**LSU Baton Rouge School of Medicine**

**PSYCHIATRY SECTION HANDBOOK**

**2025-2026**



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**Welcome to LSU BATON ROUGE PSYCHIATRY**

**Introduction**

Psychiatric education in Baton Rouge has been on an upward trajectory for the past ten years. Our residency program has grown to 8 residents per year. Our regional campus will have about 30 students per year in 2025-26. We have started our child and adolescent psychiatry fellowship this academic year.

Our existence is the result of a joint venture between the LSU Health Sciences Center School of Medicine in New Orleans and Our Lady of the Lake Hospital (OLOL) in Baton Rouge. This presents a unique training experience with rewards and challenges for residents, fellows, and the program administration that all play an important role in shaping our residents into competent, capable, and professional physicians.

Our Lady of the Lake is the largest hospital in the state of Louisiana, with its home campus here in Baton Rouge. The OLOL Children’s Hospital, which opened in 2019, will be a great home base for the child and adolescent fellowship. OLOL attracts the best and brightest physicians, serves a diverse patient population, and has access to advanced technology and treatment options for patients. This, coupled with our relationships in the private and community sectors, guarantees our residents a dynamic training experience.

We are so glad that you are here, and we welcome you to LSU Baton Rouge Psychiatry!

Adult Psychiatry Residency policies



**VISION STATEMENT OF THE ADULT RESIDENCY PROGRAM**

In conjunction with Our Lady of the Lake hospital, the vision of the LSU Baton Rouge psychiatric residency program is to be a leader in the state and in the southeast in medical education and the provision of psychiatric services.

**MISSION STATEMENT**

The mission of the LSU Baton Rouge Psychiatry residency program is to train outstanding clinicians who will contribute to the psychiatric workforce in Louisiana and beyond.

**Principles that help drive our program’s decisions**

* A strong foundation in primary care
* A strong commitment to both service and education
* Diverse experiences in psychiatry and all its subspecialties, resulting in a well-rounded physician capable of dealing with a wide spectrum of clinical scenarios
* A comprehensive didactic curriculum to include lectures, journal clubs, grand rounds, resident led presentations, assigned readings, and structured experiences in teaching medical students and junior colleagues
* Commitment to the practice of evidenced based medicine and a multidisciplinary approach with a focus on patient-centered care
* Exposure to multiple systems of care and settings of practice including hospital-based, community, private, and in-home care
* Emphasis on psychotherapy training through didactics, clinical experience and supervision
* An awareness and respect for community psychiatry
* The establishment of a supportive, collegial atmosphere of approachable faculty and residents with high morale
* Equity for all trainees in their access to education and opportunities for advancement.

**OVERALL PROGRAM GOALS & OBJECTIVES**

1. **Patient Care**: Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
   1. Residents will be competent in the psychopharmacologic management of patients.
   2. Residents must have demonstrated documented competence in supportive, group, psychodynamic and cognitive behavioral therapy.
   3. Residents must successfully complete all clinical rotations as evidenced by promotion by the Clinical Competency Committee (CCC) annually.
   4. Residents will demonstrate competence in the evaluation and treatment of patients from diverse backgrounds and ethnic, racial, sociocultural and economic backgrounds.
   5. Residents must demonstrate competence and professional adherence to outpatient clinic administrative, therapy, and caseload requirements, including continuous treatment of a core of long-term patients for >12 consecutive months.
2. **Medical Knowledge**: Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences as well as the application of this knowledge to patient care.
   1. Residents must demonstrate attendance at all didactics and seminars.
   2. Residents must successfully pass Step 3 by March their PGY-2 year, but preferentially by the end of the PGY-1 year before being able to advance to PGY3.
   3. Residents must demonstrate sufficient medical knowledge to appropriately and safely care for their patients.
   4. Residents must show competence through adequate results on the PRITE exam and will participate in remediation for scores below the 30%ile.
3. **Practice Based Learning & Improvement**: Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.
   1. Residents must participate in chart reviews to reflect on their practice.
   2. Each resident must complete the research/academic requirements that include participation in Journal club, making presentations as required, and the development of a project that culminates in a Grand Rounds presentation the last year of training.
   3. PGY 2-4 residents must participate in a scholarly activity (case report, poster presentation, QI project) annually and work to bring it to a successful conclusion.
   4. All graduating residents (and transferring child fellowship candidates) must present a grand rounds presentation to the program.
   5. All graduating residents will have completed and presented a poster presentation at least once at an academic meeting.
4. **Interpersonal & Communication Skills**: Residents must demonstrate interpersonal and communication skills that result in effective exchange of information and collaboration with patients, their families and health professionals.
   1. Residents must demonstrate these skills as rated within core competency evaluations, portfolio entries, and 360 evaluations throughout training.
   2. Residents must keep up with their medical records in a timely fashion.
5. **Professionalism & Ethics**: Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles
   1. Residents must demonstrate professional and ethical behavior as rated within core competency evaluations throughout training.
   2. Residents will be free from gross boundary violations during their training.
   3. Residents are expected to abide by the APA Principles of Medical Ethics
6. **Systems Based Practice**: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health as well as the ability to call effectively on other resources to provide optimal health care.
7. **Overall Performance**: Residents must demonstrate an overall satisfactory performance as evidenced by
   1. a core competency evaluation of each rotation and didactic seminar,
   2. a successful promotion each year of their training,
   3. a satisfactory summative evaluation at the end of training,
   4. Suitable progression in their milestone evaluations in all competencies,
   5. Successful completion of 3 clinical skills verification exams.

**CURRICULUM OVERVIEW**

**Rotations**

Our academic, clinical, and didactic curriculum has been specifically developed to meet the educational needs of the residents and to satisfy the requirements for residency training in psychiatry as outlined by the ACGME. Rotation schedules and didactics (including grand rounds) schedules are always available via New Innovations. Links to all can be found in the Addendum.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1 | 2 | 3 | 4 | 5 | 6 | | 7 | 8 | 9 | 10 | 11 | | 12 |
| 1 | Primary Care Rotation | | | | Neurology | | | Inpatient Psych | | | | | | |
| 2 | CL Psychiatry | | | | EMBH | | C&A | | NF | Add. | Geri | | For | Elect |
| 3 | Outpatient psych | | | | | | | | | | | | | |
| 4 | CL | Jr Att | Electives | | | | | | | | | | | |
| Continued Outpatient Clinic | | | | | | | | | | | | | |

**Grand Rounds**

Occurs every other Wednesday 12:00-1pm. Presentations for outside speakers will continue virtually but local presentations will occur in person. **All residents should attend grand rounds in-person unless they are on an off-site rotation or are on medicine/neurology.** This schedule is always available on QGenda and the program website. Outlook calendar invites are sent out on the 1st Monday of each month for that entire month.

**All Resident Meetings**

There will be an all-resident meeting the second Wednesday of every month (in place of Grand Rounds).

**DIDACTICS**

|  |  |  |  |
| --- | --- | --- | --- |
| **PGY 1** | **PGY 2** | **PGY 3** | **PGY 4** |
| Interviewing  Psychosis module  Affective disorders module  Anxiety Disorder module  Substance abuse module  Motivational interviewing | Psychopharmacology  Supportive psychotherapy  CL  Geriatrics  CBT  Implicit Bias | Psychopharmacology  Psych testing  Bariatric evals  Woman’s Health  Narrative medicine  Ethics  Psychodynamic therapy  Social Disparities in Mental Health  Transitioning to practice | Psychopharmacology  Narrative medicine  ACT  Didactic teaching  History of medicine  Psychodynamic therapy  Transition to practice  Medical Student teaching |
| Hospital-based Case Conference | | Clinic-based case conference | |
| Process group  Patient safety  Journal club  Neurology/Neuroscience | | | |
| Wellness afternoons | | | |

**\*\***[**Lecture Schedule - Google Sheets**](https://docs.google.com/spreadsheets/d/1VtHpm_LZGkIq48KvD9aVJd77iaY9QtNagjgwa_I03mc/edit?gid=504707456#gid=504707456)

**Attendance at Didactics**

Attendance of 100% at all scheduled residency meeting functions is our goal. DIDACTICS ARE NOT OPTIONAL. **The ACGME requires 80% attendance/participation in didactic events, and this is inclusive of the time you miss for vacation and night float. Therefore, there isn’t room left to miss for other reasons.** If a resident is unable to attend a particular event, it is his/her responsibility to notify the coordinator so that the absence can be recorded properly.

**CALL POLICY**

It is the policy of the LSU Baton Rouge Psychiatry residency program that the call/night float experience be one that enhances the resident’s education.

On-call activities are educational experiences, and adequate time and faculty support are required so that learning, skill acquisition, mentoring, and supervision can and do take place.

Skill sets to be addressed include the following, with an emphasis on progressive independence, autonomy, and confidence in providing service in the on-call setting.

* + Initial Assessment and Triage of presenting problems.
  + Crisis Intervention skills,
  + Case Presentation skills in the on-call environment,
  + Consultation skills in the on-call environment,
  + Decision-Making Strategies for Disposition of on-call presenting problems, particularly as applies to inpatient after hours concerns and outpatient clinic calls
  + Appropriate hand-off procedures,
  + Legal and ethical parameters that impact the on-call physician,
  + Safety issues that apply to on-call settings, particularly in the ED,
  + Team Leadership skills that apply to the on-call environment.

If a resident doesn’t respond to a call within 15 minutes, the faculty back up will be called and will handle the clinical situation. However, the program director will be made aware of any such instance the next morning and will handle it administratively.

All call schedules are the responsibility of the chief resident(s). Schedules and call requests must be made in advance by April 1. Once the schedule has been published, the resident on the schedule is responsible for finding a replacement if he/she is unable to cover. The Program Coordinator must be informed of all changes.

In case of emergency, the back up call schedule will be used. Chief residents will decide if the rationale for not covering one’s call responsibilities rises to the level of needing to call in back up. If a chief has an emergency, the program director will make the decision as to whether their situation warrants calling in back up. All schedules can be found on our google docs spreadsheet

**CALL RESPONSIBILITY BY YEAR**

|  |  |  |  |
| --- | --- | --- | --- |
| **PGY 1’s** | **PGY 2** | **PGY 3** | **PGY 4** |
| Interns will work nights and weekends as required by off service rotations.    On Psychiatry, they will have 4-6 days off per month and will know their schedule by the first of the month.  PGY 1’s on inpatient will work holidays their attendings are working. | PGY 2’s on CL will cover all weekends and holidays during their assigned months on CL or as per the call schedule (and holidays on EMBH)  .  PGY 2’s will work all holidays that their attending is scheduled to work  All services home call on Saturday nights, 5PM to 7AM.  Four weeks of night float in the PGY 2 year | PGY 3’s will be the secondary CL person every 6-8th weekend and holidays  All services home call on Friday nights, 5PM to 7AM.  Night float 2 weeks (or more, if needed) over the course of the year | Night float 1-2 weeks in the fall  First night (all night) in house call with PGY 2’s doing their night float month.  No holidays or weekend work. |

# INPATIENT PSYCHIATRY EXPECTATIONS

# All interns and med students will work 2 weekends a month with their faculty.

# All interns must stay on the unit to finish their notes. This will allow them to have more time to interact with staff and patients. If they have a doctor's appointment or emergency, they can finish notes at home, but otherwise this is a hard and fast rule.

# CHIEF RESIDENT SELECTION AND ELIGIBILTY

Chief Residents are determined from the rising PGY 4’s. The term of office is April 1 to March 31. Rising PGY- 4 residents in good standing can choose to be considered for a shared role as chief resident. The ultimate decision as to who can be a chief resident is the program director.

**COMMUNICATION WITH ATTENDING POLICY/SUPERVISORY CHAIN**

All Psychiatry clinical rotations have an attending directly responsible for patient care and team issues. Two attending physicians are available after hours and on weekends—one to back up the resident on CL and outpatient clinics, one to back up the resident for inpatient and ED calls. All call schedules are available on our google spreadsheet. If for any reason, the appropriate attending cannot be reached, call Kathleen Crapanzano, MD. (225-572-9894), Sydney Melancon, MD (504)256-6744 or Melissa Watson, MD (225)505-3267.

**CONTINUITY OF CARE IN CASE OF RESIDENT EMERGENCY**

If a resident is unable to perform his/her duties or is on vacation or sick leave, the faculty responsible for patient care assumes responsibility (but may distribute to other residents to assist) for continuity of care during the day. For nights and weekends, there is a backup call schedule available on our google docs spreadsheet. The effectiveness of this policy will be reported to and reviewed by the program director, and any cases of deviation from this policy will be reviewed at the PEC meeting to ensure optimal patient care.

**CLINIC PROTECTED TIME POLICY**

The following are guidelines for clinic protected time.

* 1. If you are on clinic call during your “protected time”, you have to be present in clinic.
  2. Your notes must always be caught up.  Protected time is to help you be sure you have that done. The standard should be that one does not finish their week on Fridays until all clinic notes are done.
  3. Your prior authorizations need to be caught up.
  4. You should check My Chart every weekday, near the end of the day, and respond to correspondence from patients or families as needed.
  5. If there are any readings required by various seminars, protected time is a good time to do it.
  6. If you are involved in a research project or writing up a case report…, protected time is good time to work on it.
  7. If a faculty member needs to meet with you, your protected time is a good time to do it.
  8. If you have doctor’s appointments or need an inspection sticker or have to meet a repairman at home, protected time is good time to do it, if all academic and work-related activities are complete.

1. What is not acceptable for protected time:
   1. Doing anything to the exclusion of keeping up with your work or readings.  Unless you have a good reason. We expect everyone to read their assignments and be up to date on their work by virtue of having this time.
   2. Not being reachable by phone
   3. Not checking your MyChart near the end of the day.
   4. Not being available for work related requests because “you had plans at that time” (and the plans aren’t a doctor’s appointment, but rather a plan to work out for example…).
   5. Abuse of protected time will result in an individual being required to stay in clinic during that time.

**CORE CURRICULUM SERIES**

LSUHSC requires that all employees, fellows, residents, and students complete online compliance modules at different intervals throughout your employment/training. All residents are given a KDS account ([Knowledge Delivery System](https://www.lsuhsc.edu/administration/ocp/training_requirements.aspx)), and access to the account is sent to you directly from the LSUHSC Office of Compliance.

The American Medical Association (AMA) has created a series of GME competency modules for residents and fellows to complete. These modules are an integral part of the educational component of your residency/fellowship with LSU School of Medicine and are to be completed during your first, second, and third year of training. Link to complete the modules: [https://edhub.ama-assn.org/gcep/pages/login](https://nam10.safelinks.protection.outlook.com/?url=https%3A%2F%2Fedhub.ama-assn.org%2Fgcep%2Fpages%2Flogin&data=05%7C01%7Ckcrap1%40lsuhsc.edu%7C67b6eb70879845c2a09808db61d0da55%7C3406368982d44e89a3281ab79cc58d9d%7C0%7C0%7C638211321875770539%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=hL8nkLLmWl4eZOoOdqUHr8LJp%2BzeQjo4%2FSQImYib0Kg%3D&reserved=0).

Promotion to the next level of training cannot occur until modules are completed for the year.

**MENTORSHIP PROGRAM**

The purpose of the residency mentorship program is to provide a semi-formal process by means of which residents in all training years have an opportunity to interact with a faculty member and receive guidance and support during their training. Resident mentors for new interns will be assigned by the chief residents soon after the match. New interns are encouraged to use that relationship for support and questions with back up from the program director.

From a faculty perspective, the mentoring relationship is different from the traditional supervisory relationship, which emphasizes teaching and training. The mentor-mentee relationship is meant to provide the resident with a sounding board and exert a facilitating influence on the resident’s adaptation to the training program. A major goal is to promote growth and maturation of the resident as he/she moves through the training experience of becoming a competent psychiatrist. Career goals may also be discussed. Residents are encouraged to develop relationships with faculty members they feel can help them meet those goals.

**NATURAL DISASTER PLAN**

If OLOL activates its emergency plan, the MBH leadership will meet to develop our own response plan. Residents on C-L, child and adolescent (resident or fellow), and in the ED rotations as well as the scheduled in-house call resident will be up to stay in house if the disaster necessitates it. Residents scheduled to be on Substance Abuse, child and adolescent (resident or fellow), forensic and geriatrics will potentially be needed for the recovery team. Residents will be contacted and directed to their assignments in this event. Depending on the nature and scope of the disaster, other residents may be called upon to help in an unpredictable fashion.

**PSYCHIATRY RESIDENT IN TRAINING EXAM** **(P.R.I.T.E**.)

The In Service exam for Psychiatry is administered by the [American College of Psychiatrists](https://www.acpsych.org/) in the fall of each academic year for all residency programs. ***Psychiatry Resident In Training Exam*** **(P.R.I.T.E**.). All residents must take this exam each year. **The 2025 exams will be the week of September 22-25, 2025. Vacation is not allowed on these dates.**

This exam assesses overall medical knowledge in Psychiatry, Neuroscience, and Neurology. It is an indicator of areas of comparative strength and deficits. This guides the resident in his/her continued reading and study.

The exam allows a resident and a program to assess medical knowledge, to compare one’s progress over time, and to compare a resident and program to his/her peers nationally. The program uses the data from the PRITE for Milestone evaluations and to review/update its didactic curriculum.

**POLICY ON P.R.I.T.E. PERFORMANCE**

1. Our goal is for all residents to score at or above the average standard score in all three categories of the PRITE (Psychiatry, Neurology, and Neuroscience) for their respective cohorts.
2. Residents who score below the average standard score in any of the 3 areas will be given the opportunity to participate in extra study materials and provided mentoring if requested.
3. Residents who score below the equivalent of the 30%ile in any of the three sections will be given a warning, and a repeat score that low could be grounds for academic probation. The resident will meet with the program director (or designee) and a remediation plan will be developed for the resident to follow. If the resident is currently moonlighting, all moonlighting activities must cease at an agreed upon date with the program director until a plan for remediation can be discussed. If a resident wishes to moonlight, permission will not be granted until the remediation plan is deemed successful.

**PROGRAM COMMITTEE STRUCTURE**

**Faculty Meetings**

All core faculty members are asked to participate in monthly faculty meetings as well as one of the subcommittees of the program. During faculty meetings, faculty will hear announcements about the section as well as committee reports. A topic related to faculty development will be presented as well.

An annual meeting will be offered to all faculty who participate in the program.

**Program Evaluation Committee (PEC)**

The Program Evaluation Committee (PEC) is composed of the Program Director, Associate Residency Training Director, core faculty, chief residents, and the residency coordinator. Ad hoc or invited guests may also attend the meetings at the discretion of the program director. The Program Director chairs the activities of the committee.

The PEC subcommittee (Leadership), which consists of the program director, associate directors, section chief, and the program coordinator, under the direction of the Program Director, is responsible for planning, developing, implementing and evaluating all significant educational activities of the residency program. They meet every week or as needed.

The PEC is responsible for the annual evaluation of the program and for assuring that areas of non-compliance with ACGME standards are corrected. Data from resident and faculty evaluations must be included in this annual evaluation and action plan. For that purpose, the committee meets annually and involves the chief residents.

**Clinical Competency Committee (CCC)**

This committee evaluates and tracks the residents’ progress in core competencies; its membership includes all core faculty. There is one for PGY 1’s, PGY 2’s and then PGY3&4’s. The committee will be responsible for reviewing evaluations for each resident and will meet quarterly. From the collected evaluations and verbal input of committee members, the committee will monitor each resident for their appropriate level of milestone development. The committee is responsible for reporting the Milestone evaluations to the ACGME semi-annually. The CCC determines promotion of each resident annually.

If progression appears to be in jeopardy, the committee will advise the program director as to its recommendation. This committee can require actions including remediation, probation, repetition of rotations, non-promotions, or referral to the Employee Assistance Program for psychiatric evaluations and/or treatment, or other remediating measures.

If the CCC decides the above actions are insufficient, it can propose suspension, non-renewal of contract, immediate termination, or reclassification of training level lower than the resident’s current training level

In all cases, all evaluation and review proceedings shall be as private as possible to protect the resident and faculty members involved, as well as maintaining objectivity. Institutional Due Process is described in detail in the LSUHSC House Officer Manual. The determination of the committee is to be considered as advisory to the program director and Department Chair, who shall be regularly apprised of their actions.

The committee is also responsible for determining methods of evaluating for all the milestones are available and in use. Their feedback on the instruments and methods being employed will be referred to the PEC.

**Resident Liaison Committee (RLC)**

This committee meets monthly with the chief residents, two members of each resident class, and the Program Coordinator. The purpose is to allow the residents the opportunity to present issues or suggestions in a formal way to the program administration. The program director attends as needed to address concerns or bring in information. The chief residents meet regularly with the program director to ensure the transfer of information back and forth.

**Recruitment and Selections Committee**

The recruitment and selections committee operates primarily September to March and is tasked with the recruitment of new residents. Their responsibilities include the design of the recruiting process and the choice of applicants who will receive interviews. They also oversee the ranking of applicants for ERAS and the match process. At the end of the recruitment season, they will evaluate the process and make recommendations for next year. Membership is a mix of the faculty. Resident representation is also expected in the process. The chief resident will be included in the ranking process and other residents’ input is included from their own feedback meeting with recruitment chair.

**Multicultural Committee**

This committee will look at issues of advocacy, education, and culture around the variety of cultures, races, and human differences in the world!

**RESIDENT EVALUATION & ADVANCEMENT CRITERIA POLICY**

From the collected evaluations and verbal input of committee members, the Clinical Competency Committee (CCC) will monitor each resident for satisfactory progression toward timely promotion to the next PGY level. If progression appears to be in jeopardy, the committee may establish a remediation plan, propose a probationary period, requirements regarding additional training, or decide upon termination of a resident.

For successful advancement in the program, the resident must successfully complete all clinical rotations with satisfactory evaluations from faculty. Any assigned remediation plans must be successfully completed. The CCC must review all documentation from the resident file and agree with the decision to promote the resident. The Program Director has the authority to make the final decision regarding promotion, advancement, or adverse action.

The following procedures are guidelines for resident evaluation.

1. Residents will be routinely evaluated monthly by faculty and staff on each rotation.
2. Residents will complete annual peer evaluations.
3. The Program Coordinator is responsible for reminding the supervisors and instructors to complete the evaluation form and making sure that each completed form is reviewed with the resident in person.
4. Residents will be given a semi-annual summative evaluation by the Program Director or her designee. At that time, the Program Director (or her designee) completes a competency based evaluation tool and progress summary report and reviews it with each resident every 6 months. Milestone evaluations are part of this process.
5. Evaluation forms may be submitted electronically through New Innovations. The Program Coordinator will maintain these forms as part of the resident’s file.
6. If a resident is judged by any of his/her supervisors/teachers to be having difficulties, the supervisors are asked to document these issues carefully and attempt to correct the problem. If the problem continues, the Program Director is to be alerted. The Program Director may either counsel the resident in ways to improve his/her performance, require the resident to do remediation, require probation, and/or ask the Evaluations Committee to make other recommendations.

**RESIDENT GOALS & OBJECTIVES FOR ADVANCEMENT**

**PGY I**

**Assignments to Inpatient Psychiatry**

1. Residents will independently obtain medical and psychiatric histories and present their findings in the medical record.
2. Residents will independently perform mental status examinations, and present their findings in the medical record.
3. Residents will independently develop a differential diagnosis and diagnostic plan.
4. Residents should independently assess patients who might require seclusion and/or restraint and order seclusion and/or restraint when indicated for patient and/or staff safety.
5. Residents will select diagnostic studies in conjunction with supervising faculty.
6. Residents will arrive at a working diagnosis supported by clinical and laboratory findings in conjunction with supervising faculty.
7. Residents will develop and implement a biopsychosocial treatment plan and write orders under direct faculty supervision.
8. Residents will supervise medical students in any activity in which the students are allowed to act independently.

**PGY II**

**Assignments to Forensic, Consultation/Liaison, Child and Adolescent, Geriatric, Community/Substance Abuse, and Emergency Psychiatry**

1. Residents will independently obtain medical and psychiatric histories and present their findings in the medical record.
2. Residents will independently perform mental status examinations, and present their findings in the medical record.
3. Residents will independently develop a differential diagnosis and diagnostic plan.
4. Residents should independently assess patients who might require seclusion and/or restraint and order seclusion and/or restraint when indicated for patient and/or staff safety.
5. Residents will select diagnostic studies in conjunction with supervising faculty.
6. Residents will arrive at a working diagnosis supported by clinical and laboratory findings in conjunction with supervising faculty.
7. Residents will develop and implement a biopsychosocial treatment plan and write orders under direct faculty supervision.
8. Residents will supervise medical students in any activity in which the students are allowed to act independently.
9. Residents will supervise medical students and first year residents in any activity in which the students/ residents are allowed to act independently.
10. Residents will be able to do a capacity assessment.
11. Residents will be able to initiate supportive therapy on appropriate patients

**PGY III**

**Assignments to Outpatient Psychiatry**

1. Residents will independently obtain medical and psychiatric histories and present their findings in the medical record.
2. Residents will independently develop a differential diagnosis and diagnostic plan.
3. Residents will select diagnostic studies independently in most cases.
4. Residents will arrive at a working diagnoses supported by clinical and laboratory findings independently in most cases.
5. Residents will develop and implement a biopsychosocial treatment plans and write orders independently in most cases.
6. Residents will be competent in the psychopharmacological management of long-term outpatients.
7. Residents will strive for competence in the provision of supportive, CBT and psychodynamic psychotherapy.
8. Residents will be able to appropriately assess risk for outpatients and choose the correct level of care to meet their needs.
9. Residents will supervise medical students or lower-level residents in any activity in which the students/residents can act independently.

**PGY IV**

**Assignments to Junior Attending and Electives**

1. Residents will independently obtain medical and psychiatric histories and present their findings in the medical record.
2. Residents will independently perform mental status examinations and present their findings in the medical record.
3. Residents will independently develop a differential diagnosis and diagnostic plan.
4. Residents will independently select diagnostic studies.
5. Residents will independently arrive at a working diagnosis supported by clinical and laboratory findings, generally independently.
6. Residents will independently develop and implement a biopsychosocial treatment plan.
7. Residents will appropriately teach and supervise junior residents and students.
8. Residents will be able to evaluate a patient and write up a disability assessment.

**RESIDENT LEAVE POLICIES**

The total amount of leave granted to residents each academic year is according to [the LSUHSC House Officer Manua](http://www.medschool.lsuhsc.edu/medical_education/graduate/HouseOfficerManual.aspx)l. According to policy, leave does not accumulate; if it is not used by June 30 of each year, it is forfeited.

Vacation is available for residents at all levels of training as specified below. Residents are required to submit vacation requests (all but 7 days of their annual vacation) for the July 2026-June 2027 academic year by April 1 of each year.

* PGY 1 residents are allowed 3 full weeks of vacation but are not allowed to take vacation during the inpatient medicine, inpatient pediatrics rotations.
* PGY 2 residents are allowed 4 full weeks of vacation but are not allowed to take off during the night float month and are asked to minimize time off on the consultation liaison rotations.
* PGY 3 and 4 residents are allowed 4 full weeks of vacation.

Preferred vacation requests are approved at the discretion of the program director or program coordinator who take into consideration the needs of the residency program and sponsoring institutions/services. Whenever possible, requests for preferred vacation dates will be honored.

**Planning your other 7 days of vacation and annual leave:**

**For off-service rotations (medicine, peds, ER, neurology), residents must give 90 days’ notice for vacation and educational leave. For on-service (all psychiatry rotations) residents must give 30 days’ notice for vacation and educational leave. This is because when any one person is out it affects the workflow of many others. We are a team, and we must work together!**

**Vacation request stipulations**

* Vacation cannot be accumulated and carried over into the new year.
* No more than one week can be taken for any month-long rotation.
* 2 of the 3 weeks for PGY 1 residents and 3 of the 4 weeks for PGY 2-4 residents MUST be taken in 7-day blocks which include two weekend days.
* One week of vacation each year can be broken into smaller increments.
* Residents can make switches to their weeks off, but they must find coverage for any weekend, call or back up schedule where they have a work assignment, and they must do this with the appropriate notice as per the bolded instructions above.
* Residents are encouraged **not** to take vacation on the following days:
  + Intern retreat (PGY 1 only) August 29, 2025
  + Annual resident retreat May 1, 2026
  + Graduation June 12, 2026
  + PRITE exam week of September 22, 2025

**Holiday block scheduling**

Holiday coverage for non-major holidays is determined by whatever the policy of the site/rotation.

For inpatient psychiatry, residents are expected to work the holidays that their faculty are assigned to work. No vacation requests will be honored for holidays (including Thanksgiving) on these rotations if the faculty is scheduled to work.

For PGY 2 residents, OLOL holidays must be covered, and a schedule will be provided.

For PGY 3 and 4’s, if you request a vacation for a week where there are other holidays (ie Thanksgiving), you must request the entire week to ensure you won’t be on back up, night float or CL call.

For Christmas and New Year’s, we have a holiday block schedule where residents will work either the week of Christmas or the week of New Year’s. No vacation requests will be honored for this two-week period. Residents will rotate between the two weeks over the course of their training. This leave is in addition to ACGME required vacation.

**Requesting individual days off**

The full week blocks of leave for each resident must be submitted by April 1 of each academic year for the following year. Residents are able to request the 7 individual days off as needed throughout the year. The process for getting those days approved is to clear with your assigned faculty member, check for any call or back up responsibilities (and make switches if you are scheduled), then let the coordinator/program director know. For off-service rotations (medicine, peds, ER, neurology), residents must give 90 days’ notice for vacation and educational leave. For on-service (all psychiatry rotations) residents must give 30 days’ notice for vacation and educational leave.

Once the call schedules are developed, changes to the call, back up or weekend schedule will be the resident’s responsibility to arrange before making the administration aware. Requests should be made as far in advance as possible. Requests made with short notice may not be granted.

Clinic residents are expected to reschedule their own patients for vacation day requests that already have scheduled patients.

If you have a special situation that requires more than 7 days off, these will be considered on a case-by-case basis by program leadership.

**Educational Leave for All Residents (5 days)**

1. 5 consecutive or non-consecutive days
2. The program must be informed of the nature of your request and be provided with confirmation of registration at meetings/conferences if attending.
3. Educational leave can only be used by PGY 1s for Step 3 studying and for taking the actual exam. Only the days leading up to and the days of the actual exam are permitted for educational leave.

**Sick/Emergency Leave for All Residents (14 days)**

1. Sick leave can be used for doctor’s appointments, illness or treatment of illness, planned procedures and/or recovery from such, attending appointments with a loved one or caring for a loved one.
2. Sick days are not guaranteed days off and should not be seen as a way to get more days off
3. Appreciate the impact on others as we are a team—extra work, longer days, patients who don’t get seen.
4. For unanticipated instances on the use of these days, the resident must immediately notify their attending and then notify the coordinator and program director.
5. We will not inquire about the nature of the request unless it exceeds 2 consecutive days. For any sick/emergency leave more than 2 consecutive days, please speak with the program because it may be necessary to request documentation from a physician.
6. There is a back-up call schedule for emergencies when a resident is unable to work. Please be advised that should you need to use the back-up system, you will be expected to make up that call later. This make-up date will be chosen for you.

**Bereavement Leave**

LSU allows leave to be granted to attend the funeral or burial rites of a parent, stepparent, child, stepchild, brother, stepbrother, sister, stepsister, spouse, mother-in-law, father-in-law, grandparent or grandchild. A maximum of two days of special leave may be granted on any one occasion.

**Extended Leave**

1. Once a resident has been employed by LSU for 12 months, they are entitled to Family and Medical Leave (FMLA).
2. Any leave beyond the limits set by LSUHSC can be designated as Family and Medical Leave (FMLA as specified in Chancellor’s Memorandum 50), Maternity Leave, or Leave Without Pay (LWOP).
3. Note that in these circumstances, your residency may be extended to account for the leave as well as retain your ABPN eligibility upon graduation. Please speak directly with the Program regarding this matter.

**Leave Without Pay (LWOP)**

1. Life circumstances may require an extended absence from residency. LWOP is processed through the Residency Program. You must discuss this with the Program before considering this option.
2. This also applies to residents who are graduating or taking a fellowship position that must depart from the program early and have no remaining vacation days - you will be given LWOP for those days. Approval to leave early and take LWOP will be approved at the discretion of the program leadership.

**Family and Medical Leave Act (FMLA)**

1. As of July 1, of your PGY 2 year, you are eligible to qualify for FMLA. This is a process that is conducted through LSUHSC Human Resources in New Orleans and requires certification from a physician. The resident is solely responsible for this process. This secures your residency spot in our program if you are on extended leave.
2. Before considering FMLA, please speak with the program to discuss your options.
3. Note that FMLA must first exhaust all remaining vacation and sick leave. If you do not have enough leave to carry you through the physician’s recommended period, you must take Leave Without Pay (LWOP).

**Maternity/Paternity Leave**

1. Leave due to the birth/adoption of a child will first exhaust sick leave, then vacation. If the requested leave must extend beyond available leave, the resident may need to use FMLA or LWOP.
2. FMLA or LWOP may result in extension of training.
3. As soon you are ready to share, confidentially, with the program that you will be taking Maternity/Paternity Leave, discuss your options with the program.

**Coverage when a resident is unexpectedly out:**

Residents will be expected to arrange/provide the following coverage if they are out

1. Night float: the backup resident will be expected to cover any shifts that are left uncovered.
2. Adult Consults: remaining residents will be expected to cover the entire service.
3. Child and Adolescent Consult service: the child fellow or PGY 2 is expected to cover the service alone.
4. EMBH: back up call schedule will be activated for call coverage from 5-8 PM on days the EMBH resident is out.
5. Clinic:
   1. If a resident must call out sick from clinic on short notice due to illness, etc, they must alert the clinic office manager (Stephanie Wooster (225-963-3898) by phone due to short notice, as well as email to her and others for documentation) as well as the program (Latoya/Lakeysha/Dr. Crapanzano/Hunsinger). The front staff can assist with contacting patients regarding cancellation for the day and rescheduling.
   2. The resident calling sick must also notify the clinic call resident and communicate if any follow-up patients need to be seen. The clinic call resident will work them into their schedule or coordinate with a fellow resident/Chief/faculty as needed to ensure adequate care.
   3. The resident calling in sick must also notify any therapy or group supervisors they are to meet with that day.
   4. Any new patients on the schedule if a resident calls in sick will be moved to any other resident who has an open new patient that day.
   5. If the on call resident is calling in sick, they must notify the above but also the chief residents who will activate the back up resident.
   6. If a resident is changing a planned vacation, they must request the change with the clinic (Stephanie/Dr. Hunsinger) and the program administration (Latoya/Lakeysha/Dr. Crapanzano). If they are on clinic call or back up, they must ensure an appropriate swap before the leave will be approved. Residents are responsible for notifying and rescheduling their own patients. They also must notify therapy or group supervisors who will be affected.
   7. Change in vacation requests that are too short notice and/or will have a significant impact on scheduled patient care may not be approved.
6. No cross coverage will be provided for other inpatient rotations, VA, Substance Abuse, forensic, Baton Rouge General, and 4th year electives

**RESIDENT RETREAT**

A resident retreat will occur every spring for all residents. No leave should be scheduled by residents on this day as this is a MANDATORY event for ALL residents and interns. The interns also have a fall retreat. Clinical coverage on the services will be provided by the faculty on these days.

**RESIDENT SELECTION**

The LSU Baton Rouge Psychiatry residency program abides by all policies of the NRMP and LSUHSC regarding residency recruitment and selection and participation in ERAS (see LSUHSC Applicant Handout). Our Residency Recruitment committee is responsible for decisions as to our internal interview criteria and ranking process. We review applications from US public, private, and osteopathic medical schools. We will also consider US citizens from international medical schools and nonUS citizens with ECFMG sponsorship on a case by case basis. We are not able to sponsor J-1 visas.

**STEP 3 EXAM USMLE/COMLEX**

USMLE STEP 3 EXAM POLICY

According to Louisiana state law, a resident cannot be promoted to their 3rd year of training without having passed the [USMLE Step 3 exam](http://www.usmle.org/step-3/) . The LSBME will not issue you a permit to continue to the 3rd year without having received a copy of your USMLE transcripts verifying that you passed Step 3.

All psychiatry residents are encouraged to register for and take Step 3 by the end of their PGY I medicine rotations.  If the exam is scheduled during the PGY 1 year, the program will pay for it. All residents should take Step 3 by September of PGY2 year.  If necessary, residents are required to attempt a second time by December of their PGY 2 year and a third attempt by April 15. It is highly recommended and suggested that you take and pass Step 3 in the intern year.

When a resident fails the exam, the resident will be required to discuss a remedial plan with program director. If the resident fails again, individual tutoring or a review course will be encouraged for the resident. During the orientation process, the program director meets individually with each new intern to discuss the Step 3 process in detail.

Registration for [USMLE](http://www.usmle.org/step-3/) and [COMLEX](https://www.nbome.org/exams-assessments/comlex-usa/comlex-usa-level-3/) exams is completed on line. Please send confirmation of your registration (for reimbursement and scheduling purposes) to the Program Coordinator. All interns have 5 protected days off for this examination for the days of and the days leading up to the exam.

**STEP 3 PROTOCOL**

**Payment & Registration:** The program will pay for the entire amount once your testing dates are confirmed and forwarded to the program as long as you register by June 30 of your intern year and you are up to date on your administrative responsibilities. Be sure to forward your confirmation of dates to the Program as soon as you receive the email. You can either pay for the exam and get reimbursed by LSU or coordinate with the LSU Business Office for them to pay for it upfront.

**Scheduling:** Each intern is allotted 5 educational days to study for and take the exam. You cannot use educational days after the last exam date. Both the USMLE and COMLEX exams are 2 day exams.

**Study Materials:** We will purchase a study bank (such as Uworld question bank). You can either pay for the question bank and get reimbursed by LSU or coordinate with the LSU Business Office for them to pay for it upfront.

**Promotion: The LSBME will not allow promotion to PGY 3 without a passing score on Step 3.**

**PER LSBME:** Applicants are limited to 4 attempts to take and pass the USLME Step 3. An applicant who fails USMLE Step 3 after the third attempt must take 6 months of approved training before permitted to take Step 3 for the fourth and final time. This applies to all examinations (FLEX, SPEX, NBME, NBOME, COMLEX-USA, or a combination thereof).

**LSUHSC requires residents to pass USMLE Step 3 before entering the second year of residency. Failing to pass step 3 by March 1st of PGY2 year may lead to non-renewal of the contract for PGY3. Again, LSBME will not allow promotion to PGY3 without a passing score on Step 3 at time of applying for PGY3 license.**

**THERAPY REQUIREMENTS**

**PGY 2’s:** will have the option to work with one therapy patient starting in January of the PGY 2 year. While on Consults and EMBH, residents will have to schedule patients according to their schedules and clinic availability.

**PGY 3’s:** will participate in group and individual therapy in the clinic. Residents are expected to carry about 5 patients per week (about 5 hours/week) but will be required to complete 105 hours of individual therapy by the end of the academic year.

**PGY 4’s:** must have completed 75 hours of individual therapy by the end of the academic year.

**Versus Panic Button Badges**

The inpatient units and EMBH have a system that allows you to get help if a situation were to arise where you feel uncomfortable by wearing a versus badge that alerts when you need help. All 1st and 2nd year residents will be assigned a badge. When given their badge, residents will sign a document acknowledging the following:

1. The versus badge will only alert on MBH Inpatient units (Adol, St Clare, 1N, GBC), EMBH, and the Emergency Department areas. There are not receptor beacons in other areas of the hospital.
2. It must be worn on the upper left or right collar
3. The badge is programmed to only work for the assigned resident. It will not work if you share with someone else.
4. The battery will last up to 2 years however it is up to the individual wearing the badge to check for the blinking red indicator light above the “k” on the badge. That is the low battery indicator.
5. The badge number is the ID: on the back of the badge.
6. Do not press the button to test it.
7. Press button if you feel as though you are being threatened, trapped, or attacked.
8. The badge must be turned in at the end of the second year. If the badge is lost, damaged or stolen, the resident is responsible for the replacement cost which (at the time of this being written) is $75.

LSU Baton Rouge Psychiatry Residency

Clinic Year Handbook

2025- 2026



*<<Pgs 3-6: Given by front staff to patients for review and signature at initial visit and annually>>*

**The Center for Psychiatric Services   
Clinic Policies and Treatment Agreement**

Welcome to The Center for Psychiatric Services. Please review the following information:  
  
General Clinic Information:  
The Center for Psychiatric Services is a teaching clinic. Your new patient appointment consists of an evaluation with a resident psychiatrist (a medical doctor in specialty training), which is staffed with the faculty psychiatrist who is attending that day. The goal of the evaluation is to establish an initial diagnosis (or diagnoses) and treatment plan. The unique treatment plan developed for you at the initial evaluation may include one or more of the following: medication management; progress reports (from you to your doctor); individual therapy; group therapy; referral for/to psychological testing, diagnostic labs or imaging, one or more of your other medical providers, and/or an alternate mental health care provider or program. The length of time to the recommended follow up appointment with your psychiatrist is determined by the acuity of your problem, the treatment plan, and your progress.   
  
Arrival at the Clinic:  
For new patient appointments, please arrive at least 30 minutes prior to your scheduled appointment.  
For established patient appointments, please arrive at least 15 minutes prior to your scheduled appointment time.  
If you are more than 15 minutes late for your appointment, you may be rescheduled.  
  
Appointment Length:  
Appointment times may vary in length. New patient appointments with the Center for Psychiatric Services resident providers are scheduled for 2 hours. You must be available for the duration of your appointment time, or you may be asked to reschedule.  
  
Appointment Types:  
All new patient visits and transitional visits are required to be in-person. After that, a collaborative decision can be made on whether treatment may continue in part via telehealth/video visits. Please note that this clinic is *not* primarily a telehealth clinic, and as such most visits are done in person. Additionally, insurance and professional regulatory requirements frequently change, and it may be required for you to be seen in person.   
  
Child and Adolescent Visits:   
Both Child/Adolescent and Parent/Guardian should be available for the duration of the visit.  
Please complete the requested intake paperwork *prior* to your scheduled appointment.

Missed Appointments:  
Please let the clinic know as soon as possible if you must miss a scheduled appointment (225-374-0400). At least 24 hours advance notice is requested, to allow other patients to be scheduled.  
  
If you miss an appointment, please contact the clinic to schedule another appointment within two weeks of the missed one, or let the clinic know if there are extenuating circumstances.  If we don’t hear from you, we may call or send a letter reminding you to call/reschedule.  A lack of response may result in your care being transferred out of the clinic, including any prescriptions.  
  
If you are not seen for an appointment for 6 months, you may be re-scheduled as a new patient with a new resident provider in the clinic. There may be a waitlist for this process.

Medications & Refills:  
Starting a new medication, or changing the dosage of a current medication, often requires a full visit due to the complexity of decision-making. Please reach out about scheduling an appointment if you would like to discuss these topics.

Medication refill requests are generally processed within 2 business days. Sometimes the process is delayed due to requirements by your pharmacy or insurance company.

Medication refill requests will only be processed during clinic business hours.

If you are prescribed any controlled medications in the clinic, such as stimulants or benzodiazepines, your doctor may not authorize early refills. Additionally, lost or misplaced prescriptions may not be replaced. For any treatment involving the prescription of controlled substances, we may require urine drug screens at your appointments.

Communication with Other Providers & Family:

To facilitate continuity and collaboration in your care, it may be medically necessary for your provider to contact or request records from past providers (physicians, therapists, hospitals) and/or speak to family members or supports. In those circumstances, your provider will discuss this and request you sign an Authorization for Release form.

If we have concerns about your safety or your ability to follow treatment recommendations, we may require communication with a family member/support person to ensure safe and effective care.

Additional Care Guidelines:

**Firearms and weapons of any kind are strictly prohibited in this clinic, and we have a zero-tolerance policy for disrespectful, aggressive, or violent behavior.** We respectfully advise that such behavior will not be tolerated in the clinic, either by a patient by anyone a patient brings with them to their appointment. If you demonstrate aggressive written, verbal, or physical communication with any of the clinic staff, no matter if in person or by phone, or if a weapon is brought on the premises, our treatment relationship may be immediately ended and there may be restrictions on your ability to return to the clinic.

We provide care based on evidence-based guidelines.Should you feel that our recommendations do not fit with your goals of care, we may be unable to serve you. If we feel that you require more comprehensive psychiatric care than we can provide, or that you would best served by a higher level of care, this will be discussed with you and referral options provided.

If we become concerned for your immediate safety or the safety of others, we may advocate for an inpatient psychiatric hospitalization or require an emergency evaluation. If you are ever in acute crisis, please contact local crisis services, 988, or go to the nearest emergency department.

If you choose not to continue care with your resident physician, please be aware that we do not transfer care between physicians within the clinic. In that case, we will provide referrals where you may seek care elsewhere. With your consent, we may share medical records with any outside provider you choose.

Use of Audiovisual Recording:   
Your resident might discuss the use of audiovisual (AV) recordingof one or more of your sessions to optimize their education. Because of its ease of use and accuracy, AV recordings have become state-of-the-art in resident training nationally. While it is not a requirement, please consider consenting to its use if you are asked. Of note, we never record without consent, all clinical recordings stored in protected HIPPA-compliant sites, and each recording is destroyed after it is viewed with the resident’s supervisor unless express permission is obtained otherwise.

Please also review the financial and termination of care policies provided at your initial visit for further information about this clinic’s policies.

**I acknowledge that I have read, understand, and agree with the above procedures and policies of the clinic regarding treatment:**

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 Patient Name Patient Signature Today’s Date

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 Parent/Guardian Name Patient/Guardian Signature Today’s Date

**Video Visits with the Center for Psychiatric Services and Family Center O’Donovan**

For the best experience in your video visit, please review the following guidelines:

**Before Your Visit (*at least one day before your appointment*):**

* Sign up for your [MyChart account](https://ololrmc.com/mychart/).
* Download the Mychart app to your smartphone or tablet, or log-in on your computer.
* Sign in and test your Video and Audio in MyChart to make sure both are working properly for the video visit.
* Complete the e-Check in process (Note: this can be done up to 7 days prior to your visit).

**On the Day of Your Appointment:**

* Login in *at least 15 minutes prior* to your video visit appointment time.
* Complete the e-Check in process and Select the Start Video Visit button.
* Please stay logged in and waiting. Clinic personnel will be with you on the visit as soon as possible.

**Additional Important Guidelines for Your Virtual Appointment:**

* Be in a private, well-lit space.
* Do not drive a vehicle during your appointment time.
* Child and Adolescent Video Visits: Both Child/Adolescent and Parent/Guardian should be available for the duration of the visit as you would at the doctor’s office. Please be in an area where you and your child have private space to speak with the provider separately.

Following these guidelines can help avoid problems at the time of your visit.  
If the video visit is unable to be completed at the time of your appointment,   
you may be asked to reschedule.

**Overview of Treatments and Services Available in Clinic**

The following is a (non-exhaustive) list of available treatments and services in the OLOLPG Family Center O’Donovan and Center for Psychiatric Services:

* New patient evaluations and subsequent treatment
* Individual Psychotherapy (available for appropriate established patients with either a psychiatric resident or with LSU Psychological Services)
* Group Psychotherapy (available for appropriate established patients)
* Neuropsychological or educational testing (available for appropriate established patients with LSU Psychological Services)
* Transcranial Magnetic Stimulation
* Esketamine (Spravato)
* Pharmacogenomic testing (now through Genesight)
* Urine drug screening
* Buprenorphine treatment for opioid use disorder

The following services are not provided by the psychiatric residents at Center for Psychiatric Services:

* Disability or other forensic evaluations
* Evaluation solely for the assessment or treatment of ADHD, without other co-morbidity.
* Neuropsychological or educational testing (though these services may be available to appropriate established patients in the clinic, provided by LSU Psychological Services)

**Resident Clinic Policies and Standards – Internal**

These policies and standards practices are applied to patients and resident physicians of the psychiatric resident clinic, Center for Psychiatric Services, towards the goal of providing standardized, equitable care, and towards ensuring a robust educational experience for our learners in clinic.

**New Patients**

* All patients receive the intake packet (Page 3), PHQ-9, GAD-7 and SBQ-R along with the usual OLOLPG clinic required documentation.
* All new patient appointments with resident psychiatric physicians are scheduled in person.
* All new patients are called by clinic front staff one day prior to their scheduled appointment to confirm. This telephone contact (successful or not) should be documented in the appointment desk.
* Patients who do not come to their scheduled appointment and who fail to call ahead (‘No Show’), will be placed at the back of the clinic waitlist by scheduling staff. If this occurs a second time, patients will not be rescheduled.
* Patients who are unable to attend their appointment but call prior to the scheduled appointment time will be offered an opportunity to reschedule their new appointment to a later date by front scheduling staff.

**Follow Up Care, Treatment Duration and Frequency**

* Treatment duration and frequency is determined based on individual patient needs. Patients in the resident clinic will typically be seen every 1-3 months, with more frequent appointments available if needed (example: weekly psychotherapy or CAMS). Patients requiring less frequent care may be appropriate for transition out of the resident clinic to an alternate provider.
* If a patient is not seen in 6 months, they may be assigned to a new resident provider as a new patient. Exceptions to this can be discussed on a case-by-case basis with supervising faculty.
* Appointment length for routine medication management appointments is typically 30 minutes.
* Appointment length for psychotherapy is 60 minutes (to account for 50 minutes of psychotherapy with patient and 10 minutes of wrap up/documentation/process notes).
* 60-minute visits may periodically be scheduled for complex cases or other unique case

needs. Discuss this with supervising faculty on case-by-case basis.

**Video Visits**

* This clinic is *not* primarily a telehealth clinic, and as such most visits should be done in person.
* All new patients and all initial transition visits are scheduled in person in clinic.
* Follow Up and Therapy appointments may occasionally be virtual (video visits) in appropriate cases. Discuss this on an individual case basis with your supervisor(s).
* Residents should be physically present in clinic for all visits (i.e. do not conduct video visits from home or elsewhere unless you have accommodation for specific reason from the program).

**Scheduling**

* Front office staff schedules initial evaluations.
* Residents schedule their own follow up appointments during the visit with the patient.
* If a patient calls to reschedule an appointment, front staff will schedule on the resident’s behalf.
* Front office staff take calls and may schedule across business hours. Check your schedule at end of each business day, to make sure you know when your first patient of the day is tomorrow.
* Front office staff typically should not schedule patients for same day appointments without speaking with you first, but it is possible if you have openings depending on circumstance.
* If a patient arrives late, they may be offered to reschedule at next available appointment per OLOL policy. If they arrive late and you have an opening directly after that time slot, they may still be checked in to be seen.

**Medication Prescribing and Refills**

* Residents should generally aim to provide adequate refills to last until the next appointment.
* Residents should not provide excessive refills if you are seeing the patient frequently (i.e. if you are seeing them back in 1-2 months, don’t give 5 refills (6 months) of medication)
* The clinic call resident handles requests when a resident is out on leave, but non-urgent refill requests or messages may be deferred to the scheduled resident’s return

**Additional Notes Regarding Medications Classified as Controlled Substances:**

* Schedule 2 controlled substances (stimulants) are provided in single prescriptions (i.e. a month supply), and refills are not allowed. Up to 3 prescriptions for a stimulant can be provided for patients stable on their regimen, if clinically appropriate, to bridge between scheduled follow-up appointments. Patients prescribed stimulants should be seen for follow-up at least every 3 months.
* Advise patients that urine drug screens may be a component of care in clinic, especially if on a controlled substance.

**MyChart InBasket**

* MyChart is for patients to ask non-urgent questions about their care, or request refills on medications. Patients should not use MyChart to communicate urgent or emergent issues.
* Residents will receive patient messages, staff messages, refill requests, and other clinic related messages through the MyChart InBasket in Epic. Messages should be responded to within 2 business days.
* If you are out for a half day (example: VA morning), you may still receive MyChart messages, but you are not expected to respond until you are back in clinic.
* You are not expected to check your MyChart during schedule time off (i.e. vacation). Set an ‘Out of Contact’ alert on your MyChart when you will be out for an extended period, to ensure your InBasket is covered while you are out. You may occasionally receive non-urgent messages that can wait to be handled until your return to clinic.

**Expectations while on clinic call:**

* Clinic call typically occurs in one-week rotating intervals across the clinic year, during business hours (8AM-5PM). The clinic call resident handles: any issues that arise related to patients of residents who are out, including absent residents’ patient emergencies, calls, messages, and refills, and occasionally other matters that are time sensitive. Residents are also expected to be physically in the clinic on call days, including during protected time, unless you have to step out for a brief meeting, etc.

**Clinic Supervision:**

* New patients are to be supervised (checked out) with faculty in real time. Follow ups are to be checked out in the same half day as they are seen, with exceptions made for child & adolescent cases and therapy cases where supervision is occurring at alternate times during the week.

**Documentation:**

* Residents should complete follow up patient notes by end of that business day and new patient notes by end of the following business day. Friday afternoon protected time is allocated as an additional buffer for extenuating circumstances. All notes must be done by end of the week.The Lake has a policy regarding open encounters (unfinished charts) that includes loss of privileges for those in violation.

**Dress Code:**

* The clinic dress code is business casual and follows the FMOLHS Dress and Personal Appearance policy, as it is an FMOLHS site clinic.
  + A copy is available on the T: drive🡪Data🡪Residents🡪Psychiatry🡪Clinical Site Information🡪Center For Psychiatric Services🡪 FMOLHS Dress Code pdf

**Patient Dismissal From Clinic:**

* The resident clinic follows the OLOLPG/FMOLHS policy for patient dismissal. Potential reasons for patient dismissal are listed in item 1 of the policy. If you are considering dismissal of a patient, it must be discussed with clinic faculty and the clinic manager. There are specific criteria and a protocol that are to be followed.
  + A copy of the policy is available on the T: drive🡪Data🡪Residents🡪Psychiatry🡪Clinical Site Information🡪Center For Psychiatric Services🡪 FMOLHS Dismissal Policy pdf

**Patient Transitions of Care within Clinic:**

* Patients are not typically permitted to transition care between residents mid-year. Residents should discuss any potential exceptions that arise with clinic faculty.
* Transitions between graduating residents and incoming clinic residents occurs in June of the academic year using a formal handoff process in clinic.

**Additional Important Information:**

* Residents are not permitted to block their own Epic clinic schedules outside of scheduling patients. Requests to block time in the schedule (for meetings, appointments, time off, co-therapy, etc) should be approved first by the program, then sent to the clinic manager to complete the change.
* Consideration for referral for TMS (Transcranial Magnetic Stimulation) or esketamine treatments in clinic should be discussed in advance with clinic faculty.
* Residents are not permitted to deliver esketamine treatments without supervision.
* Residents are not permitted to handle the TMS equipment except under direct supervision with clinic faculty in context of patient care. TMS should never be performed outside of the scope of active treatment on an established patient under supervision of faculty.
* Vacation change requests in the clinic: Changes to vacation/time off should be requested at least 30 days in advance except in extenuating circumstances. Vacation requests may denied if given in too short notice, if it interferes with clinic call duties (and you have not arranged for an appropriate swap with a peer), or if it interferes excessively with patient care.
* See the Program Handbook regarding other important information and rules about changing call shifts or vacation.

**If you need to PEC a patient in the clinic:**

* It is not acceptable to let a patient who meets PEC criteria voluntarily leave the clinic with the plan they will go to the ER later that day (after getting errands done, feeding the cat, etc). If they meet PEC criteria, they should have a PEC and get to the ER via emergency services. The front desk/nursing staff can assist you with this and let a faculty member know as well.
* It’s a good idea to keep some blank PECs in your office.
* If you have a patient coming in that you think you may have to PEC, tell the supervising attending, RN/MAs and clinic manager prior to the appointment so they can be helpful to you.
* If you want someone to sit in with you, we can make that happen.

**PGY-3 Resident Clinic Year Overview, 2025-2026 Academic Year**

* New Patient evaluations, averaging 2-4 per week
* Child & Adolescent (C&A) half days, averaging 2 per week
  + Resident C&A new patients will be scheduled these half days, corresponding with C&A faculty supervision. Residents are encouraged to schedule their C&A follow-ups on these days as well.
* VA rotation, averaging one half day weekly across the year
* Psychotherapy
  + Averaging 3-5 individual psychotherapy cases weekly
  + Therapy Supervision
    - 1 hour per week with dedicated 1:1 therapy supervisor to discuss cases
    - 2 hours per week of group CBT and CAMS supervision, Tuesdays 8-9:30 AM
* Group Therapy: Residents get to experience being a co-therapist for 6 months of the year on one half-day per week, alongside an experienced group therapy supervisor.
* Didactics – Thursday afternoons
* Protected time- Friday afternoons (see policy below)
* Special Topics Workshops
  + Occurring approximately one-half day monthly, on a variety of psychotherapy and related topics
* Special rotations/electives may include:
  + Women’s Health
  + OUD/Buprenorphine clinic
  + Transcranial Magnetic Stimulation

**CLINIC PROTECTED TIME POLICY**

The following are guidelines for clinic protected time.

* + If you are on clinic call during your “protected time”, you have to be present in clinic.
  + Your notes must always be caught up.  Protected time is to help you be sure you have that done. The standard should be that one does not finish their week on Fridays until all clinic notes are done.
  + Your prior authorizations need to be caught up.
  + You should check My Chart every weekday, near the end of the day, and respond to correspondence from patients or families as needed.
  + If there are any readings required by various seminars, protected time is a good time to do it.
  + If you are involved in a research project or writing up a case report…, protected time is good time to work on it.
  + If a faculty member needs to meet with you, your protected time is a good time to do it.
  + If you have doctor’s appointments or need an inspection sticker or have to meet a repairman at home, protected time is good time to do it, if all academic and work-related activities are complete.

What is not acceptable for protected time:

* Doing anything to the exclusion of keeping up with your work or readings.  Unless you have a good reason. We expect everyone to read their assignments and be up to date on their work by virtue of having this time.
* Not being reachable by phone
* Not checking your MyChart near the end of the day.
* Not being available for work related requests because “you had plans at that time” (and the plans aren’t a doctor’s appointment, but rather a plan to work out for example…).
* Abuse of protected time will result in an individual being required to stay in clinic during that time.

**Psychotherapy Guidelines for PGY-3 and PGY-4 Residents**

**A cartoon of a person lying down in a chair next to a person lying down

AI-generated content may be incorrect.**

**Patient load for Individual Therapy:**

* **PGY-3s**
  + Aim for 3-5 hours of individual therapy a week
  + Ideally, your patients will come weekly. Therapy works best this way. If they come less often, you will likely not get to the deeper issues.
  + However, if you and your supervisor agree that the patient is unable to come weekly (usually due to work, childcare issues or finances), then you will need to have more individual patients to fill in that gap.
  + Try to have CBT cases, psychodynamic cases and the other case(s) can be anything (CBT, psychodynamic, supportive, DBT skills, CAMS, etc.) As above, if they aren’t coming weekly, you will have more than 3 cases.
  + **You have required hours of individual therapy.** **You must meet these required hours. If you do not meet them, we will send a letter to your fellowship or new job stating that you did not complete these requirements.** 
    - **You need to have completed 105 hours of individual therapy by the end of June.**
    - This does not include no-shows or cancellations; this is patients you see for an hour of therapy.
    - **You are responsible for keeping an excel spreadsheet with the date you saw the patient, their initials and a running total of therapy hours. (T:drive** 🡪**Data🡪Residents🡪Psychiatry🡪Therapy Hours)**
      * Update this sheet monthly at least, by the last day each month.
* **PGY-4s**
  + Aim to have 1-3 hours of individual therapy a week
  + Same as above, it is best if they come weekly.
  + **Additionally, you will be strongly encouraged to see one couple’s therapy case during the year**
    - This is often a short-term case: maybe 3-5 months
    - Referrals can come from your colleagues and faculty
    - It is challenging and fun!
    - You should not do couples therapy if there is domestic violence in the relationship.
  + **You have required hours of individual therapy.** **You must meet these required hours to graduate.**
    - **You need to have completed 75 hours of individual therapy during your PGY-4 year by the end of June.**
    - This does not include no-shows or cancellations; this is patients you see for an hour of therapy.

**Therapy Recording:**

* We may be using webcams to record therapy patient sessions
* The only exception will be if you discuss it with the patient and your supervisor agrees it would be bad for the patient (i.e. patient is psychotic and thinks the FBI is recording her).
* For existing therapy patients, discuss recording with them and record if they agree
* It vastly improves supervision!
* The videos are only for you to view and for you and your supervisor to view together. You are responsible for erasing them after 30 days.
* If you want to use a clip during lectures (psychodynamic or CBT lectures), get permission from the patient to do so.
* **Unfortunately, if the patients are doing video visits, we cannot record those visits**
* See if your office has a web cam (it should). If not, let us know so we can get you one.

**Referrals:**

* PGY-3s will all start with several patients from the graduating residents
* Future referrals will be a combo of referrals from faculty, some self-referrals from your psychopharm clinic patients, and sometimes referrals from your co-residents
* **However, discuss any new therapy case with one of your therapy supervisors before confirming with the patient.** It’s required to discuss new therapy cases with a supervisor before committing to therapy with them because sometimes we can see certain challenges ahead. (I.e. Just because a patient says they want to do therapy doesn’t mean it will be a good learning case for you, and we want to help you have a balanced case load of different diagnoses, genders, ages and levels of insight.)
* It’s useful to assess a patient’s motivation for therapy as well as psychological mindedness prior to starting therapy.
  + See pages 20-23 in Psychodynamic Psychotherapy by Deborah Cabaniss for more info on how to assess these things
  + Can a patient see how their past affects them now?
  + What is their capacity for self-reflection?
  + What are their goals in therapy/how do they think it could help them?

**Scheduling:**

* You can schedule your patients several weeks in a row, so they have a consistent day/time for therapy if that is important for the patient.
* If you would like to see a patient twice a week or more, discuss this with your supervisor. We would like to encourage biweekly visits when clinically appropriate.
* Discuss with your patients at the first meeting that you are a resident and plan to be here for 1-2 years. Also, discuss with them that you will be talking about their case to an individual supervisor and sometimes in group supervision with other residents.

**Evaluations:**

* We request that you fill out an evaluation on your supervisor quarterly. Your supervisors will do the same. Latoya Wilson will distribute the forms via new innovations.

**Workshops:**

* You will have 1-2 workshops per month. PGY-3s are required to attend all workshops unless you are on night float or vacation.
* PGY-4s are welcome to attend workshops as long as their other rotation faculty agree.

**Process Notes:**

* After your session, spend 5-10 minutes taking process notes. You will use these notes in supervision. They are not part of the patient’s chart. Just write their initials and the date of the session. Keep these locked in your office.
* You can write down general themes, note moments that were uncomfortable, where you didn’t know what to say, or use direct quotes from the session.
* Come to supervision with your process notes and questions in mind, as well as parts of the recording you want to show your supervisor.
* You may have your first supervision session before you see any therapy patients. That’s fine! Talk about how to start, what your concerns are, etc.

**No-shows:**

* If a patient no-shows to an appointment, please discuss how to address this with your therapy supervisor. It is case specific and we may suggest waiting, calling or sending the patient a letter.

**Boundaries:**

* Social media requests: You should not accept any social media requests from patients or their friends/family. You should look into your safety settings on any social media websites you use at least yearly – now is a great time to do that! If you have contact with a patient or their friends/family via social media, discuss with your therapy supervisor.
* Gifts: It may be reasonable to accept gifts valued at (roughly) less than $20. Discuss with your supervisor. Gifts can hold great meaning to patients and should be processed with your supervisor to determine the best course of action. This may be something to consider in advance of the holiday season or termination.
* Meeting outside of clinic: You should not schedule any meetings with your patient outside of the clinic or outside of business hours. The only acceptable place for resident-patient interactions is in the clinic within a therapeutic session.
* Discuss with your patients what you will do if you see them outside of the clinic. Generally, you should not acknowledge any patient outside of the clinic or hospital unless they approach you first. If they do, be polite and professional.
* Email through MyChart: Discuss with your patients that this type of communication is best for scheduling appointments or asking for refills. Make sure they know that it goes in their chart and others involved in their care (nurses and other doctors) can see it. It is not ideal for very personal topics as we can never fully guarantee privacy through their email. **It should never be used to communicate in an emergency or crisis situation.**
* We STRONGLY recommend that you do not give your cell phone or email to patients. It can be appropriate but can also lead to boundary violations and burnout. It’s better to wait a few years before deciding if you want to give any patients that information.
* Obviously, your relationship with any patient must be professional at all times. It is never OK to engage in romantic/sexual encounters or any form of violence with your current or former patients.

**Therapeutic Alliance:**

* Try and make your patient comfortable. It can be very stressful for many people to come to therapy.
* Don’t take a phone call during a therapy session unless it is an emergency.
* Have tissues available (available in the supply closet).
* Keep patient’s privacy and do not talk about therapy or medications in the hallways.
* We suggest keeping note writing during the session minimal, if at all.
* Keep the frame by starting and ending on time. If this is difficult for some reason (i.e. the patient brings up the most serious/difficult things on the way out of the door) discuss it with your supervisor.

**High risk patients (SI, HI or psychiatric admission):**

* Let a supervising faculty member know about any high-risk patient you have (with SI, HI, current psychiatric admission).

**Collateral:**

* It’s a good idea to get permission from patients (in writing) to speak with a close family member or friend. This is especially useful if they no-show to the appointment and you are worried. If you already have permission, you may call this family member or friend and ask if they have seen them recently. This permission should be documented in the chart.
* If a family member/friend of a patient calls to talk to you about them, you may listen to them without permission from the patient (and respond **only** if you have the patient’s permission.) We suggest telling the caller right away that you would like to hear what they have to say, but you will need to discuss anything they tell you with the patient. You should talk to your supervisor about how to discuss this interaction with the patient. We do not recommend keeping secrets from patients that are shared by family members.

**Supervision:**

* PGY-3s will each have one individual supervisor as well as group CBT/CAMS supervision, and you will meet with both weekly.
* See your individual schedules regarding supervision times.
* Let your supervisor know ahead of time if you cannot meet that day because of being night float, vacation, out sick, etc. If you are late, call or text to let them know.
* If you have any concerns about your supervisors, discuss them with Dr. Aubin or Dr. Crapanzano.
* Individual therapy supervisors for residents will change every 6 months for PGY-3s and will be for a year for PGY-4s. CBT is group supervision for PGY-3s and does not change. PGY-4s are invited to attend CBT supervision as well on Tuesday mornings, schedules permitting (and if cleared with rotation faculty).

**Group Therapy:**

* You will co-lead a group for your PGY-3 year for 6 months (see the schedule).

**CBT with Psychology Interns**

* You may also co-lead a CBT case with the psychology interns
* For the first case you want to refer to them, coordinate with them so you can go to all sessions. Scheduling can be tough, but it is totally worth it!!

**Termination and referral at the end of residency:**

* We will discuss termination as the year goes on. **PGY-4s and PGY-3s leaving early for child fellowship:** You should begin talking with each therapy patient about termination by Feb (perhaps earlier, discuss with your supervisor) and you will work with the patient and your supervisor to make a good transition plan (i.e. refer to another resident, refer elsewhere or end therapy and refer for medication management.)

**LSU Child and Adolescent Psychiatry fellowship policies**

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**VISION STATEMENT**

Our vision is that children, adolescents and families will be able to access psychiatric assessments and appropriate treatment within their communities. Our mission is to produce child and adolescent psychiatrists who will provide effective psychiatric services to children and families in need. Our education philosophy is that resident education needs should be driven by both the needs of the individual trainee as well as by the fact that there are core training elements (assessment and treatment) that must be taught and learned in order for fellows to practice child/adolescent psychiatry effectively. Service demands do not guide our approach to education.

**MISSION STATEMENT**

Our mission for the LSU Baton Rouge Child and Adolescent fellowship is to increase access to quality behavioral healthcare for children and adolescents of greater Baton Rouge and through the training, increase the child and adolescent psychiatric workforce in the community.

**PROGRAM AIMS**

**The fellowship will produce well trained child and adolescent psychiatrists who will help ease access gaps by focusing on these 9 aims:**

* A strong foundation in primary care
* A strong commitment to both service and education
* Diverse experiences in psychiatry and all its subspecialties, resulting in a well-rounded physician capable of dealing with a wide spectrum of clinical scenarios.
* A comprehensive didactic curriculum to include lectures, journal clubs, grand rounds, resident led presentations, assigned readings, and structured experiences in teaching medical students and junior colleagues
* Commitment to the practice of evidenced based medicine and a multidisciplinary approach with a focus on patient-centered care
* Exposure to multiple systems of care and settings of practice including hospital-based, community, private, and in-home care
* Emphasis on psychotherapy training through didactics, clinical experience and supervision
* An awareness and respect for community psychiatry.
* The establishment of a supportive, collegial atmosphere of approachable faculty and residents with high morale
* Equity for all trainees in their access to education and opportunities for advancement.

## **EDUCATIONAL PHILOSOPHY**

Physicians who train with us will be exposed to all evidence-based psychosocial and pharmacological treatments for children, adolescents and families. Our training philosophy provides progressive autonomy as fellows advance and supervision is provided to ensure fellows will master the skills they need to become excellent child/adolescent psychiatric practitioners. Rotations are provided in settings that represent the treatment venues in which most child/adolescent psychiatrists work. We focus not only on the symptoms and behaviors with which our patients present but also on the context within which they live, including family, school, neighborhood and friends as well as issues such as social determinants of health (transportation, shelter, food) in order to truly understand our patients’ situations but also to develop novel and effective ways to intervene. Because our field is constantly growing and changing, we strive to inculcate the notion that learning is a life-long process and residency and fellowship training are just the beginning of the child/adolescent psychiatry learning experience.

 A graduate of our Fellowship Program in Baton Rouge will:

1. Possess a strong identity as a physician and child/adolescent psychiatrist
2. Be an expert in diagnosis and treatment of mental illness and substance use in children and adolescents and their families
   1. Diagnosis and assessment
      1. Will have intimate knowledge of the DSM
      2. Will have the skills to conduct a thorough assessment
      3. Will know and use evidence-based assessment tools
      4. Will be able to formulate a case and develop an effective treatment plan
   2. Treatment
      1. Will have a thorough knowledge of psychopharmacology and its applications to child/adolescent patients
      2. Will learn and be able to implement evidence-based psychosocial treatments for infants, children, adolescents and families
      3. Will have a working knowledge of various approaches such as infant treatments like parent-child interactive therapy and child-parent psychotherapy, psychodynamic treatments, cognitive and cognitive/behavioral treatments as well as evidence-based programmatic treatments such as dialectical behavioral therapy, multi-systemic therapy, functional family therapy, among others.
   3. Possess interpersonal strength and practice in accord with ethical principles
      1. Demonstrate a high degree of professionalism and personal awareness
      2. Demonstrate flexibility and maturity
      3. Will recognize one’s own biases and work to minimize their effect on patients
   4. Possess a special sensitivity to children and their needs
      1. Will understand how context impacts child-related behaviors and symptoms
      2. Will understand how family is the key to development and optimal functioning
      3. Will understand how bias impacts children with special needs as well as those who operate outside of the usual norms.

**CLINICAL ROTATIONS**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1 | | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1st year | Pediatric Neurology2 | The Maples (residential treatment facility)3 | | | | | | | CL/ED4 | | | | |
| 2nd year | Outpatient C&A psychiatry6  Involvement in OLOL School based clinics7 virtually 0.1 FTE, 6 months of the year (within the outpatient clinic)  Observation of “normal children”, observation of Juvenile court, observation of ABA therapy (0.1 FTE) | | | | | | | | | | | | |

1. This rotation will take place at the OLOL Adolescent psychiatry unit
2. OLOL Neurology group will host the fellows along with Pediatric residents, 1 month
3. This rotation will take place at Maples LLC, a residential treatment program for adolescent girls.
4. This rotation will take place primarily at the Our Lady of the Lake’s Children’s Hospital with a robust emergency department and inpatient consults.
   1. Will include participation in OLOL e-consult program
5. OLOL outpatient clinic: general psychiatry clinic for residents to see longitudinal patients with potential for the development of specialty clinics
6. OLOL School based clinics—OLOL has Nurse practitioner (Pediatric) and counselor at 7 local schools. Fellows will do consults from the School based clinics virtually while in the outpatient year.

**DIDACTIC CURRICULUM**

Year One

Development: 20 sessions

Interview and Assessment: 20 sessions

Pharmacotherapy: 20 sessions

Psychopathology: 20 sessions

Psychotherapy: 40 sessions

Special topics: 40 sessions

**PROGRAM COMMITTEE STRUCTURE**

**Faculty Meetings**

All core faculty members are asked to participate in monthly faculty meetings. During faculty meetings, faculty will hear announcements about the section as well as fellowship related topics. A topic related to faculty development will be presented as well.

An annual meeting will be offered to all faculty who participate in the LSU Baton Rouge section

**Program Evaluation Committee (PEC)**

The Program Evaluation Committee (PEC) is composed of the Fellowship Director, core faculty, section chief, chief fellows, and the residency coordinator. Ad hoc or invited guests may also attend the meetings at the discretion of the program director. The Fellowship Director chairs the activities of the committee.

The PEC is responsible for the annual evaluation of the program and for assuring that areas of non-compliance with ACGME standards are corrected. Data from resident and faculty evaluations must be included in this annual evaluation and action plan. For that purpose, the committee meets annually and involves the chief residents.

**Clinical Competency Committee (CCC)**

This committee evaluates and tracks the fellows’ progress in core competencies; its membership includes all core faculty. The committee will be responsible for reviewing evaluations for each fellow. From the collected evaluations and verbal input of committee members, the committee will monitor each resident for their appropriate level of milestone development. The committee is responsible for reporting the Milestone evaluations to the ACGME semi-annually.

If progression appears to be in jeopardy, the committee will advise the program director as to its recommendation. This committee can require actions including remediation, probation, repetition of rotations, non-promotions, or referral to the Employee Assistance Program for psychiatric evaluations and/or treatment, or other remediating measures.

If the CCC decides the above actions are insufficient, it can propose suspension, non-renewal of contract, immediate termination, or reclassification of training level lower than the resident’s current training level.

In all cases, all evaluation and review proceedings shall be as private as possible to protect the resident and faculty members involved, as well as maintaining objectivity. Institutional Due Process is described in detail in the LSUHSC House Officer Manual. The determination of the committee is to be considered as advisory to the fellowship director and Department Chair, who shall be regularly apprised of their actions.

The committee is also responsible for determining/reviewing methods of evaluating for all the milestones are available and in use. Their feedback on the instruments and methods being employed will be referred to the PEC.

**Recruitment and Selections Committee**

The recruitment and selections committee operates primarily September to March and is tasked with the recruitment of new fellows. Since the section is starting a combined 5 year track, it will interact closely with the adult program recruitment process. Their responsibilities include the design of the recruiting process and the choice of applicants who will receive interviews. They also oversee the ranking of applicants for ERAS and the match process. At the end of the recruitment season, they will evaluate the process and make recommendations for next year. Membership is a mix of the faculty. Fellow representation is also expected in the process. The chief fellow will be included in the ranking process and other fellows’ input is included from their own feedback meeting with recruitment chair.

**LSU Baton Rouge Section of Psychiatry policies**

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**ADEQUATE REST POLICY**

In order to ensure residents and fellows have adequate rest between duty periods and after on-call shifts we adopt the following policies:

1. Our Duty Hours Policy contains the following relevant language:

1. Clinical and educational work hours are limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in house call, clinical and educational activities, as well as clinical work done from home and moonlighting.
2. Residents and fellows should have at least 8 hours off between shifts.
3. Residents and fellows must have minimum of 14 hours free of clinical work after 24 hours of in-house call (although we currently do not have any rotations that require in house call)
4. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over 4 weeks). At home call cannot be assigned on those free days.
5. Clinical and educational workloads may not exceed 24 hours of continuous scheduled assignments (up to an additional 4 hours is allowed for transitions in care “patient continuity” and education…).
6. Time spent at home doing on-call activities must be logged and count towards the 80-hour limit.
7. In-house call no more than every 3rd night. At home call has no limit but all patient care time counts toward 80 hour limit.

2. All employees of LSUHSC are under [Chancellors Memorandum 37](http://www.lsuhsc.edu/administration/cm/cm-37.pdf) which is the LSUHSC Fitness for Duty Policy. This describes the expectations for employees to report to work fit and safe to work. It further defines what are considered unsafe/impaired behaviors, the requirement for self or supervisor referral to the Campus Assistance Program, and what steps are taken thereafter.

3. The institutional Policy of Professionalism and Learning Environment further amplifies the expectations for residents and fellows to be fit for duty and to take it upon themselves to be well rested.

4. Residents and fellows must take personal responsibility for and faculty must model behaviors that promote:

1. Assurance for fitness of duty.
2. Assurance of the safety and welfare of patients entrusted in their care.
3. Management of their time before, during and after clinical assignments.
4. Recognition of impairment (e.g. illness or fatigue) in self and peers.
5. Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

5. The moonlighting policy anticipates potential trouble areas and describes a method for monitoring the effects of moonlighting on residents and fellows.

6. Adequate sleep facilities are in place at each institution and our alertness management / fatigue mitigation policy and process encourages good sleep hygiene as well as recommending such strategies and pre-call strategies, strategic napping and post-call naps.

7. Foremost our Professionalism and Learning Environment Policy requires faculty to model behaviors that encourage fitness for duty as noted above and our Supervision Policy requires faculty to observe for signs of fatigue especially during transitions.

**ADVERSE ACTION**

**Intervention, Remediation, Probation, & Termination**

Our program follows the policy and procedures of [LSUHSC House Officer Manual](http://www.medschool.lsuhsc.edu/medical_education/graduate/HouseOfficerManual.aspx) in regard to remediation, probation, and termination. Our Clinical Competency Committee will review information and make recommendations to the program director of any cases potentially requiring adverse action.

The conditions for reappointment, policies regarding termination, non-reappointment, and other adverse actions as well as due process, summary suspensions, and grievance procedures are found in the LSUHSC House Officer Manual.

Certain issues may require the program to report a resident to LSBME.

**Suspension**

Any supervisor, Medical Director (for example, at one of the hospitals), or the Program Director has the right and responsibility to immediately suspend a resident/fellow’s clinical privileges at any time if it is felt that patient care or welfare is being severely jeopardized by the resident/fellow, or if the resident/fellow is behaving unprofessionally. Such a decision must be reported to the Program Director immediately. The Program Director will comply with LSUHSC policies regarding summary suspension in conjunction with the Clinical Competency Committee..

# Dismissal

The conditions for reappointment, policies regarding termination, non-reappointment, and other adverse actions as well as due process, summary suspensions and other grievance procedures are found in the LSUHSC House Officer manual and will be followed by the LSU Baton Rouge Psychiatry residency program’s Clinical Competency Committee.

**ALERTNESS MANAGE/FATIGUE MANAGEMENT**

**Policy and Process**

Residents, fellows, and faculty are educated about alertness management and fatigue mitigation strategies via on line modules, at orientation and in departmental conferences. Further, all faculty will be on the lookout for fatigued residents and fellows to ensure patient and resident/fellow safety. We make the following suggestions:

1. Warning Signs

* Falling asleep at conferences/rounds
* Restless, irritable w/ staff, colleagues, family
* Rechecking your work constantly
* Difficulty focusing on care of the patient
* Feeling like you just don’t care

2. Sleep Strategies

* Never drive while drowsy

Pre-call Residents and fellows

* Don’t start Call w/a SLEEP DEFICIT – GET 7-9 ° of sleep
* Avoid heavy meals / exercise w/in 3° of sleep
* Avoid stimulants to keep you up
* Avoid ETOH to help you sleep

On Call Residents and fellows

* Tell Chief/PD/Faculty, if too sleepy to work!
* Nap whenever you can for > 30 min and < 2hours
* BEST circadian window 2PM-5PM & 2AM- 5AM
* AVOID heavy meal
* Strategic consumption of coffee (t ½  3-7 hours)
* Know your own alertness/sleep pattern!

Post Call Residents and fellows

* Lowest Alertness 6AM –11AM after being up all night
* Full Recovery from Sleep Deficit takes 2 nights
* Take 20 min. nap or Cup Coffee 30 min before driving

In addition, programs will employ back up call schedules as needed in the event a resident/fellow can’t complete an assigned duty period.

**Monitoring**

* The institution and program will monitor successful completion of the online modules.
* Residents and fellows are encouraged to discuss any issues related to fatigue and alertness with supervisory residents and fellows, chief residents/fellows, and the program administration.
* Supervisory residents and fellows will monitor lower level residents and fellows during any in house call periods for signs of fatigue.
* Adequate facilities for sleep during day and night periods are available at all rotation sights and residents and fellows are required to notify Chief Residents and fellows and program administration if those facilities are not available as needed or properly maintained.
* At all transition periods, supervisory residents and fellows and faculty will monitor lower level residents and fellows for signs of fatigue during the hand off.
* The institution will monitor implementation of this indirectly via monitoring of duty hours violations in New Innovations, the Annual Resident Survey (administered by the institution to all residents and fellows and as part of the annual review of programs) and the Internal Review process.

**Strategic Napping**

Strategic napping is utilized while on call or moonlighting to ensure that residents and fellows can avoid fatigue. Residents, fellows, and moonlighters are encouraged to nap overnight especially between the hours of 10:00 PM through 8:00 AM to avoid excessive fatigue. The effectiveness of this process will be monitored by the faculty responsible for patient care that the resident is involved in the following day. Difficulties will be reported to the program director for review.

Residents and fellows who are excessively fatigued such that they cannot adequately perform their job should exhibit professional behavior and make their attending aware. Please see Call policy, Frequency and Intensity of House call events, for how this is to be handled.

Any difficulties in management of alertness will be evaluated daily by supervising faculty and reported to the program director. Any reported problems will be reviewed at the PEC meeting.

**S.A.F.E.R**

# (Sleep, Alertness, and Fatigue Education in Residency)

**Fatigued residents and fellows typically have difficulty with:**   
Appreciating a complex situation while avoiding distraction   
Keeping track of the current situation and updating strategies   
Thinking laterally and being innovative

Assessing risk and/or anticipating consequences   
Maintaining interest in outcome   
Controlling mood and avoiding inappropriate behavior

**Signs of fatigue include**

Involuntary nodding off Waves of sleepiness

Lethargy, irritability, mood lability Problems focusing

Difficulty with short-term recall Poor coordination

Tardiness or absences at work

**High risk times for fatigue-related symptoms are:**   
Midnight to 6:00

Early hours of day shifts   
First night shift or call night after a break  
Change of service  
First 2 to 3 hours of a shift or end of shift  
Early in residency or when new to night call  
  
Fatigue can be modeled as the result of forces producing fatigue and forces reversing its effects, i.e. recovery.    
  
**Moves to limit fatigue-related problems include:**

* The 80-hour limitation to which our programs are held will certainly help reduce the total number of hours worked.
* In general, the residency workload should allow for as little variation in work schedules as is feasible.  Rapid or frequent shifts from day to night work are known to increase the risk of fatigue.
* Individual residents and fellows may need individualized schedules to accommodate idiosyncratic energy cycles.
* Many physical illnesses can present as fatigue and should be ruled out when daytime fatigue seems out of proportion to the resident’s workload. The resident should be encouraged to consult his/her primary care physician.  Sleep studies may be warranted.
* Depression and other psychiatric syndromes may first be manifest as fatigue.  Proper diagnosis and treatment should be recommended.

**ANNUAL IMMUNIZATIONS**

LSU and OLOL require an annual Influenza vaccination each year by Nov 30. Failure to do so will result in having to wear a mask always through the entirety of flu season. In the spring of each year, residents and fellows are required to have a TB skin test and a Mask Fit Test. Usually during the month of July, OLOL will have a TB Mask Fit Testing fair in the hospital, and all residents and fellows are required to participate. All testing and vaccination are available to residents and fellows at OLOL Employee Health. You must submit proof of all annual immunizations and screenings to the Program Coordinator.

COVID vaccinations are available and strongly recommended but as of June 2024 no longer required of all residents and fellows.

**ARTIFICIAL INTELLIGENCE**

The involvement of artificial intelligence in healthcare is likely to grow in coming years. AI has great potential to improve education, evidence-based care, measurement-based care, and clinical efficiency. However, AI may interfere with the development of important clinical skills and may pose risks for patient safety and privacy. Residents are permitted to use specialized AI tools, such as OpenEvidence, to review the clinical literature and help answer clinical questions. However, **they must not input any personally identifiable information into these tools** because AI algorithms collect inputs as data, which may compromise patient privacy. Residents should recognize that AI summaries may be inaccurate or based on limited data. Therefore, residents should review the AI’s cited sources to ensure that appropriate conclusions are reached before making clinical decisions. Residents should not use AI to generate notes, formulations, or treatment plans, or other assignments, as we believe it is essential for residents to develop these clinical reasoning skills independently so that they can supervise and critique the performance of AI tools. Once independent skills have been mastered, the Program Director may consider authorizing the use of specific AI tools that have been approved by (our institution) for patient care/documentation purposes to give residents practice and familiarity with using these tools consistent with (our institution's) policy.

At this time, OLOL has not approved any AI tools for use within EPIC.

**CANNABIS USE POLICY**

LSUHSC New Orleans follows federal guidelines for the Drug Free Workplace Act which states Marijuana is a schedule I drug and is illegal. Our Lady of the Lake will withdraw privileges for the use of illegal substances and a resident’s license could then be in jeopardy as they would be required to report it. As an LSUHSC employee, you are subject to random drug screens.

**CALL SCHEDULE SOFTWARE USE**

A repository of all of our call schedules is on QGenda.

Please report any errors, changes, or discrepancies in the schedule to Latoya Wilson at 225-757-4210 or lwil76@lsuhsc.edu

**Continuity of Care Ensured in the Case Where a Resident is Unable to Perform**

If a resident or fellow is unable to perform his/her duties or is on vacation or sick leave, the faculty is responsible for patient care or fellow residents and fellows assume responsibility for continuity of care. See the rules on coverage as part of the Leave policy. The effectiveness of this policy will be reported to and reviewed by the program director, and any cases of deviation from this policy will be reviewed at the PEC meeting to ensure optimal patient care.

**CLINICAL AND EDUCATIONAL WORK HOURS (formerly known as DUTY HOURS)**

It is the job of the program to ensure that clinical and educational work hours are within the limits set forth by the ACGME. These limits are in place to protect residents and fellows from extreme fatigue during residency/fellowship and allow for a well-rounded educational experience that goes beyond patient care or service needs. Clinical and educational work hours include time spent on clinical work, time spent on educational activities, home call (for the time one receives a call), and moonlighting.

Hours vary according to the rotation. Residents and fellows are always responsible for their patients during regular hours unless other coverage has been arranged. Coverage afterhours and on weekends is site specific and ensures work hour compliance. Attending physicians will cover clinical responsibilities during resident/fellow didactics.

Residents and fellows are encouraged and required to enter their hours accurately, even if that will result in a violation. This helps us monitor the rotations and make changes when required.

Please see the LSUHSC House Officer manual for institutional policy on Clinical and Education Work hours, which is in accordance with the ACGME Clinical and Education Work Hour (found on pages 37-39 of the ACGME “*Program Requirements for Graduate Medical Education in Psychiatry*”. Our program adheres strictly to these policies.

**Types of Clinical and Educational Work Hours Used by our Program**

***Shift*** All hours worked that are not in our outpatient psychiatry clinic. This also refers to any required hours on holidays or weekends that are outside of At-Home Call.

***Night Float*** Schedule night float weeks. Not to be confused with Call.

***Call*** This type is used only for in-house call that requires a resident to be present in the hospital for the entire duration of the call period. Psychiatry does not use this type, as we do not have in-house call.

***Conference*** These are entered by the Coordinator while residents are on psychiatry rotations. Residents do not enter their own psychiatry conference hours. These hours refer to department didactic activities where a resident was in attendance.

PGY 1 residents on off-service rotations are responsible for logging their own conference hours if they attend didactics in those departments.

***Clinic*** Pertains only to PGY 3 and 4 residents in our outpatient clinic – Center for Psychiatry Services.

***Vacation*** These are entered by the Coordinator. Residents do not log their own vacation time.

***At Home Call*** This type pertains only to call that is specified as home call and does not require time in the hospital. If called in to the hospital while on home call, all active hours in the hospital are logged as “At Home Call – Called In”. The remainder are logged as “At Home Call – Not Called In”. It is rare for weekday home call to require a resident to be called in.

***Moonlighting*** This is only for residents at a PGY 2 level or above who have their own medical license, DEA license, and malpractice, and who have received both institutional and program approval to participate in moonlighting activities.

***Break/*** This type was created to correct work hour violations. This is for times of the

***Not Working*** day when you are not working in the middle of a shift (i.e. lunch breaks). These will show up as gaps in your schedule. Please use this type to fill those gaps.

***Research*** This is for dedicated research time for residents who have research as part of their electives.

**Location of Clinical and Educational Work**

OLOL will always be your location. Department is always OLOL Psychiatry unless you are rotating with the LSU Internal Medicine or Emergency Medicine program, in which the department would be Baton Rouge Programs/BR.

**Entry & Monitoring of Clinical and Educational Work Hours**

Hour entry and monitoring is done through New Innovations, our electronic residency management database. ***Residents and fellows are expected to enter hours on a weekly basis but required to do so on at least a monthly basis***. Waiting any longer risks that you will not recall your exact work hours which can result in erroneous logs. Reports are not only used to track resident work hours, but they are also used in internal and institutional audits and reviews. Therefore, timely entry and correct entry of hours is extremely important.

Residents and fellows who fail to log hours or log erroneous hours are subject to disciplinary action by the program. New Innovations has great Help modules that can assist demonstrate how to log hours. You may also consult the Program/fellowship Coordinator or senior resident/fellow for assistance.

If a resident or fellow is fatigued, the faculty responsible for patient care will assess the resident or fellow and make provisions for resident and patient safety. Options may include early dismissal, ensuring adequate rest, the use of a strategic nap, or in mild cases the limited use of caffeine. The effectiveness of this process will be monitored and reviewed by the program and/or fellowship director a, utilizing the data provided from the Clinical and Education Work Hour capturing system (New Innovations) and direct report from residents, fellows, and faculty. Therefore, hours must be reported timely and accurately to ensure correct reports.

Hour reports are generated on a monthly basis by the program/fellowship coordinator and available for the program and/or fellowship director to review at any time, but must be reviewed no less than semiannually.

The LSU Health Sciences Center adopted the ACGME Clinical and Educational Work Hours (eff 7/1/17) that may be summarized as:

**Maximum Hours of Clinical and Educational Work per Week**

Clinical and educational hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities, clinical work done from home, and all moonlighting.

**Mandatory Time Free of Clinical Work and Education**

Residents must be scheduled for a minimum of one day (24 hours) free of work every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

**Maximum Clinical and Educational Period Length**

* Clinical and educational work periods for residents and fellows must not exceed 24 hours of continuous scheduled clinical assignments. Programs must encourage residents and fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
* It is essential for patient safety and resident education that effective transitions in care occur. Residents and fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
* Residents and fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
* In unusual circumstances, residents and fellows, on their own initiative, may remain beyond their scheduled period of work to continue to provide care to a single patient. Justifications for such extensions of work are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
* Under those circumstances, the resident must:
* Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
* Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program or fellowship director.
* The program or fellowship director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
* These additional hours of care or education are counted towards the 80-hour weekly limit.

**Minimum Time Off between Scheduled Work and Education Periods**

* Residents and fellows should have minimum of 8 hours free of clinical and educational activities between scheduled work periods.
* Residents must have at least 14 hours free of clinical work and educational activities after 24 hours of in-house call.
* Residents must be scheduled for a minimum of one-day-in seven free of clinical work and required education (when averaged over four weeks).
* At-home call cannot be assigned on these free days.
* Circumstances or return-to-hospital activities with fewer than eight hours away from the hospital by residents must be monitored by the program or fellowship director. This must occur within the context of the 80-hour and the one day in seven off requirements.

**Maximum Frequency of In-House Night Float**

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirement.

**Maximum In-House On-Call Frequency**

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

**At-Home Call**

* Time spent in the hospital by residents and fellows on at-home call must count towards the 80-hours maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
* At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each resident.
* Residents and fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

Residents and fellows are required to log in all clinical and educational hours in New Innovations Software program or its replacement program. Those who fail to log hours or log erroneous hours are subject to disciplinary action (GMEC Feb 2011). The institution as well as each program is required to monitor and document compliance with these requirements for all trainees. To accomplish this, the institution will implement the following policies and procedures:

1. Each program will need to sign a statement attesting to compliance with these requirements at all sites.

2. Each program will develop their own written clinical and educational work hours policy that is in keeping with the ACGME and Institutional policy. This policy will be distributed to all trainees and faculty with a copy provided to the GME Office. The policy must delineate specifically how compliance will be monitored and what actions will be taken to remedy problems. Yearly changes or revisions to policies must be forwarded to the GME Office.

3. Programs must monitor residents and fellows for fatigue. The institution will develop resources to educate faculty and residents/fellows about sleep deprivation and fatigue.

4. The institution will ask each participating institution to advise it where legally permissible of incidents or trends suggesting fatigue as a component of the problem.

5. If the program has developed and instituted a method to monitor for individual resident/fellow clinical and educational work hour compliance (eg work hour logs) it will regularly share this data with the institution.

6. The institution encourages programs to add questions on the clinical and educational work hour requirements to their monthly rotation evaluations in addition to other monitoring.

7. The institution will make it clear to residents and fellows that our Ombudsman is available to field questions or complaints about clinical and educational work hours and those such complaints will remain anonymous.

8. The resident agreement of appointment/contract includes a reference to clinical and educational work hours policy and an agreement to participate in institutional monitoring of clinical and educational work hours.

9. Special Focused Reviews may include detailed sections on clinical and educational work hours.

10. An annual web-based questionnaire will be administered to residents and fellows regarding clinical and educational work hours by the GME Office. Responses will be anonymous.

11. The GME Office will randomly audit programs.

12. Program specific data will be presented annually in the End of Year Program Review Minutes submitted to the GME Office for review.

13. Violations of clinical and educational work hours requirements by participating institutions may result in removal of residents or fellows from that institution.

14. Programs with violations will be subject to close, regular monitoring by GMEC.

15. Programs cited by the ACGME for clinical and educational work hour violations will have special monitoring programs implemented.

16. Moonlighting must be strictly approved in writing and monitored to assure resident fatigue does not become a problem.

17. Clinical and Educational Work Hours Hotline is established to monitor residents’ complaints.

This policy applies to every site where trainees rotate.

**CLINICAL AND EDUCATION WORK HOUR (DUTY HOUR) VIOLATIONS**

New Innovations automatically calculates duty hours and activates a violation if a resident/fellow has exceeded maximum duty hours in each period. Violations inevitably occur during residency, but it is our program’s goal to structure a resident/fellow’s work schedule so that these violations do not occur on a regular basis. If a violation does occur, you must report this appropriately in New Innovations by selecting a cause for the violation from the drop-down menu provided, and entering comments as to the nature of the violation. It is important to note that you are not penalized for violations. Report any concerns to the program coordinator or director regarding situations that could potentially cause a violation.

**DRIVER SAFETY & RISK MANAGEMENT**

Successfully completion of the Driver Safety module and its requirements is the first step of a 2-step process to obtain approval to drive on state business or to renew your approval to drive on state business. You have already completed the first 2 steps before arriving by providing a certified copy of your driving record. The second step is completion of the online modules and that must be done within the first 90 days of employment. For out-of-state driver’s licenses, these residents must furnish LSUHSC with a certified copy of their driving record each year in order to renew contracts.

If you get into an accident while on state business, there is a strict process for reporting the accident to ensure that your LSUHSC secondary liability coverage is activated. Your personal insurance is the primary insurer. The LSUHSC Office of Risk Management provides coverage in excess over any other collectible insurance.

**CLINICAL SKILLS VERIFICATION**

**Components of the Clinical Skills Evaluation and Scoring Criteria**

The [American Board of Psychiatry and Neurology](https://www.abpn.com/) (ABPN) requires that residents demonstrate mastery of the following three components of the core competencies to apply for certification in the specialty of psychiatry. They are:

1. **Physician-Patient Relationship**: For performance to be scored acceptable, the resident must develop rapport with the patient, respond appropriately to the patient, and follow cues presented by the patient.
2. **Conduct of the Psychiatric Interview**: For performance to be scored acceptable, the resident must obtain sufficient data for formulating a DSM Axes I-V 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**: For performance to be scored acceptable, the resident must present an organized and accurate history and an organized and accurate summary of the mental status findings.

All 3 competency components are to be assessed in the context of a patient evaluation that is conducted in the presence of an ABPN-certified psychiatrist. A resident must pass a total of 3 CSVs to graduate from the program.

Training programs may elect to do more than 3 CSVs if necessary. They may also assess additional competency components in the evaluation, e.g. differential diagnosis, treatment planning. But the minimum requirements must be met.

**Timing of the Evaluations**

The program will offer a clinical skills verification each of the first three years of the program and will consider it essential to moving to the next level of training that the CSV examination each year has been passed. It is anticipated that all three CSV exams will successfully completed by the time the resident enters his/her fourth year of training. For residents wishing to enter into a fellowship after their 3rd year of training, you must have at least 2 passing CSVs to apply. However, it is recommended that at the time of application, your CSVs are completed.

**Selection of Patients**

The selection of patients is at the discretion of the residency program director, and any patient type, in any clinical setting may be used. The program will use a patient from the inpatient setting the first year of the program, an adolescent from the second year of training, and an outpatient for the third year of training.

**Evaluators**

Each of the three evaluations must be conducted by an ABPN-certified psychiatrist. At least two of the evaluations must be conducted by different ABPN-certified psychiatrists. The evaluator must observe the resident’s performance and score the resident on the physician-patient relationship; psychiatric interview, including mental status examination; and case presentation.

**Duration of Each Evaluation**

At a minimum, each evaluation session should last at least 45 minutes. The resident should be given a minimum of 30 minutes to conduct the psychiatric interview. Thereafter, he/she should have a minimum of 10-15 minutes to present the case. If appropriate, the evaluator may give feedback to the resident.

**Evaluation Forms**

Evaluations will be completed on one of the two ABPN-approved forms. The evaluations can be completed on paper or electronically in New Innovations. Forms are available in New Innovations and in the program office.

**Determination of Acceptable Performance**

The individual evaluator will determine if the resident performed acceptably on each of the three competency components. An acceptable score is required for all three components. Regardless of when during training the resident takes the evaluation, the standard for acceptable performance remains the same. Because the resident may take each of these clinical skills evaluations multiple times if necessary (which will not affect the resident’s admissibility to the ABPN certification examination), there should not be pressure to score a resident’s performance as acceptable on an evaluation. If a resident is unsuccessful in completing the evaluations, any remediation activities are the responsibility of the training program.

**Submission of Documentation to the ABPN**

At the time of application for certification, the ABPN requires attestation from the residency program director of an ACGME-accredited psychiatry program. Documentation must include a statement that the resident performed acceptably on three clinical skills evaluations and must include the full names of the ABPN-certified evaluators and the dates of the evaluations. It is recommended that the program retain the evaluation forms as part of the resident’s training file. The ABPN reserves the right to audit the evaluation process. The evaluations are valid for five years following completion of residency training.

**Board eligibility**

It is the goal of the LSU Baton Rouge Psychiatry residency program that all of our graduates will be eligible and eventually achieve Board Certification. The American Board of Psychiatry and Neurology (ABPN) governs this process. Guidelines require that graduating residents successfully complete 3 (three) clinical skills verification exams during their training and that a letter to that effect be forwarded to them at the completion of the residency. Furthermore, program must complete a pre-CERT application on each graduating resident to ensure they are eligible to sit for their written boards at the completion of the program.

Child fellows must also complete 3 CSV’s—at least two from different age groups (preschool, school aged and adolescent). One CAP eval can be used to meet general adult psychiatry requirements, but not vice versa.

**DRESS CODE**

Professional appearance and demeanor are a demonstration of respect for the patient and the profession, and of self-respect.

* Business casual attire is expected in clinical settings.
* Scrubs may be appropriate in certain settings; the determination of whether scrubs or business casual attire is preferred should be deferred to the individual rotations.
* Open-toe shoes should not be worn in clinical settings, due to safety concerns.
* Excessive fragrances or smell of smoke are inappropriate, as they may adversely affect patients with respiratory concerns.
* Official identification badges must be worn above the waist and be clearly visible at all times

# EMAIL POLICY

The program will be communicating with you mostly through your LSUHSC email. Residents and fellows must check email regularly throughout the work day. Residents and fellows are required to use LSU email accounts. The department, university, and ACGME will send emails to your LSU account. Personal email accounts will not be used for work purposes. You are expected to respond promptly to emails, and to use professional language and conversation in email communication. Please be mindful of HIPPAA regulations when communication with your colleagues regarding patient care. Identifying information about patients should not be communicated over email.

All new residents and fellows must activate their LSUHSC email accounts online and on their smartphones PRIOR to July 1.

**EMPLOYMENT & BENEFITS**

As a resident in this program, you are a full-time employee of the LSU Health Sciences Center. Your employment is managed by [Human Resources](http://www.lsuhsc.edu/administration/hrm/) on the main campus in New Orleans. Benefits are managed by LSU HSC Human Resources in New Orleans at 504-568-4834 with questions.

**HOLIDAY COVERAGE**

Residents and Fellows will follow the holiday schedules of the institutions (hospitals, etc) where they are rotating. Time off for holidays is determined by the policies of each individual rotations and patient coverage needs. We will attempt to spread call coverage out equally over the course of the residency. We have a two week holiday coverage schedule that will allow for an extra week off either the week of Christmas or New Year’s

**INFORMED PATIENT CARE**

All residents and faculty will introduce themselves to patients and inform the patient of their respective role upon initial presentation, and repeatedly as warranted during patient care. If the patient expresses a wish not to have learners involved in their care, the request will be honored.

**EVALUATION OF RESIDENTS/FELLOWS**

The program uses a 360 approach to the evaluation process. End-of-Rotation evaluations should be submitted no later than 2 weeks after the completion of a rotation. All evaluations are reviewed by the Program Director and the Clinical Competency Committee. All forms are available to view in New Innovations and in the program office. All documents related to a resident/fellow’s progress and/or performance in the program will be kept in the resident/fellow’s promotion file with the program coordinator

**CSV evaluations**—done throughout program on rotations. Residents are expected to do one per year.

**Faculty Evaluation of Resident** – Completed at the end of each rotation in New Innovations. Form is specific to the rotation/fellow.

**Resident Evaluation of Rotation** – Completed at the end of each rotation in New Innovations. Reviewed annually by the program director

**Resident Evaluation of Program** – Completed annually in the spring in New Innovations.

**Resident Evaluation of Faculty** – Completed annually in the spring in New Innovations.

**Resident Peer Evaluation** – Completed annually in the spring in New Innovations.

**ACGME Resident Survey** – Distributed electronically from the ACGME in the spring each year.

**LSU GME End of Year Survey** – Distributed electronically from the GME office in the spring each year.

**360 Patient & Treatment Team Feedback** – Distributed on paper and electronically in the clinics, on the psychiatric units, and with the mental health team in the emergency department.

**Semi-annual reviews:** The ACGME requires that programs perform a semiannual review of all residents for each year of residency. This is a formal process that requires a one-on-one meeting in the fall and spring of each year with a Program Director. Evaluations of the resident/fellow, in service exam scores, learning plans, self-reflection, milestones, career plans and goals, etc. are all discussed at length during this meeting. The Program Coordinator will contact you to arrange these meetings twice a year, typically in January and July.

**INCOMPLETE/DELINQUENT MEDICAL RECORDS for outpatient**

(Excerpted from OLOL Lake Physicians’ Group Open Encounters Policy)

The expectation is for all closeable open encounters to be completed and closed by the physician or advanced practitioner within 24 hours. A medical record is considered delinquent if the record remains unsigned after 7 business days.

The Medical Director or designee will ensure that all providers complete documentation and that patient encounters are closed *prior* to approval of scheduled time off (Ex. Vacation) and leaves of absence.

Providers will be notified weekly of any open encounters. All providers will have three business days, after notification, to close all encounters.

If the open encounters are not rectified by close of business on the 3rd day, physicians will be pulled from work until they are done.

**LEVELS OF SUPERVISION & PROGRESSIVE RESPONSIBILITY**

**Policy and Process**

Several of the essential elements of supervision are contained in the Policy of Professionalism detailed elsewhere in this document. The specific policies for supervision are as follows.

**Levels of Responsibility Defined**

* + **Direct Supervision by Faculty** - faculty is physically present with the resident being supervised. All incoming interns will start their supervision at direct level.
  + **Direct Supervision by Senior Resident** – same as above but resident is supervisor.
  + **Indirect with Direct Supervision IMMEDIATELY Available – Faculty** – the supervising physician is physically present within the hospital or other site of patient care and is **immediately** available to provide Direct Supervision.
  + **Indirect with Direct Supervision IMMEDIATELY Available** **– Resident**-- same but supervisor is resident.
  + **Indirect with Direct Supervision Available** -- the supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities and is available to provide Direct Supervision.
  + **Oversight** – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

**PGY 1 residents may not initially be unsupervised in the hospital setting, although they can progress quickly to indirect supervision according to the ACGME Psychiatry RRC.**

**Monitoring**

The institution will monitor implementation of the policies through Annual Review of Programs and Internal Reviews. The institution monitors supervision through a series of questions in the Annual Resident Survey. The program will monitor this through feedback from residents and monitoring by chief residents/fellows and program/fellowship directors. Supervision will be added to the annual review of programs.

**Faculty responsibilities for supervision and graded responsibility**

Residents and fellows must be supervised in such a way that they assume progressive responsibility as they progress in their educational program. Progressive responsibility is determined in several ways including:

1. GME faculty on each service determine what level of autonomy each resident/fellow may have that ensures growth of the resident/fellow and patient safety
2. The program/fellowship director assesses each resident/fellow’s level of competence in frequent personal observation and semi-annual review of each resident
3. Where applicable, progressive responsibility is based on specific milestones:
   1. For progression from direct supervision to indirect supervision with direct supervision available (by either faculty or PGY-2 resident or higher),
      1. In accordance with the psychiatric RRC, PGY-1 residents will have to demonstrate competence in the ability and willingness to ask for help when indicated; gathering an appropriate history; the ability to perform an emergent psychiatric assessment; and presenting patient findings and data accurately to a supervisor who has not seen the patient
      2. The program director is ultimately responsible for certifying the competencies required to move to indirect supervision, based on inpatient faculty assessments.
      3. Progression to this level of supervision is a requirement for promotion to PGY-2
      4. For the ability to work with indirect supervision, a PGY-1 resident must do the following:
         1. The program will offer training on expectations for asking for help and getting supervision during orientation
         2. Upon arrival on the wards, the resident will have a psychiatric evaluation of a patient observed in completeness by an attending and an assessment completed on New Innovations
         3. After successful completion of these requirements, the program director will certify the resident as ready for indirect supervision
   2. For the ability to provide supervision to a PGY-1 resident, a higher-level resident/fellow must have successfully completed all the first-year rotations, and must be given permission by the training director based on the recommendation of the Clinical Competence Committee.
   3. The ability to progress to the level of oversight is reserved for third and fourth year residents or fellows. The decision to grant this level of supervision will be based on a review of the resident’s progress in his/her annual evaluation by the Clinical Competency committee and the resident will be given permission by the training director based on that recommendation. The ability to function at this level of supervision is a requirement for progression to the third year of the curriculum.
4. The expected components of supervision include:
   1. Defining educational objectives
   2. The faculty assessing the skill level of the resident by direct observation
   3. The faculty defines the course of progressive responsibility allowed, starting with close supervision and progressing to independent as the skill is mastered
5. Documentation of supervision by the involved supervising faculty must be customized to the settings based on guidelines for best practice and regulations from the ACGME, JCAHO and other regulatory bodies. Documentation should generally include but not be limited to:
   1. progress notes in the chart written by or signed by the faculty
   2. addendum to resident/fellow’s notes where needed
   3. counter-signature of notes by faculty
   4. a medical record entry indicating the name of the supervisory faculty
6. In addition to close observation, faculty are encouraged to give frequent formative feedback and required to give formal summative written feedback that is competency based and includes evaluation of both professionalism and effectiveness of transitions.
7. Fellows who are the result of training in our program will have oversight supervision (as it would be required for them to have progressed this far). Fellows from other institutions will be evaluated upon arrival to determine if they are ready for this level of supervision.
8. For supervision to be provided on inpatient units:
   1. Direct faculty supervision will be available for all evaluations, physical examinations, medication orders, and group and individual psychotherapy sessions until the resident has been judged capable of working with indirect supervision
   2. After a resident has been accorded the right to practice with only indirect supervision, a faculty member will always be available either at the Tau Center or in the hospital during the work day
   3. Throughout the rotation, the resident will call the faculty member to discuss each admission and the expected plan of care
   4. A general treatment plan will be developed by the resident in conjunction with his faculty supervisor and orders related to that plan of care may be written throughout the day. Deviations from that plan related to a change in the patient’s condition should be discussed with the faculty member.
9. For supervision of residents to be provided in the Emergency Room (PGY 2 and above):
   1. After a resident has been accorded the right to practice with only indirect supervision, an assigned faculty member will always be available either at the Tau Center or in the hospital during the work day and/or by phone in the evenings
   2. Throughout the rotation, the resident will call/discuss with the faculty member to discuss each emergency room evaluation and the expected plan of care
   3. While on night float, the following levels of graded responsibility will take place:
      1. PGY 2’s must check out to faculty for every admission (though can be the next day if on NF). They cannot discharge from the ED at night. They can call faculty with any questions or concerns
      2. PGY 3’s must check out to faculty regarding admissions. They must call faculty for every discharge from ED. They can call faculty with any questions or concerns
      3. PGY 4’s do not have to call faculty unless they have questions or concerns.
   4. A general treatment plan will be developed by the resident in conjunction with his faculty supervisor and orders related to that plan of care may be written throughout the shift. Deviations from that plan related to a change in the patient’s condition should be discussed with the faculty member
10. For supervision to be provided in outpatient settings:
    1. The opportunity to practice in an outpatient setting will be given to PGY-2’s and higher who have progressed to at least indirect supervision. They will have direct supervision immediately available in the clinic during all clinic hours.
    2. The model of supervision in the outpatient clinic during the 3rd year will be oversight (assuming a resident has been certified for that level) and individual supervision on their cases will occur every day and psychotherapy supervision will occur two hours per week
    3. Residents in the clinic will be provided an orientation that includes the indications for asking for immediate help
11. For supervision to be provided on call:
    1. PGY-2 though 4’s who have progressed to oversight status can provide on call services. Their assignments for call will not violate any duty hour requirements.
    2. PGY-2 through 4’s, who have not progressed to oversight status may take call on site with indirect supervision. Their assignments for call will not violate any duty hour requirements.
    3. Supervision will include a faculty member available to supervise any case in person or to discuss any situation on the phone.
    4. Notes written on any encounters that occur while on call will be sent to the appropriate faculty member on call to be signed and the appropriate clinician who will follow up on the patient.
    5. Rules for faculty supervision are as follows:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Clinic/Consult calls | EMBH/Inpatient call | |
| Admissions | Discharges |
| PGY 2 | Faculty are on call to assist with any clinical situation in which the resident feels unsure. There should be a low bar for calling for help. | Must call faculty to review ALL admissions and any situation they are unsure of (unless directed otherwise by individual faculty) | Not allowed to discharge from the EMBH at night. |
| PGY 3 and 4 | Must call faculty with any questions or concerns, but do not have to call with every admission or orders  Must call faculty with any questions or concerns, but do not have to call with every admission or orders | If they want to discharge someone from the EMBH at night, they must call faculty to discuss and get their sign off. |
| PGY 5 fellows |

**Levels of supervision and progressive responsibility**

**Inpatient Services**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *PGY* | *Direct by Faculty* | *Direct by senior residents* | *Indirect but immediately available - faculty* | *Indirect but immediately available - residents* | *Indirect available* | *Oversight* |
| **I** | **X** | **X** | **X** | **X** | **X** |  |
| **II** |  |  | **X** | **X** | **X** |  |
| **III** |  |  |  | **X** | **X** |  |
| **IV/IV fellows** |  |  |  |  | **X** |  |
| **V fellows** |  |  |  |  | **X** | **X** |

**Emergency Room**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *PGY* | *Direct by Faculty* | *Direct by senior residents* | *Indirect but immediately available - faculty* | *Indirect but immediately available - residents* | *Indirect available* | *Oversight* |
| **I** | **X** | **X** | **X** | **X** | **X** |  |
| **II** |  |  | **X** | **X** | **X** | **X** |
| **III** |  |  |  | **X** | **X** | **X** |
| **IV/IV fellows** |  |  |  |  | **X** | **X** |
| **V fellows** |  |  |  |  | **X** | **X** |

**Outpatient Clinic Settings**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *PGY* | *Direct by Faculty* | *Direct by senior residents* | *Indirect but immediately available - faculty* | *Indirect but immediately available - residents* | *Indirect available* | *Oversight* |
| **I** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| **II** | **X** | **X** | **X** | **X** |  |  |
| **III** |  |  |  |  | **X** | **X** |
| **IV/IV fellows** |  |  |  |  |  | **X** |
| **V fellows** |  |  |  |  |  | **X** |

**Consult Services**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *PGY* | *Direct by Faculty* | *Direct by senior residents* | *Indirect but immediately available - faculty* | *Indirect but immediately available - residents* | *Indirect available* | *Oversight* |
| **I** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| **II** |  |  | **X** | **X** | **X** | **X** |
| **III** |  |  |  |  | **X** | **X** |
| **IV/IV fellows** |  |  |  |  | **X** | **X** |
| **V fellows** |  |  |  |  | **X** | **X** |

**Procedure Rotations (ECT, TMS and esketamine)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *PGY* | *Direct by Faculty* | *Direct by senior residents* | *Indirect but immediately available - faculty* | *Indirect but immediately available - residents* | *Indirect available* | *Oversight* |
| **I** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| **II** | **X** |  |  |  |  |  |
| **III** | **X** |  | **X (TMS and esketamine)** |  |  |  |
| **IV/IV fellows** | **X** |  | **X (TMS and esketamine)** |  |  |  |
| **V fellows** | **X** |  | **X (TMS and esketamine)** |  |  |  |

**Progressive responsibility of residents**

1. **PGY-1’s:** while working on inpatient units, all orders and clinical decisions will have to be staffed by staff physician or senior resident in a timely manner (although not required before an order can be entered). All patients must be seen every day by a faculty member.
2. **PGY-2’s:** All consults must be staffed by faculty member. Follow ups that were checked out by the weekday team will be discussed with faculty. Whether they will be seen or not by faculty will be at their discretion.

When residents are in EMBH, they will check out every patient to a faculty attending for a review of the assessment and disposition.  Faculty will go and interview anyone being considered for discharge in person.

While on night float, PGY 2’s are not allowed to discharge from the ED as there are no onsite faculty members. Second year residents will have to clear a higher bar of comfort than third year residents for faculty to approve a discharge given their more limited experience.

1. **PGY-3’s:** Clinic work and weekend calls can be handled without calling faculty if the resident feels comfortable with the scenario. EPIC messages will be sent to the primary physician on all calls received during the call period. All new patients must be seen in person by a faculty member but follow ups can be staffed at the end of the day.

For 3rd year residents who are on night float, faculty should be consulted (in person or by phone) for any patient who is being considered for discharge.  The decision whether to approve the plan will be up to the faculty member's level of comfort with the assessment and proposed follow up plan.

1. **PGY-4’s/PGY fellows:** 4th year residents who are working in the EMBH/Children’s Hospital ED at night or during the day may discharge a patient after a complete assessment, to include collateral information.  However, they are encouraged to call faculty on any case about which they have questions or concerns.
2. **PGY 5 fellows:** who are working in the Children’s Hospital ED at night or during the day/Consults or inpatient may discharge a patient after a complete assessment, to include collateral information.  However, they are encouraged to call faculty on any case about which they have questions or concerns.
3. **Frequency and Intensity of Call Events**:The frequency and intensity of call events will be captured in the duty hour reporting in New Innovations. If a resident/fellow is too fatigued to complete a shift, the back up system will be instituted. Residents/fellows will be encouraged to go to sleep in a call room before attempting to drive home. The faculty responsible for patient care the following day will assess the resident/fellow and make provisions for resident/fellow and patient safety. Options may include early dismissal, ensuring adequate rest, the use of a strategic nap, or in mild cases the limited use of caffeine. The effectiveness of this process will be monitored by the program/fellowship director and reviewed at the bi-monthly program/fellowship leadership meeting, utilizing the data provided from the duty hour capturing system and direct report from residents, fellows, and faculty.

**LIASON & OVERSIGHT POLICY**

While residents/fellows are rotating at other sites and on different services, it is the program director’s responsibility to ensure that the rotations are occurring successfully and that rotations are meeting stated goals and objectives. To that end, the following liaison and oversight procedures are in place:

1. The program director will meet with chief residents/fellows regularly to get feedback from them as to the quality of the experiences and any potential problems they are experiencing. They will also review all rotation evaluations and respond to problems.
2. The residents/fellows will complete a rotation evaluation on each rotation. Results will be compiled and reviewed at least annually during the program self-evaluation.
3. The program director will educate the rotation directors of all program policies and make them aware of any deviance or problems reported by residents.
4. The program director will be available by phone 24/7 to respond to resident, fellow, and faculty concerns or problems. Phone number will be readily available to faculty and residents.
5. Faculty will be given feedback as to the perceived quality of the teaching experience during their annual evaluation by the program director or sooner if the problem requires immediate remediation.
6. Evaluation of the quality of the rotations and the educational experience will be part of the annual program evaluation.
7. The program director will stay in regular contact with other rotation/program directors to allow communication of problems to be shared.

**LOUISIANA STATE BOARD OF MEDICAL EXAMINERS**

Interns are granted a temporary license (permit) from the [Louisiana State Board of Medical Examiners](http://www.lsbme.la.gov/) (LSBME) when starting at LSU. This license is strictly for the purposes of training. A $100 renewal fee must be paid in the Spring of each year to renew the permit. A resident can use the training permit for the duration of the residency. Checks are collected from residents and the Program Coordinator hand delivers them to the LSBME office in New Orleans. This $100 fee is eligible for reimbursement for residents thru the OLOL educational reimbursement fund. Once you have passed Step 3, you must log in through your FSMB account and have your transcript sent to the LSBME. Your PGY 3 license cannot be renewed without it. The program strongly encourages residents to take and pass Step 3 by the end of their intern year.

Residents are *not* required to seek permanent licensure during residency. After a resident has passed USMLE Step 3 and completed your intern year for American medical graduates (and three years of training for International medical graduates), he/she can apply for permanent medical licensure. This will allow the resident to obtain a DEA license and participate in moonlighting if desired and approved by the program. Online verification of a physician’s license status is available to the public.

**LIBRARY ACCESS**

Residents and faculty have access to the extensive online library resources of the LSU Library. We also have an onsite librarian in the MEIB building, first floor, who will be able to help with any library services needed. If you have any issues with this, please let the Program Coordinator know so that this can be resolved timely.

**MALPRACTICE COVERAGE**

All residents are provided malpractice coverage by the State of Louisiana while employed as a resident as LSUHSC.

* Insurance Carrier: State of Louisiana is self-insured through a State Health Care Provider Fund
* Policy Number/State Provision Number: LA R.S. 40:1299.39.1 et seq
* Liability Coverage Limit: $500,000.00 per occurrence
* Aggregate: $500,000.00 per occurrence
* Tail Coverage: Yes, tail coverage continues to apply to any incidents during the physician’s employment with the LSUHSC.
* Coverage Terminates only at the end of employment with the LSUHSC

Residents or fellows who choose to moonlight will be responsible for securing and paying for their own malpractice coverage.

**MANDATORY NOTIFICATION OF FACULTY POLICY**

**Policy and Process**

In certain cases, faculty must be notified of a change in patient status or condition. The table below outlines those instances in which faculty must be called by PGY level. The following situations require mandatory direct communication with the faculty responsible for patient care, during routine working hours, or after hours and weekends:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** | **PGY 1** | **PGY2** | **PGY 3** | **PGY 4** | **PGY 5** |
| Death | X | X | X | X | X |
| Suicide attempt | X | X | X | X | X |
| Violence requiring physical restraints | X | X | X | X | X |
| Any time a patient in the hospital reports abuse or neglect | X | X | X | X | X |
| Pregnancy (initial notification) | X | X | X | X | X |
| Transfer of care to another medical or surgical service | X | X | X | X | X |
| Any serious adverse event from pharmacologic or psychotherapeutic intervention | X | X | X | X | X |
| Any complex decision making process that the resident doesn’t feel qualified to undertake without immediate input from faculty | X | X | X | X | X |
| DNR or other end of life decision | X | X | X | X | X |
| Emergency surgery | X | X | X | X | X |
| Acute drastic change in course | X | X | X | X | X |
| Unanticipated invasive or diagnostic procedure | X | X | X | X | X |
| Decision to admit or to refuse admission | X | X | X | X | X |
| Decision to discharge | X | X | X | X | X |
| Use of a prn for Psychiatric emergency | X |  |  |  |  |

**Monitoring**

Chief Residents/fellows, faculty, and programs will monitor by checking for proper implementation on daily rounds, morning reports, and other venues. Faculty will make the program director aware of any violations of this policy. The institution will be aware of deviations of this policy as part of the annual review of the program or if an egregious incident occurs with a resulting poor outcome, the DIO will be made immediately aware by the program director. Reported events will be reviewed by the Program Director.

**MONTHLY SCHEDULE CERTIFICATIONS**

As part of your administrative responsibilities to the program, you must certify your rotation schedule on a monthly basis with the Program Coordinator. This is done electronically, and you will receive an email near the end of each month asking you to review your schedule for accuracy. These reports are used to conduct hospital and institutional audits, so it is very important that they are accurate and submitted in a timely manner. Schedule certifications are then sent by the Program Coordinator to the Office of Graduate Medical Education and Payroll Departments at LSUHSC New Orleans so that paychecks can be issued.

**MOONLIGHTING**

Moonlighting is defined to as any activity outside the scope of the residency program (including volunteer or clinical work) that is not required as part of training. The LSU Baton Rouge Psychiatry residency program permits external moonlighting for independently licensed, independently insured, upper levels residents. Internal moonlighting is permitted for all PGY 2-4 residents in good standing once they have completed night float and 1 consult month. However, this work must not exceed the 80hr/week maximum Duty Hour limit set for by the ACGME. Residents must also score above the 30%ile on the PRITE exam or make special arrangements with the program director to be approved.

Before considering or pursuing moonlighting, please speak with the program director. Formal written request for approval and receipt of approval must be appropriately documented with the correct forms. The LSUHSC Form PM-11 must be submitted to the Associate Dean for Faculty Affairs in New Orleans.

**PHARMACEUTICAL OR OTHER INDUSTRY INTERACTIONS**

**Background**

The pharmaceutical industry manufactures products that are indispensable for the treatment of mental disorders, yet there is concern within academia as a whole, and this program specifically, about the interface between industry representatives and psychiatry residents. The issue at hand involves not only the possibility of bias, conflict of interest, or the appearance of quid pro quo prescribing practices due to the provision of gifts, meals, etc., but also the culture that the program wishes to embrace with regards to the nature, frequency and quality of interactions between residents and industry. As ongoing contact with industry representatives will occur throughout a physician's career, the program also recognizes that part of the program's mission should be to provide residents with instruction and guidance on critically evaluating information provided by industry.

Per the LSU Vendor/industry relations policy, relations to vendors and all other private entities are covered by the Code of Government Ethics and the policies promulgated by the LSUHSC Conflict of Interest Committee via various Chancellors Memoranda. All state employees are bound by the ethics statutes with the most relevant being Louisiana Code of Governmental Ethics Title 43, Chapter 15 number 6 page 14 – Gifts. To paraphrase ‐ “no public employee shall solicit or accept directly or indirectly anything of economic value as a gift or gratuity from any person if the public employee does or reasonably should know such a person conducts activities or operations regulated by the public employee’s agency or has substantial economic interests which may be substantially affected by the performance or nonperformance of the public employee’s duty. “ When in the various training sites the resident is further bound by the rules and policies of that institution

**Guiding Principles**

1. For-profit companies can only donate resources that are not tied to any quid pro quo, such as an unrestricted educational gift.

2. To ensure that the gifts are truly for educational purposes (and therefore for the benefit of patients in the long run) and not a marketing interaction, the following conditions must be met:

a. Gifts must be for enhancing education or patient care.

b. If the gifts are meant to incidentally enhance education (e.g., provision of meals), then they must be within the bounds of accepted community expectations, and must play a clearly enhancing role in the process of education or patient care.

c. If the gift directly benefits education, then greater allowances can be made with respect to monetary value.

d. The gifts must not be explicitly tied to any marketing activities directed at the residents.

e. Textbooks, modest meals and other gifts are acceptable if they serve a genuine educational value. Cash payments are not acceptable.

f. Individual gifts of minimal value are permissible as long as they are related to the physician’s work (ie pens and notepads)

g. No gifts should be accepted if there are strings attached.

3. Provisions should be made in the curriculum to help residents develop self-monitoring and skills to critically read literature gathered and presented under the sponsorship or funding of pharmaceutical companies, as well as to deal effectively with these conflicts of interest situations after they leave the program.

1. Residents are free to attend local vendor sponsored events outside of work hours as long as they comport with the LSUHSC Vendor/industry relations policy. These will not be required by the program.

5. These policies and guidelines apply to all residents, fellows, and students within the LSU Baton Rouge Psychiatry residency program.

6. Nothing in this policy should be considered to supersede the LSU School of Medicine Vendor/Industry relations policy in the House officer manual

**PAYROLL AND RATE OF PAY**

Residents are paid via direct deposit from LSUHSC New Orleans on a bi-weekly basis. The LSUHSC House Officer pay scale increases as you progress through the PGY levels. Residents can make changes to withholding and direct deposit accounts at any time. Please see the Program Coordinator for any questions regarding payroll.

##### 2024-2025 House Officer Pay Scale

January 1 2025 - June 30 2025

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Annual** | **Monthly** | **Semi-Monthly** | **Hourly** |
| **HO 1** | $60,241.00 | $5,020.08 | $2,510.04 | $20.63 |
| **HO 2** | $62,222.00 | $5,185.17 | $2,592.58 | $21.31 |
| **HO 3** | $64,290.00 | $5,357.50 | $2,678.75 | $22.02 |
| **HO 4** | $66,975.00 | $5,581.25 | $2,790.63 | $22.94 |
| **HO 5** | $69,979.00 | $5,831.58 | $2,915.79 | $23.97 |

**Policy on Professional Boundaries and Mentoring Relationships**

**1. Purpose**

This policy establishes clear guidelines to maintain professional boundaries within the LSU-BR Psychiatry Residency Program (including medical students, residents and fellows; also called “trainees” for simplicity, ensuring ethical faculty-trainee relationships while fostering an environment conducive to professional mentorship and personal growth. It seeks to:

1. Protect trainees from boundary violations that could harm their well-being or hinder their education.
2. Guide faculty and trainees in maintaining a respectful, productive, and ethical learning environment.
3. Preserve the core mentoring relationship as an essential component of trainee education.

**2. Scope**

This policy applies to all participants in the residency program, including:

1. Faculty members, such as attendings, supervising clinicians, and advisors.
2. Residents
3. Fellows
4. Medical students
5. Administrative staff involved in program operations.

The policy governs all interactions within clinical, educational, and informal settings tied to the program.  
  
**3. Definitions**   
  
**Professional Boundaries**: Professional boundaries delineate the appropriate limits of faculty-trainee relationships. They safeguard trainees from undue influence, exploitation, or harm while promoting ethical conduct and professional growth. Key principles include:

1. Respect for trainees' autonomy, privacy, and dignity.
2. Avoidance of relationships that may create conflicts of interest.
3. Maintenance of a professional focus on education, clinical training, and mentorship.

**Boundary Violations**: In the context of faculty-trainee relationships, boundary violations occur when faculty overstep the limits of professional conduct.   
  
**Mentorship:** a collaborative relationship between a more experienced professional (the mentor) and a junior learner (the mentee) where the mentor provides guidance and support in issues related to their profession. Mentorship should be supportive and professional, focusing on the trainee’s professional development without crossing into personal or emotional relationships.  
  
Key signs a mentorship might be crossing the line to a boundary violation:

1. **Excessive personal sharing:** Discussing private issues or problems that are not directly related to work performance or career development.
2. **Frequent social interaction outside of work:** Regularly meeting for drinks, outings, or activities not related to professional development.
3. **Unprofessional behavior and communication:** Flirting, inappropriate touching, or making comments that are sexually suggestive, talking about sexual content outside the scope of appropriate clinical care. Unprofessional communication, including bullying, discrimination, or disparaging remarks, either directed at trainees or made within the broader institutional environment.
4. **Power imbalance concerns:** A mentor taking advantage of their position to manipulate or pressure the mentee.
5. **Emotional dependence:** The mentee relying heavily on the mentor (or vice versa) for emotional support beyond what is appropriate for a professional relationship.
6. **Failure to Maintain Objectivity:** Allowing personal feelings or relationships to influence professional decisions, such as evaluations or feedback.

**Dual Relationships:** a situation where a medical professional has a personal or professional relationship with a trainee in addition to their educative role.

Key points about dual relationships in medical education:

1. **Potential issues:**
   1. **Compromised evaluation:** A personal connection might influence how a faculty member grades or assesses a trainee's performance.
   2. **Confidentiality breaches:** Sharing personal information with a learner could lead to ethical issues.
   3. **Appearance of impropriety:** Even if no harm is intended, a close relationship could create the perception of favoritism.

* **Examples of dual relationships:**
  1. Socializing frequently with a trainee outside of clinical/teaching activities.
  2. Providing personal advice or counseling that goes beyond the scope of academic support.
  3. Engaging in romantic relationships with a trainee.
  4. Employing a trainee in a personal business venture.
  5. Pre-existing relationships

**4. Faculty Responsibilities**  
  
Faculty must uphold professional boundaries and act as role models in all interactions with trainees. Specific responsibilities include:  
  
Professional Behavior:

1. Do not exploit the inherent power imbalance between faculty and trainees.
2. Refrain from initiating or participating in personal or romantic relationships with trainees.
3. Maintain clear boundaries when trainees request personal advice, referring them to appropriate resources when necessary.
4. Respect for Others: Professionalism involves demonstrating respect for patients, colleagues, faculty, staff, and trainees. This includes being mindful of cultural, personal, and professional differences.

Mentoring:

1. Provide constructive, unbiased feedback that focuses on professional development.
2. Ensure interactions are educational and supportive, avoiding favoritism or discrimination.
3. Respect trainees' time by limiting communications outside working hours to emergencies or pre-agreed mentoring activities.

Accountability:

1. Participate in regular training on boundaries and ethical mentoring practices.
2. Seek guidance from ethics or program leadership when faced with potential boundary dilemmas.
3. Avoid personal or financial conflicts of interest in faculty-trainee interactions.

**5. Trainees Responsibilities**  
  
Trainees are expected to:

1. Engage with faculty respectfully and professionally, maintaining open communication about boundaries when needed.
2. Report concerns regarding boundary violations promptly through appropriate channels.
3. Avoid forming personal relationships with faculty that may compromise professional interactions.
4. Respect faculty's professional and personal boundaries, refraining from requests that fall outside the scope of mentorship or supervision.

**6 Reporting and Addressing Concerns**   
  
Reports of boundary violations may be made:

1. Directly to the Program Director
2. To class PALs (Peer advocate liaison program) representative
3. Via annual program, LSU or ACGME feedback surveys
4. Anonymously by learners to the LSU Ombudsman, Michael Brochu, 225-578-0337.
5. Witnessed or experienced sex or gender harassment, discrimination, misconduct, or exploitation (ie Title IX and Power-Based Violence complaint) should be reported through LSU website at [Title IX & Power-Based Violence Formal Complaint Form](https://cm.maxient.com/reportingform.php?LSUHealthNOLA&layout_id=3) or through ethics complaint hotline 855-561-4099. When submitting the form online, you may choose to do so anonymously.
6. Witnessed or experienced conduct that discriminates, harasses, or harms anyone in our community based on their identity (such as race, color, ethnicity, national origin, sex, gender identity or expression, sexual orientation, disability, age or religion) should be reported through LSU website at [Bias or Discrimination Incident Report](https://cm.maxient.com/reportingform.php?LouisianaStateUniv&layout_id=6). This can also be done anonymously.
7. If the trainee or faculty member does not feel their concerns are being addressed by any of the above methods, they can file a complaint directly to the ACGME in response to specific incidents.

**PROFESSIONALISM & LEARNING ENVIRONMENT POLICY**

Our GME program wishes to ensure:

1. Patients receive safe, quality care in the teaching setting of today

2. Graduating residents/fellows provide safe, high quality patient care in their future practice

3. Residents/fellows learn professionalism and altruism along with clinical medicine in a humanistic, quality learning environment

To that end, we recognize that patient safety, quality care, and an excellent learning environment are about much more than duty hours. Therefore, we wish to underscore that any policies address all aspects of the learning environment, including:

1. Professionalism including accepting responsibility for patient safety
2. Alertness management
3. Proper supervision
4. Transitions of care
5. Clinical responsibilities
6. Communication / teamwork

Residents/fellows must take personal responsibility for (and faculty must model behaviors that promote):

1. Assurance for fitness of duty
2. Assurance of the safety and welfare of patients entrusted in their care
3. Management of their time before, during, and after clinical assignments
4. Recognition of impairment (e.g. illness or fatigue ) in self and peers
5. Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data

The program further supports an environment of safety and professionalism by:

1. Providing and monitoring a standard Transitions Policy as defined elsewhere
2. Providing and monitoring a standard policy for Clinical Education Work Hours as defined elsewhere
3. Providing and monitoring a standard Levels of supervision and progressive responsibility policy as defined elsewhere
4. Providing and monitoring a standard scheduling approach in New Innovations (seminars) and qGenda (rotations and call)
5. Adopting an institution wide policy that all residents/fellows and faculty must inform patients of their role in the patient’s care.
6. Providing and monitoring a policy on Alertness Management and Fatigue Mitigation that includes:
   1. Online modules for faculty and residents/fellows regarding signs of fatigue
   2. Education about fatigue mitigation and alertness management including pocket cards, back up call schedules, and promotion of strategic napping
7. Assurance of available and adequate sleeping quarters when needed
8. Requiring that programs define what situations or conditions require communication with the attending physician

**Process for implementing Professionalism Policy**

The programs and institution will assure effective implementation of the Professionalism Policy by the following:

1. Program presentations of this and other policies at program and departmental meetings
2. Core Modules for program director and residents/fellows on Professionalism, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and Substance Abuse and Impairment
3. Institutional Fitness for Duty and Drug Free Workplace policies.
4. Institutional Duty Hours Policy which adopts the ACGME Duty Hours Language
5. Language added specifically to the Policy and Procedure Manual, the House Officer manual and the Resident/fellow Contract regarding Duty Hours Policies and the responsibility for and consequences of not reporting Duty Hours accurately.
6. Comprehensive Moonlighting Policy incorporating the new ACGME requirements
7. Orientation presentations on Professionalism, Transitions, Fatigue Recognition and Mitigation, and Alertness Management

**Monitoring Implementation of the Policy on Professionalism**

The program and institution will monitor implementation and effectiveness of the Professionalism Policy by the following evaluation of resident/fellow and faculty including:

1. Daily rounding and observation of the resident/fellow in the patient care setting.
2. Evaluation of the resident/fellows’ ability to communicate and interact with other members of the health care team by faculty, nurses, patients where applicable, and other members of the team.
3. Monthly and semi-annual competency-based evaluation of the resident/fellows.
4. Institutional Annual Reviews of the program and Internal Reviews.
5. Successful completion of modules for faculty and residents on Professionalism, Impairment, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and others.
6. Program and Institutional monitoring of duty hours and procedure logging as well as duty hour violations in New Innovations.

**RESIDENT AND FELLOW SAFETY POLICY**

The purpose of this policy is to promote a safe and healthy training environment, to minimize the risk of injury in training, to provide a procedure to report unsafe training conditions, and to provide a mechanism to take corrective action. Resident, fellow, patient, and staff safety is an important topic to be discussed on every resident/fellow rotation and policies and procedures related to safety should be part of the orientation to every rotation. Additional training in techniques to manage potentially dangerous situations will be provided to all interns during their inpatient OLOL Psychiatry rotation by the education department and these techniques are universal and appropriate for use in other clinical situations. All clinical situations in which a resident/fellow believes there is risk for violence should be discussed with a supervisor as soon as possible.

1. All psychiatry resident/fellows who experience verbal threats, physical intimidation, and physical assault by patients should be reported to the supervisor and the Program director’s office.
2. The site director will assure that the incident is documented, that debriefing occurs, that opportunities to fix situations are identified, and that, if appropriate, the situation is discussed in an educational setting. Additionally, the site director will consider an alternate disposition and/or provider for the patient who initiated the assault or threat.
3. In case of assault:
   1. The resident/fellow notifies his/her attending at the training site and/or the on call attending if the incident happened while the resident/fellow was on call.
   2. The primary attending works with the resident/fellow to decide if a medical evaluation is necessary. At that time, a decision is made as to whether the resident/fellow can continue with his/her duties or will be discharged from his/her duties for the rest of the day.
   3. The primary attending then notifies the chief of service, the program chief resident/fellow and the program director.
   4. The chief of service considers an alternative disposition and/or provider for the patient who initiated the threat or assault. The patient is evaluated for continued dangerousness.
   5. The primary attending conducts a timely debriefing with the resident/fellow.
   6. The training director immediately assesses the resident/fellow’s needs following an assault. They with a chosen supervisor or referral for psychiatric care and evaluation is warranted. In addition, the program director and the chief resident/fellow will collaborate to determine if debriefing/support is necessary for other residents/fellows.
   7. The training program coordinates administrative issues that may arise such as scheduling time off or rearranging the call schedule. The program checks to ensure the policy has been followed to remove the burden from the resident/fellow.

**RESIDENT AND FELLOW SENTINEL EVENT POLICY**

A sentinel event is a patient event that results in death, permanent harm, or severe temporary harm. Most pertinent in the field of psychiatry is a patient suicide, a well known occupational hazard for mental health professionals. According to reports, 25% to 60% of psychiatrists will have a patient die by suicide during their career and 1/3 of psychiatry trainees experience a patient suicide during residency. In studies of clinicians who had a patient die by suicide, up to 38% of psychiatrists reported severe distress. Reaction to a patient’s suicide by clinicians can range from severe distress about treatment decisions, anger, and guilt to serious self-doubt about one’s choice of profession. Psychiatrists are often more vulnerable than other health care professionals because their connection to the patients is unique compared to their colleagues from other fields. There’s a certain unique emotional connection and empathic attachment that these clinicians make with their patients which exposes them to trauma when the latter take their own lives.

Another event that can “sentinel” to the victim is experiencing acts of harassment or discrimination for whatever reason. In the event of any of these events in the life of a resident or fellow, the following checklist of activities will be followed and completed with documentation placed in the resident or fellow’s GME file. The Checklist is to be completed after any serious suicide attempt, adverse event or completed suicide. An attending should be involved in the process, and the completed form should be returned to the program director.

Adverse event checklist

\_\_\_In cases of patient sentinel events, all residents and/or fellows, the program director, and the attending involved with patient were notified.

\_\_\_Immediate check-in with the resident/fellow by program director occurred.

\_\_\_Discussion about how patient family interactions should be handled. (if pertinent)

\_\_\_Resident/fellow was assisted with immediate duties and given option to leave (If during business hours, tx team and chief resident/fellow will facilitate this. If on call, back up call system may be utilized).

\_\_\_Resident was given the option not to work with patients or faculty/staff who are verbally or physically abusive/inappropriate and appropriate remediation plan was developed.

\_\_\_Resident/fellow was offered days off as appropriate and offered up to 5 days without call.

\_\_\_Team debriefing was completed, including involved attending, all involved residents/fellows, involved medical students, and nursing if appropriate within 1 week of event. (where appropriate)

\_\_\_Individual meeting between involved resident/fellow and designated check-in/support person occurred within one week of event.

\_\_\_Follow up meeting with check-in support person within 8 weeks following event was held.

\_\_\_Additional treatment was arranged for resident/fellow if indicated (resident/fellow and check-in person decide together).

\_\_In cases of harassment or discrimination, appropriate parties will conduct an investigation and determine appropriate response which will be communicated to the resident.

**LSUHSC SCHOOL OF MEDICINE SOCIAL MEDIA GUIDELINES**

At LSUHSC School of Medicine – New Orleans (SOM), social networking (both on LSUHSC-provided services and on commercially available services) can help support our mission of medical education, research, and service to the community. The SOM is committed to facilitating a successful social media strategy for its faculty, staff, and students.

The following guidelines are for all individuals affiliated with the SOM including but not limited to faculty members, residents, students, and staff employees who participate in social media. Social media includes personal blogs and other websites, including but not limited to WordPress, Facebook, LinkedIn, Twitter, Instagram, and YouTube. These guidelines apply to anyone posting to his or her own sites, university sponsored sites, or commenting on other sites.

General Principles:

1. Follow all applicable LSUHSC policies. For example, you must not share confidential or proprietary information about LSUHSC and you must maintain patient privacy. Among the policies most pertinent to this discussion are those concerning patient confidentiality; computer, e-mail and internet use; HIPAA and FERPA; photography and video; and release of patient or student information to media.

2. Be professional, use good judgment and be accurate and honest in your communications; errors, omissions, or unprofessional language or behavior reflect poorly on LSUHSC, and may result in liability for you or LSUHSC. Be respectful and professional to fellow employees, business partners, competitors, faculty, students, and patients.

3. Social media is “real life.” Behavior in social media is no different from e-mail, public speech, classroom lecture, conversation with friends, or a poster on a wall, with the exception that it is always available in cyberspace. Anything considered inappropriate offline is likely also inappropriate online. When in doubt, it is better not to share.

4. If you are a member of the SOM community, but acting in social media as an individual, make it clear that you are expressing your own opinion and not that of the SOM or LSUHSC.

5. Ensure that your social media activity does not interfere with your work commitments.

Responsibility to Patients and Trainees:

1. The SOM strongly discourages “friending” of patients on social media websites. Providers (faculty, house staff, or other staff) in patient care roles generally should not initiate or accept friend requests except in unusual circumstances such as the situation where an in-person friendship pre-dates the treatment relationship.
2. The SOM strongly discourages personnel in management or supervisory roles from initiating personal “friend” requests with trainees they manage. “Friend” requests may be accepted if initiated by the trainee, and if the supervising personnel do not believe such contact will negatively impact the work relationship or pose potential bias regarding the trainee.

Responsibility to Institution:

1. Write in the first person. Where your connection to the SOM and LSUHSC is apparent, make it clear that you are speaking for yourself and not on behalf of the SOM or LSUHSC. In those circumstances, you should include a disclaimer such as: “The views expressed on this [blog; website] are my own and do not reflect the views of the SOM or LSUHSC.” Consider adding this language in an “About me” section of your blog or social media profile.

2. If you identify your affiliation to the SOM or LSUHSC, your social media activities should be consistent with our high standards of professional conduct.

3. If you communicate in public about the SOM or LSUHSC or the SOM- or LSUHSC-related matters, you must disclose your connection with SOM and/or LSUHSC and your role at the institution. When acting as a representative of the SOM clearly identify you or your group’s relationship to the SOM and link back to the appropriate SOM or LSUHSC web page to reinforce the connection to the SOM or LSUHSC.

4. The SOM does not endorse people, products, services and organizations. On social media websites where your affiliation to the SOM is known, it should be made clear that you are speaking for yourself and not on behalf of the SOM or LSUHSC when personal recommendations are made.

5. Unless approved, your social media name, handle and URL should not include the SOM or LSUHSC’s name or logo.

6. Represent yourself accurately and be transparent about your role at the SOM or LSUHSC. Consider that you are in an academic environment and the implications of utilizing a LSUHSC-provided platform that automatically identifies you in your role at the SOM or LSUHSC. If you present inaccurate information, correct it immediately.

7. When creating or managing a social media account for a SOM entity (such as a training program social network), ensure access credentials are shared by at least two people in case one team member is unreachable or no longer at the University.

8. When representing the SOM or LSUHSC, follow relevant style guidelines when creating profile/avatar images, graphics, or written content. Speak in accordance with your role at the university. If you have questions, contact the appropriate public affairs personnel.

**TRANSITIONS POLICY**

The transitions policy is created in recognition that multiple studies have shown that transitions of care (handoffs) create the most risk or medical errors (ACGME teleconference July 14, 2010.) In addition to the below specific policies, promotion of patient safety is further ensured by:

1. Provision of complete and accurate rotational schedules in New Innovations; every effort will be made to design schedules that minimize the number of transitions in patient care.
2. Use of a google spreadsheet with accurate and complete listings of who is on call and responsible at any given time.
3. Presence of a backup call schedule for those cases where a resident is unable to complete their duties.
4. The ability of any resident to be able to freely and without fear of retribution report their inability to carry out their clinical responsibilities due to fatigue or other causes.

**Policy and Process**

Residents receive educational material on Transitions in Orientation and as a Core Module.

In any instance where care of a patient is transferred to another member of the health care team, an adequate transition must be used. It is strongly recommended that transition communication follow the “IPASS” framework (I- illness severity, P- Patient summary, A- Action list, S- Situation awareness and contingency planning, S- Synthesis by receiver). There are different transitions that must be addressed with different clinical implications. Please see the summary below. The process by which this information is distributed is via Orientation presentations to residents.

The rotation supervisor will include an evaluation of the resident’s performance of this procedure in the monthly assessments of rotating residents. The evaluation should assess the resident’s skill in providing information as well as in receiving transition information. The handoff process will be witnessed at least once each rotation by the supervising faculty member.

Emergency Department: There are three shift change/handoffs each day in the EMBH – at 8 AM after night float shift, at 5 PM when faculty are leaving, at 8 PM when night shift resident is coming on. All hand offs are done in person.

Inpatient units: To be determined by the service/staff and how they manage patient transitions.

Consultation-Liaison service: The CL service keeps a daily iPass checkout in EPIC. Furthermore, they do internal, in person handoffs on Friday afternoons for weekend coverage.

Outpatient clinic: residents in the clinic may send a message to the on call resident if they believe a patient may have reason to call. If the person on call does receive a call from a clinic patient, it will be documented in EPIC and a message sent to the resident who is caring for that patient. When residents are leaving the clinic, in person hand offs are given on each patient to the resident who is taking over their care.

**WELL-BEING, BURNOUT, AND GETTING HELP**

The well-being of our residents is a priority. Our goal is to promote a culture of wellness across our training sites and train happy and confident physicians. Below are avenues through which the program and department fosters a supportive and enriching environment to ensure resident well-being throughout their training. In addition, the Baton Rouge section of the LSU School of Medicine Department of Psychiatry has a Wellness Subcommittee comprised of residents, fellows, faculty, and staff that focuses on optimizing ways in which the department can create and sustain a culture that fosters wellness.

**Psychiatry training program initiatives and events**

* Open door policy with section leadership.
* Resident to resident mentorship program.
* Frequent resident and fellow liaison committee meetings with feedback directly to program and fellowship directors
* Weekly protected time for PGY 3’s, 4’s, and fellows.
* Quarterly Wellness half days.
* List of recommended therapists
* Annual intern retreat in the fall, all resident retreat in the Spring. Fellow semi-annual retreat
* Fatigue awareness training at orientation and check in at all semi-annual reviews.
* LSUHSC Campus Assistance Program referrals if needed.
* Free access to the OLOL health club/exercise room
* Protected time for doctor/therapy appointments.

**Taking care of the caretakers**

Taking care of yourselves is good for you and good for patients. Self-care is a vital part of professionalism, and a skill that needs to be learned and supported during training. As part of this effort, we aim to train you in a model of graduated responsibility, a model in which you are not alone! We offer support from training directors, supervisors and peers (including a monthly S group). We also want to ensure that you are taking steps to promote well-being and prevent burnout, and are aware of resources available to you in that effort.

**You are encouraged to:**

 Attend medical, mental health, and dental care appointments, including during working hours, in coordination with your supervisor and our coordinator. However, you must request sick leave if you will be gone more than 2 hours.

 Perform self-screenings for burnout, depression, anxiety and other problems (see team page)

 Exercise, eat well and get plenty of sleep!

 Practice mindfulness and self-compassion.

 Keep up with your avocational activities

 Find meaning in your work; identify your particular passions

 Ensure you are working no more than 80 hours a week

 Not spend too many evenings at work (2 max on average)

 Seek supervision for help with organization and efficiency (especially for documentation)

 Enhance professional relationships through organized psychiatry and other activities (LPMA, AACAP, APA, etc.)

 Turn off your phone when you are away

 Do not give your cell phone or beeper number to patients

If something is getting in the way of being able do these things, we want to know!

**How to get help**

# **Campus Assistance Program (CAP)**

The mission of the LSUHSC Campus Assistance Program (CAP) is to support the mental, emotional, and physical well-being of students, faculty, staff, and immediate family members in order to promote the overall health and effectiveness of the LSUHSC-NO community.

The Campus Assistance Program is a free service provided by LSU Health Sciences Center at New Orleans to assist faculty, staff, residents, students and their immediate family members in resolving personal, academic or work-related problems.  Faculty, staff or residents who are enrolled or employed with LSUHSC-NO programs in other cities are also eligible for CAP services.  
  
LSUHSC-NO recognizes that everyone, at some time, needs a “helping hand” or assistance. Whether you have a simple or a complex problem, the Campus Assistance Program can help.  
  
**A counselor is on call 24 hours a day to assist in time of crisis. If you feel you have an emergency or need immediate assistance at any time, contact the counselor on call by following the instructions on the main line (504) 568-8888.**

**Emergencies** – Please go to your nearest emergency room.

**Consultation for non-mental health issues** – Our coordinators, Latoya Wilson and Lakeysha Deloch, are always available to talk about concerns. However, if it is something that you do not what to discuss within the program Ashley Walker  [acomea@lsuhsc.edu](mailto:acomea@lsuhsc.edu) of the GME office is a resource for residents

LSU Baton Rouge is committed to maintaining a culture where parties may raise concerns about possible errors or wrongdoing without fear. Do not hesitate to talk to any of us or to ask who to talk to with concerns.

**Faculty-specific policies**

**A purple paw print with yellow border

Description automatically generated with medium confidence**

**LSU BR Psychiatry Section Leadership**

Kathleen Crapanzano, MD

Section Chief

Kathleen Crapanzano, MD Richard “Dick” Dalton, MD Residency Program Director Child Fellowship Director

Sydney Melancon, MD Mary Nance, MD

Associate Residency Program Director Medical Student Co-Director

Medical Student Co-director

Residency Coordinator: Latoya Wilson

Medical Student and Child Fellowship Coordinator: Lakeysha Deloch

Resident clinic director: Natalie Hunsinger, MD, Andrew Aubin, MD

Recruitment chair: Kathleen Crapanzano, MD

CCC Chair: PGY-1s: Sydney Melancon, MD

PGY-2s: Mary Nance, MD

PGY3s/4s: Kathleen Crapanzano, MD

**FACULTY RESPONSIBILITIES**

Per the ACGME, faculty members much

* Be role models of professionalism
* Demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care
* Demonstrate strong interest in the education of residents.
* Devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities
* Administer and maintain an educational environment conducive to educating residents
* Regularly participate in organized clinical discussions, rounds, journal clubs, and conferences and
* Pursue faculty development designed to enhance their skills at least annually as educators, in quality improvement and patient safety, in fostering their own and their residents’ well being, and in patient care based on their practice-based learning and improvement efforts.

Core faculty members are expected to be more intimately involved in the running of the program and to complete the annual ACGME survey. They are also expected to participate in recruitment, didactics, curriculum development, program evaluation and scholarly activity with goals negotiated with the section chief.

All faculty are expected to do the following to remain in good standing

1. Complete evaluations of any fellow/resident/medical student they work with in a timely manner
2. Strive to exhibit cultural humility with learners, appreciate different backgrounds and points of view.
3. Communicate expectations, goals, objectives, and the schedule for the rotation (including expected days off) to trainees at the start of the rotation.
4. Give informal in the moment feedback and formal feedback to trainees
5. Answer program emails promptly
6. Attend grand rounds periodically
7. Make the program aware of any residents who are struggling as soon as possible
8. Make the program aware of any unprofessional behavior by a resident as soon as possible
9. Attend annual faculty meetings/faculty development
10. Participate in the CCC process (if applicable)
11. Practice evidence-based medicine

**Center for Psychiatric Services Clinic Supervision Guidelines for Supervisors**

Components to review during supervision:

* Clinical care- assessment, diagnosis, treatment planning, prescribing (both plan and logistics), alliance, transference, psychotherapy (if applicable)
* Interim communication or issues with patients-calls, Mychart messages, unanticipated medication adjustments, etc
  + Some residents do this already without prompting, but some do not. Faculty should review the chart and/or check in with residents about this topic
* Documentation/Notes
* Billing/Coding
* Scheduling (when are they seeing the patient back, how frequently, appt length, appt type)
  + Resident medication management visits should typically by 30 minutes (with appropriate exceptions for some child/adolescent or otherwise complicated cases). If the resident wants to do complex (60 minute) visits, they should discuss with faculty the need/rationale.

Additional considerations:

* Residents should discuss with a supervisor letters or forms that are requested of them.
* **Residents are expected to** **come by that half day to check out all their patients**. If a resident is not checking out a patient to the faculty that half day, the resident should communicate that (and why) explicitly. Faculty must ensure that all patients for their half day are checked out or that the residents have an appropriate alternate plan for such.
  + Examples: C&A, therapy only, working with specific faculty on the case for a specific reason (state the reason)
* If there is more than one faculty on a given half day, faculty should communicate to ensure all patients are covered.

We request that supervisors attend quarterly evaluation meetings to discuss resident progress, and that you fill out an evaluation on the residents you are supervising quarterly. Our program coordinator Latoya Wilson will distribute the forms via New Innovations.

Contact Dr. Crapanzano, Dr. Aubin or Dr. Hunsinger if any concerns about a resident you are supervising.

Unique resident clinic billing/scheduling quirks to be aware of:

* Therapy is always billed at 90834 within the residency clinic (rather than with add-on E&M codes) due to specific supervisory and cost considerations. Therapy visits are scheduled as 60-minute appointment length to allot for “50-minute hour” therapy with time for wrap up/documentation/process notes.
  + If the resident makes a medication change during a therapy visit, they should check this out with clinic faculty on the half day. The therapy supervisor should be primary cosigner of the note, but the faculty supervising medication management portion can add a separate note regarding their supervision of the encounter.
* Transition visits at the beginning of the academic year are all scheduled for 60 minutes to allot adequate time for new clinic learners but may billed per E&M (i.e. 99213/4).

**Psychotherapy Supervision Guidelines for Supervisors:**

* Please plan to meet with your supervisees weekly.
* The residents should let you know ahead of time if they need to cancel and you should do the same.
* Please keep short notes about the patients discussed in your private files. You should include the patient’s initials and the date discussed. This can just be a few lines. These should be kept locked in your office.
* Please keep track of any patients you are supervising and follow up if someone drops off the list.
* **Encourage therapy recording and use it in supervision!!!**
* If you have any concerns about the resident you are supervising, please contact Dr. Andrew Aubin or Dr. Kathleen Crapanzano.
* We request that you fill out an evaluation on the resident(s) you are supervising quarterly. Latoya Wilson will distribute the forms via new innovations.
* The supervisors will meet monthly from noon-1pm on the 3rd Tuesday of the month.
* If you have any questions about billing, contact: Dr. Kathleen Crapanzano [kcrap1@lsuhsc.edu](mailto:kcrap1@lsuhsc.edu)

**Contact information:**

* **Program Director,** Kathleen Crapanzano, MD, [kcrap1@lsuhsc.edu](mailto:kcrap1@lsuhsc.edu)
* **Resident Clinic Lead,** Andrew Aubin, MD, \*\*\*
* **Residency program coordinator**, Latoya Wilson, can answer questions about new innovations, [lwil76@lsuhsc.edu](mailto:lwil76@lsuhsc.edu)
* **Clinic manager**, Stephanie Wooster, can answer question on issues with scheduling or clinic staff, Stephanie.Wooster@fmolhs.org

**ADDENDUM: Helpful Links**

LSUHSC GME Policy Manual

<https://www.medschool.lsuhsc.edu/medical_education/graduate/HouseOfficerManual/House%20Officer%20Manual%202024-2025.pdf>

House officer resources to include the LSU House officer manual

<https://www.medschool.lsuhsc.edu/medical_education/graduate/house_officers/>

ACGME Milestones for Psychiatry

<https://www.acgme.org/globalassets/pdfs/milestones/psychiatrymilestones.pdf>

ACGME Program Requirements for Graduate Medical Education in Psychiatry

<https://www.acgme.org/globalassets/pfassets/programrequirements/400_psychiatry_2023.pdf>

APA Principles of Medical Ethics

<https://www.psychiatry.org/getmedia/3fe5eae9-3df9-4561-a070-84a009c6c4a6/2013-APA-Principles-of-Medical-Ethics.pdf>

Medical Student Policies





Department Title

SYLLABUS

Baton Rouge Regional Campus

Psychiatry Clerkship

Third Year Medical Students

2025-2026

**Updated 6/2025**

**Introduction to Psychiatry Clerkship**

**LSU Health Sciences Center**

**Baton Rouge Regional Campus**

The Psychiatry Clerkship at LSU School of Medicine-Baton Rouge Branch Campus is a 6-week, full-time rotation for third-year medical students. The objective of the clerkship is to provide a broad view of clinical psychiatry, enabling students to participate in a variety of patient care settings, and to promote learning in a supportive, patient-centered environment. All students will rotate on inpatient psychiatric units and on the consultation-liaison psychiatry service embedded on the medical/surgical wards at Our Lady of The Lake Regional Medical Center. Optional additional clinical experiences include outpatient general psychiatry clinic, child and adolescent psychiatry, and emergency psychiatry, as available.

To make this a beneficial learning experience, this syllabus has been prepared outlining the clerkship learning objectives, course material, evaluations and grading procedures, special duties and performance criteria.

We encourage all of you to participate actively in the clerkship, make use of the resources available to you and seek mentoring from our residents and faculty. We welcome your feedback and encourage you to reach out to us at any time via the contact information listed below.

# BATON ROUGE COORDINATOR:

La’Keysha Deloch, Clerkship Coordinator

Office 225-757-4212

[ldeloc@lsuhsc.edu](mailto:ldeloc@lsuhsc.edu)

**BATON ROUGE SITE DIRECTORS:**

Dr. Mary Nance

[Mnanc1@lsuhsc.edu](mailto:Mnanc1@lsuhsc.edu)

Dr. Sydney Melancon

[ssmi43@lsuhsc.edu](mailto:ssmi43@lsuhsc.edu)

**NOTE**: **Email is the primary (though not exclusive) means of notification of changes in the schedule. Students are responsible for checking email daily**. **Changes may also be made/added on Moodle, so students are also responsible for checking Moodle daily.**

**Clerkship Goals:**

The LSUHSC 3rd year psychiatric clerkship is a required 6-week clerkship focusing on management of acute and chronic psychiatric conditions. We have sites in New Orleans, Baton Rouge and Lafayette to accommodate students that are stationed in each of those areas for their clinical experiences. Exposure to specific areas of the psychiatric care continuum may vary slightly, depending on the facilities available in each city; however, our goal is to provide a foundational exposure to all aspects of psychiatric care and foster an understanding and interest in the field. Each element of the course has been refined to provide the best and most educational exposure possible, and we have adapted the schedule based, in part, by previous feedback. It is our goal during this rotation to educate and provide experiences caring for patients with mood disorders, psychotic disorders, substance use disorders, and personality disorders as well as provide education regarding other areas of behavioral health that will assist in caring for patients across all ages and socioeconomic circumstances regardless of what specialty that our learners decide to pursue. Students will be monitored for progress throughout the rotation, given formal and informal feedback by attendings, residents, and fellows and will have required activities to ensure progress in all applicable areas. The following clerkship objectives are mapped to the LSU School of Medicine EPOS.

**Clerkship Objectives:**

**Patient Care (PC)**

* Students will be able to elicit and record a complete physical examination, psychiatric history, and mental status examination. **(EPOs PC 1,** **PC 2, ICS 4)**
* Students will be able to conduct patient interviews in a manner that facilitates information gathering of a therapeutic alliance, i.e. demonstrate respect, empathy, responsiveness, and concern regardless of the patient’s problems or personal characteristics and be able to use basic strategies for interviewing disorganized, hostile/resistant, mistrustful, circumstantial/hyperverbal, hypoverbal, and potentially assaultive patients. **(EPOs PC 1, KP 3, KP 4, ICS 1, PB 3)**
* Students will be able to assess the presence of general medical illness in psychiatric patients and determine the extent to which a medical/surgical illness contributes to a patient’s psychiatric problem. **(EPOs PC 3, PC 4, PC 5, KP 1, KP 2)**
* Students will be familiar with psychiatric terminology and be able to use the DSM-V in evaluating patients. **(EPOs PC 4, PBLI 1, KP 2)**
* Students will be able to use laboratory testing, imaging tests, psychological tests, and consultation appropriately to assist in diagnosing of the patient with neuropsychiatric symptoms. **(EPOs PC 3, PC 4, PC 5, KP 1, KP 2)**
* Students will be able to evaluate and begin management of psychiatric emergencies. **(EPO PC 6)**
* Students will be familiar with the hypotheses regarding etiology, the epidemiologic features, the common signs and symptoms, the DSM-V criteria, the differential diagnosis for the following groups of disorders and be able to formulate a biopsychosocial treatment plan for each: **(EPOs PC 4, PC 5, KP 5, KP 2, SBP 1, SBP 2)**
  + Psychotic Disorders
  + Mood Disorders
  + Anxiety Disorders
  + Personality Disorders
  + Addictive Disorders

**Knowledge for Practice (KP)**

* Students will be familiar with basic psychopharmacology, i.e., be able to summarize the indications, basic mechanisms of action, common side effects and drug interactions of the following classes of psychotropic medications: **(EPO KP 1, KP2)**
  + Anxiolytics
  + Antidepressants (and Electroconvulsive Therapy)
  + Antipsychotics
  + Mood Stabilizing Agents

**Systems - Based Practice (SBP)**

* Student advocates for safe, high-quality care for patients considering cost, resource utilization, and risk-benefit analysis and identifying key components of the healthcare system (basic healthcare payment systems). **(EPOs SBP 1, SBP 4)**
* Student demonstrates and applies knowledge of social and structural drivers of health to reduce disparities in patient care and advance health equity. **(EPO SBP 2)**
* Students identify the causes and types of patient safety and quality issues that contribute to quality improvement processes. **(EPO SBP 3)**

**Practice - Based Learning and Improvement (PBLI)**

* Students will participate regularly in learning activities including locating and assimilating evidence necessary to maintain and advance competence and performance. **(EPOs PBLI 1, PBLI 2)**
* Students assess their learning needs, knowledge, emotional needs, and the limitation of their skills, to improve.**(EPOs PBLI 2, PB 6)**
* Students should demonstrate appropriate help seeking behavior including accepting constructive feedback when it is necessary for their own well-being or the well-being of their patients. **(EPOs PBLI 3, PB 6)**

**Interpersonal Communication Skills (ICS)**

* Students will understand the principles and techniques of psychosocial therapies sufficiently to explain to a patient and make a referral when indicated. **(EPOs ICS 1, ICS 2, ICS 3)**
* Students will clearly communicate in an organized and respectful manner to all team members using either written and/or verbal communication. **(EPOs ICS 4, ICS 5)**
* Students will demonstrate collaboration with other members of interprofessional teams to provide care that is safe, effective, and efficient. **(EPOs ICS 7, ICS 8)**

**Professional Behavior (PB)**

* Display honesty, integrity, and accountability in all assessments and written assignments. **(EPO PB1)**
* Adhere to attendance and other professional requirements and complete assignments and tasks in a timely manner, in both classroom and clinical settings. **(EPO PB 2)**
* Demonstrate sensitivity and respect for patients, families, peers, teachers, administrative staff, and healthcare team members across diverse populations in all situations. **(EPO PB 3)**
* Maintain patient privacy and confidentiality. **(EPO PB 4)**
* Consistently advocate in the best interest of one’s patients, including fair access to care. **(EPO PB 5)**
* Recognize and address personal well-being needs that may impact professional performance. **(EPO PB 6)**

**\* Medicine EPOS linked to clerkship specific objectives**

Click [**here**](https://www.medschool.lsuhsc.edu/medical_education/undergraduate/docs/LSU%20School%20of%20Medicine%20Educational%20Program%20Objectives.docx) for the LSU School of Medicine Educational Program Objectives

**Suggested Reading List**

# Introductory Textbook of Psychiatry

**(7th Edition)**

# By [Nancy C. Andreasen](http://search.barnesandnoble.com/booksearch/results.asp?ATH=Nancy+C%2E+Andreasen), M.D. & [Donald W. Black](http://search.barnesandnoble.com/booksearch/results.asp?ATH=Donald+W%2E+Black), M.D., Ph.D.

Electronic version available online at <https://www.lsuhsc.edu/library/>

Type in *Introductory Textbook of Psychiatry* in the All Resources search engine, and follow the steps. You may need to enter your LSUHSC username and password for access.

A screenshot of a computer

AI-generated content may be incorrect.

**Personal Safety on Inpatient Psychiatry Units**

Inpatient units can be loud, and patients can be visibly agitated or disorganized. Most patients are not aggressive, and very few are capable of violence. However, all hospital staff treat patients as if they ***could be*** violent and are trained to handle sudden psychiatric emergencies. You may notice that nurses and other staff can appear serene, even when confronted by an irrational and angry patient. This is intentional and serves the purpose of preventing escalation.

Here are a few common-sense safety tips:

1. The patients’ rooms are their only private space on the inpatient units. Always make an effort to interview patients in the hall, the doctors’ offices, the treatment rooms, or the dayroom.
2. If patients are not willing or able to leave their rooms, never sit on a patient's bed or on the floor to conduct an interview.
3. When interviewing a patient in an office, take care when arranging the chairs. Never confine a patient to a corner of a room and never place yourself in the corner of the room.
4. Be very cautious about interviewing patients alone in an office, and if you must do so, make sure you can easily leave the room. A good rule, regardless of the patient, is to make sure you have easy access to the doorway. It is always ok to defer an interview until the patient is calmer if you feel uncomfortable.
5. Manic patients may have trouble maintaining social boundaries. It is always proper to stop an interview and back away if any physical contact occurs, regardless of the patient’s intent. Many patients will be grateful that you reminded them about the social standards they usually uphold when they’re well.
6. Paranoid patients are understandably anxious. They may be distrustful of the whole treatment team. If you become fearful when talking with a patient, trust that feeling, and tell the patient you’ll talk with them later. By stopping the interview, you show them you’re respectful of their privacy—even if their need for privacy is based on delusional thinking—and they will be better able to trust you in the future.
7. Remember the basic rules of psychotherapy:

If a patient starts to cry, ask, “What’s wrong?”

If a patient is obviously happy, say, “You really look cheerful!”

But if a patient appears angry or hostile, say, “I’ll talk with you later, this looks like a bad time.” Pointing out that a patient seems angry often makes them angrier.

Finally, relax and have fun. Students often tell us that in psychiatry, they feel that they are treating the whole patient, medically and socially. Patients often say that their interactions with medical students were the most satisfying aspect of their treatment.

**FINAL GRADE**

The final grade is a combination of the score you achieve on the National Board Examination (40%), Team-Based Learning (TBL) lectures (40%), Clinical Skills Evaluation Form (10%), and Attendance/Professionalism (10%).

TBL lectures compose 40% of your grade regardless of how many occur during the clerkship, 20% from individual quizzes and 20% from group work.  You should complete the assigned reading prior to each TBL lecture, because the quiz will be drawn solely from that material.

The National Board subject exam is worth 40% of your final grade.  The National Board scores are usually received back in the Clerkship Office about 1 week after the examination date.  Students will be notified of their “pass/fail” grade on the exam.  **You must pass the exam to pass the course.** **A subject exam grade that is below the Modified Angoff Content-Based Recommended Passing Score for the most recent standard setting study is a “fail”. The Passing Score can be found in the NBME Psychiatry Examination Score Interpretation Guide which is available by request post exam.**

**\*The NBME recommended score is monitored throughout the academic year and is subject to change.**

**NOTE: For all psychiatry clerkship students, including those who complete their Psychiatry Clerkship in Lafayette, Louisiana or at Our Lady of the Lake in Baton Rouge, Louisiana, the final grade will consist of:**

**Shelf - 40%**

**Clinical Skills Evaluation - 10%**

**Team Based Learning Lectures - 40% (Individual quiz 20% and Group quiz 20%)**

**Attendance/Professionalism – 10%**

|  |  |
| --- | --- |
| **Final Grade Scale** |  |
| **Honors** | **90 and up** |
| **High Pass** | **80 - 89** |
| **Pass** | **69 - 79** |
| **Fail** | **68 <** |

**NOTICE FROM STUDENT AFFAIRS** – If a student misses a scheduled exam during the school year, that student will not be able to take the exam until they complete the entire year. The student can take the exam on the makeup dates that will be scheduled at a later date by the Student Affairs Office.

**The Evaluation Grade is a pass/fail rating. Each student will receive a Final Clerkship Evaluation (New Innovations) from a primary site.   Please keep in mind that this evaluation from your primary site attending will contain comments that will appear on your MSPE.**

* **YOU MUST PASS ALL EVALUATIONS IN ORDER TO RECEIVE A PASSING GRADE FOR THE BLOCK.  ANY FAILING GRADE ON A CLINICAL EVALUATION WILL RESULT IN INCOMPLETE FOR THE ROTATION.**
* During the last week of the rotation, the faculty members, residents, and students may meet to discuss the final evaluation. Any student who has questions regarding an evaluation at any given site should direct those questions directly to the faculty/resident involved.  Any changes to an evaluation form will then be routed to the Clerkship Director’s office by the faculty/resident.

**The Mid-course Evaluation** must be completed by your primary site attending that you are rotating with during the first 3 weeks of the clerkship. **It can be emailed to coordinator LeKeysha Deloch at** [**ldeloc@lsuhsc.edu**](mailto:ldeloc@lsuhsc.edu) or delivered to her office in MEIC.

This evaluation has no direct bearing on your final grade; however, the form may be used by an attending to alert the clerkship director of a concern. **The clerkship director will contact you if the evaluation raises concerns.**

**Failing Grades can result if:**

* a student does not complete assigned weekend rotation.
* a student receives an unacceptable or failing grade on an evaluation by the clinical instructor
* a student fails to show professional and/or personal qualities to be expected at their level of training
* a student with more than two unexcused absences from any required activity, e.g. a lecture/TBL, morning or afternoon rounds, a call shift, or grand rounds. The student will receive a letter grade drop in the final grade; this could result in failure of the rotation.
* all required clerkship documents (Midcourse Evaluation, Clinical Skills Evaluations, Required Clinical Activities Booklet (purple book), Psychiatry Ethics & Nutrition Modules, Interprofessional Collaboration Form) are not turned in by end of clerkship.

**REQUIRED ASSIGNMENTS**

1. **Mid-Course Evaluation:** Must be completed by your attending halfway through the rotation to ensure adequate feedback is being provided to you throughout your clerkship. This evaluation is a paper evaluation that can be turned in via email to [ldeloc@lsuhsc.edu](mailto:ldeloc@lsuhsc.edu) or by dropping it at the clerkship office with Mrs. Deloch. This evaluation MUST be completed by an attending,
2. **Clinical Activities “Purple Book”**

The Required Clinical Activities booklet (AKA: The Purple Book) contains an information sheet for each of the five (5) clinical conditions that students are required to encounter during their Psychiatry Clerkship: **Addictive Disorder, Personality Disorder, Anxiety Disorder, Mood Disorder, and Psychotic Disorder**. As the student, along with the Attending/Resident, interviews a patient with the listed condition, the student is required to complete the information sheet by documenting the patient’s diagnosis, identify if an actual patient with the condition was seen or if some type of patient simulation was used, give the age/sex of the patient, as well as **have the Attending/Resident sign the sheet documenting that they were present and observed the student participate in or observe the patient interview.**

The Required Clinical Activities booklet also includes a Progress Note Feedback form. This must be signed by your attending. Once you have completed an inpatient progress note or an outpatient clinic note, please have your attending print their name and then sign on the signature line of the Progress Note Feedback Form. When you complete the booklet, please turn it in to Clerkship Coordinator, LaKeysha Deloch.

A student will receive an incomplete for the Clerkship until the entire Required Clinical Activities booklet is completed and returned to the Clerkship Office.

If you are nearing the end of the rotation and have not completed the core clinical conditions in the purple book, please complete the corresponding cases at the following link:

<https://www.admsep.org/csi-emodules.php?c=taskforce>

1. **Interprofessional Collaboration Form**

In accordance with the LSUHSC-New Orleans School of Medicine Educational Program Objectives and Institutional Competencies,students on the Psychiatry Clerkship work in collaborative teams with other health professionals to provide care that is safe, effective, and efficient. The Interprofessional Collaboration Form is used to demonstrate those collaboration efforts. **You must complete by the end of the clerkship, or you will receive an “incomplete” for the clerkship**.

1. **Clinical Skills Evaluation Form**

Using the Clinical Skills Evaluation Form, the student will perform an initial evaluation on a patient under the supervision of their primary site attending that they are on rotation with during the second half of their clerkship (last 3 weeks). The students will be evaluated on their clinical skills in the physician-patient relationship and on conducting and presenting a psychiatry interview. **This evaluation is worth 10% of their final grade**.

**You must turn in by the end of the Clerkship or you will receive an “Incomplete” for the Clerkship**.

1. **Ethics Modules:**
2. **LA LAWS QUIZ** - Please log-on to the 3rd and 4th Year Resources page

<https://www.medschool.lsuhsc.edu/medical_education/Undergraduate/clerkships/Psychiatry-Ethics.aspx>



* **Review the Louisiana statutes, & complete the Louisiana Laws Quiz. and send “passed” verification to** [**ldeloc@lsuhsc.edu**](mailto:ldeloc@lsuhsc.edu) **before the end of your rotation.**

1. **CASE SUMMARIES** – Please follow the directions using the above link and complete the below case discussions:

-Confidentiality and Informed Consent

-Conflicts of Care for Mental and Physical Illnesses

Outline one issue from each summary and provide two 50 word responses on how you would proceed. **Your two responses must be saved as a Word file and the filename must include your name. Email responses to** [**ldeloc@lsuhsc.edu**](mailto:ldeloc@lsuhsc.edu)**.**

1. **Nutrition Module:**

* Please log on to the Psychiatry Moodle page and click on the link and follow the instructions to complete the Nutrition Module

<https://forms.office.com/Pages/ResponsePage.aspx?id=iTYGNNSCiU6jKBq3nMWNnV3Omd1SrtNMmdm5N61Jnx5UQlUzSTVKNEM0MjBQMEw0ODNOOEhMM1EzTy4u>

1. **Psychiatry Shelf Study Day:**

The Thursday prior to the Shelf Exam is a study day and you are free from clinical duty. Please remind your clinical teams and ensure all materials are turned in.

1. **New Innovations Clerkship Evaluation from Attending**:

This is a pass/fail evaluation with comments that will appear on your MSPE.

1. **Lecture Schedule with TBLS:**

Will be emailed by La’Keysha at the start of each block. If absence from a TBL is required, the student is responsible for working with the coordinator and director to make up work if able, otherwise their TBL portion of their grade may be impacted.

1. **Departmental Grand Rounds on Wednesdays from 12p-1p**

**ATTENDANCE/PROFESSIONALISM**

**(COUNTS FOR 10% OF FINAL GRADE)**

**Curriculum Policy: Absences from Clinical Rotations**

(Revised and approved by the Clerkship Director Committee June 2023; Approved by the Curriculum Steering Committee June 2023)

A student’s responsibilities in clinical rotations include caring for patients on teams and therefore take precedence over other activities. However, we understand that situations may arise when a student will need to request a brief absence from daily responsibilities on a required clerkship or other clinical rotation. The guidelines listed below give insight as to what might be considered an acceptable request, and they include visiting students on senior rotations.

Note that these are institutional guidelines and some of the clerkships and departments may have more specific policies. Details regarding absences in individual rotations, such as means of notifying the clerkship/rotation director, and policies on make-up work, will be outlined in clerkship and rotation orientations.

All requests for leave must be presented to the clerkship/rotation director; it is the student’s responsibility to make certain that they are approved. Directors of shorter clerkships/rotations will use their discretion in approving absences for non-emergencies in these rotations.

Sufficient remediation for absences will be established at the discretion of the clerkship/rotation director. Remediation may involve additional call nights, additional weekend responsibilities, clinical work on days normally set aside for NBME preparation, or make-up assignments for missed didactics. A clerkship/rotation director may require remediation of some work for absences of less than two days if they deem that learning opportunities are significantly affected by the absence.

Over the course of the clerkship/rotation, any leave totaling more than two days (for a single absence or for repeated absences, regardless of the reason) will require remediation prior to completion of the clerkship/rotation.

Requested absence days are included in the “one day in seven free of clinical work and required education averaged over the duration of the rotation,” as outlined in the student work hour policy.

Adherence to these policy guidelines is considered a matter of professionalism, therefore excessive absences or non-emergent absences may be reflected in the evaluation of the student’s work habits or professionalism.

**STUDENT RESPONSIBLITIES ON HOLIDAYS:**

Unless otherwise stated, students will be free from clinical duties on the days below. Students are expected to perform clinical duties if assigned on the weekends associated with the holidays e.g., Saturday and Sunday before Labor Day. If a student is on their acting internship, they should not consider themselves exempt from working holidays and should consult with their clerkship/rotation director at the start of the rotation.

* July 4th
* Labor Day (off Monday)
* Martin Luther King, Jr. (off Monday)
* Mardi Gras (off Monday and Tuesday)
* Easter (off Friday, Saturday, Sunday)
* Thanksgiving (off Thursday, Friday, Saturday, Sunday)
* Christmas (off 2 weeks around holidays -- off Christmas Day & New Year’s Day only if doing senior rotation in block 7)
* Memorial Day (off Monday)

**ATTENDANCE/PROFESSIONALISM cont.**

**(COUNTS FOR 10% OF FINAL GRADE)**

An **excused absence** is defined as presenting an acceptable reason, *in advance of the absence*, only by the involved student, to the office of the clerkship coordinator/director.

An **unexcused absence** is defined as not being at your assigned location, i.e. clinical duties, didactics, grand rounds, etc., without prior approval.

* A Medical Student Request for Absence or email MUST be submitted; otherwise, absence will be

considered unexcused. NOTIFYING A FELLOW CLASSMATE IS NOT AN ACCEPTABLE

EXPLANATION.

* Students are required to be present for ALL clinical assignments (defined as any required part of the

course which includes Grand Rounds, and all scheduled lectures).

* Attendance is required and monitored.
* Tardiness for clinical duties, lectures will be taken into account.
* Assignments being turned in late – such as evaluations, and ethics/nutrition modules will be taken into

account.

* It is the student’s responsibility to make sure he/she has signed the attendance sheet.
* No signatures will be permitted to be made after the attendance sheet has been collected.
* Students can sign in only for themselves. It is unacceptable for any reason to sign in for a fellow student.

1. **Emergent Absence (such as illness or funeral):**

Students should notify the clerkship/rotation director as soon as possible. If possible, the student should also notify their team (residents, interns, and attending). Leave of more than two days will require remediation prior to completion of the clerkship. Clerkship/rotation directors may require a note from the treating provider for absence due to illness. Students will be excused from clinical activities if they are ill, need to seek health services, or have infectious or environmental exposures or temporary disabilities requiring their absence. Make-up work may be assigned if the absence involves required didactics.

1. **Non-emergent Absence (such as weddings, presentations at national conferences, or school business):**

Students must request these absences from the clerkship/rotation director via e-mail prior to the start of the clerkship. The student should also notify their team (residents, interns, and attending) as soon as possible. Leave of more than two days will require remediation prior to the completion of the clerkship. Make-up work may be assigned if the absence involves required didactics.

1. **Residency interviews (for seniors):**

Students must request these absences from the clerkship/rotation director via e-mail prior to the start of the rotation or as soon as the interview is scheduled. The student should also notify their team (residents, interns, and attending) as soon as possible. Leave of more than two full days or four half days will require remediation prior to the completion of the rotation. Absences for interviews should be minimized, and students should make every attempt to schedule residency interviews at other times e.g., flex blocks. We recognize that this is not always possible.

1. **Circumstances not stated in the above categories:**

Students must request absences for other extenuating circumstances from the clerkship/rotation director via e-mail as soon as possible (before the start of the clerkship/rotation if possible), and approval is at the discretion of the clerkship/rotation director. As above, the student must notify their team and make up any work assigned by the clerkship/rotation director if the absence is approved.

Physicianship & Medical Professionalism

<https://www.medschool.lsuhsc.edu/medical_education/undergraduate/professionalism.aspx>

**SCHOOL OF MEDICINE PROFESSIONAL GUIDELINES**

**Students are expected to act in accordance with, and have an understanding of the professional guidelines and to present themselves as a professional healthcare student when representing LSUHSC-SOM NO. Students are expected to demonstrate cultural awareness and humility and treat all patients, peers, faculty and staff with respect.**

Students will **communicate** in an appropriate manner at all times with patients, peers, faculty and staff. Students are expected to:

* Communicate in a respectful manner under all circumstances including in person, emails, social media and on zoom with faculty, staff, peers and patients
* Respond to emails in a timely fashion
* Provide timely notification regarding absences to mandatory sessions and exams
* Provide constructive feedback to peers and faculty
* Use appropriate language when discussing peers and patients
* Wear appropriate attire according to the circumstances

Students will exhibit **engagement** in coursework and course activities. Students are expected to:

* Be present and exhibit punctuality to all mandatory sessions and exams
* Submit all assignments and reflections on time
  + Generative AI should not be used for these assignments as it undermines the students’ learning process of clinical reasoning, empathetic and communication skills.
  + Students will follow course policy/ assignment directions regarding use of Generative AI.
* Stay on task during all class sessions
  + No cell phone and laptops usage for non-session related activities
  + No conversations while faculty and/or peers are addressing the classroom
  + Engage and participate when asked and/or appropriate
* Follow instructions for all sessions, exams, and online activities
* Exhibit professional and timely engagement with faculty when requested
* Exhibit teamwork

Students will exhibit **honesty and integrity** at all times. Students are expected to:

* Submit original work and not use any resources that would be considered plagiarism, including generative AI.
* Adhere to the Honor Pledge for every exam, TBL, and online quizzes, tests, etc. This includes no screenshots or recording questions with intent to distribute to other students.
* Respect faculty intellectual property (PowerPoints, etc.) and not distribute outside of LSUHSC-NO
* Maintain confidentiality of peers as is expected with patients
* Communicate truthfully with faculty, staff, peers and patients

Students will strive for **personal and professional development.** Students are expected to:

* Take responsibility for their own learning and ask faculty for help when struggling
* Accept feedback as it is intended and use it for improvement
* Admit omissions and mistakes and attempt to learn from them

Students will **adhere to all** **school policies** and instructions from faculty and staff including the:

* Honor pledge
* Computer and Social Media guidelines [LSUHSC - SOM Social Guidelines](https://www.medschool.lsuhsc.edu/LSUHSC%20SOM%20social%20media%20guidelines%208-14.pdf)
* HIPAA guidelines [LSUHSC SOM HIPAA Guidelines](https://www.lsuhsc.edu/administration/ocp/docs/HIPA/HIPAPP/HIPA_HIPAPP.html)
* FERPA guidelines [FERPA Guidelines](https://lsuhsc-my.sharepoint.com/personal/jsturt_lsuhsc_edu/Documents/Preclerkship%20Course%20Director/professionalism/FERPA%20Guidelines)

**\*FAILURE TO ADHERE TO ATTENDANCE & PROFESSIONALISM POLICIES WILL RESULT IN A DROP IN YOUR ATTENDANCE/PROFESSIONALISM SCORE. \***

**BEHAVORIAL STATEMENTS, including links:**

***-Accessibility Statement*:** LSUHSC-New Orleans is committed to creating an inclusive and accessible environment according to the ADA, ADAA, and Section 504 of the Rehabilitation Act of 1973. Students in need of classroom accommodations should contact the Office of Disability Services (ODS) at [ods@lsuhsc.edu.](mailto:ods@lsuhsc.edu) Please keep in mind that accommodations take effect when an accommodation letter has been generated; they are not retroactive. New accommodation letters need to be requested every academic term in which you are enrolled. More information can be found on the [ODS website](https://www.lsuhsc.edu/administration/academic/ods/).

***-Antidiscrimination Statement*:** LSUHSC-New Orleans welcomes and respects individuals from all backgrounds and viewpoints. All faculty and students should be treated with dignity and empathy. Discrimination and harassment of any kind will not be tolerated.

***-Names:*** All students should be treated with professional consideration and respect. While our university data system requires the use of legal names and gender markers on official documents, students are welcome to inform instructors of the preferred name that they use. In some instances, preferred names may be modified on ID badges as well. Students who have questions concerning this policy are encouraged to contact the [university registrar.](https://www.lsuhsc.edu/registrar/)

***-Title IX Statement*:** LSUHSC-NO promotes integrity, civility, and mutual respect in an environment free from harassment and discrimination based on sex, gender, sexual orientation, gender identity, sexual misconduct, and power-based violence. As your course director and/or instructor, I am mandated to report to the [Title IX Coordinator](https://www.lsuhsc.edu/titleix/) any incident of Title IX or power-based violence told directly to me. Exceptions to this required reporting include disclosures that are shared in the course of academic work such as a class discussion, group work, etc. Confidential resources that do not have the reporting requirement are available through CAP and the Ombuds.

[All gender restrooms](https://www.lsuhsc.edu/titleix/all_gender_restrooms.aspx) can be found in several locations on campus.

LSUHSC-NO does not discriminate against anyone with pregnancy or parenting status. Reasonable accommodations are available to anyone who requests them. [Lactation spaces](https://www.lsuhsc.edu/titleix/lactation_spaces.aspx) are available across campus as well.

***School of Medicine Student Affairs learning environment form:***

[**https://www.surveymonkey.com/r/KP5ZJNW**](https://www.surveymonkey.com/r/KP5ZJNW)

***LSU CARES reporting form (for LSUHSC):***

[**https://www.lsuhsc.edu/administration/academic/lsuhsc-cares/**](https://www.lsuhsc.edu/administration/academic/lsuhsc-cares/)

***The link on the Student Health page, under the Exposure Protocol Policy tab:***

[**https://www.lsuhsc.edu/orgs/studenthealth/needlestickinjury.aspx**](https://www.lsuhsc.edu/orgs/studenthealth/needlestickinjury.aspx)

*Professional Conduct and Mistreatment Policies*

[**http://www.medschool.lsuhsc.edu/student\_affairs/conduct.aspx**](http://www.medschool.lsuhsc.edu/student_affairs/conduct.aspx)

**Policy Title: Policy on Clerkship Phase Work Hours**

(Revised and approved by the Clerkship Director Committee June 2023; Approved by the Curriculum Steering Committee June 2023)

**Policy Statement/Purpose:**

The clerkship phase of the curriculum includes patient care activities as well as didactic learning activities. The clerkship directors developed this policy to be similar to ACGME requirements for residency duty hours

**Policy Directives:**

Students on required clinical rotations should not spend more than 80 hours per week (on average over the duration of the clerkship) in clinical and didactic learning activities.  Students who are assigned to overnight call in the hospital should not have patient care responsibilities after 1:00 PM on the following day.  However, students are expected to attend mandatory didactic activities even after overnight call.   In-house call must occur no more frequently than every third night, averaged over the rotation.  Students must have a minimum of one day in seven free of clinical work and required education averaged over the duration of the rotation. Weekends, school holidays, and absences are included in this “one day in seven” guideline.

If a student has concerns that their duty hours have been exceeded, they should contact the clerkship director as soon as possible. If students are not comfortable contacting the clerkship director, they should contact the Director of the Clinical Sciences Curriculum, the Assistant Dean for Undergraduate Medical Education, the Director of Student Affairs, the Associate Dean for Student Affairs, or one of the Assistant Deans for Student Affairs.

**PSYCHIATRY CLERKSHIP EVALUATION**

Please access New Innovations at <https://www.medschool.lsuhsc.edu/medical_education/new-innov/>

on the LSUHSC website, Undergraduate Medical Education, under online resources.

The New Innovations System is used for selecting faculty and residents to complete evaluations. To send your primary site faculty/resident an evaluation, please log on to the New Innovations system and follow the instructions below. **NOTE: YOU MUST REQUEST AN EVALUATION FROM AT LEAST (1) PRIMARY SITE ATTENDING. ALL OTHER EVALUATION REQUESTS ARE OPTIONAL.**

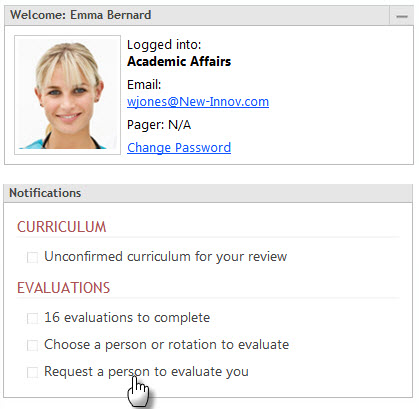
Once the faculty/resident receives an email alerting them that an evaluation is now available, it will appear on their list of evaluations to complete. When the faculty/resident completes and electronically signs the evaluation, you will be notified via email that an evaluation is available for your review and electronic signature. If you should have any questions about the evaluation before electronically signing it, please direct those questions directly to the faculty/resident involved.

**NOTE:** Please let us know ASAP via email to [mpunc1@lsuhsc.edu](mailto:mpunc1@lsuhsc.edu) if your faculty/resident and/or site location is not listed on the New Innovations Systems.

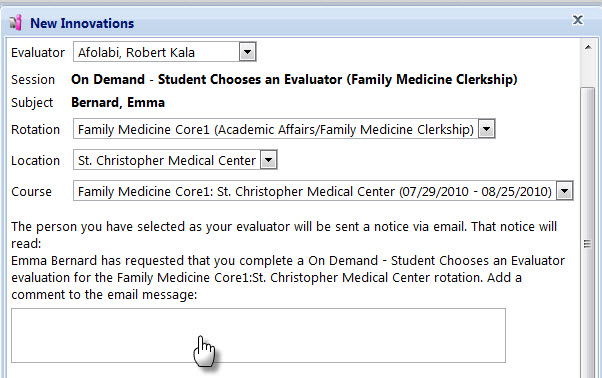
How to Request an Evaluation from a Faculty Member/Resident

**I want someone to evaluate me**

1. Go to the Notification section of your home page
2. Click on *Request a person to evaluate you*



1. Click on *Request Evaluator*
2. Select the person who should complete the evaluation.
3. Choose the rotation, location, and course (From drop down menu choose*,* ***Psychiatry Faculty Evaluation of Student Comp.***)
4. You may leave a comment for the evaluator.



1. Click on *Evaluate…*
2. The evaluator will receive and email that the evaluation is now available, and it will appear on his or her list of evaluations to complete.