626

[Mariam.hashimi@inova.org](mailto:Mariam.hashimi@inova.org)

Pamela Crawford (Psych Dep GME Coordinator)  
703-776-3626

[pamela.crawford@inova.org](mailto:pamela.crawford@inova.org)

Leave policy for rotation

E-mail Pamela well in advance as she is the one coordinating the schedules for everyone.

Parking

As described above: free with badge – in the employee parking garage.

Objectives

* To train academic and clinical psychiatrists in consultation-liaison psychiatry
* To develop comprehension of the relationship between biopsychosocial factors and medical illness, especially in patients with complex medical, neurological or surgical conditions
* To develop advanced knowledge of psychopharmacology in a medical environment with emphasis on interactions of psychotropic medications with other medications
* To understand the multiple roles of an interdisciplinary team in the patient's treatment and management plan.
* To develop in each resident curiosity and competency within this subspecialty
* To develop learning teaching skills in consultation-liaison psychiatry
* To teach non-psychiatric staff, residents, nurses, medical students and social workers about disorders treated by the Consultation-Liaison Psychiatry team, and psychological complications frequently encountered in patients with medical and surgical illness

### CNMC ADOLESCENT INPATIENT PSYCHIATRY ROTATION

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What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### NVMHI COMMUNITY PSYCHIATRY ROTATION

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([Return to Required PGY-2 Rotations](#_pkwqa1))

What to do before arriving and when to do it by

* You will need to make sure you have at least a Virginia Trainee License before rotating, everything else will be done when you get there.

What to do when you first arrive

* First day arrive between 0830 and 0845 and park in the employee parking and go in the visitor entrance. Tell them that you are a new resident and they will call Trish Gordon. She will meet you in the waiting area.
* Trish Gordon will walk you through the orientation paperwork and get your badge and keys
* Make sure you have a copy of a recent PPD or QuantiFERON result from within the last 12 months (you can print this from your AHLTA record)

During the rotation

* When and where to arrive each day: First thing you should do each day when you arrive (around 0800) is check in with Joyce in admissions and see if you have any pending admissions to see from overnight or any expected arrivals. After that you will meet with your attending and go to morning sign out (time and place depends on what team you are with). I recommend you bring
* Attire: Business casual attire
* Daily flow: Every morning first thing when you arrive, see Joyce. Make friends with Joyce. Be nice to Joyce. She will tell you about any admissions you have from overnight or pending for today. Admissions alternate between residents and you are capped at two admissions daily. You do admissions for all the teams, not just your own. After you see Joyce you will meet with your attending and go to morning sign out (either on F unit multipurpose room or on H unit depending on your attending). Time depends on attending. Sometimes during the day you will have meetings with the treatment team and CSB, the team social worker will tell you when those are. Once a week you have strategy meeting with the team where you go over all the plans for all the patients. Progress notes are written once a week (day of the week depends on attending). The rest of the time is spent seeing patients.
* Bring: Several good pens because they use paper charts!
* Approximately 0800 – 1600 daily. We cover any admissions that arrive up until 1600 so there may be times you stay later than 1600. Also, if you are re-TDOing someone you will have to attend a court hearing, which happens in the hospital before 0800 (sometimes as early as 0700).

Supervisor – multiple. Trish Gordon will tell you your supervisor once you arrive. You will work with 2 different attendings, one for each month you are there.

Important POCs

Main POC for the rotation (and to make leave requests) is Trish Gordon – email: [trish.gordon@dbhds.virginia.gov](mailto:trish.gordon@dbhds.virginia.gov). Office phone: 703-207-7168 Work Cell: 571-623-4211

Leave policy for rotation

Try to request leave prior to the rotation. You are able to take leave during this time as long as there is other resident coverage for admissions. To request leave, you email Trish Gordon (above) and she will coordinate with your supervisor.

Parking

You will be given a parking pass to park in employee parking throughout your rotation

Objectives

## REQUIRED PGY-3 ROTATIONS

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Hold down CTRL and click on a rotation below to see its description:

[FBCH OUTPATIENT PSYCHIATRY ROTATION](#_haapch)

[FBCH CAPS ROTATION](#_319y80a)

[WRNMMC OUTPATIENT PSYCHIATRY ROTATION](#_1gf8i83)

[WRNMMC CAPS ROTATION](#_40ew0vw)

### FBCH OUTPATIENT PSYCHIATRY ROTATION

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([Return to Required PGY-3 Rotations](#_2250f4o))

What to do before arriving and when to do it by

* Attend Fort Belvoir Orientation (June prior to starting). Bring something to write with and something to take notes on.
* At Orientation/during orientation:
* Ensure you have access to AHLTA, Essentris (Fort Belvoir Edition), attempt to gain access to HAIMS (need a separate account for FBCH), start the process of getting Profile, LIMDU, and ASIMS at Fort Belvoir
* You will get a badge and gain access to clinic back area

What to do when you first arrive

* Where to go: Your office, as shown on orientation. Alternatively, you can ask Dr. Greene or the NCO of the clinic.
* -Badging / Orientation (if applicable): Orientation will be conducted in June prior to starting where you will receive a lot of important information on what and how to. You will also receive a badge at this time.
* What do you need to bring: CAC Card, Fort Belvoir Badge (As obtained at orientation). You may want to bring anything else you desire to place in your office such as books, plants, lights, clocks, or anything else you deem important to make the space your own.

During the rotation

* Where to go: You will work out of your office daily (except Wednesdays). You will be introduced to both your adult and child supervisors with whom you will meet weekly (Thursdays after/during the morning child clinic with your child supervisor and on a date told to you by your adult supervisor with your adult supervisor).
* What to wear: OCP ACUs for Army and either Khakis or NWU (Type III) for Navy
* Day-to-day work explanation: Mondays you will see adult patients. Tuesday you will run group in the morning and then adult patients and then have gap didactics. Wednesday you will attend Didactics at Walter Reed. Thursday you will see child patients in the morning and adult patients in the afternoon. Friday you will see adult patients in the morning, participate in the high risk meeting, and then see adult patients in the afternoon. You will attend noon conference virtually in a classroom in Meadows on Tuesdays and Thursdays at noon.
* What do you need to bring: You must have your CAC card as well as your Hospital ID Badge from Fort Belvoir. You must have the correct uniform. All other materials are optional and must be brought by you. Examples are: lamps, plants, clocks, phone chargers, notebooks (Sometimes you can find them in the clinic), and pens (Again, sometimes there are some).
* Expected hours Monday: 0800-1600 you will see adult patients, Tuesday 0830-1000 group, 1000 to 1200 (Intake generally), 1300-1400 patients, 1430-1600 gap didactics. Wednesday WR Didactics. Thursday 0730-0930 child therapy, 1000-1200 child medication management, 1300-1600 adult patients. Friday 0800-1200 adult patients, 1300 high risk meeting, 1400 patient encounter. These times are all subject to being changed based on how you change your template to fit your needs (I.e. if your supervisor is only available to discuss cases on Thursdays at 1400, you will note see patients for that hour. If you want to come in earlier and leave later on some days to afford yourself time for training psychotherapy this is an option.) If you change your template to afford you patient appointments late in the day (After 1600), ensure that someone is present in the clinic with you to assist if you have an emergency.

Supervisor: Supervisors are assigned to you at the beginning of the year. Your adult supervisor will switch in January.

Important POCs ; Dr. Greene is the most important POC for this rotation and will provide you will all other important persons of interest.

Leave policy for rotation: In order to take leave during this year, you must know ahead of time when you would like to take leave (Preferable 2 months or more) and have your clinic times blocked off. If you must take emergency leave or short notice leave, it is a courtesy to call your patients that you are cancelling with and offer them alternative times to be seen (At lunch or early/late). If changes to your schedule occur (leave, training, any time away from clinic, etc.) after your schedule has been published, a “schedule change request” form must be completed and submitted to Dr. Greene and clinic managers for approval.

Parking You must park on the third floor or higher on the two parking garages attached to the hospital. Recommend parking in River Parking Garage. If you park on Levels 1 or 2 and are caught, you and Dr. Greene must go before the CO of the hospital to explain why you violated this rule.

Objectives

### FBCH CAPS ROTATION

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([Return to Required PGY-3 Rotations](#_2250f4o))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### WRNMMC OUTPATIENT PSYCHIATRY ROTATION

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([Return to Required PGY-3 Rotations](#_2250f4o))

What to do before arriving and when to do it by

* You will need your unrestricted permanent state license before starting this rotation
* Once you have a state license you will need your DEA number

What to do when you first arrive

* Where to go: The Adult Outpatient Behavioral Health Clinic, America Bldg, Fl 6
* Orientation: Occurs on 01 July (or the first weekday of July if 01 July falls on a weekend)
* What do you need to bring:

During the rotation

* Where to go: The Adult Outpatient Behavioral Health Clinic, America Bldg, Fl 6. You will have your own office as a PGY 3.
* What to wear: UOD (ACU/NWU on Monday-Thursday, Class B/Khakis on Fridays)
* Day-to-day work explanation: You will see a mix of new intakes, follow-ups, and acute patients scheduled based on your template schedule. One day a week you will co-lead group therapy with another PGY 3 resident.
* Expected hours: The clinic is open from 0600-1800. Residents generally see patients between 0730 and 1600. On days when you are on triage, you are expected to stay until at least 1500 to see acute patients and answer telcons. Your hours from day to day will vary based on your schedule template.

Supervisor

LCDR John Burger ([john.m.burger6.mil@mail.mil](mailto:john.m.burger6.mil@mail.mil) O: 301-295-4000)

Important POCs

Clinic Chief: LCDR Rose Grgurich ([rosa.c.grgurich.mil@mail.mil](mailto:rosa.c.grgurich.mil@mail.mil))

Administrative Team: Ms. Dana Isom ([dana.e.isom.civ@mail.mil](mailto:dana.e.isom.civ@mail.mil)) , Mr. Dejuan Rowland ([dejuan.d.rowland.civ@mail.mil](mailto:dejuan.d.rowland.civ@mail.mil)), and Ms. Melinda Daivs ([melinda.m.davis10.civ@mail.mil](mailto:melinda.m.davis10.civ@mail.mil))

Leave policy for rotation

Before submitting your leave request, you must find another PGY 3 in the clinic to cover your telcons and any acute issues. Then you go through the usual leave request process. Once that is done you should list your leave days and coverage on the clinic leave calendar found in outlook and on the sharepoint.

Parking

Objectives

### WRNMMC CAPS ROTATION

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What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

## REQUIRED PGY-4 ROTATIONS

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[WRNMMC PGY-4 INPATIENT PSYCHIATRY ROTATION](#_upglbi)

[WRNMMC FORENSIC PSYCHIATRY ROTATION](#_3ep43zb)

[WRNMMC INPATIENT NEUROPSYCHIATRY ROTATION](#_1tuee74)

[WRNMMC PGY-4 CONSULT LIAISON PSYCHIATRY ROTATION](#_4du1wux)

[FBCH INPATIENT PSYCHIATRY ROTATION](#_2szc72q)

[DC DMH EMERGENCY PSYCHIATRY ROTATION](#_184mhaj)

[SENIOR TEACHING RESIDENT ROTATION](#_3s49zyc)

### WRNMMC PGY-4 INPATIENT PSYCHIATRY ROTATION

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What to do before arriving and when to do it by

* Ensure you have access to the 7W doors as well as the doors connecting 7W and 7C. This can be done at the pass and security office currently located in Bldg. 10, 1st floor at the CDO desk.

What to do when you first arrive

* The resident room is located in the far back corner after entering the unit, room 7005. Passcode to the room is 7005\*. Sign out is at 0730.
* Dr. Williams will complete orientation likely on the first day of the rotation. An email will be sent out a few days prior with more information.

During the rotation

* 7W is located in Bldg 10, 7th floor. Take the West elevators to enter the unit. If you accidentally take the East elevators, cut across the courtyard to get to the unit doors.
* The Uniform of the Day is the appropriate attire for the rotation, with the exception of Fridays, where it is still ACUs/NWUs.
* There are two teams on 7W. Each team will carry a panel of patients admitted to the unit. Sign out occurs in the conference room (7004) at 0730 each morning, where patients admitted the previous night will be presented and nursing will give an update from the evening. After morning sign-out, which will sometimes include some teaching, teams will go back to the resident room and execute the plan of the day.
* You will act as a sub-attending for one of the teams, which means that you will run the team as if you were the attending, then staff the team with the attending.
* Mondays and Thursdays are Treatment Planning Committee (TPC) days, where social work will sit in on interviews of the patients.
* Notes for the day must be opened by 1000, as they are Multi-D notes and need to be available for other staff to edit even if the patient has not been seen by the team yet.
* Helpful resources to have for this rotation include a pocket DSM-5 as well as Stahl’s Essential Psychopharmacology Prescriber’s Guide. Neither of these tools are required.
* Normal hours are 0715-1600.

Supervisor

LCDR Williams if the department chief.

Dr. Hornbaker-Park and Dr. Nam are the team attendings.

Important POCs

All important POCs will be listed on the first page of sign out each day.

Leave policy for rotation

You may take a maximum of 1 week of leave during each month. Leave must be approved by LCDR Williams and a fellow intern must agree to cover the unit if there is a surge of patients that cannot be handled by the remaining members of the team. This intern will likely be someone on an selective.

Parking

Walter Reed Parking applies.

Objectives

LCDR Williams will go over objectives of the course on the first day during orientation.

### WRNMMC FORENSIC PSYCHIATRY ROTATION

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What to do before arriving and when to do it by

* No additional requirements before starting the rotation

What to do when you first arrive

* Where to go: 6000 MacArthur Blvd Suite 1099 Bethesda, MD 20816-5003
* Badging / Orientation: Bring your CAC, this is a military facility with a guard at the front desk of the building
* No additional badging requirements
* What do you need to bring: Notebook and pen or laptop for notetaking

During the rotation

* Where to go: 6000 MacArthur Blvd Suite 1099 Bethesda, MD 20816-5003
* What to wear : Monday – Thursday: Uniform of the Day (NWU or ACU); Friday – business casual
* Day-to-day work explanation: Typically start the day with didactics with Dr. Chiarella, then will spend the rest of the day doing readings, unless assigned to a case (706 evaluation, capacity evaluation, etc.)
* What do you need to bring: Notebook and pen or laptop
* Expected hours: 0800-1600

Supervisor: MAJ Ryan Chiarella 301.366.6777

Important POCs

Leave policy for rotation : May request leave during rotation. Coordinate leave requests prior to start of rotation. Must complete a 706 evaluation during residency, so may have opportunity to do evaluation prior to rotation.

Parking: Free parking in front of the MacArthur Blvd building

Food: Bring lunch with you, no onsite cafeteria; Offsite options for food are not walkable but there are several nearby restaurants within a mile

Objectives

### WRNMMC INPATIENT NEUROPSYCHIATRY ROTATION

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([Return to Required PGY-4 Rotations](#_2fk6b3p))

What to do before arriving and when to do it by

* 2 weeks before starting, contact Dr. David Lowell via Cureatr (preferred) or .mil email and notify him of your clinic day (PGY4) or other limits to availability. Notifying him early allows him to adjust intake times for new patients so that resident will be present.
* Thursday or Friday before the rotation,reach out to the current 7E resident for signout. If there is no resident on 7E, reach out to Dr. Lowell.
* Suggested resources / readings:
  + - Defense and Veterans Brain Injury Center (DVBIC) – management of concussion.
  + <https://dvbic.dcoe.mil/clinical-tools-providers-mild-tbi>
  + - Textbook of Traumatic Brain Injury – Silver and McAllister, Available in the Darnall Library (2 nd or3 rd ed.) Kaufman’s Clinical Neurology for Psychiatrists

What to do when you first arrive

* Where to go – 7E is located in the Walter Reed National Military Medical Center, Building 10, Eagle Zone. Access 7E via the East elevators in building 10 which are to the right of the statue and row of flags in the lobby by the entrance. Exit the patient elevators on the 7 th floor and walk to the front hallway, then turn left. 7E is at the end of the hallway. Use the doorbell for access.
* Badging / Orientation – Ensure that your WRNMMC badge is up to date. Nursing will give you an orientation to the ward upon arrival.
* Bring a stethoscope and if you already own it, bring neuro exam equip (tuning fork and reflex hammer). Otherwise, Dr. Lowell has this neuro exam equipment and is fine with you using his.

During the rotation

* Where to go – You will be working on 7E or in the POD call rooms just outside the doors of 7E.
* Uniform: Service appropriate camouflage/work uniform is the most appropriate. As 7E is a med/surg floor, scrubs would also be appropriate.
* \* Daily routine:
  + 0745 – preround, check in with Dr. Lowell as needed
  + 0815 – morning report w/nursing, rounds, Mon and Thurs – 0930 Interdisciplinary Rounds – 45min – 1 hour
  + Tues, Thurs\* – 1200 Attend noon conference
  + Wed – attend 1100 hour/Grand Rounds, CPR, and Didactics
  + On your clinic day (4 th year), Belvoir residents are gone for the entire day. Walter Reed residents work on 7E for ½ day in the afternoon.
  + 1415-1515 – Educational topics and clinical vignettes. Resident should speak with Dr. Lowell about what they are wanting to study/learn about.
  + 1515 – IPASS Signout to POD with charge nurse present. On Wednesday, resident signs out to POD after didactics.
  + Admissions are ideally at 1030 on Tuesday and Thursday. If the PGY4 resident has clinic day on Tuesday or Thursday, Dr. Lowell will adjust the admit date.
  + \* What do you need to bring – Stethoscope and (optionally) neuro exam equipment
  + \* Expected hours 0745 – 1530.
* Supervisor: Dr. David Lowell, best contacted over Cureatr.

Important POCs:

Stacy Elliot – Case manager, social worker (also on Cureatr)

Dr. Carabello, Dr. Lynch - Psychology

Dr. Law – Neuropsychology

Speech Therapy –

Occupational Therapy –

Pain – Dr. Spevak (Monday), Dr. Wain

Leave policy for rotation: If wanting to take leave, Dr. Lowell would like to be contacted one month in advance. You may take up to 5 working days of leave, best taken at one time.

Parking: park in the MUPS

Objectives

### WRNMMC PGY-4 CONSULT LIAISON PSYCHIATRY ROTATION

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**What to do before arriving and when to do it by:**

* Ensure you have access to Essentris, AHLTA and CHCS.
* Join WB POD/PCLS service on Cureatr
* Make sure you have been N-95 fit tested prior to starting rotation

**What to do when you first arrive:**

* Report first day no later than 0700 to: Walter Reed building 10, 7 Center. Take the East elevators to the 7th floor, turn left out of them (not left down social work wing), at the end of the hallway turn right.
* The resident room is the last door to the left before the double doors, room 7034 (code: 4217, it is Dr. Janke’s door # but backwards) this is where you will work and use computers.
* The conference room for sign out to the entire PCLS/geriatrics staff is next door, 7037 (code: 9307, office # to the left but backwards)
* Pager turn over from the POD is at 0700, preround (chart &/or in person) with table rounds occurring at 0800.
* During rounds you will present any changes to PCLS patients overnight, new consults, or send-outs (including their disposition plan). Be prepared with the one liner for each patient and the H&Ps for new consults overnight as they will likely ask you questions.
* You will also need to print off the patient list which can be found on the Shared Drive -> Behavioral health acute and outpatient services -> PCLS -> !PCLS Sign Out and Patient List.

**During the Rotation:**

**The PGY-4 is the sub-attending on this rotation – it is your responsibility to manage the case load, run morning report, ensure notes are done/ to standard at the end of the day, teach as necessary/ time available, and communicate with Dr Hines regularly. Assign all of the interns and medical students a day to do their 5-10min presentation, help them develop relevant topics for this.**

Daily Routine:

* 0700 – Pager is turned over from the PGY2 psychiatry resident on night float, and any new patients who were seen and any updates about PCLS patients that were signed out are discussed. This occurs in the resident room
* 0700-0800: Pre-round, organize plan of day
* 0745 - 0755 – Staff huddle in conference room
* 0800 – Morning report/ table rounds in conference room
  + New patients will be assigned, previous patients and difficult cases discussed
  + Some days there are visiting staff with their own expertise and provide a different view of how a patient can be conceptualized
* 1200-1250 Tue/ Thurs – Noon Conference
* 1400 – Take your attending to the ER with you after this time
* 1445 – Internal meeting to ensure what patients were seen and develop list for MSAs on SW to put into AHLTA for billing
* 1500 – Last consult/ page answered and accepted
* 1500 – Sign out with PGY2 on short float
* 1500- UTC Finish writing notes, staffing cases/ disposition from ER, any leftover business – Mon, Tue, Fri are available for presentations/ teaching

Pager Expectations**:**

* **Pages returned within 10 minutes**
* ER patients take priority and are seen **within 30** minutes
  + Remember, there are people waiting for you to see them and for others to be seen in the waiting room
  + You don’t need to read every single note in AHLTA and Essentris before seeing the patient
* Ward consults are seen same day unless confirmed w primary team and attending
* Consider ICU consults as having higher priority than ward (when not routine GWOT/ trauma call)

Consult Tips:

* Consultation-Liaison services do not ‘sign off’ on patients mid-hospitalization
* May change frequency of seeing patient – discuss with attending (and patient) if daily visits are unhelpful/ intrusive
* Day of surgery is usually a bad day to see the patient
* Notes are documented in Essentris. Your attending will transfer the note to AHLTA the following day.

Consultation Request Checklist:

1. Name of patient
2. Last 4 social security #/ DoD ID
3. Patient status – (active duty, dependent adult/child, retiree, veteran)
4. Location of patient
5. Who is requesting consultation – not always clear or as it seems; nurses or other staff may be pushing for it or consultant physician but not the primary physician
6. What is the reason for consultation – be as specific as possible; may need to help consultee to refine/clarify the question; not always clear or as it seems
7. Why are you consulting now – what has happened or not happened to trigger consult; what is the precipitating factor?
8. Has patient been informed we are coming and the reason for us coming
9. Urgency of consult (Urgent, ASAP, Routine) –then make your own assessment, don’t take consultee at face value; “routine” consults may actually be urgent (ie concern for suicide) and “urgent” consults may in fact be routine.
10. Give estimate of when patient will be seen.
11. Follow up with consultee after consultation complete.

Referrals from Outpatient Clinic Checklist:

1. Is patient being referred to the ER or to 7W?
   1. If 7W, have the referring provider call the POD Phone at 301-366-2968 to coordinate direct admission. Otherwise:
2. Name of patient & DoD ID
3. Name & phone number of provider making referral
4. Patient status: If active duty, does command know?
5. Appointment type: Was this an acute walk-in or schedule routine appointment
6. Provider’s concerns/ reason for ER referral
7. Is the patient voluntary/ agree with referral to ER
8. Additional information from self-report rating scales and/or collateral
9. Provider’s expectation with ER referral –second opinion for send out, admit for ‘x’ reason
10. Provider’s availability for follow up within 72 hours if patient is ultimately discharged

Consults from the Emergency Room:

1. Ask from ER physician:
   * Name
   * Bed number
   * Chief complaint, how they were brought to ER
   * Pertinent positives / negatives they gathered
   * Abnormal labs, if available
   * Patient’s behavior in ER (ie, acutely agitated and psychotic?)
   * Any known collateral already obtained? (ie, command here with patient)
   * Consult question – hospitalize/ medication changes/ etc
2. Do not let the lack of anything beyond name, bed number, and reason for consult to prevent you from agreeing to see the patient
3. Open Essentris – read notes, check vital signs (pay attention to abnormalities!), look if any interventions have occurred
   * See if previously hospitalized – review discharge summary
4. Open CHCS – Confirm/ look for lab and rads
5. Open AHLTA
   * Look for past psych history
     1. Try to read most recent note from psychiatrist and therapist
     2. Try to read SPEC note from psychiatrist and therapist
     3. If acute change or confusing/ complicated, consider reading previous 3 notes
   * Look for last appointment with primary medical home
   * Look at medication list and allergies. Organize “all outpatient” medication list alphabetically and look for previous prescriptions of psychotropics
   * Look at history of vital signs if currently abnormal in ER
6. Walk patient into AHLTA as “ACUTE” appt BEFORE going to the ER. If under your name, transfer it to your attending once the note is in for signature. If the attending was in the ER with you, do not sign and request co-signature.
7. Close AHLTA. Seriously, you don’t need to read every note.
8. Go see patient. If after 2pm, take your attending with you.

**Responsibilities:**

* Hold pager (or organize who will hold pager)
* Triage consults and set up a system to distribute patients to PCLS team
* Sign-out is at 1500 Monday-Friday in PCLS conference room (#7037)
* Notes from Dr. Ford:
  + Patients are assigned to ensure even work flow and maximize learning opportunities, typically by the PGY4 sub-attending on the service.
  + Attendings rotate between being first available for consults
  + You are a consultant providing a clinical opinion and recommendations. Frequently your opinions are taken verbatim for treatment planning, but the primary team is allowed to disagree with you.
  + Make your notes useful – put the impression and recommendations at the top. Make the recommendations clear and organized (consider problem based vs list if this helps). Add spaces between the lines.

**Supervisor:**

* Dr. Hines, PCLS Chief (c) 706-288-7894

**Uniform of the day:**

* Monday through Friday: Scrubs or uniform of the day

**Important POCs:**

PCLS Staff:

* Dr. Barrios (c) 410-428-0234 (o) 400-2022
* Dr. Janke (c) 330-703-4955 (o) 400-1984
* Dr. Villacis (c) 240-678-0654 (o) 400-0492
* Dr. Ford (c) 910-391-0787 (o) 400-2014

PCLS Social Work:

* Jasmine King (c) 240-888-7050 (o) 400-1875

Social Work ER:

* LT Bryan: (c) 301-633-7518 (o) 319-2885
* SPC Borode: 615-720-1893

PCLS/POD Pager: 202-668-1014

POD Duty Phone: 301-366-2968

### FBCH INPATIENT PSYCHIATRY ROTATION

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What to do before arriving and when to do it by

* Be up to date on BLS and HIPAA training and make sure you have an active medical license.
* You should be contacted by GME at FBCH about 30 days prior to beginning your rotation with a request for current license, BLS, and HIPAA certificates as well as IT to ensure you have access to Essentris at FBCH (separate login from WRNMMC). They prefer to have the documents prior to the start date, but you can bring them with you on day 1.
* IT can also re-activate your Essentris access if it has lapsed prior to starting this rotation

What to do when you first arrive

* On Day 1 you will head first to GME office located at the back of the center atrium/lobby.
* Badging / Orientation: Badging will be done first day if you don’t have one from earlier rotations.
* What do you need to bring:
  + copies of your BLS, HIPAA, and medical license, if you didn’t provide them earlier.
  + ID Badge, FBCH badge is required to access the unit and all locked doors.

During the rotation

* Where to go: Directly to 4N. Resident work station is in 4N staff offices just off the unit.
* What to wear: Generally UOD or working uniforms, during COVID response, scrubs were acceptable.
* Day-to-day: Morning sign-out is at 0800 in conference room. Pt rounds follow, MWF pts are seen individually with attending (via MSFT Teams during COVID), T and Th are Treatment Team days and required once weekly per patient. Pre sign-out is at 1530, Sign-out is 1600 with overnight resident.
* What do you need to bring: Yourself, your knowledge, and your training. Plus a facemask during COVID response, but surgical masks are available on the unit.
* Expected hours: Generally sign-out to sign-out, 0730-1630. Accomodation is possible as needed.

Supervisor: COL Uithol is service chief, medical director of unit. Dr. Michelle Denker and Dr. Swapna Dev are attendings. Each will likely supervise you in different capacities. COL Uithol supervises leadership/management, Drs. Dev and Denker mostly patient care, but there is some crossover.

Important POCs:

GME (May 2020): vanessa.t.henschel.civ@mail.mil

IT/Essentris (May 2020): maya.a.jones.ctr@mail.mil

COL Uithol: [scott.d.uithol.mil@mail.mil](mailto:scott.d.uithol.mil@mail.mil)

Dr. Denker: [michele.j.denker.civ@mail.mil](mailto:michele.j.denker.civ@mail.mil)

Dr. Dev: swapna.s.dev.civ@mail.mil

Leave policy for rotation: Not explicitly prohibited, but given that you will only be there usually 3 days per week due to clinic and didactics, leave is better left to other rotations.

Parking: Meadow garage is only parking facility open to staff during COVID response, otherwise may also park in river garage on floors 3 or 4. Floors 1&2 generally reserved for patients.

Objectives

### CPEP (DC DMH) EMERGENCY PSYCHIATRY ROTATION

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**INTRO TO CPEP**

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**Contacts**

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UMC-202-355-3194

WHC- 202-877-5733 x7234

PIW: 202-885-5610

Access Helpline:-202-671-3070

Attendings:

• Dr. Barbot 6279291

• Dr. Kasaci

• Dr. Ibikunle (medical/program director)

• Dr. Kamal

• Dr. Kasem

• Dr. Farooqui 6279311

Social Workers:

• Mr. Robert Smith 6279322

• Ms. Kia Smith

Phone numbers:

• Attending office: 202-673-9291

• Resident office: 202-673-9001

• Nursing station: 202-673-9321/9319

Nurses:

-Ms. Hylton

-Mr. George

Front desk – (202) 627-9319

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**First Day**

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-Ms. Tamara Burke (“Program Manager”) is your point of contact the first day

- Her office if located in the back

- She will give you the **CPEP keys**, activate your **badge** remotely, and give you access to **Credibile** (the EMR)

-Depending on who the attendings are the first day they may or may not assign you a patient. It also partially depends if there is a resident/ student there before you come. Usually the attendings/staff will ask an existing resident/ medical student to orient you.

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**Daily Routine**

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- Be there by 7:00 AM (this is when morning nursing rounds begin)

- Day ends between 2:30 PM - 3:00 PM (Unless you get an admission after 2pm, there is no reason you should ever have to leave after 2:30 PM)

- At 7:00 AM, nurses will give report on newly admitted patients and f/u patients. They create the daily census and hand it out to everyone

- By 7:30 AM, the room clears out and only attendings, the residents, and students remain. At this time, you will be assigned 3 patients. Usually medical students get 2, but once in a while they will give the student three as well. You should follow patients you were following the day before if they are still there. Otherwise, usually you are given the option of which three you want to take. Usually it doesn’t matter, unless you were particularly interested in any of the patients during report.

- There’s usually lots of time to work on three patient’s up until 2:30 pm.

**What you should review in the chart of a new patient you are picking up:**

-CPEP Psych Note (admission note)

-Psych Reassessment Notes (if you are not the first resident medical student working with the patient)

-Psych Orient Note (this is the UDS)

-Prior Physician Discharge Notes/ (if patient is frequent flier)

-Scheduled medications (current and in the past)

-What medications they got yesterday (EMAR)

-Is the patient connected to a CSA

-Does the patient have insurance

After reviewing charts, locate patients on the unit to see if they were awake or eating breakfast. If they are free, interview them immediately. If sleeping, I’d give them 1 hour and then wake them to let them know I wanted to speak to them.

- After seeing each patient, you need to develop a plan and “chief” the patient to the attending.

- The attending is only familiar with the patient I’d say 25% of the time. The only reason they would know a patient is if they admitted them or were following them the day before with you.

Information you need to convey to them:

-Age, race, gender, housing status, employment status, marital status (and if they have children)

-It is very important to know if patient is homeless at this rotation site because usually you are trying to rapidly transfer or discharge the patient

-Brief summary of what happened that they needed to be brought to CPEP

-Indicate if they are voluntary or involuntary (FD12)

-What medications did they receive yesterday (both scheduled/ involuntary), UDS (urine drug screen) results \*\* (LOOK AT CPEP ORIENT NOTE for this information)

**-Your plan today (staying another 24, going to a hospital, or releasing back to the community)**

-The attending will then tell you if they agree with your plan or want to do something different. They may also ask you to gather collateral information by calling patient's contacts. Collateral information that you gather can be placed in your progress note, or if you have already submitted your progress note you can write a **“collateral note.”**

-Once all the plans are set, go to the whiteboard (nursing station) and write down the disposition plan so that the whole team knows what is going on.

-During the day, depending on how busy it is, you may be asked to do one **admission.** After completing your interview, you input the information in **“CPEP Psych Eval.”**

-There’s also no place to get lunch. Bring lunch, order takeout, or wait until after (you’re done by 2:30 most days)

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**Disposition Planning**

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You and the attending decide from the following three options what the next step is for the patient:

**\* Observation for 24 more hours**

**\* Release back to the community**

**\* Hospital Transfer**

**Observation for 24 more hours:**

-Psychiatrist reassessment note (progress note)

-Gather collateral information from family and friends

-Make sure that patient is connected to a CSA (Core Service Agency) or has other outpatient services

\*Ask the social worker for help if you need it

**Discharge to the Community:**

- “Psychiatrist reassessment note” (progress note)

- ”Physician Discharge Note”

- Connect patient to a CSA/ Outpatient service with outpatient appointment made

\*Ask the social worker (Mr. Smith) to help you connect the patient to a CSA if patient is not connected

- Make follow up appointment for patients just by googling the CSA and talking to an appointments person or the patient’s case manager

- Make sure attending has written a prescription for a couple of weeks for the patient, get the script and give it to nursing staff

- If patient has a home find out if patient can have someone pick them up or if they can get home by themselves using public transportation (nursing staff will give patient tokens if needed)

**\*\*\*\*\* Homeless patient:**

**-**Case manager from CSA can be asked to pick up patient to take directly to CSA facility after which they will take patient to shelter

-Patient can go to homeless shelter themselves if they are willing and know where to go/ how to get there

-If patient is a “traveler” and new to the area, ask Mr. Smith (social worker) to connect patient with HOP (homeless outreach program). HOP helps patients get back to the states/ cities they are from originally and helps them board locally in the interim

-If patient still has some psychiatric symptoms and does not meet criteria to be hospitalized/ stay at CPEP they can be discharged to a “crisis bed”

-There are only two that CPEP is affiliated with:

-Jordan House

-Crossing Place

-If patient is willing to go to one of the crisis bed facilities you have to call them and see if there is availability. There rarely is, but if a bed is available they will ask for a recent TB test and some clinical information. Patient’s never have up to date TB tests so they need to be given one upon discharge and have it read when they are at the crisis facility. The crisis facility may also ask you questions about safety regarding the patient. Patient cannot be acutely suicidal, homicidal, or a danger to self/ others to go to one of these facilities. The idea of the crisis bed facilities is that they are there to help a patient that is still depressed/ manic/ withdrawing from drugs and just need a place to stay where they can be given medication for a few weeks.

-You may need to ask Mr. Smith for some help with all of this in the beginning

-Once patient is accepted by the crisis facility, ask nursing staff or Mr. Smith to get in contact with “Mobile Crisis” so patient can be transferred

**Hospital Transfer:**

-Patient can only be transferred to 4 hospitals:

**- Washington Hospital Center (WHC)** 202-877-5733 x7234

**- United Medical Center (UMC)** 202-355-3194

**- Psychiatric Institute of Washington (PIW)** (only if patient has insurance) 202-885-5610

**- Saint Elizabeth’s (SEH)** (only in very specific cases; this is not a hospital that CPEP usually transfers to)

**Use the following steps to help you transfer the patient:**

1) Quickly see the patient and write your “psychiatric reassessment note”

2) Call nursing staff and ask them to send “the clinicals” to the hospitals you are trying to transfer the patient to

3) Call the hospitals themselves and ask about availability, if they have availability first thing they will ask is if “clinicals have been sent?” Tell them yes, and get a good number you call them back on for an update once they have reviewed the clinicals

4) Call back every hour for an update, often they forget or won’t call back

5) Once you find out the patient has been accepted they will ask you for a “tracking number.” Ask them for a good call back number, because you will need to call them back.

6) Call Access Helpline **202-671-3070** and inform them that the patient is being transferred, sometimes they will have you stay on the phone so you can give them “clinical information.” Once done they will give you either a “treatment number” or a “tracking number.” Patient gets a treatment number when they are medicaid/ have no insurance. They get tracking numbers if they do have insurance.

7) Call back the hospital that accepted the patient and give them the tracking/ treatment number. At this time, ask them for the name of the accepting physician and unit/ bed number where patient will be staying.

8) Fill out the “physician EMTALA” (Directions are below)

9) Complete the “physician discharge note”

10) Inform the attending that everything is done and that they need to write the order to discharge

**^These steps work for all hospital transfers except SEH. The attending will have to help you with transferring a patient to SEH, but your main responsibility will be to write a discharge summary/ hospital course on word document and then to send it the CPEP attending/ appropriate people at SEH (attending will tell you who to email to). You will see an example DC summary that I’ve attached at the bottom.**

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**CREDIBLE**

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Credible is simple and easy to access/ use.

You can get to it using any computer and by typing: [www.crediblebh.com](http://www.crediblebh.com) (domain name: DCDBH)

A screenshot of a social media post

Description automatically generated

Once logged in, search for patients using the “**Consumer”** tab

A screenshot of a social media post

Description automatically generated

Search for a patient using their last name or **“icams number”**

A picture containing clock

Description automatically generated

After clicking “view” you should see the following:

A screenshot of a cell phone

Description automatically generated

^Above are 4 red lines indicating the most important tabs. The first red line is to create a new note. The second is to look at old notes. The third is to look at past/ current scheduled medications. The fourth shows when meds were administered, if they were refused, and if patient got PRN IM/PO medications.

**Placing a new note (First red line in last picture):**

A screenshot of a cell phone

Description automatically generated

Program: Always CPEP-PES

Location: Always DBH’s Comprehensive Psychiatric Emergency Program

Service/ Note Types you will input:

CPEP Psychiatrist Reassessment (Progress Note)

CPEP Psych Eval (Admission Note)

CPEP Physician Discharge (Discharge Note)

CPEP Legal Emtala (needed for ambulance transfer to another facility)

CPEP Collateral Note (only needed if you have new information and you already submitted the reassessment note)

^All the notes are pretty self explanatory except for the **EMTALA note** which should be filled out as follows:

**• 1a. Choose A; 1b. check the box**

**• 2. Choose A**

**• 3. Fill in destination of hospital (i.e. UMC), Accepted by (if UMC, usually put Mr. Tyler),**

**Accepting physician (if UMC, usually Dr. Kandel), and your initials in last box if you got the**

**acceptance over the phone**

**• 4. Type Elopement Risk**

**• 5. Type “Psychiatric Stabilization” Underneath, put the pre-authorization number, AHL**

**tracking number, or AHL treatment number if applicable**

**• 6a. Check BLS**

**• Don’t fill out any further.**

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EXAMPLE SEH Discharge Note

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**Clinical Information:** Ms. A.H

**Referred By:** Community Support Work (CSA Hillcrest) (Case Manager: Mr. B 999-999-9999)

(Clinical Manager Ms. V 999-999-9999)

**From:** Community

**Legal Status:** Involuntary (CMOP)

**Reason for Admission:** Psychosis/Bizarre Behavior

**History of Present Illness:**

Pt. is a 69 yrs. old AAF, domiciled, living in an apartment independently, CMOP, linked to Hill Crest

CSA, diagnosed to have Schizophrenia, paranoid type, and HTN, chronically non-compliant with

treatment. Pt. is brought to CPEP today escorted by police with an FD12 written by Ms. B

M of MCS ( 999-999-9999). Ms. M accompanied the pt. to CPEP and reported to writer

that OAG had called MCS chief Ms. T.M that pt. is CMOP and her neighbors are

complaining that she is putting herself and her neighborhood at risk by her behavior. She is allowing drug

dealers to go in an out of her home, living in unhealthy living conditions with bed bugs in her home

putting neighbors at risk of infestation as well. MCS staff observed her walking in the parking lot without

shoes . She was very delusional claiming that she is pregnant with triplets and gave birth to a baby last

night. When asked about her medications she stated that she gets a shot and does not take oral meds.

When asked when did she get her last shot, she became upset , yelling ' Get off my property. I own the

United States and the police department and sunset.' She became increasingly agitated, yelling at police

officers and MCS that ' she does not know them and does not deal with niggers.' Pt. was considered to

have poor insight and impaired judgment , putting herself and others by her behavior. She was

hospitalized to WHC on 5-26-16 with FD12 written by MCS for inability for self care and aggressive

behavior but was discharged a few days later. It is not clear to writer when pt. was d/c from WHC and if

she received her LAI injection at WHC or not. Pt's CM is Mr B at Hillcrest 999-999-9999.

Upon triage at CPEP pt. was noted to be very dirty, disheveled, malodorous with matted short cropped

hair and poor personal hygiene. She is almost edentulous and appeared malnourished and older than

her stated age. Pt. was uncooperative with admission process and needed lot of encouragement to

cooperate with VS and FS check. She seemed to be phasing in and out of alertness. For a moment she

would sit on the chair as if dosing off but the next minute would be screaming , yelling, cursing and

threatening loudly everybody in the room including writer, her nurse, counselor , security and police

officers. She called writer ' a White Bitch' and stated that she does not want to talk to anyone. She

claimed that her doctor is at Hill Crest and she does not know if writer is a doctor or not. She loudly

refused oral meds. offered to her claiming that she needs no medication and demanded that her hand

cuffs be removed immediately. Pt. was escalating in verbal threats, stood up abruptly , moved towards

her nurse and had a loud anger outburst directed at her nurse who was trying to reassure her. Pt.

needed urgent i/m meds. to ensure others' safety. Her VS Showed BP 130/67 mm Hg. P: 91/min. R/R:

18/min. and T: 97.7\*F. FS: 103 mg /dl. BAL : 0.00. UDS: pending.

**Past Psychiatric History (Include: CSA, case management, hospitalizations):**

The patient is 69 Y/o AAF with long h/o mental illness, diagnosed to have Schizophrenia , paranoid type,

( however, CSA note reports diagnosis of Bipolar I D/O with psychotic features and alcohol dependence

as her diagnoses). She is chronically non-compliant with treatment, h/o multiple psychiatric

hospitalizations to CPEP and local area psychiatric inpatient units. CMOP , linked to Hill Crest CSA. Mr.

B is her CM at Hill Crest 999-999-9999.

For her most recent CPEP encounter pt. was brought to CPEP on 2-9-18 under following circumstances.

Police wrote the FD12 certificate after her property manager called to state that pt. was cooking and left

the pot on the stove and the fire department had to be called because of the risk of fire setting in the

building, The property manager had concern that the patient will end up causing a fire or blow up the

apartment building. DBH and Hillcrest have reportedly some concerns that she can not live

independently. In summary this is considered a high profile case that has come to the attention of the DC

Mayor 's office. In addition the patient allegedly has been defecating in the hallway and there are

clothing, food, roaches all over her apartment. Upon her arrival at our intake unit she was very agitated,

attempted to spit on staff members at the intake unit, was selectively mute and laying on the ground. She

did have tor receive some emergency medication including Haldol 10 mg and Benadryl 50 mg im x 1

dose stat.

On 2-11-18 pt. was transferred to PIW for extended inpt. treatment. From there she was transferred to

St. Elizabeths hospital. Psychiatrically committed on 4-25-18.

Her CSA note on 4-17 -18 reports that pt. has Bipolar I D/O with psychotic features and Alcohol

dependence. Has been refusing treatment for alcohol dependence. She was found to be +ve for PCP on

her admission to WHC 2 weeks prior to her admission to CPEP on 2-9-18. She has not been paying her

rent on a regular basis and has been spending her money on buying alcohol from a nearby liquor store.

Reportedly pt. was most recently hospitalized to WHC on 5-26-18 with FD12 for inability for self care ,

urinating on herself and in public areas, walking on broken glass barefoot etc. and apparently released

prematurely a few days later. It is not clear how long she was at WHC and if she received any LAI

injection before d/c or not.History of Suicidal/Homicidal/Violent

**Behavior:** She has a history of aggressive and violent behavior

**Social History (family, emotional, physical, sex abuse, legal, substance use):**

Details unknown. She lives in an apartment independently. Her CSA has been questioning her ability to

live independently and nursing home placement is being considered as per ICAMs notes.

Medical History (head injuy, seizure disorders, surgeries, etc.): H/O HTN, Arthritis, Asthma, NKDA.

**Condition at Discharge:**

Ms. H is a 69 YO AAF who is single, unemployed, and domiciled (in the process of being evicted).

She has a history of Schizophrenia and was brought to CPEP after she found roaming the community

disorganized, disoriented, and delusional.

Ms. H was seen walking slowly and needed some assistance to walk into the interview booth. She

was disheveled with poor dentition. She explained that she was here (at CPEP), because she was

pregnant and needed to give birth. She was unable to recall her correct age or the date. She stated that

she lives "day by day," with the inability to recall events the previous day. Furthermore, she stated that

during the day time she sometimes drinks alcohol but limits her intake due to her pregnancy. She stated

that she "ran out" of her medications in the community and doesn't remember when she last took them.

She was counseled on the need to take her psychiatric medications and advised not to use recreational

Drugs.

Due to her disorganized/ psychotic behavior upon admission she required Haldol 10 mg / benadryl 50

mg / Ativan 2 mg (all IM). Subsequently, she has been willing to take her PO medications and has been

receiving Haldol 5 mg PO BID, Cogentin 0.5mg PO BID, and Chlordiazepoxide 25 mg PO BID (alcohol

withdrawal).

**Plan:**

- Patient with cognitive deficits and acute psychotic symptoms which require further hospitalization

- Plan to transfer patient back to SEH for stabilization

- Recommend switching patient to PO Invega and then administer long acting injection (She has

received Invega Sustenna in December 2017)

- Recommend switching Cogentin to Amantadine to prevent EPS symptoms

Disposition: SEH

Explain Responses & Include Suicidal/Homicidal/Violence Assessment:

Denied SI/HI/AVH

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**SAMPLE PROGRESS NOTE (“Psych Assessment Note”)**

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Ms. J.P. is a 76 YO WHI (Polish American Jew) female who is unemployed, homeless was brought to CPEP on FD-12 because she was confused and was unable to answer any questions or follow any commands.

Ms. P was willing to come to the inteview booth today to discuss her disposition. Many times during the interview she got upset and called the writer an "Anti-Semite" and other times she tried to build rapport with writer and asked him to help her get to a synagogue in NYC. She was ordered Zyprexa 2.5 mg PO QHS which she refused last night and continued to state that she would not be taking any medications. Similarly, today, she denied mood symptoms, SI/HI/AVH.

She perseverated on having someone help her get in contact with a Synagogue in NYC. She provided an address and phone number but no synagogue could be found as she described. Writer found other Synagogue's in Brooklyn (where she is from) and provided them to her. Writer explained to her that she would be discharged to a homeless shelter where they would help to provide transportation for her back to NYC. She accepted the plan.

Assessment:

1. Schizophrenia, chronic

2. Poor medication compliance

- Not an imminent danger to self/ others at this time

Plan:

- Discharge patient to shelter

- Consider providing script for Zyprexa (although she refuses to take medications)

- Will call family member in Michigan who she has report with to update her on Ms. P's disposition

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**SAMPLE DISCHARGE NOTE (“Physician Discharge Note”)**

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**\*\*FOR HPI COPY AND PASTE from CPEP Psych NOTE**

**\*\*For Hospital Course/ Disposition Copy and Paste your most recent reassessment note (only if your reassessment note is inclusive with enough details)**

History of Present Illness:

76 y/o white female who was brought to CPEP on an FD12 document by the Amtrak Police. According to the officers the pateint who was at Travelers Aids stated that her purse was stolen at Mc. Donald.. according to one of her niece who live in Michigan Ms. D.F 999-999-9999 whom the officer were able to contact said she has a 30 year history of schizophrenia has not been taking medications for 3 years has been homeless in NY where she came rom. She said she came here in order to meet a senator about issue concerning LGBT and she is lesbian herself, and her niece who often send her money by Western Union told the officer she has some money there but refused to go pick it up

Past Psychiatric History (Include: CSA, case management, hospitalizations): As per the officer he niece who live in Michigan D.F. 999-999-9999 state her aunt has a 30 year history of schizophrenics, has been off medications for 3 years has been homeless in NY for 3 ye and has been in DC for a week and came by the peter pan bus line History of

Suicidal/Homicidal/Violent Behavior: Unknown

Social History (family, emotional, physical, sex abuse, legal, substance use): Unknown she reportedly was homeless in NY. She said that she has a master in OBA. Medical History (head injuy, seizure disorders, surgeries, etc.): History of chronic Dermatitis, Arthritis and S/P lumpectomy in the Right Breast. She also reportedly is allergic to PNC and had a reaction to Haldol

Hospital Course:

Ms. J.P. is a 76 YO WHI (Polish American Jew) female who is unemployed, homeless was brought to CPEP on FD-12 because she was confused and was unable to answer any questions or follow any commands.

Ms. P was willing to come to the interview booth today to discuss her disposition. Many times during the interview she got upset and called the writer an "Anti-Semite" and other times she tried to build rapport with writer and asked him to help her get to a synagogue in NYC. She was ordered Zyprexa 2.5 mg PO QHS which she refused last night and continued to state that she would not be taking any medications. Similarly, today, she denied mood symptoms, SI/HI/AVH.

She perseverated on having someone help her get in contact with a Synagogue in NYC. She provided an address and phone number but no synagogue could be found as she described. Writer found other Synagogue's in Brooklyn (where she is from) and provided them to her. Writer explained to her that she would be discharged to a homeless shelter where they would help to provide transportation for her back to NYC. She accepted the plan.

Assessment:

1. Schizophrenia, chronic

2. Poor medication compliance

- Not an imminent danger to self/ others at this time

Plan:

- Discharge patient to shelter

- Consider providing script for Zyprexa (although she refuses to take medications)

- Will call family member in Michigan who she has report with to update her on Ms. P's disposition

### SENIOR TEACHING RESIDENT ROTATION

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([Return to Required PGY-4 Rotations](#_2fk6b3p))

What to do before arriving and when to do it by

* If you do your continuity clinic at FBCH and your clinic day is Tuesday or Thursday please change the day of continuity clinic for the duration of the rotation. We recommend doing this at least a month in advance
* Review the STR Memorandum (MFR) (link will go here) for Record at least a month in advance
* The STR will meet with the program director (PD) one week prior to starting the rotation to receive guidance and faculty development.
* Organize your own schedule based on the recommended schedule in the MFR

What to do when you first arrive

* Where to go: See above
* Orientation; Review the MFR and see above

During the rotation

* Where to go: Noon Conference is generally in Heroes Fl 3 Rm 3007/08 or as designated in the CPR e-mail, BH Tech instruction occurs in the PCLS conference room.
* What to wear: Uniform of the Day (usually ACU or NWU)
* Day-to-day work explanation: 1 Hour Noon Conference on Tuesdays and Thursdays, 1 Hour Morbidity & Mortality Conference on the First Thursday of the month following Noon Conferenc 2 hours of BH Tech teaching on Wednesday Mornings, observing and providing feedback on IPASS sign-out on PCLS/7W 6 times over the course of the rotation. Weekly meetings with the PD to review feedback. The rest of the time is spent reviewing the readings, preparing for Noon Conference, and engaging in self-study.
* Expected hours- see schedule in MFR

Supervisor

MAJ Rohul Amin ([rohul.amin.mil@mail.mil](mailto:rohul.amin.mil@mail.mil) O:301-400-1924)

Important POCs

Academic Chairs- CPT Jane Ma ([jane.ma.mil@mail.mil](mailto:jane.ma.mil@mail.mil) C: 515-326-0236) and CPT Francis Ridge ([francis.o.ridge2.mil@mail.mil](mailto:francis.o.ridge2.mil@mail.mil) C: 716-534-4021)

7W Service Chief- LCDR Raquel Williams ([raquel.t.williams4.mil@mail.mil](mailto:raquel.t.williams4.mil@mail.mil))

PCLS Service Chief- LTC Shannon Ford ([shannon.c.ford.mil@mail.mil](mailto:shannon.c.ford.mil@mail.mil) O: 301-400-2014)

Leave policy for rotation

The STR will ensure to provide the Chief Resident coverage for any planned leave during this rotation. The Chief Resident will ensure coverage is provided and communicated with the Academic Chairs when needed.

Parking

Objectives

## SELECTIVE ROTATIONS

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Background

Selective rotations are…

Hold down CTRL and click on a rotation below to see its description:

[INTERVENTIONAL PSYCHIATRY ROTATION](#_meukdy)

[WRNMMC PSYCHIATRY CONTINUITY SERVICE (IOP) ROTATION](#_36ei31r)

[WRNMMC CAPS ROTATION](#_1ljsd9k)

[FBCH INPATIENT CAPS ROTATION](#_45jfvxd)

[SLEEP MEDICINE ROTATION](#_2koq656)

[PAIN MEDICINE ROTATION](#_zu0gcz)

[EMERGENCY MEDICINE ROTATION](#_3jtnz0s)

[NEUROLOGY OUTPATIENT ROTATION](#_1yyy98l)

[NEUROLOGY INPATIENT ROTATION](#_4iylrwe)

[ADVANCED PSYCHOPHARMACOLOGY ROTATION](#_2y3w247)

[SCHOLARLY ACTIVITY / RESEARCH ROTATION](#_1d96cc0)

[DC VAMC INPATIENT PSYCHIATRY ROTATION](#_3x8tuzt)

[FBCH CAPS PARTIAL HOSPITALIZATION ROTATION](#_2ce457m)

What to do to setup your selective rotation

### INTERVENTIONAL PSYCHIATRY ROTATION

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([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### WRNMMC PSYCHIATRY CONTINUITY SERVICE (IOP) ROTATION

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([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### WRNMMC CAPS ROTATION

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([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### FBCH INPATIENT CAPS ROTATION

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([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### SLEEP MEDICINE ROTATION

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### PAIN MEDICINE ROTATION

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### EMERGENCY MEDICINE ROTATION

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### NEUROLOGY OUTPATIENT ROTATION

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([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### NEUROLOGY INPATIENT ROTATION

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([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### ADVANCED PSYCHOPHARMACOLOGY ROTATION

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### SCHOLARLY ACTIVITY / RESEARCH ROTATION

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([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### DC VAMC INPATIENT PSYCHIATRY ROTATION

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([Return to Selective Rotations](#_279ka65))

What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

### FBCH CAPS PARTIAL HOSPITALIZATION ROTATION

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What to do before arriving and when to do it by

* Any requirements for starting the rotation

What to do when you first arrive

* Where to go
* Badging / Orientation
* What do you need to bring

During the rotation

* Where to go
* What to wear
* Day-to-day work explanation
* What do you need to bring
* Expected hours

Supervisor

Important POCs

Leave policy for rotation

Parking

Objectives

## ELECTIVE ROTATIONS

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

Background

Elective rotations are…

Elective Rotation Options

Hold down CTRL and click on a rotation below to see its description:

Organize own electives across the region

Rotation at the Pentagon clinic

Operational rotations (under development)

Navy ship hospital rotation

Landstuhl rotation (under development)

What to do to setup your elective rotation

# DIDACTICS

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

Background

Courses are designed to ensure specific topics are not just presented but learned and integrated into practice. To help ensure there is a shared model of what is important within each topic, teachers are required to submit objectives. These should both guide the learner and help the learner give feedback as to the effectiveness of the course.

## RECURRING ACADEMIC MEETINGS

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Hold down CTRL and click on an event below to see its description:

[TUESDAY AND THURSDAY NOON CONFERENCE](#_4anzqyu)

[WEDNESDAY 1100 CONFERENCE](#_2pta16n)

[GRAND ROUNDS](#_14ykbeg)

### TUESDAY AND THURSDAY NOON CONFERENCE

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([Return to Recurring Academic Meetings](#_1qoc8b1))

Format

A PGY 1, 2, or 3 will present a case, and the Senior Teaching Resident will facilitate discussion and provide teaching on a topic relevant to the case.

Purpose

Case presentations are a clinically-based learning platform intended to cultivate critical thinking skills. This is NOT a platform for detecting and reporting adverse events or criticizing quality of care. Feedback for residents is expected; however, this should be done in a professional and appropriately discrete manner. Case presentations are meant to be a learning tool to stimulate clinical thinking, develop mental models, and encourage resident participation in order to produce maximum teaching/learning effectiveness.

Objectives

Primary: Cultivate critical thinking skills as it applies to the following:

* Identify baseline knowledge and recognize what is unknown
* Develop differential diagnoses
* Recognize pertinent information as well as pertinent unknown information
* Identify all factors contributing to patient presentation
* Construct effective treatment plans and dispositions, including military disposition

Secondary: Develop oral case presentation skills (junior resident) and advance clinical teaching skills (senior teaching resident)

Responsibilities

Junior Level resident

* Work with Senior Teaching Resident and senior level resident to select a clinical case
* Prepare and deliver oral case presentation

Senior Teaching Resident

* Work with junior level resident to select case
* Lead and facilitate interactive discussion with open-ended questions
* Specific details outlined in Senior Teaching Resident Objectives, but will include covering a wide range of topics, from medical/biological contributions to mental health problems to ethical implications

Audience

* Actively participate and contribute to discussion

Faculty

* Approximately last 10 minutes of conference will be reserved for faculty participation; often one faculty member will be asked to think through the case out loud in order to help residents develop mental models and learn from your experience

Selected Readings

Bhugra, D. (2010) How Shrinks Think: Decision Making in Psychiatry. *Australasian Psychiatry: Bulletin of the Royal Australian and New Zealand College of Psychiatrists*, 18:5, 391-393. DOI: 10.3109/10398562.2010.500474

Croskerry, P. (2003) The Importance of Cognitive Errors in Diagnosing and Strategies to Minimize Them. *Academic Psychiatry,* 78(8), 775-780

David C. M. Taylor & Hossam Hamdy (2013) Adult Learning Theories: Implications for Learning and Teaching in Medical Education: AMEE Guide No. 83, *Medical Teacher*, 35(11), e1561-e1572, DOI: 10.3109/0142159X.2013.828153 . https://doi.org/10.3109/0142159X.2013.828153

Houghtalen, R.P. et. Al (2002) Residents’ Morning Report in Psychiatry Training: Description of a Model and Survey of Resident Attitudes. *Academic Psychiatry,* 26(1), 9-16

Vogel, W. & Viale, P.H. (2018) Presenting with Confidence. *Journal of the Advanced Practitioner in Oncology*, 9(5), 545-548

### WEDNESDAY 1100 CONFERENCE

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([Return to Recurring Academic Meetings](#_1qoc8b1))

Objective(s)

* Journal Club- This is a time to discuss both current and historic literature with a critical lens with the guidance of the JAMA user’s guide.
* Quality Improvement/Process Improvement- an opportunity for QI/PI teams to present their projects and provide updates.
* M&M Conferences – Learn to assess cases for change.

Teacher:

### GRAND ROUNDS

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The up-to-date schedule for grand rounds is in the Shares Folder at:

[\\WRNMDFPISISMBD1\DeptShares$\Dept3\PSYCHIATRY2\Academics\Grand Rounds](about:blank)

## ALL YEAR GROUP ACADEMIC EVENTS

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Hold down CTRL and click on an event below to see its description (list is alphabetical):

[APA PRACTICE PRESENTATIONS](#_243i4a2)

[ARTISS SYMPOSIUM](#_j8sehv)

[END OF YEAR HUDDLE](#_338fx5o)

[FIFTH WEDNESDAY](#_1idq7dh)

[HALF-YEAR HUDDLE](#_42ddq1a)

[PRITE](#_2hio093)

[PROGRAM DIRECTOR DAY](#_wnyagw)

[SUD SYMPOSIUM](#_3gnlt4p)

### APA PRACTICE PRESENTATIONS

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([Return to All Year Group Academic Events](#_3oy7u29))

Objective(s)

Teacher:

### ARTISS SYMPOSIUM

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([Return to All Year Group Academic Events](#_3oy7u29))

Objective(s)

Teacher:

### END OF YEAR HUDDLE

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([Return to All Year Group Academic Events](#_3oy7u29))

Objective(s)

Teacher:

### FIFTH WEDNESDAY

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Objective(s): Please see Wellness section on Fifth Wednesday

### HALF-YEAR HUDDLE

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([Return to All Year Group Academic Events](#_3oy7u29))

Objective(s)

Teacher:

### PRITE

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Objective: Please see ABPN section on PRITE

### PROGRAM DIRECTOR DAY

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Objective(s)

Teacher:

### SUD SYMPOSIUM

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([Return to All Year Group Academic Events](#_3oy7u29))

Objective(s)

Teacher:

## DIDACTICS SCHEDULE

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The up-to-date schedule for didactics in the Shares Folder at:

[\\WRNMDFPISISMBD1\DeptShares$\Dept3\PSYCHIATRY2\Academics\Schedules](about:blank)

## PGY-1 COURSES

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Hold down CTRL and click on a rotation below to see its description (list is alphabetical):

[ACADEMIC PSYCHIATRY](#_2uxtw84)

[ADDICTION PSYCHIATRY](#_1a346fx)

[BASIC PSYCHOTHERAPY](#_3u2rp3q)

[BASIC PSYCHOPHARMACOLOGY](#_2981zbj)

[CBT – INSOMNIA](#_odc9jc)

[CONSULT LIAISON PSYCHIATRY](#_38czs75)

[ED ASSESSMENT OF A SUICIDAL PATIENT](#_1nia2ey)

[EMERGENCY PSYCHIATRY](#_47hxl2r)

[EVALUATION & MANAGEMENT OF PERSONALITY DISORDERS](#_2mn7vak)

[GERIATRIC PSYCHIATRY](#_11si5id)

[INPATIENT PSYCHIATRY](#_3ls5o66)

[INPATIENT SUICIDE ASSESSMENT & PREVENTION](#_20xfydz)

[INTRODUCTION TO PSYCHOTHERAPY – CBT](#_4kx3h1s)

[INTRODUCTION TO PSYCHOATHERAPY – INPATIENT GROUP](#_302dr9l)

[INTRODUCTION TO PSYCHOTHERAPY – MOTIVATIONAL INTERVIEWING](#_1f7o1he)

[INTRODUCTION TO PSYCHOTHERAPY – PSYCHODYNAMIC](#_3z7bk57)

[INTRODUCTION TO PSYCHOTHERAPY – SUPPORTIVE](#_2eclud0)

[INTRODUCTION TO SCHOLARLY ACTIVITY](#_thw4kt)

[LEARNING PSYCHOTHERAPY](#_3dhjn8m)

[MENTAL STATUS EXAM](#_1smtxgf)

[NEUROLOGY EXAM](#_4cmhg48)

[ON CALL PSYCHIATRY](#_2rrrqc1)

[PSYCHIATRIC FORMULATION](#_16x20ju)

[PSYCHIATRIC INTERVIEWING](#_3qwpj7n)

[PSYCHOLOGICAL ASSESSMENT](#_261ztfg)

[RESIDENTS AS TEACHERS I](#_l7a3n9)

[SUICIDOLOGY](#_356xmb2)

### ACADEMIC PSYCHIATRY

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Objective(s)

Teacher:

### ADDICTION PSYCHIATRY

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### BASIC PSYCHOTHERAPY

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### BASIC PSYCHOPHARMACOLOGY

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### CBT – INSOMNIA

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Objective(s)

Teacher:

### CONSULT LIAISON PSYCHIATRY

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Objective(s)

Teacher:

### ED ASSESSMENT OF A SUICIDAL PATIENT

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### EMERGENCY PSYCHIATRY

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### EVALUATION & MANAGEMENT OF PERSONALITY DISORDERS

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### GERIATRIC PSYCHIATRY

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### INPATIENT PSYCHIATRY

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### INPATIENT SUICIDE ASSESSMENT & PREVENTION

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### INTRODUCTION TO PSYCHOTHERAPY – CBT

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### INTRODUCTION TO PSYCHOATHERAPY – INPATIENT GROUP

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### INTRODUCTION TO PSYCHOTHERAPY – MOTIVATIONAL INTERVIEWING

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### INTRODUCTION TO PSYCHOTHERAPY – PSYCHODYNAMIC

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### INTRODUCTION TO PSYCHOTHERAPY – SUPPORTIVE

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### INTRODUCTION TO SCHOLARLY ACTIVITY

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### LEARNING PSYCHOTHERAPY

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### MENTAL STATUS EXAM

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### NEUROLOGY EXAM

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### ON CALL PSYCHIATRY

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### PSYCHIATRIC FORMULATION

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### PSYCHIATRIC INTERVIEWING

([Return to Table of Contents](#_TABLE_OF_CONTENTS))

([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### PSYCHOLOGICAL ASSESSMENT

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### RESIDENTS AS TEACHERS I

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([Return to PGY-1 Course List](#_4fsjm0b))

Objective(s)

Teacher:

### SUICIDOLOGY

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Objective(s)

Teacher:

## PGY-2 COURSES

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Hold down CTRL and click on a course below to see its description (list is alphabetical):

[ADVANCED INPATIENT PSYCHIATRY](#_44bvf6o)

[ATTENDING COLD CASE CHALLENGE: CASE SYNTHESIS](#_2jh5peh)

[CHILD & ADOLESCENT PSYCHOPATHOLOGY](#_ymfzma)

[COGNITIVE BEHAVIORAL THERAPY](#_3im3ia3)

[CRITICAL APPRAISALS OF RCTs](#_1xrdshw)

[EVIDENCE-BASED PSYCHOTHERAPY FOR PTSD](#_4hr1b5p)

[INTRODUCTION TO OUTPATIENT GROUP](#_2wwbldi)

[INTRODUCTION TO PSYCHODYNAMIC THERAPY](#_1c1lvlb)

[GROWTH & DEVELOPMENT](#_3w19e94)

[MEDICINE FOR PSYCHIATRISTS](#_2b6jogx)

[NEUROPSYCHOLOGY](#_qbtyoq)

[POST WAR HEALTH](#_3abhhcj)

[RESIDENTS AS TEACHERS II](#_1pgrrkc)

[SLEEP MEDICINE](#_49gfa85)

[TRANSITION TO PGY-3 (INCLUDING FBCH ORIENTATION)](#_2olpkfy)

### ADVANCED INPATIENT PSYCHIATRY

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### ATTENDING COLD CASE CHALLENGE: CASE SYNTHESIS

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### CHILD & ADOLESCENT PSYCHOPATHOLOGY

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### COGNITIVE BEHAVIORAL THERAPY

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### CRITICAL APPRAISALS OF RCTs

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### EVIDENCE-BASED PSYCHOTHERAPY FOR PTSD

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### INTRODUCTION TO OUTPATIENT GROUP

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### INTRODUCTION TO PSYCHODYNAMIC THERAPY

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### GROWTH & DEVELOPMENT

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### MEDICINE FOR PSYCHIATRISTS

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### NEUROPSYCHOLOGY

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### POST WAR HEALTH

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### RESIDENTS AS TEACHERS II

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### SLEEP MEDICINE

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

### TRANSITION TO PGY-3 (INCLUDING FBCH ORIENTATION)

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([Return to PGY-2 Course List](#_1kc7wiv))

Objective(s)

Teacher:

## PGY-3 COURSES

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Hold down CTRL and click on a rotation below to see its description:

[ACADEMIC PSYCHIATRY](#_22vxnjd)

[ADVANCED PSYCHOPHARMACOLOGY](#_i17xr6)

[BRIEF DYNAMIC PSYCHOTHERAPY](#_320vgez)

[COGNITIVE BEHAVIORAL THERAPY](#_1h65qms)

[CONSOLIDATED TRAUMA-FOCUSED THERAPY](#_415t9al)

[COUPLES THERAPY](#_2gb3jie)

[DIALECTICAL BEHAVIORAL THERAPY](#_vgdtq7)

[EVIDENCE-BASED PSYCHIATRY](#_3fg1ce0)

[EVIDENCE-BASED PSYCHOTHERAPY FOR PTSD](#_1ulbmlt)

[FAMILY THERAPY](#_4ekz59m)

[FORENSICS](#_2tq9fhf)

[FTX BUSHMASTER](#_18vjpp8)

[MANAGING YOUR PRACTICE](#_3sv78d1)

[OP GROUP SEMINAR](#_280hiku)

[OPERATIONAL MEDICINE](#_n5rssn)

[READINESS COMPETENCIES](#_375fbgg)

[RESIDENTS AS TEACHERS III](#_1maplo9)

[TRANSITION TO PGY-4](#_46ad4c2)

### ACADEMIC PSYCHIATRY

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### ADVANCED PSYCHOPHARMACOLOGY

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### BRIEF DYNAMIC PSYCHOTHERAPY

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### COGNITIVE BEHAVIORAL THERAPY

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### CONSOLIDATED TRAUMA-FOCUSED THERAPY

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### COUPLES THERAPY

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### DIALECTICAL BEHAVIORAL THERAPY

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### EVIDENCE-BASED PSYCHIATRY

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### EVIDENCE-BASED PSYCHOTERAPY FOR PTSD

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### FAMILY THERAPY

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### FORENSICS

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### FTX BUSHMASTER

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### MANAGING YOUR PRACTICE

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### OP GROUP SEMINAR

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### OPERATIONAL MEDICINE

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### READINESS COMPETENCIES

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### RESIDENTS AS TEACHERS III

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

### TRANSITION TO PGY-4

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([Return to PGY-3 Course List](#_13qzunr))

Objective(s)

Teacher:

## PGY-4 COURSES

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Hold down CTRL and click on a rotation below to see its description (list is alphabetical):

[ADMIN PSYCH – BEING A SERVICE CHIEF](#_10kxoro)

[ADVANCED PSYCHODYNAMIC CONCEPTS](#_3kkl7fh)

[ADVANCED SLEEP MEDICINE](#_1zpvhna)

[ETHICS](#_2yutaiw)

[HEALTH PSYCHOLOGY](#_1e03kqp)

[INTERVENTIONAL PSYCHIATRY](#_3xzr3ei)

[LEADING ORGANIZATIONAL CHANGE AND LEAVING A MARK](#_2d51dmb)

[MILITARY OFFICER COMPETENCIES](#_sabnu4)

[NEUROLOGY REVIEW](#_3c9z6hx)

[NEUROPSYCHIATRY](#_1rf9gpq)

[OSCAR MIKE: BECOMING THE BEHAVIORAL HEALTH SME](#_4bewzdj)

[PAIN MANAGEMENT](#_2qk79lc)

[POPULATION BEHAVIORAL HEALTH NEEDS ASSESSMENT](#_15phjt5)

[TRANSITION TO PRACTICE](#_3pp52gy)

### ADMIN PSYCH – BEING A SERVICE CHIEF

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### ADVANCED PSYCHODYNAMIC CONCEPTS

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### ADVANCED SLEEP MEDICINE

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

**CLINICAL APPLICATIONS OF PSYCH EPIDEMIOLOGY**

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### ETHICS

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### HEALTH PSYCHOLOGY

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### INTERVENTIONAL PSYCHIATRY

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### LEADING ORGANIZATIONAL CHANGE & LEAVING A MARK

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### MILITARY OFFICER COMPETENCIES

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Objective(s)

Teacher:

### NEUROLOGY REVIEW

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### NEUROPSYCHIATRY

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### OSCAR MIKE: BECOMING THE BEHAVIORAL HEALTH SME

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### PAIN MANAGEMENT

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Objective(s)

Teacher:

### POPULATION BEHAVIORAL HEALTH NEEDS ASSESSMENT

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

### TRANSITION TO PRACTICE

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([Return to PGY-4 Course List](#_2lfnejv))

Objective(s)

Teacher:

# RESEARCH

## RESEARCH OPPORTUNITIES

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National Intrepid Center of Excellence

USUHS

Robust faculty led research projects

Home of Army STAARS

NIH collaboration

Walter Reed and Fort Belvoir

# EDUCATIONAL RESOURCES AND BOARD PREPARATION

## THERAPY TRAINING MODALITIES

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* PESI: Free for active duty military (<https://www.pesi.com/>)
* CDP: PE, CPT, CBT-I, CBT for suicide prevention, and CBT-D (<https://deploymentpsych.org/workshops>)

## SELF-DIRECTED LEARNING CONTENT

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* Audio Digest
  1. The DHA has licensed AudioDigest platinum that would cost you $1000/year to purchase.
  2. You can get it for free: <https://membership.audio-digest.org/registration/institutions>
  3. You must sign-up from work or while VPN’d in. Use Chrome (internet explorer acts up). When signining up, the “My Contact Information” is already filled out so leave it as-is.
  4. Create your account and then obtain the free online app. Login with your account and you are in business. Earn CMEs/CEUs.
* BoardVitals Psychiatry
  1. Questions:
     + <https://www.boardvitals.com/app/#/exams/new?question_bank_id=17>
  2. Vignettes
     + <https://www.boardvitals.com/app/#/exams/new?question_bank_id=49>
* Kaufman’s Clinical Neurology for Psychiatrists
  1. <https://www-clinicalkey-com.wrnmmc.idm.oclc.org/#!/browse/book/3-s2.0-C20150000557>
* Massachusetts General Hospital Comprehensive Clinical Psychiatry
  1. <https://www-clinicalkey-com.wrnmmc.idm.oclc.org/#!/browse/book/3-s2.0-C20090325519>
* Core Psychiatry
  1. <https://www-clinicalkey-com.wrnmmc.idm.oclc.org/#!/browse/book/3-s2.0-C20090532205>

# ABPN BOARD CONTENT

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|  |  |
| --- | --- |
| Schizophrenia spectrum and other psychotic disorders | 8-12% |
| Depressive disorders | 8-12% |
| Anxiety disorders | 7-9% |
| Substance-related and addictive disorders | 7-11% |
| Neurocognitive disorders | 6-8% |
| Personality disorders | 5-7% |
| Bipolar and related disorders | 4-6% |
| Trauma- and stressor-related disorders | 4-6% |
| Neurologic disorders | 4-6% |
| Dimension 2 topics without a corresponding Dimension 1 topic | 4-6% |
| Neurodevelopmental disorders | 3-5% |
| Sleep-wake disorders | 3-5% |
| Developmental processes and development through the life cycle | 2-4% |
| Obsessive-compulsive and related disorders | 2-4% |
| Somatic symptom and related disorders | 2-4% |
| Eating disorders | 2-4% |
| Sexual dysfunctions | 1-3% |
| Disruptive, impulse-control, and conduct disorders | 1-3% |
| Other conditions that may be a focus of clinical attention | 1-3% |
| Dissociative disorders | 1-2% |
| Elimination disorders | 1-2% |
| Gender dysphoria | 1-2% |
| Paraphilic disorders | 1-2% |

# ABPN BOARD COMPETENCIES

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|  |  |
| --- | --- |
| Treatment | 35.00% |
| Neuroscience and mechanisms of disease | 23.00% |
| Clinical aspects of psychiatric and neuropsychiatric disorders | 23.00% |
| Diagnostic procedures | 12.00% |
| Behavioral/social sciences and psychosocial mechanisms of diseases | 6.00% |
| Professionalism, ethics, and the law | 5.00% |
| Practice-based learning and improvement | 5.00% |
| Systems-based practice | 5.00% |
| Interpersonal and communication skills | 4.00% |

* Source: <https://www.abpn.com/wp-content/uploads/2018/11/2019_Psychiatry_CERT_Content_Specifications.pdf>