Advanced Practice Psychiatric Provider Fellowship Program Handbook of Policies and Procedures

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Preface

This handbook outlines the policies and procedures for the APPPFP at the University of Washington. It defines the roles and expectations of the program leaders, faculty and fellows. It covers topics such as program mission, vision and goals, structure and requirements, leave policies, grievance and remediation procedures. This handbook does not override any University of Washington and Medical Center policies, procedures or requirements.

Disclosures

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Mission, Vision, and Goals

Mission

The mission of the University of Washington Advanced Practice Psychiatric Provider Fellowship Program is to improve the health of Washingtonians by preparing advanced practice providers to deliver high–quality behavioral health care through an innovative advanced care fellowship program.

Vision

We believe there is no health without mental health and that by empowering Advanced Practice Psychiatric Providers in evidence-based care, we will transform the access to effective mental health care across Washington state through collaboration, community support, and sustainable access to care for patient families.

Fellowship Goals

- Expand Washington's behavioral health workforce through advanced psychiatric training for newly graduated advanced practice psychiatric providers that emphasizes clinical competence, confidence, and sustained professional development
- Foster the development of advanced practice psychiatric clinical leaders who are accountable for providing team-based, patient-centered care to all persons in need of behavioral health services in the community
- Increase workforce capacity for delivering data-driven continuous quality improvement as part of a learning behavioral healthcare system
- Enhance advanced practice psychiatric provider career satisfaction and retention in the behavioral health workforce
- Develop a cohort of advanced practice psychiatric provider graduates with skills as clinical educators to contribute to sustainable behavioral health workforce development and mentorship

Staffing, Operations, and File Policy

Scope
All participating fellows, staff, faculty and relevant stakeholders in the APPPFP at the University of Washington.

Purpose
Outlines process for requesting time off for fellows. The information storage policy for fellow application and data created during the fellowship. Details description of required faculty in the program and support staff, along with information regarding retention of staff information.

Policy
1. Leave requests and sick leave process:
    a. See UW appointment benefits for information on the amount of leave and sick leave available to fellows.
    b. For leave requests it is expected to submit requests at least 3 months in advance. Fellows are expected to follow the leave request and sick leave process as shown in clinical rotation guides.
    c. For extended sick leave it is expected the fellow will discuss catch-up plans with the program director at their earliest convenience. Extended sick leave may impact the ability to complete the fellowship.

Documentation and Information Storage
1. The Fellow Portfolio
    a. Each fellow will have a dedicated and protected repository that provides a comprehensive record of educational activities in the fellowship program and is used to verify completion of or participation in the fellowship. The fellow file may be maintained in hardcopy and/or electronic formats. The hard copy portion of the file, if it exists, will be maintained in a secure location, and the electronic portion of the file will be maintained in a secure electronic location within the secure UW network.
    b. File Contents:
        i. Each fellow's File can include the following:
            1. Appointment information
            2. Record of educational activities
                a. Curricular activities (including weekly journal entries)
                b. Clinical activity (patient mix, procedures, and visits/encounters, specialty rotations)
                c. Certification

d. Awards
e. Evaluations and self-assessments
f. Disciplinary actions
g. Special projects such as presentations to UW faculty and staff
h. QI project
i. Additional elements of the learning portfolio can be added by both the postgraduate trainee or the program and assist with preparation for postgraduate trainee evaluation and coaching sessions.

c. File Access:
    i. The file will be available only to the program director, assistant program director, designated program administrative staff and any designated institutional official. The program director and the designated institutional official or designee may disclose the file, or portions thereof, to individual with a business need for the information; this may include matters relating to the education in the program, the quality of patient care in the program, hospital site visits, or accreditation site visits. The program director and the designative institutional official or designee may also disclose the file, or portions thereof, to others as authorized in writing by the fellow for credentialing purposes.
    ii. Fellow Access to The File:
        1. Upon request a fellow or graduate shall be provided with timely access to their File. The fellow is responsible for the cost of printing and postage of documents, as applicable.
        2. A digital copy of the portfolio will be available to the fellow at the completion of the program.
    iii. Public Records Requests:
        1. UW School of Medicine (SOM) and the UW School of Nursing are state agencies and therefore resident files are subject to disclosure under Washington's Public Records Act. If the SOM/SON receives a public records request, the applicable department contacts will be notified. Information specific to the request will be included in the notice, and all questions must be directed to the SOM/SON Records Manager.
d. Fellow Information Retention Schedule:
    i. The Human Resources department maintains records and documentation of the fellow relevant to their job title. This

document is not intended to supersede, describe, limit or in any way influence the requirements of the HR department.

ii. APPPFP Fellow and Program Data Storehouse:

1. Provides a comprehensive record of accepted applicants to the fellowship program. Documents the completion of fellowship education requirements (or early departure from program prior to completion), and may include evaluations, letters of recommendation, application (with proof of meeting eligibility criteria), correspondence, certifications, grievances made by the fellow, documentations of disciplinary action, etc. for each program fellow. See UW policy.

e. Staff Records:

i. All current key program staff, including but not limited to the Program Director, Assistant Director, Core Faculty, and additional Program staff assigned to the APPPFP will be maintained by the Program. Documents include a current resume or curriculum vitae (CV) and job description that outlines the role and responsibilities as it relates to the Postgraduate Training Program.

ii. Information related to faculty development, including faculty evaluation forms, are to be kept in a protected folder within the staff records (please see the Faculty Evaluation and Development Section of the Policy Handbook for full description of faculty evaluation).

2. Program Staffing:

a. The Program must have the appropriate leadership and oversight from the administrative, programmatic and clinical perspective. An Advanced Registered Nurse Practitioner must be in the position of Program Director.

i. **Program Director** is a 0.6 FTE position that is responsible for:

1. Program and Curriculum Development

a. Plan and implement PMHNP ARNP Fellowship Program

b. In partnership with the UW SoN and the Department of Psychiatry faculty develop/improve the educational curriculum for an accredited Fellowship training program

c. Oversee, develop, and organize internal and external educational programs, clinical training, and didactic partnerships
d. Establish new and review annually existing policies, procedures, and protocols for the Fellowship Program, including Fellow selection, evaluation, promotion, and dismissal.
e. Prepare and maintain accurate records and reports in compliance with organizational policy and accreditation requirements.
f. Create and maintain collaborations with national NP Fellowship partners to promote NP Fellowships.

2. Program Leadership and Facilitation
    a. Lead the recruitment, selection, training of the Fellows, and evaluation of the performance/competence through reliable measures not limited to direct observation and faculty consultation.
    b. Oversee the accreditation process, reporting progress to the funder and the accrediting body.
    c. Select supervising faculty, ensure teaching competence, appropriately monitor fellows and fellow supervision, and review faculty performance annually.
    d. Provide leadership and direction for the clinical faculty, including faculty development, mentorship, supervision, and conflict resolution.
    e. Provide oversight and annually evaluate clinical partners to ensure the quality of educational experiences.
    f. Ensure the quality of comprehensive, didactic, and clinical education.
    g. Lead, coordinate and conduct on-site meetings and educational sessions with Fellows, faculty, and preceptors.
    h. Develop and lead fellow development programs, assign workload/projects, monitor, and evaluate performance, initiate corrective actions, and perform other related leadership functions.

i. Plan, develop and monitor PMHNP Fellowship Program budget, ensure long-term financial sustainability, and provide an annual report.

3. Clinical Supervision
    a. Act in the role of preceptor for fellows. See Clinical Program Faculty section below.
4. Other Administrative Duties
    a. Create and maintain collaborations with national NP Fellowship partners to promote NP Fellowships.
    b. Collaborate with the healthcare facility HR to develop onboarding standards for fellows
    c. Actively participate in quality improvement programs and activities
    d. Initiate the quality improvement project and process improvements to attain quality service and educational program delivery

ii. **Assistant Director** is a 1.0 FTE position that is responsible for:

1. Program Development and Implementation
    a. Support the PI's and Program Director in the planning and implementation of the PMHNP ARNP Fellowship Program. To include, but not limited to:
        i. Facilitation of the program accreditation process.
        ii. Stakeholder meeting management and support
        iii. Manage project goals and day-to-day tasks in support of program implementation
        iv. Develop a detailed process to monitor and track the progress of the project
        v. Create and maintain a comprehensive project documentation
    b. Drive the processes operations for the development of the educational curriculum for an accredited Fellowship training program.
    c. Collaborate with Impact Office to develop and provide program implementation progress reporting procedures
2. Program Management and Operations

a. Manage the day-to-day tasks in support of program operations
b. Create and manage a system to track required program benchmarks and deliverables
c. Collaborate with Impact office develop and provide regular program benchmark reports
d. Support the Director in establishing new and review annually existing policies, procedures, and protocols for the Fellowship Program, including Fellow selection, evaluation, promotion, and dismissal.
e. Liaison with clinical sites to create fellow's clinical placement schedules
f. Work with the fellowship director to coordinate clinical schedules with required didactics
g. Assist in preparing and maintaining accurate records and reports in compliance with organizational policy and accreditation requirements.
h. Assist in developing and conducting program evaluation activities
i. Manage database for organizing accreditation-related data and other materials
j. Assist with preparing reports for accreditation and the funder.

3. Other Administrative Functions
    a. Provide administrative, operational and technical support
    b. Interact with and develop strong working relationships with all UW project stakeholders

iii. Clinical Program Faculty

1. There must be sufficient Clinical Program Faculty to provide postgraduate trainees with dedicated support during clinical practice experiences that enable the essential knowledge and skills to be acquired in order to meet Program goals and competencies. The clinical program faculty may include preceptors, mentors, didactic lecturers, faculty with expertise in leadership, and any other clinical training staff.
2. Please see the Faculty Evaluation and Development portion of the handbook for further role description

b. Logistics and Support:
    i. The program director or relevant designee is to ensure sufficient organizational support staff (administrative and technical) to support Program staff and postgraduate trainees in their day-to-day operations. The organizational support staff and services may include, but are not limited to:
        1. Information Technologies (IT)
        2. Business intelligence (reports and data analytics)
        3. Practice management (schedules, templates, case mix)
        4. Clinical support staff (medical assistants, RNs, and others to support the team care model)
        5. Quality improvement to support continuous QI activities within the practice
        6. Human Resources
    ii. Proof of satisfactory support is to be identified within the organization itself and within each clinical location prior to the start of a rotation.

Eligibility, Recruitment, and Selection Policy

Purpose:

This policy is designed to ensure fair and consistent consideration and decision-making for all applicants to the APPPFP program. Evaluation of applicants is performed by the respective program director, responsible faculty, and department leadership.

Policy:

1. Eligibility:
    a. APPPFP eligibility is anchored in specialty-specific requirements as specified by the relevant attainment of certification from accrediting body and receipt of applicable degree. In the case of Advanced psychiatric nurse practitioners (ARNP), requirements include completion of an MSN or DNP program from an accredited institution and successful completion of the American Nurse Credentialing Center (ANCC) Psychiatric Mental Health Nurse Practitioner Across the Lifespan (PMHNP) board exam.
        i. APPPFP leadership reviews submitted applications and follows up with accepted candidates to ensure timely completion of requirements prior to program start
    b. Employment Eligibility: We do not currently accept applicants requiring Visa sponsorship, and all applicants must be eligible to work in the United States.
2. APPPFP engages in practices that focus on ongoing, mission-driven, systematic recruitment and retention of a diverse, equitable and inclusive workforce of fellows while maintaining compliance with Washington State Law and University of Washington policies addressing diversity in recruitment.
3. APPPFP recruits Fellows among eligible applicants based on training program-related criteria such as their preparedness, ability, aptitude, alignment with program mission, growth mindset, academic credentials, communication skills, and personal qualities such as motivation and integrity, as well as professionalism.
4. Under University of Washington Executive Order No. 31, the APPPFP recruits applicants without regard race, color, creed, religion, national origin, sex, pregnancy, age, marital status, sexual orientation, gender identity or expression, genetic information, disability, veteran, and based upon their qualifications and ability to do the job.
5. Recruitment and selection:

a. The recruitment and selection processes are available on the APPPFP website.
b. Written application process
    i. Applications are open once a year and are based on match.
    ii. Written applications are posted on the program website and include the following:
        1. 3 letters of recommendation (from program faculty, clinical preceptors, or relevant managers/directors of a workplace if the applicant is already working as a PMHNP.)
        2. Program application, including demographics and essay responses
        3. Unofficial transcripts
        4. Graduate school diploma (if applicable)
        5. Copy of RN licensure
        6. Copy of ARNP licensure, if applicable
        7. Copy of board certification, if applicable
        8. Current Curriculum Vitae
            a. For applicants who apply during ongoing schooling; items 4, 7, and 6 are not required for program acceptance, but must be received prior to the start of the program.
    iii. Applications are blinded for reviewers, with each applicant's name and identifiers redacted, and each application is given a numerical identification number.
    iv. Each aspect of the application is graded by evaluators on a standardized scale, with the final application given a numerical score.
c. Oral Interviews
    i. Applicants invited to interview for a fellowship position are informed in writing or by electronic means, of the terms, conditions, and benefits of their appointment to the fellowship program in the event of acceptance into the program. This includes stipends, benefits, vacation, leaves of absence, professional liability coverage, disability insurance, and health insurance accessible to their eligible dependents.
        1. Oral interviews consist of standardized questions for each applicant

2. Interviews are conducted by the leadership team, which includes, at a minimum, the program director and relevant faculty.

d. Following interviews, the leadership team meets to review submitted evaluations on applicants, which are to be arranged according to the combined numerical score from written and oral applications.
    i. This order is designed to be a tool to assist in the application process. Each applicant's evaluation may be adjusted following holistic review by the interview team based on individual applicant's alignment with the program's mission and vision.
    ii. Decisions are made by consensus, with the program director casting the tie-breaking vote. Basis for decision making (overall score and particular alignment with program mission and vision) will be kept by the program.
e. Applicants are notified of acceptance, wait-list or non-acceptance in writing, either via email or standard postage.

6. Offer letter:
    a. In coordination with Human Resources, the APPPFP leadership will maintain a formal employment agreement via an offer letter. This agreement includes, but is not limited to, the following:
        i. Postgraduate trainee requirements and responsibilities
        ii. Length of agreement of 12 months, which is non-renewable.
        iii. Core program requirements
        iv. Financial compensation and other included benefits
        v. Notice of Professional liability insurance coverage through the University of Washington
        vi. Policies and procedures for postgraduate trainee withdrawal or dismissal
        vii. Other policies and procedures in accordance with the University of Washington and UWMC
    b. Please see the appendix for an example of an offer letter.
7. Accommodations
    a. Applicants who require disability accommodation for the interview may request an accommodation from the UW Disability Services Office. In the event that such an accommodation is requested, the UW Disability Services Office will inform the program director of the request to facilitate an appropriate accommodation, if indicated.

Fellow Appointment and Performance Management Guidance

Scope

This guidance applies to individuals appointed as a Fellow in the Advanced Practice Psychiatric Provider Fellowship Program (APPPFP). This guidance should be applied in coordination with the template offer letter for APPPFP Fellows.

Purpose

This guidance is intended to assist individuals who supervise and manage appointments of APPPFP Fellows. The guidance addresses processes for appointments, appointment renewals, managing individuals throughout their appointment term, and ending appointments. Supervisors, including PI's and program directors, are expected to consult with department leadership and administrators, including academic personnel/HR administrators, to implement the processes.

1. APPPFP Fellow Appointments
    a. Duration of Appointments
        i. Fellow APPPFP appointments are annual (read: 12 month) appointments. Under extenuating circumstances, training time may be extended depending on funding and availability.
    b. Ending an Appointment before the Appointment End Date
        i. If at any point a license or required certification lapses, the trainee will be ineligible to continue working or participating in the program until such requirements are met.
            1. If trainee is notified of pending litigation or investigation into a state license the trainee is to inform the HR department or the program director within 24 hours.
        ii. Under limited circumstances, ending an appointment of an APPPFP Fellow prior to the appointment end date reflected in the appointment may be warranted for the following reasons:
            1. Unsatisfactory performance or behavior after providing documented reasonable opportunity to improve;
            2. Misconduct including but not limited to violation of University or other policies (e.g. Executive Order No. 31 and UW Policy and Procedure on Workplace Violence)

iii. The required process to end an appointment under each of these circumstances is detailed further under Section 2.

2. Process for Ending an Appointment Before the Appointment End Date
    a. Unsatisfactory Performance
        i. The following process must be employed and documented to support the rare occasion that warrants ending an appointment for unsatisfactory performance or behavior before the anticipated appointment end date:
            1. If there is a clinical performance issue this would be addressed by the Program Director and the clinical Service Chief and the UW faculty policy. If the supervisor determines the APPPFP Fellow has not made sufficient progress according to a performance management plan, has documented the deficiencies, documented allowing the Fellow reasonable time to improve, and has consulted with the leadership team a notice of termination may be issued.
            2. The department shall provide the Fellow written notice of intent to end the appointment for unsatisfactory performance as soon as practicable, but at least 30 days before the date of termination.
            3. If the fellowship program requirements are not completed the fellow will not receive a certification of program completion.
        ii. Note: Additional remediation mechanisms may be found in the Fellow Remediation Policy and Grievance Procedure section of the handbook
    b. Violation of Policy/Misconduct
        i. Conduct that violates University or other policy may result in immediate dismissal. This guidance is not intended to supersede existing applicable University processes or procedures that apply to instances of misconduct.
            1. The supervisor must meet with the Fellow and provide written documentation of relevant facts, any policies/rules/regulations potentially violated and proposed consequences. The supervisor should allow the Fellow an opportunity to respond verbally or in writing.
            2. Additional steps, per university policy, may be taken depending on violation.
    c. Loss of Funding

i. Funding for APPPFP Fellow appointments is expected to continue for the completion of the program.
    1. Decisions to terminate an appointment due to loss of funding prior to the appointment end date will include a minimum of 60 days' advance written notice with pay.
ii. In the event of a loss of funding requiring program cessation, the program leadership will support each fellow in connecting to another fellowship program to complete training.

3. APPPFP Performance Expectations
    a. The offer letter from the University of Washington describes clinical responsibilities and educational goals and objectives of the training program describe performance expectations for Fellows.
        i. Performance monitoring:
            1. The Program Director or faculty designee and Fellow will meet to review clinical goals and/or performance expectations to clarify expectations, offer recommendations for improving performance, and to identify deficits, if any, during regularly scheduled meetings (see Fellow Evaluation section of the handbook for details). Additional check-ins will be occur to allow the supervisor to monitor progress and support the Fellow in improving performance. Frequency of the meetings (bi-monthly, bi-weekly) are determined based on the level of monitoring and support required;
            2. The supervisor summarizes the meeting(s) in a written communication as part of the Individualized Plan to the fellow that documents goals and expectations, and the plan for achieving goals and expectations (See Fellow Evaluation section of the handbook, for details)
    b. Leave:
        i. In the event a fellow will be out sick or otherwise out of the office they will need to contact the assistant director/program director and the clinic site as soon as is feasible following the established procedure for taking time off (vacation or otherwise) as stated on Canvas.
    c. Graduation requirements:
        i. Graduation is dependent on satisfactory completion of didactics and clinical rotations.
        ii. Attend no less than 85% of didactics (verified by completion of evaluation)

1. There is an opportunity to make up didactics during protected makeup time throughout the year. Make-up didactics are due by the last day of the program.

iii. Attend no less than 85% of clinical rotations, including provided sick and vacation leave (verified by site attendance).
    1. Successful clinical attendance requires progressive skill and knowledge acquisition and the subsequent participation in independent clinic as set-forth in this policy under the Supervision and Accountability section.
iv. Satisfactory completion of the QI project

Fellow Onboarding

1. Onboarding checklist will be sent along with offer letters to track onboarding requirements
2. **APPPFP Credentialing Policy**
    a. **Policy:** Fellows must be fully credentialed prior to commencement of training. Appointment to the APPPFP training program is conditional and contingent upon successful completion of the credentialing process, which includes satisfactory completion of the criminal background check process, verification of satisfactory prior training (if applicable), and eligibility for employment in the United States.
    b. **Procedures:** Fellows must complete and/or submit the credentialing requirements as request by the Office of Medical Staff Appointments (OMSA) and HR.
        i. Disability Accommodation
            1. Fellows who require a disability accommodation can request accommodation from the UW Disability Services Office as early as possible. Fellows are not required to disclose any health conditions.
3. DEA Registration
    a. It is the responsibility of the individual Fellow to obtain and maintain DEA registration. Fee waivers may be available through the University of Washington.
4. **Compliance:** Fellows are responsible for ensuring timely submission of all required documents, unless otherwise indicated, prior to commencement of training.
5. There will be a formal onboarding process in the first month to assist in the fellow's success.

Supervision and Accountability Policy

1. **Graduated Responsibilities and Accountability in Fellow Training:**
   A. During clinical rotations, an identifiable and appropriately-credentialed and privileged provider will be available to support fellows
   B. Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.
   C. **Factors within Rotations:**
      a. Precepted clinics
         i. Time spent with patients where the fellow is receiving a dedicated form of supervision by the preceptor.
         ii. **Supervision Definitions**
            1. To promote clarity for graded responsibility, the following levels of supervision are recognized during clinical rotations:
               a. Direct Supervision:
                  i. In this situation, the supervising provider is present with the fellow and patient.
               b. Indirect Supervision with direct supervision immediately available:
                  i. In this scenario, the supervising provider is immediately available to provide direct supervision in person or via telephonic and/or electronic modalities
               c. Oversight:
                  i. Here, the supervising provider is available to provide review of procedures/encounters with feedback provided after care is delivered. There will always be a supervisor available by telephonic and/or electronic modalities if needed.
      b. Independent clinic/clinical care
         i. An opportunity for fellows to begin to provide care with minimal oversight by preceptors. These periods will gradually increase in frequency during the year. While the fellow is providing independent care during this period the preceptor is available for support and oversight (see definition above)

1. The amount of independent clinic will vary based on fellow progress in the program and type of rotation. Full independent clinic is not guaranteed in every rotation.

c. Caseload supervision
    i. Time spent individually or as a group with the preceptor.
    ii. Activities include but are not limited to:
        1. Reviewing Electronic Medical Record (EMR) inboxes
        2. Reviewing and fielding patient referrals
        3. Case presentations
        4. Notes review

d. Documentation/Chart review
    i. Protected time to prepare for patient visits or complete documentation.

e. Other
    i. Rotation specific factors may occur which are unique to that rotation which may include but is not limited to: shadowing, assistance with procedures, attending grand rounds or other educational experiences and attending caseload review in rotations that use the Collaborative Care model of integrated care.

D. **Ramp up Schedules:** As part of their education program, fellows are given graded progressive responsibility structured to increase the amount of independent clinic over the course of the year and decrease the amount of precepted clinics. The purpose of this ramp-up is to provide a supportively environment to facilitate the successful transition to independent practice. While the specific amount of precepted schedule and schedule density will vary, the expectation is that, by graduation, the fellow will be practicing with a schedule density at least 75% of a non-fellow provider and a panel that is at least 75% independent clinic. This ramp generally occurs in each rotation (continuity and specialty). The program director has the discretion to adjust the amount of supervision in any given rotation according to the individual's clinical experience, judgment, knowledge and technical skill. Each fellow must know the limits of their scope and clinical experience and reach out for additional support as indicated.
    a. Program director will check in with each preceptor and fellow prior to increase in schedule density and independent clinic.

2. **Circumstances and Events in which Supervising Faculty Member (s) MUST be Contacted**

a. The supervising attending needs to be informed whenever the following occurs:
    i. when the patient's condition deteriorates unexpectedly
    ii. when additional information puts the working diagnosis in doubt or questions the treatment plan
    iii. when information is obtained that raises concerns regarding the patient's risk for self-harm or harm to others
    iv. when the patient or family members disagree with the treatment plan
    v. when there are serious disagreements or conflicts within the treatment team or with other services or providers
    vi. when decisions need to be made that have major clinical or legal implications, such as decisions not to hospitalize suicidal or homicidal patients.

3. **Emergency Procedures**
    a. It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The fellow may attempt any of the procedures normally requiring supervision in a case where death or irreversible loss of function in a patient is imminent, and an appropriate supervisory provider is not immediately available, and to wait for the availability of an appropriate supervisory provider would likely result in death or significant harm. The assistance of other qualified individuals should be requested as soon as practically possible. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible.
4. **Preceptor Responsibilities:**
    a. During precepted clinical times, faculty must be fully available to the postgraduate trainees for consultation, teaching, and directed assessment of patients. An Attending who is precepting more than one (1) postgraduate trainee in an out-patient is not to be scheduled for any other direct patient care responsibility during the precepted session.
        i. Expectations during precepted sessions:
            1. During direct precepted sessions, preceptor either shadows fellow or has fellow shadow the preceptor
            2. In indirect precepted sessions, initial expectations include
                a. Introducing self and fellow to patient; review fellow notes, be present for case presentation.
                b. Preceptor may decide to reduce direct patient contact depending on fellow progression.

b. Faculty members functioning as preceptors must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow.
c. Postgraduate trainees are not required to perform clinical or non-clinical work for the Program that is not for the purpose of educational training or to meet the Program's training goals, objectives and competencies.

Fellow Evaluation, Assessment and Development

Purpose

The following policy provides guidance on specific evaluation methods and frequencies related to fellow development towards program completion.

Policy

1. Informal Fellow Evaluation:
    a. A crucial component of professional development occurs in the clinic environment in the form of feedback. **Feedback** is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empowers fellows to provide much of that feedback themselves in a spirit of continuous learning and self-reflection, for example, through weekly reflective journaling. Feedback from faculty members in the context of routine clinical care should be frequent and may not always be formally documented.
    b. Provides opportunity to identify performance concerns and clinical deficiencies. Mentors and faculty are available to support individual development plans as needed.
2. Formal Fellow Evaluation:
    a. Formal written evaluations for fellows are vital to progression and success. Evaluations provide measurements on defined program goals that assist in measuring fellow progression and identifying opportunities for learning and growth. Both self and faculty evaluations will occur in each pillar of the program (clinical, didactic and QI). Some evaluations, such as the Pre-Post Competency Self-Assessment, are taken at program initiation and completion. Others, such as clinical evaluations, are completed in each rotation and reoccur over time. Each phase of the evaluation incorporates a closed loop communication system in which feedback is obtained, collated, and reviewed by the program director and relevant faculty as part of the overall process to evaluate the ongoing progress and intended outcomes. If areas of concern are noted, these will be discussed with the fellow during the evaluation meeting and added to the fellows Individual learning plan (described below) for ongoing monitoring. Evaluations related to fellow progression are as follows:
        i. <u>Evaluations completed by the fellow:</u>
            1. *Pre-Post Competency Self-Assessment*: The purpose of this summative evaluation is to assesses program level learner outcomes for competency of program's core elements and milestones. Content is tailored towards the eight core

program standards. Competency domains include: clinical skills, treatment modalities, quality improvement skills, and attitudes and opinions aimed at measuring wellness, resilience, burnout and inclinations towards life-long learning.

a. Frequency: Program start and program completion

2. Individual development plan:
    a. This document is designed to guide individual goals for program, professional development and career planning. It provides an opportunity to explore long-term goals related to the profession and to evaluate the progress on current personal goals, as well as assess wellbeing, resilience and burnout (through a burnout survey). Additional sections include reflection and goal setting around strengths and areas for growth, and performance expectations and remediation (if applicable. Please see the section: *Fellow Appointment and Performance Management Guidance for details of performance management*).
        i. Frequency: Document is created at program start and updated during collaboration meetings with the program-director or delegated faculty leadership. Individual develop meetings shall occur no less than every twice during the program.
            1. During meetings, the self-report and faculty evaluations (see description below) are used formatively to make adjustments, as indicated, to ensure proper progression towards program completion.
        ii. Form will be part of fellow portfolio (see section below for description of portfolio) and the portfolio will be referenced as part of iterative updates to the Individual Development Plan.

ii. Evaluations completed by the program faculty:
    1. *Clinical Evaluation--Faculty Rated.* Evaluation related to learner outcomes for rotation specific competencies by faculty. These competencies are nested within larger

program goals. The purpose is to guide specific learning on individual rotations, where more granular assessment of competency is warranted. Faculty with complete a clinical evaluation of the fellow during each clinical rotation. Form is completed by preceptors for each rotation. Frequency will be no less than once per rotation. Additional evaluations may occur based on clinical rotation length. For example, 2-4-month rotation may have an evaluation at mid-point and completion, while a year-long rotation may be have 3 evaluations.

2. *Didactic Evaluation--Faculty Rated:* This form provides formal faculty evaluation of knowledge for practice, interpersonal skills and practice-based learning as they relate to program goals and objectives. Completed didactic faculty
    a. Frequency: Three times a year (1st trimester, 2nd trimester and program completion).
3. *QI Evaluation--Faculty Rated:* This evaluation assesses knowledge of practice-based learning and improvement and systems-based practice as they relate to program goals and objectives. This form is completed by QI faculty.
    a. Frequency: Three times a year (1st trimester, 2nd trimester and program completion).
4. *Professionalism Evaluation--Faculty Rated.* This form evaluates awareness and implementation of principles of Diversity, Equity and Inclusion (DEI) and personal and professional development as they relate to program goals and objectives. This form is completed by the Program Director in consultation with relevant program faculty and preceptors.
    a. Frequency: Three times a year (1st trimester, 2nd trimester and program completion).

3. The Portfolio
    a. Each fellow will have their own portfolio that will be built over the course of the year. Contents include all of the above evaluations, along with demographic data--including diagnoses treated--of patients at each clinical site. Additional information will include journal entries, iterations of the Individualized Development Plan, didactic assignments, QI project, awards, recognitions, or publications.

b. The portfolio may be used by the postgraduate trainee as well as by Program Faculty and/or the Program Director in preparing for evaluation and coaching sessions, which would then be used to update the IDP.
c. Review of the portfolio depends on the content. For example, the faculty will review the journal entries weekly, whereas the program director will review the relevant contents of the portfolio with the trainee at each bi-monthly meeting
d. Please see Staffing/Operations/File Policy for more details.

Faculty Evaluation and Development Policy

Purpose

Establish UW APPPFP expectations of faculty engagement in the education and supervision of fellows

Policy

1. Definition: Clinical program faculty may include preceptors, mentors, didactic lecturers, faculty with expertise leadership, and any other clinical training staff
2. The APPPFP leadership (program director, School of Medicine affiliate lead) will evaluate each faculty member's performance at least annually. If a faculty member does not interact with fellows, feedback is not required.
    a. The program director will share performance information with faculty, acknowledging members may not excel in all areas of this evaluation and can be recognized for their unique strengths and contributions to educational program.
3. The APPPFP leadership will collect evaluation data from various sources, including trainee evaluations. Results of the faculty educational evaluations will be incorporated into program-wide faculty development plans.
4. Faculty Expectations/Requirements:
    a. Faculty members must have a strong commitment and desire to provide residents with optimal education and work opportunities. Faculty members involved in precepting fellows must (1) directly observe, evaluate, and frequently provide feedback on fellow performance during each rotation or similar educational assignment *and (2)* establish feedback as an expected and frequent educational routine. Evaluation must be documented at the completion of the assignment (Please see the Fellow Evaluation, Assessment and Development section of the Handbook for details on evaluations).
    b. Core faculty members: Core faculty members must (1) have a significant role in the education and supervision of fellows*;* (2) devote a significant time to fellow education and/or administration*;* (3) as a component of their activities, teach, evaluate, and provide formative feedback to fellows; and participate in completion of the annual program review.
        i. The program will have a minimum of 3 core faculty members.
    c. Faculty will submit a CV and a list of professional development yearly
    d. The faculty will notify the program director/assistance director if, at any time, a fellow is not present for a scheduled rotation.

e. In the event the faculty member will be on leave or is sick, they will contact the fellowship leadership in advance, if possible. Steps will be made to provide coverage for the faculty, if feasible.

5. Faculty development
    a. A faculty development event will be held annually. Topics include Adult Learning Theories, giving/receiving clinical feedback, and methods for auditing clinical documentation.
    b. Faculty are expected to participate in at least one faculty retreat or equivalent faculty development activity yearly. Professional development records, including continuing education, licenses, certifications, will be updated on an annual basis.
    c. **Faculty program Evaluation:** Each faculty development seminar includes evaluations of the program by the faculty and suggestions for future topics, which is collated and reviewed as part of the annual self-study
6. Evaluation of Faculty Candidates:
    a. Evaluation of candidates prior to approval to teach entails assessment of the following and documented via the faculty onboarding checklist:
        i. Alignment with program mission and goals
        ii. Appropriate clinical site (able to accommodate fellow needs and space, specialty focus is in-line with mission of program to increase confidence, competence and depth of knowledge.)
        iii. Faculty has the time, interest and ability to educate/precept fellows
    b. The program director has the authority to:
        i. Approve program faculty members for participation in the program education at all sites
        ii. Remove program faculty members from participation in the program education at all sites
        iii. Designate faculty with broad knowledge of and involvement in the program as core faculty
        iv. Review core faculty's level of involvement in the program annually
        v. Remove core faculty designation if their level of involvement decreases,
7. Faculty Evaluation Guidelines
    a. Faculty clinical teaching abilities and supervision
        i. Can be demonstrated by:
            1. Average overall score of teaching ratings by fellows over time (see Program evaluation policy section for details on this form).

2. Teaching ratings for specific composite-scales/sub-domains/individual items (such as attitudes or learning climate) by fellows over time.
3. Comparison with department/division/clinical service faculty averages or expected performance
4. Other Teaching: Outside program expectations, for example:
    a. Clinical knowledge item average from a clinical peer evaluation form
    b. Classroom teaching item/form
    c. Teaching of other learners (e.g., medical students or nurses) (with evaluations)

b. Engagement with the educational program
    i. Can be demonstrated by:
        1. Yes/no or quantity:
            a. Participation in review and interviews of applicants
            b. Serving on program committees
            c. Participation as a faculty mentor for fellows (e.g., mentoring fellows for research or QI projects)
            d. Co-authoring papers/abstracts with a fellow
            e. Attendance and participation at education program retreats, faculty meetings, and/or conferences
            f. Regular participation in organization clinical discussions, rounds, journal clubs, and conferences
            g. Teaching and/or organizing resident didactics
            h. Other measures important to individual program/department.

c. Clinical performance and professionalism
    i. Program director will check with service chief yearly to assess faculty clinical skills

8. Prompt identification of Faculty Performance concerns
    a. In addition to yearly evaluation APPPFP leadership may be called upon to address urgent performance concerns
        i. There are several means through which this may occur:
            1. Fellow expresses concern about quality or supervision to APPPFP leadership. If concern is related to leadership, concern should be voiced to clinic medical director or chief of psychiatry or anonymously through designated feedback system.

2. Faculty or leadership expresses concern.

ii. When a concern is identified, the Program director will meet with both parties to determine specific area of concern.
iii. In the event a concern is substantiated, an improvement plan is created with measurable goals.
iv. In the event the concern violates a clinic, UW or UWMC or other University policy the program director will defer to appropriate channels

Fellow Remediation Policy and Grievance Procedure

Purpose

The University of Washington Advanced Practice Psychiatric Provider Fellowship Program (APPPFP) is committed to providing high quality post-doctoral training and education. Towards this end, Fellows are expected to pursue acquisition of all required competencies that allow them to meet evaluation standards and practice safe and effective care. In addition, Fellows must adhere to standards of professional conduct expected by UW Medicine. This policy outlines the remediation actions related to the fellowship. Other disciplinary concerns about clinical work or function in the capacity as an employee are to be addressed through the appropriate UW channels, including human resources--this includes but is not limited to egregious conduct, removal from site due to lapse of required licensure and violation of UW policy.

Policy

1. General Principles of Fellow Progress & Remediation
    a. Satisfactory program completion is neither assured nor guaranteed, but contingent on satisfactory demonstration of progressive advancement in scholarship and continued professional growth as evidenced by satisfactory engagement in all aspects of the program and satisfactory progress in evaluations.
    b. Unsatisfactory fellow evaluation(s) can result in required remediation
    c. Due process refers to an individual's right to be adequately notified of charges or proceedings against that individual and the opportunity to respond to these actions and potentially remediate their behaviors.
        i. The program director should give the fellow specific examples of concerning performance, expected behaviors, required remediation steps and a timeline for completion.
    d. There may be separate University of Washington HR policies that impact the ability to participate in the program.
2. Remediation
    a. Fellows, the program director and faculty are encouraged to make efforts to resolve disagreements or disputes by discussing their concerns with one another. When appropriate, reasonable efforts will be made to take action(s) that best address the deficiencies and needs of the individual fellow and/or the training program.
        i. **Fellow Evaluations**

1. The APPPFP conducts formal performance reviews on a standardized timeline (see fellow Evaluation, Assessment and Development section of the policy handbooks). Additional reviews can occur as a result of concern from a preceptor or staff at a clinic, patient complaint or notice of action by HR. If a Fellow exhibits sub-standard performance, the program director will decide whether it can be addressed through the normal evaluation processes or whether formal intervention and remediation is required.
2. Grievance: Fellows may submit written responses to their evaluations within thirty (30) calendar days. Written responses will be retained in the Fellow's program file

ii. **Types of Remediation:**
    1. **Internal Program Remediation:**
        a. **Performance Concern:**
            i. When a fellow is identified as practicing sub-standard performance (whether through self-identification, preceptor identification, clinical site identification, or via individual meetings with the program director) a remediation plan will be made in coordination with the fellow, depending on the nature of the concern. The remediation plan will consist of the following, at a minimum:
                1. measurable goals designed to address the sub-standard performance, which may include more direct supervision or additional training or educational assignments.
                2. Specific time frames to accomplish each goal. Progress on goal(s) will be evaluated by the program director on a regular basis via individual follow up meeting with the fellow.
                    a. At a minimum, remediation action will be included in the Individual Learning Plan (IDP) and reviewed during IDP conference (see Fellow

Evaluation and Development Policy for details)

b. **Focus of Concern**
    i. A focus of concern is a document that details significant issue(s) of performance or behavior that require(s) remediation. A meritorious written complaint by a patient, sentinel event, tort claim, or professional liability lawsuit should, at minimum, trigger a focus of concern. A focus of concern letter should include recommended actions that the fellow should follow to resolve the issue(s) described. Failure to adequately address the focus of concern in the prescribed time may lead to dismissal from program.
    ii. Focus of concern documentation will not usually be considered part of the Fellow's program file or reported as a negative evaluation to outside entities—except for accrediting bodies—if the recommended actions or remediation plan has been completed within the prescribed time frame. A focus of concern letter can be made part of the permanent file at the discretion of the program director. A fellow may request that focus of concern documentation be removed from their program file only after successful completion of the remediation. The program director will confirm with the fellow that the letter has been removed or will explain why it will not be removed.

2. **Remediation Actions Requiring Notification/Coordination with Human Resources:**
    a. **Training Site Actions**
        i. In situations where a training site, such as a hospital or clinic, withdraws permission for a fellow to train at that site, the fellow may be reassigned to another site or to administrative activities, depending on the circumstances that led to the withdrawal and in conjunction with

consultation with human resources. A training site's withdrawal of permission to train may also result in a legal requirement that the University notify an appropriate licensing body of such action.

b. **Suspension**
    i. A program may suspend a fellow from some or all education activities, include didactic participation and QI involvement. Reasons for suspension may include, but are not limited to:
        1. Unprofessional behavior:
            a. Violation of patient privacy rules, including but not limited to HIPAA regulations;
            b. Unexcused absences outside of relevant faculty policy;
            c. Conduct that is illegal, unethical, or in conflict with the University of Washington, School of Medicine, School of Nursing, or training regulations site policies or compliance programs;
            d. Conduct that is inconsistent with the UW Medicine Policy on Professional
            e. Conduct (Policy on Professional Conduct | UW Medicine)
            f. Performing duties while in an impaired physical or mental state
                i. Fellows may be referred to Nursing Care Quality Assurance Commission, who may help enroll the fell in Washington Health Professional Services supporting health professionals with substance use disorder.

2. Failure to comply with conditions of probation or other corrective action.

ii. The length of the suspension should be appropriate to address the reason(s) for the suspension. A suspension may be indefinite in length if it requires action by the fellow

c. **Dismissal for Cause**

i. A fellow may be dismissed for cause from the program if the fellow fails to meet standards of performance expected at their level of training, fails to fulfill the conditions of appointment to the program, or fails to meet the requirements of the hospital or clinic to which they are assigned. The fellow's overall academic performance and professional behavior shall be considered in decisions to dismiss for cause. If a fellow is dismissed for cause, the program director must notify the individual in writing of the reason(s) for the dismissal.

3. **Appeal:**

a. Fellows may appeal a decision to end an appointment before the appointment end date under the following circumstances:

i. the appointment was ended due to poor performance;

ii. the appointment was ended due to misconduct violating University or other policy; or the appointment was ended due to loss of funding with fewer than 60 days' notice.

Well-Being Resources

Scope

All fellows and enrolled in the APPPFP at the University of Washington as well as APPPFP staff.

Background

The well-being of fellows and faculty is a crucial aspect of successful learning and safe practice. The APPPFP has approached wellness in two ways. In the first approach, dedicated time is reserved monthly for didactics, training and practices to promote well-being. The second approach is built into the framework of the program itself, with a structure designed aimed to promote wellness and reduce burnout. Efficacy in this area is monitored through fellow journal articles, faculty interactions and burn-out surveys.

This policy defines the infrastructure, services, resources, and leave for training that supports well-being. In addition, it acknowledges the importance of nurturing and developing meaningful engagement through protecting time with patients, minimizing non-provider related obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships.

Policy

1. Policy Review Timeframe:
    a. Review of this policy, along with assessment of its impact as measured by evaluations, will be reviewed yearly by the Fellowship Advisory Committee (FAC) as part of the program self-study and improvement process.
2. Diversity, Equity, and Inclusion
    a. The APPPFP provides a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of fellows, faculty,, and staff. No staff, fellow or faculty member should experience discrimination or harassment. Any bias incident--offensive remarks/actions--are subject to the UW Medicine Policy on Professional Conduct and UW Executive Order 31. For support and resources, see:
        i. Bias Reporting Tool
        ii. UW Diversity Blueprint
        iii. UW Medicine Healthcare Equity Toolkit

iv. UW SOM Center for Health Equity, Diversity, and InclusionUW Network of Underrepresented Residents and Fellows (NURF)
v. UW SOM Committee on Minority Faculty Advancement (CMFA)
vi. UW Diversity (UW campus-wide resources on diversity)

3. Services:
    a. Well-Being hour
        i. An hour every month is blocked in the fellow calendar. This time is meant to be a moment of rejuvenation. It be used to practice health-promoting techniques, attend lectures/groups on Well-being, and/or complete training in well-being topics, such as Mindfulness-Based Stress Reduction.
    b. Employee Assistance Program:
        i. Offered to UW employees, this service offers a variety of well-being and assistance programs, including counseling.
        ii. Please see HR and/or employee health for details on accessing UW EAP
4. Leave Request
    a. Please see UW HR and program leave policy for details
5. Concern Reporting System
    a. The program director must provide a learning and working environment in which fellows have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation. Fellow and faculty members are encouraged to alert the program director or other designated personnel when they are concerned that another fellow or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence. Any bias incidents or violation of nondiscrimination and nonretaliation must be reported through the mechanisms described in the UW Medicine Policy on Professional Conduct, UW Bias Reporting Tool, University Complaints Investigation and Resolution Office (UCIRO), or UW Executive Order 31. In case of provider impairment, every individual, including program directors, faculty, and fellows, is responsible to (1) monitor signs of impairment; and (2) follow the Handbook policy for reporting.
6. Well-Being Resources/Tools
    a. The following resources are to be shared, discussed and easily posted on the program service site:
        i. The Whole U (holistic wellness)

ii. UW EAP (counseling, legal advice, work-life solutions, incident response services)
iii. UW Childcare Resources
iv. Washington Physicians Health Program
v. Washington Health Professional Services (WHPS
vi. Well-Being Index (free online tool to assess medical professional's well-being)
vii. Action Collaborative on Clinician Well-Being and Resilience (National Academy of Medicine)
viii. Now Matters Now (skills and support for coping with suicidal thoughts)
ix. American Foundation for Suicide Prevention
x. Violence

Professional Conduct

1. Fellows are expected to adhere to the UW medicine professional and conduct guidelines. The following link includes information on UW medicine policy and professional conduct expectations: Policy on Professional Conduct | UW Medicine
2. Telehealth Meetings: See guidelines on telehealth/telemeeting: Policy on Professional Conduct | UW Medicine. You will need to log on to access this guideline by logging in using your NETID: AMC*username* and NETID password.
3. Additional expectations specific to APP fellows:
    a. Basic Professionalism
        i. Fellows are expected and encouraged to attend to their own self-care and well-being and assist peers in doing the same. Assistance is available (program staff can guide you and UW medicine has its own EAP system).
        ii. Fellows are expected to maintain a professional demeanor and attire in workplace settings. Examples of professional attire include: dress shoes with a low or flat heel; pants, slacks, skirts or dresses; button-down shirts, professional tops, blouses and sweaters.
        iii. Fellows are expected to treat all patients, staff and families with respect using a trauma-informed approach to care.
        iv. Fellows are encouraged to learn about their won implicit biases and gain supervision and training in this area
    b. Communication and Time Management:
        i. Fellows are expected to communicate effectively and professionally in all APPPFP related interactions
        ii. Fellows are expected to be truthful and honest in all interactions and duties.
        iii. Fellows are expected to arrive on time, rested and ready to work and learn and to alert preceptors and staff if there is a need to leave early.
        iv. Fellows are required to complete all notes including H&Ps, progress, and discharge notes in a timely manner. This is to ensure good communication and enhance patient safety.
    c. Safety:
        i. Fellows are required to follow current infection control and prevention requirements.
        ii. Fellows are reminded to be aware of their surroundings and to seek assistance from staff and security if needed.

iii. Fellows are required to complete annual safety training

d. Teamwork:
    i. Fellows are expected to demonstrate a high level of teamwork amongst themselves and interdisciplinary staff.

Volunteering and Moonlighting

Fellows are in a faculty title and must follow UW faculty policy regarding volunteering, moonlighting and outside work.

Program Evaluation Policy and Procedures

Purpose

Establish APPPFP process for conducting program evaluations through completion of self-study assessments. This includes the appointment of The Fellowship Advisory Committee (FAC) and the completion of evaluations by faculty and trainees.

Process

1. The FAC:
    a. The FAC role is to serve the program in providing input and guidance regarding individual components and direction of the program by reviewing programmatic curricula, evaluations, etc. and based on that review provide guidance on how to adjust and evolve the program. The Committee meets at least semi-annually and maintain an agenda and meeting minutes.
        i. Function of meetings:
            1. Program direction
            2. Curricula
            3. Ongoing evaluation of all sites used for postgraduate trainees' clinical practice experiences. The evaluation of each site should include:
                a. The site itself (e.g., the resources provided, staffing)
                b. The experience for the postgraduate trainees at the site
            4. reviews and assesses the operational and financial impact of the program on the overall sponsoring organization and assesses for any improvements or efficiencies in business operations
            5. Reviews current policies and procedures, submitting adjustments as indicated by consensus
        ii. Minutes will be saved in program folder
    b. **FAC Membership:** Members of the FAC must be appointed by the program director and must include at least three faculty members. Other members of the committee should include the program director and assistant program director.
2. The program will perform an annual self-study assessment. These results will be presented during FAC meetings. Topics of the assessment will include:
    a. Programmatic assessment and corresponding outcome measures:
        i. Postgraduate trainee completion rates

ii. Postgraduate trainee withdrawals or dismissals
iii. Postgraduate trainee evaluations of core program elements via the Competency Self-Assessment (CSA)

b. Preceptor evaluations of postgraduate trainee performance
c. Fellows formal evaluation of the Program
    i. Information from fellow evaluation of program elements (clinical sites, didactics, faculty) will be used to guide the yearly program evaluation and improvement.
        1. **Program level evaluation:** This evaluation is tied to the program level goals and is designed for the fellow to provide timely feedback on program level goals. Information from this survey will be used for ongoing program evaluation and improvement.
            a. Frequency: Will be completed at least annually
        2. **Didactic evaluations:**
            a. Fellows will evaluate each didactic session on relevance and quality
            b. Frequency: At conclusion of each didactic session
        3. **Clinical Site and Preceptor Evaluations:**
            a. Fellows will evaluate the quality of mentorship/preceptorship and the clinical site environment
                i. Frequency: For rotations longer than 4 weeks, evaluations will be at least midpoint and clinical rotation completion
            b. **QI evaluations:**
                i. Fellows will complete a review of quality improvement aspects of the fellowship program, including implementation, didactic delivery and Qi project structure.
                    1. Frequency: No less than twice throughout program length.
        4. In addition to formal evaluation, fellows are encouraged to use escalation steps in the event there is urgent concern about a specific facet of the program, faculty or progress.
            a. Escalation system:
                i. Fellow identifies point of concern
                ii. Fellow discusses concern with most immediate supervisor or faculty, if applicable

iii. In the event most immediate supervisor is not available or is unable to address the concern, the fellow should contact the next highest supervisor (varies depending on context, but a list will be made for each facet of the program, i.e., clinic sites, didactics, QI).
iv. If context specific supervisor is not available or unable to address the concern, the fellow should contact the program director directly.
v. If the program director is unavailable or unable to address the concern, the fellow should contact the PI and/or, department chief office.

b. Escalation system for each site will be posted on program LMS. In person discussion should be attempted, if feasible. Virtual and telephone (including leadership phone-lines) will also be posted.
c. If, at any time, the fellow is concerned about the program at large and would like to lodge a complaint, they can do so by contacting the Consortium of Advanced Practice Providers here.

5. In addition to evaluations, A fellow may be asked to be part of the Fellowship Advisory Committee (FAC) as part of program improvement.

d. Post-program completion employment/practice data
e. Alumni satisfaction at a minimum at program completion and 12-18 months later
f. Review of program's goals and progress toward meeting them, including and development of new goals based upon outcomes.
g. Annual assessment should also consider prior self-study results and CfAPP letters of notification and comments from previous accreditations (if applicable).
h. Documentation of program's self-assessment results will be compiled in a **Meeting Summary** and corresponding **Action Plan** that includes:
    i. Identified strengths, gaps and opportunities for improvement
    ii. Structural or content program adjustments to address gaps and areas of improvement
    iii. Evidence of improvement through implementation of the action plan as a result of the evaluation results

i. The Annual Program Evaluation, including the Meeting Summary and Action Plan, must be distributed to and discussed with the members of the teaching faculty and the fellows and uploaded to secure APPPFP server.

Appendix

1. Offer Letter example
2. Example Program Calendar
3. Example Continuity Clinic Schedule
4. Example Specialty Clinic Schedule
5. Example of Past Didactic Topics
6. Evaluation Examples
    a. Evaluations completed by the fellow
        i. Self-performance evaluations completed by the fellow
            1. APPPFP Individual Learning Plan
            2. Pre-Post Competency Assessment Questions
            3. Pre-Post QIKAT
            4. Satisfaction, Burnout, and Lifelong Learning Survey
        ii. Program evaluations completed by the fellow
            1. Didactic Session and Teaching Evaluation
            2. Clinical Site Evaluation
            3. Clinical Teaching Evaluation
            4. QI Call Evaluation
            5. Program Goals Evaluation
    b. Evaluations completed by program faculty
        i. Evaluations of Fellow progress
            1. Clinical Evaluation
            2. Didactic Evaluation
            3. QI Evaluation
            4. Professionalism Evaluation
        ii. Faculty Evaluation of Program

Appendix

1. Offer Letter example
2. Example Program Calendar
3. Example Continuity Clinic Schedule
4. Example Specialty Clinic Schedule
5. Example of Past Didactic Topics

DATE, 2023

PERSONAL & CONFIDENTIAL

DRAFT OFFER LETTER

NAME, degree(s)
via email: *email*

Dear Dr. NAME,

I am pleased to offer you an appointment as Teaching Associate in the Department of Psychiatry & Behavioral Sciences in the University of Washington School of Medicine at 100% FTE.

The terms of this offer are outlined below and are contingent on the approval of the relevant University bodies described below, work authorization, as well as the items addressed under the heading "Conditions of Employment," including a criminal background check and sexual misconduct and other required disclosures.

This offer is contingent upon final approval of the voting faculty of the Department of Psychiatry & Behavioral Sciences, the Dean of the School of Medicine, and the Provost.

MISSION AND DIVERSITY STATEMENTS

The University of Washington School of Medicine is dedicated to improving the general health and well-being of the public. In pursuit of its goals, the School is committed to excellence in biomedical education, research and healthcare. The School is also dedicated to ethical conduct in all activities.

The School of Medicine values diversity and inclusion and is committed to building and sustaining an academic community in which teachers, researchers and learners achieve the knowledge, skills and attitudes that value and embrace inclusiveness, equity and awareness to unleash creativity and innovation.

Please visit the UW Medicine website for additional information on our mission and values.

APPOINTMENT RANK AND TERMS

Your full-time (100% FTE) faculty appointment will be as a Teaching Associate, effective September 1, 2023 through June 30, 2024. Renewal of this appointment is possible on an annual, academic year (July 1–June 30) basis, contingent upon satisfactory performance, departmental needs, funding availability, and in accordance with University policy and procedure governing reappointment, but reappointment of less than a full academic year is possible. During the academic year, you will be reviewed for and notified of renewal for the upcoming academic year (July 1, 2024–June 30, 2025) by March 31, 2024 to continue your one-year appointment through August 31, 2024.

The Department also expects you to be a proactive participant in your growth, and seek out opportunities, advice, and mentorship. You are encouraged to speak with your chair or mentor about additional resources, mentorship, or support the Department may provide.

As with all of our faculty, you will receive an evaluation of your prior year's performance from your Service Chief, Dr. Ryan Kimmel. These ratings will also be shared with me as your Chair.

Jürgen Unützer, MD, MPH, MA, Professor and Chair
Department of Psychiatry & Behavioral Sciences | School of Medicine | **UW Medicine**
1959 NE Pacific Street · Box 356560 | Seattle, WA 98195-6560 | 206.543.3752 | unutzer@uw.edu | uwpsychiatry.org/

The UW Policy Directory, in particular Chapter 24 of the Faculty Code, governs the faculty appointment and promotion process and describes the rights and responsibilities of the University's faculty. I recommend that you acquaint yourself with the *Faculty Code* should you accept this position.

COMPENSATION

Your full-time annual base salary will be $XXXXXX ($XX per month). Funding for your base salary will be paid through the University of Washington.

This is a twelve-month appointment with salary paid over twelve months for eleven months of service. You will be eligible to participate in UW faculty salary increases as they occur and within University guidelines.

RESPONSIBILITIES

We will expect you to be an active participant in the academic, teaching, and clinical care missions of the Department. As a Teaching Associate, you will be based at UW Medical Center (UWMC), where you will report directly to Dr. Brendan McDonald, to Dr. Ryan Kimmel as your Service Chief and to me as your Chair. The primary responsibilities of this position are as follows:

- Provide clinical care at within the UW Medical Center (UWMC) hospitals and clinics.
- OTHER THINGS
- You may have other responsibilities as assigned by the Chair or Service Chief by mutual agreement.

You may work with your Service Chief and Chair to modify your duties over time as your career develops.

PROFESSIONALISM AT UW MEDICINE

UW Medicine values professionalism among its members in carrying out UW Medicine's mission of improving the health of the public through teaching, research, and patient care. Professionalism includes demonstrating excellence, integrity, respect, compassion, accountability, and a commitment to altruism in all your work interactions and responsibilities. In addition to the expectations set forth in the UW Policy Directory inclusive of the Faculty Code, you are expected to conduct yourself in a professional manner, including creating an inclusive environment where every person is valued and honored. An assessment of professionalism will be a factor considered in performance reviews, salary adjustments, and promotion to successive ranks. A copy of the UW Medicine Policy on Professional Conduct is attached and can be found on the UW Medicine website.

You are expected to comply with the UW Medicine Compliance Code of Conduct, which is intended to ensure consistent standards of conduct throughout UW Medicine and outlines basic principles of the UW Medicine Compliance Program in a range of areas. Please familiarize yourself with UW Medicine's compliance policies.

PRACTICE PLAN MEMBERSHIP

As a faculty clinician, you will have membership and employment with University of Washington Physicians (UWP), our clinical practice organization. We will ask you to sign a practice agreement with UWP. You will be an Associate without incentive.

If you accept this offer, UWP will send you a packet of information summarizing UWP benefits and detailing your responsibilities regarding HIPAA, billing, and documentation compliance.

CLINICAL ACTIVITIES AND TRAINING REQUIREMENTS

In order for you to begin work and see patients, you must have obtained the following: 1) your license to practice medicine in the State of Washington, 2) a medical staff appointment at UWMC, 3) a faculty appointment, and 4) membership in the UWP physicians practice plan.

If you accept this offer, you will be provided with credentialing forms that must be completed and returned to the offices indicated. It is important to complete these forms and any steps required in a timely manner, and failure to do so may result in a delay of your appointment start date or withdrawal of this offer of appointment at the University's discretion.

You will also be required to complete certain training requirements. These include (1) privacy (HIPAA) training, which must be completed within 30 days of the first day of your practice plan membership, and (2) documentation, billing, and coding compliance training, which must be completed on or before your first day of UWP practice plan membership. Documentation, billing, and coding compliance training is conducted in two parts, and both parts are available for you to complete before your first day of UWP membership. If you do not elect to complete this training before you arrive, you will need to complete it on the first day of your practice plan membership. You will not be permitted to engage in any clinical activity until you have completed the documentation, billing and coding compliance training. The first day of practice plan membership is generally the first day of your faculty appointment. If the effective date of your faculty appointment is a holiday or weekend, your first day of practice plan membership would be considered the first working day thereafter, unless you have completed training prior to the weekend or holiday.

You must complete related training on or before the start of your appointment. It will be necessary for us to modify your effective start date if these training requirements are not met.

As part of the UW Medicine medical staff, and having clinical privileges at UWMC, FHCC, and/or HMC, you will be required to complete UW Medicine onboarding training before you may engage in patient care activities. The training will include: medical staff orientation, electronic medical record and computerized provider order entry; while infection control must be completed within 30 days of your arrival. You will receive registration information for the training in advance of your start date.

CONDITIONS OF EMPLOYMENT

In addition, this offer is contingent upon acceptable outcomes regarding the following:

- **Sexual misconduct declaration**: State law requires that the University of Washington obtain a Disclosure of Sexual Misconduct declaration signed by the candidate, as well as conduct a reference check concerning any sexual misconduct at current or past Washington state postsecondary educational institutions. The declaration requires you to disclose any substantiated findings of sexual misconduct, to authorize current and past employers to disclose to the UW any sexual misconduct currently being investigated and/or committed by you, and to release current and past employers from any liability. If the results of the disclosure or reference check are unacceptable, you will not be offered a position at the UW.
- **Title IX training**: All UW employees must complete the UW's Title IX course about preventing and responding to sex- and gender-based violence and harassment. You will receive more information and a link to the 60- to 90-minute online course from the Office of the Title IX Coordinator.
- **Background check**: Your employment in this position is conditioned, among other approvals, upon obtaining a satisfactory criminal conviction background check result. A-Check Global is the consumer reporting agency vendor that conducts background checks for the University. You will receive an email message from A-Check that explains how to log in to their secure site and provide the information that is needed to complete the background check process. This will include, among other things, your birth date, social security number, and any other names by which you have been known.
- **Duty to Inform**: In offering you this appointment, the UW has relied on representations made by you and others regarding your qualifications and professional conduct. Before accepting this offer and at all times thereafter, you have an obligation to inform me immediately of any information of which you are aware

that might impact my appointment decision, including but not limited to findings and investigations related to research misconduct, sexual misconduct, discrimination, retaliation, or unprofessional conduct. Any information indicating a change in qualifications or departure from professional conduct may provide grounds to modify or rescind this offer prior to your official appointment date.

- COVID-19: Under University of Washington (UW) policy, as a condition of employment and/or other University-compensated appointment, individuals must be fully vaccinated against COVID-19 and provide proof thereof, or receive a UW-approved medical or religious exemption. This offer is contingent upon the UW verifying your vaccination status or approving an exemption request prior to the start date of your appointment. If you wish to be considered for a medical or religious exemption, you are expected to request an exemption by notifying your UW hiring unit as soon as possible, but no later than two weeks before your start date. Failure to provide proof of vaccination or to obtain a UW-approved exemption prior to the appointment start date may result in a withdrawal of this offer.

OTHER SUPPORT

UW Medical Center Psychiatry & Behavioral Sciences OTHER will provide you with office space, a computer, and equipment equivalent to that provided to other faculty members at your rank, FTE, and clinical duties.

POTENTIAL CONFLICTS OF INTEREST AND OUTSIDE ACTIVITIES

As a new faculty member at the University, it will be important for you to familiarize yourself with the policies regarding conflict of interest and compensation for outside activities. These provisions have been adopted to assure that faculty members remain in compliance with Washington state ethics laws.

Generally, UW Medicine expects faculty members to avoid or, in certain cases, disclose and address perceived or real conflicts of interest between their responsibilities as faculty of the School of Medicine and their activities with outside commercial or non-profit entities. At the same time, UW Medicine encourages appropriate relationships between SOM faculty and industry in so far as those relationships further the mission of UW Medicine to improve the health of the public through discovery, education, and patient care. If you wish to engage in outside activities for compensation, you must obtain prospective approval for these activities by completing the Request for Approval of Outside Professional Work for Compensation and the SOM Supplement to Request for Approval forms. Please refer to Policy on Potential Financial Conflicts of Interest for guidance on conflicts of interest, approval forms, and further information on related topics.

As a faculty clinician, you may not engage in the outside practice of medicine.

All sites of practice, including any at which you engage in volunteer activities, must be approved by the School and practice plan sites of practice approval process, per the enclosed Committee on Medical Practice Initiatives and Sites of Practice Policy on Approval for Clinical Practice (SOP Committee Policy).

The medical malpractice liability coverage provided for you through the University and practice plan will only apply to these approved sites of practice where you are practicing in your capacity as a University of Washington faculty clinician.

BENEFITS

As a University of Washington employee employed at least 50% FTE in a Public Employees Benefit Board (PEBB) eligible position, you will be eligible for an insurance package offered through PEBB which currently includes medical, dental, life, and long-term disability insurance options. You may also be eligible for a

retirement plan and your specific retirement plan options are based on many individual factors and will be sent to you during the employee onboarding process.

A comprehensive description of UW benefits, including enrollment deadlines, is available online, with full information provided on the UW Benefits website. If your employment begins on the first calendar or business day of the month, your benefits eligibility will start on the same day. If your employment begins later in the month, you will be eligible for benefits on the first day of the following month.

As a member of UWP, you may also be eligible for benefits through UWP. If you accept this offer, you will receive a packet of information summarizing the benefits. If you have any questions regarding these programs, contact the UWP Benefits team (uwpben@uw.edu).

Housing: Please see the UW HR website for information about home loans and other relevant assistance.

Workday: The UW uses the Workday human resources and payroll management system. When you receive your UW NetID—your network identification that allows you access UW information and online services—you should sign up for Duo, a two-factor authentication system that provides a second layer of security when signing into Workday. In Workday you will be asked to complete various onboarding tasks, including completing direct deposit and withholding information, submitting I-9 forms and other specified tasks. Workday will also allow you to sign up for benefits online and review your pay. Please review the training aids (including a video on basic navigation) provided by the UW Integrated Service Center to better understand how to navigate in Workday (note that you will need to sign in using your UW NetID to access these resources). If you have questions regarding Workday, please reach out to Kimberly Quigley.

We are delighted to have you join us at the University of Washington! Please contact Academic HR Manager Kimberly Quigley (kquigley@uw.edu) or me (unutzer@uw.edu, 206.543.3752) with any questions or for more information about this appointment.

Sincerely,

Jürgen Unützer, MD, MPH, MA
Professor and Chair of Psychiatry & Behavioral Sciences
Paul G. Ramsey Endowed Chair for Brain Health Solutions
Director of the Garvey Institute for Brain Health Solutions

Sign below to indicate you have reviewed and accept the above described terms of this appointment:

_____

NAME, Degree Date

cc: Ryan Kimmel
Brendan McDonald
Anna Ratzliff
Michelle Lynch

Enclosures:

- Committee on Medical Practice Initiatives and Sites of Practice Policy on Approval for Clinical Practice (SOP Committee Policy)
- Practice Agreement
- Background check forms

UW Medicine Policy on Professional Conduct

Policy

UW Medicine is committed to high standards of professionalism in patient care, research, and education among our faculty, staff, residents, fellows, and students. Professionalism is integral to our mission of improving health, and includes demonstrating excellence, respect, integrity, compassion, altruism, and accountability in all endeavors and creating an environment supportive of diversity in ideas, perspectives, and experiences. All individuals in our UW Medicine community are responsible for creating an inclusive environment where every person is valued and honored.

All members of the UW Medicine community are expected to conduct themselves in a professional and ethical manner with colleagues, patients, and the public. Leaders in our community are expected to model, promote, and advocate for a strong and visible culture of professionalism.

Values and Principles

Excellence represents dedication to continuous improvement of quality of care, research inquiry, and teaching effectiveness. Excellence also includes promoting and cultivating an institutional culture of inclusion, equity, and diversity in all its forms. Pursuit of excellence should be accompanied by respect, integrity, compassion, altruism, and accountability.

Diversity is integral to excellence, and refers to the variety of personal experiences, values, and worldviews that arise from differences of culture and circumstance. Such differences include race, ethnicity, gender, age, religion, language, abilities/disabilities, sexual orientation, gender identity and expression, socioeconomic status, and geographic region, and more. The aims of diversity are to broaden and deepen our experience in all areas of learning and work that support our mission of improving the health of the public. For the aims of diversity to be fully realized, the institutional culture must be one of inclusion, where all individuals are valued and honored, and resources and opportunity are distributed equitably and without undue bias.

Respect includes actions that recognize the inherent dignity and value of all persons and that seek to understand the perspectives of others. Working to achieve effective communication and acknowledging power differentials (formal or informal) are key to fostering mutual respect and trust.

Integrity refers to honesty in all interactions and upholding high moral and ethical standards in all endeavors.

Compassion is recognition of suffering and taking action to help. Compassion must also extend to self, recognizing that self-care is a key element of personal wellness.

Altruism reflects a commitment to advocate for the needs and interests of others.

Accountability refers to accepting responsibility for one's behavior and striving to uphold professional standards, as well as acknowledging that—as members of a larger community—we are answerable to each other for our conduct and outcomes. Accountability includes working to recognize and address one's own biases (conscious and unconscious), and mitigating their impact on behavior as providers of care, teachers, scientists and learners. Accountability includes assisting UW Medicine in recognizing and addressing institutional racism and other forms of bias and taking action that demonstrates intolerance of discrimination, in contrast to condoning or perpetuating discrimination through inaction.

Professionalism in clinical practice settings includes adherence to the UW Medicine service culture guidelines and includes, but is not limited to safeguarding the privacy and confidentiality of patient information, communicating effectively in an interprofessional environment, observing established standards for patient safety and timely completion of medical records, participating in quality improvement initiatives, exercising cultural humility, reporting errors, and following rules for billing and compliance.

Professionalism in the conduct of research includes, but is not limited to fostering a collaborative environment, employing collegial, non-threatening and fair treatment of research team members, which include faculty, staff, fellows and students. Research should be undertaken and conducted in a manner that is inclusive of diverse opinions, ideas and populations.

Professionalism in education includes, but is not limited to respect for diverse experiences and perspectives, modeling community and civil discourse, a commitment to the highest standards of scholarship, innovation in teaching methods, and leadership through modeling of life-long learning.

Professionalism in administration includes, but is not limited to respect for the culture and values of the academy, commitment to creation of collegial partnerships with co-workers one is responsible for and responsible to, support of the work of collaborative teams, recognition of the needs of patients and our professional community, and dedication to the mission of the institution.

Ethics in decision-making and relationships means establishing safeguards to ensure that decisions are free of improper bias or influence, guaranteeing that personal and professional relationships do not present a conflict that threatens (or is perceived to threaten) the integrity of the decision, and removing oneself from decisions where fairness may be compromised, especially decisions made in the context of supervisory relationships.

Ethical business practices mean the wise and fair use of resources and practices that comply with laws, regulations, and policies governing conflicts of interest, sponsored research, and the delivery of and reimbursement for healthcare services.

Ethical research practices mean practicing intellectual integrity, ensuring the welfare of human and animal research subjects, exercising diligent and unbiased acquisition, evaluation, and reporting of scientific information, and adhering to university regulations for the conduct of research.

Unprofessional behavior means behavior that violates laws or rules regarding discrimination and harassment, violates rules of professional ethics (including professionalism in clinical, educational, research or business practices), or is disrespectful, demeaning, retaliatory, or disruptive. Bullying is unprofessional behavior that misuses power to control or harm others.

Rules of professional ethics means the adoption of ethical standards that have been established by external professional societies and associations (e.g., American Association of Medical Colleges, National Institutes of Health) or by UW Medicine entities for various professions (e.g., physicians, nurses).

Discrimination and harassment are defined in University of Washington (UW) Executive Order 31. As of the effective date of this policy, this includes discrimination or harassment on the basis of race, color, creed, religion, national origin, citizenship, sex, age, marital status, sexual orientation, gender identity or expression, disability, or military status.

Disrespectful, retaliatory or disruptive behavior includes, but is not limited to behavior that in the view of reasonable people has a negative impact on the integrity of the healthcare or research team, the care of patients, the education of students or trainees, or the conduct of research, such as:

- Physical assault or other uninvited or inappropriate physical contact;
- Shouts, profane or offensive language;
- Degrading or demeaning comments;
- Discriminatory or harassing behavior or language (as defined above);
- Retaliation in response to a person raising concerns about a behavior that may violate laws or policies (such as discrimination), or present a threat to safety or security;
- Threats or similar intimidating behavior, as reasonably perceived by the recipient;

- Exploiting, neglecting or overworking those in subordinate positions;
- Unreasonable refusal to cooperate with others in carrying out assigned responsibilities;
- Failure to respond to inquiries within a reasonable time frame; and
- Obstruction of established operational goals, beyond what would be considered respectful dissent.

Procedures and Values in Action

Engagement of our community to advance professional values. All members of our community should seek opportunities to acknowledge, promote, and celebrate professionalism in our environment. Leaders in our community are especially accountable for creating a culture of professionalism in their own units by exhibiting professionalism, recognizing individuals and teams that exhibit best practices and demonstrate core principles, finding opportunities to convey the importance of professionalism in our shared work, and making time for collaborative, inclusive dialogue around challenging issues. To ensure that the professionalism standards outlined in this policy are upheld, those aware of the behavior are responsible for raising their concerns within a reasonable time frame so that the behavior can be addressed and remediated as appropriate.

Incorporating the principles of professionalism into applicable documents. UW Medicine units should incorporate these principles as appropriate into their policies, procedures, and practices. Professionalism expectations should be included in offer letters, merit evaluations and promotion criteria. Expectations and any available measures of professional behavior should also be specifically highlighted in annual performance reviews, as well as in documents that relate to situations where the evaluator becomes aware of acts of unprofessional behavior.

Supervisor responsibility. Supervisors, including health care and research team leaders and teachers, are expected to exhibit professionalism, set clear expectations, and manage performance of their subordinates in accordance with these standards through regular communication and timely performance reviews. Supervisors must confront unprofessional behavior effectively and engage in conversations that may be difficult or uncomfortable. In these challenging situations, supervisors should draw on existing resources including their own supervisors, administrative leadership, and human resources offices. Supervisors are expected to respect diversity of opinions and will not retaliate against subordinates who offer their respectful, dissenting views. Finally, supervisors are expected to address professionalism concerns and deficiencies through routine performance evaluations, counseling, discipline, or other action as appropriate in accordance with policies and procedures within the UW, UW Medicine, affiliates, and partner entities.

Mentor responsibility. Mentor relationships can occur formally and informally, including but not limited to principal investigator to postdoctoral fellow, program advisor to graduate student, faculty to student or trainee, or faculty to faculty. Mentors bear responsibility for sharing knowledge and expertise with mentees, as well as creating shared expectations around professionalism. Mentors will look for ways to counterbalance the inherent power differential found in a mentoring relationship and will promote the welfare of mentees in ways that increase mentee development, engagement and empowerment.

For individuals covered by collective bargaining agreements, UW Medicine managers and supervisors are expected to apply this policy in a manner consistent with the principles of just cause, as well as any other applicable requirements of the labor agreements.

For hospitals and clinics that are part of UW Medicine, this policy is intended to define "professionalism" at UW Medicine. Under this policy, "desirable behavior" means demonstrating professionalism as described above and "disruptive behavior" means engaging in conduct that is unprofessional as described above. The hospitals and clinics will have policies and practices implementing these principles and may further define expectations regarding appropriate conduct.

Mechanisms for addressing unprofessional behavior. UW Medicine does not condone or tolerate unprofessional behavior, and individuals who engage in such behavior may be subject to disciplinary action up to and including termination. Supervisors are expected to address unprofessional behavior as described above. Members of our community at all levels may also raise concerns and/or ask for support through a number of avenues depending on the particular circumstances. The many avenues of redress outlined below are meant to provide viable options that can be pursued alone or in conjunction with other options. Members of our community seeking to raise concerns may seek counsel from within the member's administrative structure, supervisory chain of command or one of the offices responsible for addressing conduct in violation of UW policies.

Avenues to raise concerns include but are not limited to the following: (1) informal and collegial one-on-one resolution; (2) bringing the issue to a supervisor or the next highest individual of authority, if the concerns involve the supervisor; (3) following applicable grievance procedures under collective bargaining agreements; (4) contacting Human Resources or Academic Human Resources; (5) contacting the University Complaint Investigation and Resolution Office (UCIRO); (6) contacting the University Title IX office; and/or (7) contacting the University of Washington Ombud. The UW Safe Campus office is also available as a resource in situations involving non-urgent safety concerns.

For certain types of concerns, a particular avenue may be most appropriate, or even required by UW policy. For example, Administrative Policy Statement 46.3 (Resolution of Complaints Against University Employees), contains information and processes for addressing complaints about employees, including violations of the University's non-discrimination policy and other concerns. Detailed administrative or contractual processes also exist to address specific types of complaints including classified and professional staff complaints, whistleblower complaints, and patient complaints. There are existing processes for addressing student conduct issues outlined in the MD Program Handbook, and processes for addressing faculty members' rights to resolve or adjudicate issues under the Faculty Code. Individuals should contact their supervisor for help in determining whether a particular behavior is covered by an established procedure.

This policy was implemented May 5, 2009, revised in November 2016 and October 2017 by the Continuous Professionalism Improvement (CPI) Committee, with engagement and feedback from UW School of Medicine elected Faculty Councils and Vice Deans, the Medical School Executive Committee (MSEC) and the UW Medicine Strategic Leadership Council. The CPI committee reviews the policy annually, with formal renewal when changes are needed. Please send feedback regarding this policy to the Chair of the CPI Committee, Giana Hystad Davidson, M.D., M.P.H., at ghd@uw.edu.

Approved by,
Paul G. Ramsey, M.D.
CEO, UW Medicine
Executive Vice President for Medical Affairs and
Dean of the School of Medicine,
University of Washington
10/12/17

2. Example of Program Calendar

	MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY		
Date	**Fellow 1**	**Fellow 2**	**Fellow 3**	**Fellow 1**	**Fellow 2**	**Fellow 3**	**Fellow 1**	**Fellow 2**	**Fellow 3**	**Fellow 1**	**Fellow 2**	**Fellow 3**	**Fellow 1**	**Fellow 2**	**Fellow 3**
9/4-9/8	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive
9/11-9/15	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive
9/18-9/22	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive
9/25-9/29	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive	Intensive
10/2-10/6	QI/ DIDACTIC	QI/ DIDACTIC	QI/ DIDACTIC	BELLTOWN BHIP IN PERSON	BELLTOWN BHIP IN PERSON	BELLTOWN BHIP IN PERSON	SHORELINE BHIP IN PESON	SHORELINE BHIP IN PESON	SHORELINE BHIP IN PESON	OPC	OPC	OPC	Inpatint Geripsych	Fred Hutch	Inpatient CL
10/9-10/13															
10/16-10/20															
10/23-10/27															
10/30-11/3															
11/6-11/10															
11/13-11/17															
11/20-11/24															
11/27-12/1				BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	SHORELINE BHIP IN PESON	SHORELINE BHIP TELEHEALTH	SHORELINE BHIP TELEHEALTH						
12/4-12/8				BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH	SHORELINE BHIP TELEHEALTH	SHORELINE BHIP IN PESON	SHORELINE BHIP TELEHEALTH						
12/11-12/15				BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON	SHORELINE BHIP TELEHEALTH	SHORELINE BHIP TELEHEALTH	SHORELINE BHIP IN PESON						
12/18-12/22				BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	SHORELINE BHIP IN PESON	SHORELINE BHIP TELEHEALTH	SHORELINE BHIP TELEHEALTH						
12/25-12/29				PES rotation	BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH	PES rotation	SHORELINE BHIP IN PESON	SHORELINE BHIP TELEHEALTH	PES recovery/Afternoon OPC			PES rotation		
1/1-1/5					BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON		SHORELINE BHIP TELEHEALTH	SHORELINE BHIP IN PESON						
1/8-1/12					BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH		SHORELINE BHIP IN PESON	SHORELINE BHIP TELEHEALTH						
1/15-1/19					BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON		SHORELINE BHIP TELEHEALTH	SHORELINE BHIP IN PESON						
1/22-1/26	1st trimester Individual Learning Plan meeting and update	1st trimester Individual Learning Plan meeting and update	1st trimester Individual Learning Plan meeting and update	BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	SHORELINE BHIP IN PESON			OPC	OPC	OPC	INPATIENT CL	INPATIENT GERIPSYCH	FRED HUTCH
1/29-2/2	QI/ DIDACTIC	QI/ DIDACTIC	QI/ DIDACTIC	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH		SHORELINE BHIP IN PESON			OPC				
2/5-2/9				BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON						
2/12-2/16				BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	SHORELINE BHIP IN PESON								
2/19-2/23				BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH		SHORELINE BHIP IN PESON							
2/26-3/1				BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON						
3/4-3/8				BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	SHORELINE BHIP IN PESON								
3/11-3/15				BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH		SHORELINE BHIP IN PESON							
3/18-3/22				BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON						
3/25-3/29				BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	SHORELINE BHIP IN PESON								
4/1-4/5				BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON	BELLTOWN BHIP TELEHEALTH		SHORELINE BHIP IN PESON							
4/8-4/12				BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP TELEHEALTH	BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON						
4/15-4/19				BELLTOWN BHIP IN PERSON	PES rotation	BELLTOWN BHIP TELEHEALTH	SHORELINE BHIP IN PESON	PES rotation			PES recovery/Afternoon OPC			PES	
4/22-4/26				BELLTOWN BHIP TELEHEALTH		BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON						
4/29-5/3				BELLTOWN BHIP IN PERSON		BELLTOWN BHIP TELEHEALTH	SHORELINE BHIP IN PESON								

5/6-5/10				BELLTOWN BHIP TELEHEALTH		BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON						
5/13-5/17	2nd trimester Individual Learning Plan meeting and update	2nd trimester Individual Learning Plan meeting and update	2nd trimester Individual Learning Plan meeting and update		BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON							
5/20-5/24				SHORELINE BHIP IN PESON			SHORELINE BHIP IN PESON								
5/27-5/31						BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON						
6/3-6/7					BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON							
6/10-6/14				SHORELINE BHIP IN PESON			SHORELINE BHIP IN PESON					OPC			INPATIENT GERIPSYCH
6/17-6/21						BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON						
6/24-6/28					BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON			OPC		FRED HUTCH	INPATIENT CL	
7/1-7/5				SHORELINE BHIP IN PESON			SHORELINE BHIP IN PESON								
7/8-7/12	QI/ DIDACTIC	QI/ DIDACTIC	QI/ DIDACTIC			BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON						
7/15-7/19					BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON							
7/22-7/26				SHORELINE BHIP IN PESON			SHORELINE BHIP IN PESON								
7/29-8/2						BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON						
8/5-8/9					BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON				PES recovery/Afternoon OPC			PES
8/12-8/16				SHORELINE BHIP IN PESON		PES	SHORELINE BHIP IN PESON		PES						
8/19-8/23					BELLTOWN BHIP IN PERSON			SHORELINE BHIP IN PESON							
8/26-8/30				SHORELINE BHIP IN PESON			SHORELINE BHIP IN PESON								

3. Example of Continuity Clinic Schedule

BHIP Schedule. Fellowship month 2-3 (October and November).

No independent clinic, first 2 sessions are shadowing preceptor, other sessions are direct supervisor observation, around 20-25% schedule density* Fellows will be on preceptor schedule and their schedule will be closed during this time. This is in person time for all fellows.

Preceptor: Being shadowed or shadowing fellows (flex in this part)

	Preceptor	FELLOW 1	FELLOW 2	FELLOW 3
0800-0830		Pre Charting	Pre Charting	Pre Charting
0830-900	Fellow 1 direct supervision; preceptor shadowing (first 1-2 weeks)	**INTAKE**	Documentation/ chart review	Documentation/ chart review
0900-0930			Documentation/ chart review	Documentation/ chart review
0930-1000	Fellow 2 direct supervision; preceptor shadowing (first 1-2 weeks)	Documentation/ chart review	**INTAKE**	Documentation/ chart review
1000-1030		Documentation/ chart review		Documentation/ chart review
1030-1100	Fellow 3 direct supervision; preceptor shadowing (first 1-2 weeks)	Documentation/ chart review	Documentation/ chart review	**INTAKE**
1100-1130		Documentation/ chart review	Documentation/ chart review	
1130-1200	Debrief	Debrief/ Documentation/ chart review	Debrief/ Documentation/ chart review	Debrief/ Documentation/ chart review
1200-1300	Lunch	Lunch	Lunch	Lunch
1300-1330	**Rotating shadowing or Fellow Intake (blocked for first two weeks)**	Documentation/ chart review (second intake clinical week 3/6)	Documentation/ chart review (second intake clinical week 4/7)	Documentation/ chart review (second intake clinical week 5/8)
1330-1400				
1400-1430	Case review (preceptor led)	Case review	Case review	Case review
1430-1500				
1500-1530				
1530-1600	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief
1600-1630	Caseload Supervision/Referral Review	Caseload Supervision/ Referral Review	Caseload Supervision/ Referral Review	Caseload Supervision/ Referral Review
1630-1700				

BHIP Schedule. fellowship Month 4-6 (December, January, February).

Around 30-50% schedule density, 12.5% to 25% independent clinic Precepted sessions are direct supervisor observation or indirect observation with direct observation available. Independent clinics are indirect supervision or oversight.

This rotation will transition to hybrid care, with rotating distance telework vs in-person which rotates weekly starting with fellow 1 in-person. This continues throughout the rest of the year

Preceptor responsibilities: Introduce to pt and orient fellow; chart review, receive case presentation for pts (one minute preceptor and SNAPPS)

	Preceptor	FELLOW 1	FELLOW 2	FELLOW 3
0800-0830		Pre Charting	Pre Charting	Pre Charting
0830-900	Indirect supervision with direct supervision available for all fellows.	**INTAKE**	Documentation/ chart review	Documentation/ chart review
0900-0930	Fellow 1 supervision (beginning/end of session and/or as needed)		**INTAKE**	Documentation/ chart review
0930-1000	Fellow 2 supervision (beginning/end of session and/or as needed)	Documentation/ chart review		**INTAKE**
1000-1030	Fellow 3 supervision (beginning/end of session and/or as needed)	Documentation/ chart review	Documentation/ chart review	
1030-1100	Indirect supervision with direct supervision available for all fellows.	**INTAKE**	Documentation/ chart review	Documentation/ chart review
1100-1130	Fellow 1 supervision (beginning/end of session and/or as needed)		**INTAKE**	***Independent clinic Follow-up/ Therapy;*** *documentation*
1130-1200	Fellow 2 supervision (beginning/end of session and/or as needed)	Documentation/ chart review		Documentation/ chart review
1200-1300	Lunch	Lunch	Lunch	Lunch
1300-1330	Indirect supervision with direct supervision available for all fellows.	***Independent clinic Follow-up/ Therapy****; or documentation*	***Independent clinic Follow-up/ Therapy;*** *or documentation*	**INTAKE**
1330-1400	Fellow 3 supervision (beginning/end of session and/or as needed)	Documentation/ chart review	Documentation/ chart review	
1400-1430	Case review-leader rotates weekly	Case review	Case review	Case review
1430-1500				
1500-1530				
1530-1600	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief
1600-1630	Caseload Supervision/Referral Review	Caseload Supervision/ Referral Review	Caseload Supervision/ Referral Review	Caseload Supervision/ Referral Review
1630-1700				

BHIP Schedule. Fellowship month 7-9 (March, April, May).

Around 50-75% schedule density, 33% - 66% independent clinic) Precepted sessions are direct supervisor observation or indirect observation with direct observation available. Independent clinics are indirect supervision or oversight

	Preceptor	FELLOW 1	FELLOW 2	FELLOW 3
0800-0830		Pre Charting	Pre Charting	Pre Charting
0830-900	Indirect supervision with direct supervision available for all fellows	**INTAKE**	Documentation/ chart review	Documentation/ chart review
0900-0930	Fellow 1 supervision (beginning/end of session and/or as needed)		**INTAKE (independent clinic beginning May)**	Documentation/ chart review
0930-1000	Fellow 2 supervision through mid-April (beginning/end of session and/or as needed)	Documentation/ chart review		**INTAKE (independent clinic beginning May)**
1000-1030	Fellow 3 supervision through April supervision (beginning/end of session and/or as needed)	Documentation/ chart review	Documentation/ chart review	
1030-1100	Indirect supervision with direct supervision available for all fellows	**INTAKE (independent clinic beginning May)**	Documentation/ chart review	Documentation/ chart review
1100-1130	Fellow 1 supervision to April (beginning/end of session and/or as needed)		**INTAKE**	**INTAKE/Follow Ups (independent clinic)**
1130-1200	Fellow 2 supervision (beginning/end of session and/or as needed)	Documentation/ chart review		
1200-1300	Lunch	Lunch	Lunch	Lunch
1300-1330	Indirect supervision with direct supervision available for all fellows	***INTAKE/ Follow ups (independent clinic)***	***INTAKE/ Follow ups (independent clinic)***	**INTAKE**
1330-1400	Fellow 3 supervision (beginning/end of session and/or as needed)			
1400-1430	Case review-leader rotates weekly	Case review	Case review	Case review
1430-1500				
1500-1530				
1530-1600	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief
1600-1630	Caseload Supervision/Referral Review	Caseload Supervision/ Referral Review	Caseload Supervision/ Referral Review	Caseload Supervision/ Referral Review
1630-1700				

BHIP Schedule. Fellowship month 10-12 (June, July, August)

Around 75-100% schedule density, 75%-100% independent clinic Precepted sessions are direct supervisor observation or indirect observation with direct observation available. Independent clinics are indirect supervision or oversight .* will need to wind down follow-ups during August. One time consults still okay.

	Preceptor	FELLOW 1	FELLOW 2	FELLOW 3
0800-0830	Pre Charting	Pre Charting	Pre Charting	Pre Charting
0830-900	Indirect supervision with direct supervision available for all fellows	**INTAKE (Independent starting mid July 14, 2024)**	Documentation/ follow up	**INTAKE (independent clinic)**
0900-0930	Fellow 1 supervision (if needed)		**INTAKE (independent clinic)**	
0930-1000	Indirect supervision with direct supervision available for all fellows	**INTAKE (independent clinic)**		**INTAKE (Independent starting mid July 14, 2024)**
1000-1030	Fellow 3 supervision (if needed)		**INTAKE/ Follow ups (independent clinic)**	
1030-1100	Indirect supervision with direct supervision available for all fellows	**INTAKE (independent clinic)**		Documentation/follow up
1100-1130	Indirect supervision with direct supervision available for all fellows		**INTAKE (Independent starting mid July 14, 2024)**	**INTAKE (independent clinic)**
1130-1200	Fellow 2 direct supervision (if needed)	Documentation/Follow up		
1200-1300	Lunch	Lunch	Lunch	Lunch
1300-1330	Indirect supervision with direct supervision available for all fellows	***INTAKE/Follow UPs* (independent clinic)**	***INTAKE (independent clinic)***	**INTAKE/ Follow Ups (independent clinic)**
1330-1400	Indirect supervision with direct supervision available for all fellows			
1400-1430	Case review-leader rotates weekly	Case review	Case review	Case review
1430-1500				
1500-1530				
1530-1600	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief	Wrap-Up/ Overflow/ Debrief
1600-1630	Caseload Supervision/Referral Review	Caseload Supervision/ Referral Review	Caseload Supervision/ Referral Review	Caseload Supervision/ Referral Review
1630-1700				

4. Example Specialty Clinic Schedule

Fred Hutch Specialty Rotation **Week 1-4. 20-40% schedule density; up to 25% independent clinic**		
	Preceptor	Fellow
0800-0830		Documentation/ chart review
0830-0900		Documentation/ chart review
0900-0930	direct supervision/ preceptor shadowing first week	
0930-1000		**INTAKE**
1000-1030	See own Patient	Documentation/ chart review
1030-1100		Documentation/ chart review
1100-1130	See own Patient with indirect supervision of fellow if needed	Shadow preceptor Initially; Follow up/Intake (independent) beginning week 3-4
1130 - 1200		Documentation/ chart review
1200-1300	Lunch	Lunch
1300-1330	direct supervision/ preceptor shadowing first week	INTAKE
1330-1400	Fellow 2 direct supervision or preceptor shadowing (first 1-2 weeks)	INTAKE
1400-1430	See own Patient	Documentation/ chart review
1430-1500	Fellow 3 direct supervision or preceptor shadowing (first 1-2 weeks)	Documentation/ chart review
1500-1530	See own Patient	Shadow Preceptor
1530-1600	Caseload Supervision	Caseload Supervision
1600 - 1630	Caseload Supervision	Caseload Supervision
1630-1700	Documentation	Documentation

Fred Hutch Specialty Rotation. **Week 5-8. 60% schedule density, 25-50% independent clinic.**		
	Preceptor	Fellow
0800-0830		Documentation/ chart review
0830-0900		Documentation/ chart review
0900-0930	Direct/indirect supervision	**INTAKE/Follow up**
0930-1000		
1000-1030	See own Patient	Documentation/ chart review
1030-1100		Documentation/ chart review
1100-1130	See own Patient with indirect supervision of fellow if needed	Follow up/Intake (independent)
1130 - 1200		
1200-1300	Lunch	Lunch
1300-1330	Direct/indirect supervision	**INTAKE/Follow up**
1330-1400		
1400-1430	See own Patient	Documentation/ chart review
1430-1500		
1500-1530	See own Patient with indirect supervision of fellow if needed	Follow up/Intake (independent)
1530-1600		
1600-1630	Caseload Supervision	Caseload Supervision
1630-1700		

Fred Hutch Specialty Rotation. **Week 9-12. 80% schedule density, around 60-80% independent clinic**		
	Preceptor	Fellow
0800-0830		Documentation/ chart review
0830-0900		Documentation/ chart review
0900-0930	Direct/indirect supervision	**INTAKE/Follow up**
0930-1000		
1000-1030	See own Patient with indirect supervision of fellow if needed	Follow up/Intake (independent)
1030-1100		
1100-1130	See own Patient with indirect supervision of fellow if needed	Follow up/Intake (independent)
1130 - 1200		
1200-1300	Lunch	Lunch
1300-1330	Direct/indirect supervision	**INTAKE/Follow up**
1330-1400		
1400-1430	See own Patient	Documentation/ chart review
1430-1500		
1500-1530	See own Patient with indirect supervision of fellow if needed	Follow up/Intake (independent)
1530-1600		
1600-1630	Caseload Supervision with Fellow	Caseload Supervision with Fred Huch Preceptor
1630-1700		

Fred Hutch Specialty Rotation. **Week 9-12. 80-100% schedule density, 80-100% independent clinic.**		
	Preceptor	Fellow
0800-0830		Documentation/ chart review
0830-0900		Documentation/ chart review
0900-0930	Direct/indirect supervision (need varies)	**INTAKE/Follow up**
0930-1000		
1000-1030	See own Patient with indirect supervision of fellow if needed	Follow up/Intake (independent)
1030-1100		
1100-1130	See own Patient with indirect supervision of fellow if needed	Follow up/Intake (independent)
1130 - 1200		
1200-1300	Lunch	Lunch
1300-1330	See own Patient with indirect supervision of fellow if needed	Follow up/Intake (independent)
1330-1400		
1400-1430	See own Patient with indirect supervision of fellow if needed	Follow up/Intake (independent)
1430-1500		
1500-1530	See own Patient with indirect supervision of fellow if needed	Follow up/Intake (independent)
1530-1600		
1600-1630	Caseload Supervision with Fellow	Caseload Supervision with Fred Huch Preceptor
1630-1700		

5. Example of Past Didactic Topics

Session Title (Folder Label)
Population Health
Journal Club
Collaborative Care (CoCM)
Medical contributors to mental health
Treatment planning
Medical effects of psychotropics
Psychoendocine
Psychopharm in context of renal or hepatic impairment
Psychopharm adherence
Discontinuation
Sleep hygiene
Depression
Anxiety
Bipolar
PTSD
Assessment and Diagnosis Basics
Controlled Substances
ADHD pharm
Behavioral mgmt of ADHD
Translating Evidence to Practice
DEIA in the mental health care space
SUD Management
Harm reduction
MAT
Intoxication/withdrawal
Teaching; Mentoring; Leadership
Aging and mental health
Capacity and consent; Cognitive assessments
Neurocog disorders; revisit neuropsych referral
QI
Pain; Somatic symptoms
Personality disorders
Team communication; integration challenges; Team interpersonal/cultural factors

Psychosis and long-active injectables
Boundaries
Reproductive psychiatry
Sleep disorders
Alcohol; Diet and Lifestyle
Smoking; Marijuana
Pharmacogenomics; Herbals
Phototherapy; Neuromodulation; Ketamine
Efficient practice
Reflective Practice; Transition to Practice
Wellbeing and Resilience
EDI Training: Identity, Privilege, and Intersectionality
Assessment, Diagnosis and the Differential
Working with Eating Disorders
Note-Writing and Open Notes
Applying the Integrated Care Approach (core and Advanced)
EDI Training: Interrupting Bias and Microaggressions
EKGs and Cardiac Psychiatry
Behavioral Health Measures
Foundations for Ethical Practices: Ethics & Mandated Reporting
EDI Training: History of Race and Racism in Science and Medicine
ITA, grave disability, and de-escalation
Psychiatric emergencies and acute care planning
Substance use and intoxication
EDI Training: Gender and Sexual Diversity
Behavioral Activation Therapy Training
Labs
Problem Solving Therapy training
Telehealth
Billing

6. Evaluation Examples
    a. Evaluations completed by the fellow
        i. Self-performance evaluations completed by the fellow
            1. APPPFP Individual Learning Plan
            2. Pre-Post Competency Assessment Questions
            3. Pre-Post QIKAT
            4. Satisfaction, Burnout, and Lifelong Learning Survey

University of Washington Advanced Practice Psychiatric Provider Fellowship Program
Individual Learning Plan.

A draft of this plan should be developed by the fellow in collaboration with their advisor as part of each advisory meeting. As you consider goals, please think about making them "SMART" (specific, measurable, achievable, relevant, and time-based).

Fellow Name: _____

Advisor name: _____

Period covered: Program start (Beginning in September); Review One (January); Review two (April); Other

Response: _____

Current Long-Term Goals: Insert and review previous quarter-length Goals, If applicable (N/A for first meetings). *(In entering goals, please share areas of interest or impactful experiences. Note this is a place to list possibilities.)*

Goal 1: _____

Goal 1 progress/change: _____

Goal 2: _____

Goal 2 Progress/change: _____

Well-Being: Consider personal and Professional Well-being (Do you have any concerns? How do you plan to promote your well-being? Do you need any support or resources?)

Response: _____

Strengths and areas for Growth *(This can be helpful as you work to create a learning plan for the next quarter)*

Patient Care *(In considering this area, reflect on topics such as conducting comprehensive screening and assessments; developing and narrowing a differential; providing patient-centered, including patient collaboration; care-management—including updating and managing care plans for those who are and are not responding to care; and efficiency in clinical encounters).*

- **Select one:** Strength, On track, Growth Opportunity: _____

- **Explain your selection** *(250 word max)*: _____

Interpersonal and Communication Skills *(In considering this area, reflect on topics such as frequency and efficacy around engaging patients and family in care; skill and frequency in tailoring care to the individual's literacy, culture and preference; Effective communication, including awareness and effort to mitigate the negative effects of implicit bias and countertransference; skill in navigating conflict in patient-care settings; and timely written communication).*

- **Select one:** Strength, On track, Growth Opportunity: _____
  - **Explain your selection** *(250 word max)*: _____

Professionalism *(In considering this area, reflect on topics such as consistency in adherence to ethical principles such as autonomy, confidentiality and consent; accountability in care provided and integration of principles of integrity, accountability and respect in clinical practice).*

- **Select one:** Strength, On track, Growth Opportunity:_____
  - **Explain your selection** *(250 word max)*: _____

Interdisciplinary Collaboration *(In considering this area, reflect on topics such as the level of skill and comfort with working in interdisciplinary teams and demonstrating a climate of mutual response and inclusion; effective an appropriate delegation to facilitate care delivery; understanding of the interdisciplinary roles and responsibilities).*

- **Select one:** Strength, On track, Growth Opportunity: _____
  - **Explain your selection** *(250 word max)*: _____

Systems-based Practice *(In considering this area, reflect on topics such as the skill in obtaining, synthesizing and applying relevant clinical population and research data to improve patient and program outcomes; level of understanding and adherence to optimal care systems for effective coordination and maximization of outcomes with attention to healthcare costs; and the level of engagement in shared responsibility and degree of active leadership related to executing QI projects).*

- **Select one:** Strength, On track, Growth Opportunity: _____
  - **Explain your selection** *(250 word max)*: _____

Knowledge for Practice *(In considering this area, reflect on topics such as the level of awareness related to emerging trends affecting population health and health care; the ability to identify the impact of systemic and social determinants of health in active engagement in mitigation; and the use of evidence-based principles in clinical decision-making).*

- **Select one:** Strength, On track, Growth Opportunity:_____
  - **Explain your selection** *(250 word max)*: _____

Practice-based Learning and Improvement *(In considering this area, reflect on topics such as the comfort and skill in using technology and clinical resources to optimize learning and care delivery; and degree of systemic analysis of practice using QI methods to identify areas of improvement).*

- **Select one:** Strength, On track, Growth Opportunity: _____
  - **Explain your selection** *(250 word max)*: _____

Diversity, Equity and Inclusion *(In considering this area, reflect on topics such as skill and comfort with incorporating DEI principles into professional activities to promote an inclusive workplace environment; and understanding of, and ability/comfort in employing, anti-bias strategies in clinical and academic settings).*

- **Select one:** Strength, On track, Growth Opportunity: _____
  - **Explain your selection** *(250 word max)*: _____

Personal and Professional Development *(In considering this area, reflect on topics such as the skill and comfort with self-reflection related to personal limitations and implicit bias as a means to promote resilience and personal growth; active use of a growth mindset, including the practice of humility, tolerance of ambiguity in the healthcare arena, and the ability to embrace change; and the use of leadership skills to enhance team functioning).*

- **Select one:** Strength, On track, Growth Opportunity: _____
  - **Explain your selection** *(250 word max)*: _____

New short-term learning goals *(Which areas of growth listed above could be an area of focus? Do you have goals related to career exploration? Do you have goals related to research, scholarship or QI? Please include strategy/plan, potential resources and how you will accomplish your goals.)*

New Quarter-length goal 1: _____

New Quarter-length goal 2: _____

Performance expectation/remediation *(To be completed with advisor. Put N/A if not applicable)*:

General comments from Fellow: _____

Advisor Comments: _____

Advanced Practice Psychiatric Provider Fellowship Program

Pre- and Post- Program Assessment Questions

1. How competent do you feel with the diagnosis and management or providing treatment recommendations of the following:	Not at all	Not very	A little	Some	Very
a. Depression	1	2	3	4	5
b. Anxiety Disorders	1	2	3	4	5
c. Bipolar Disorders	1	2	3	4	5
d. PTSD	1	2	3	4	5
e. Alcohol Use Disorders	1	2	3	4	5
f. Substance Use Disorders	1	2	3	4	5
g. Psychotic Disorders	1	2	3	4	5
h. ADHD	1	2	3	4	5
i. Eating disorders	1	2	3	4	5
j. Somatic symptom disorder	1	2	3	4	5
k. Personality disorders	1	2	3	4	5
l. Catatonia	1	2	3	4	5
m. Delirium	1	2	3	4	5
n. Neurocognitive disorders (including dementia)	1	2	3	4	5
o. Comorbid Mental Health and Neuropsychiatric Conditions (including TBI, post-COVID)	1	2	3	4	5
p. Comorbid Mental Health and General Medical Conditions	1	2	3	4	5
q. Perinatal mental health	1	2	3	4	5
r. Safety Concerns/Suicidality	1	2	3	4	5
s. Chronic Pain	1	2	3	4	5
t. Sleep disorders	1	2	3	4	5
u. Medical care for people with serious mental illness (SMI)	1	2	3	4	5

2. How competent do you feel with the following:	Not at all	Not very	A little	Some	Very
a. Use of Telepsychiatry	1	2	3	4	5
b. Addressing Public Health Impact	1	2	3	4	5
c. Balancing the mental health needs of individuals and populations	1	2	3	4	5
d. Using a registry to monitor a population of patients	1	2	3	4	5
e. Using symptom measures to guide treatment	1	2	3	4	5

2. How competent do you feel with the following:	Not at all	Not very	A little	Some	Very
f. Patient Engagement	1	2	3	4	5
g. Using Quality Improvement Strategies	1	2	3	4	5
h. Working as part of an Inter-Professional Team	1	2	3	4	5
i. Leading an Inter-Professional Team	1	2	3	4	5
j. Using point-of-care resources	1	2	3	4	5
k. Documentation, billing and coding	1	2	3	4	5
l. Describing the level of evidence for interventions	1	2	3	4	5
m. Disseminating evidence-based findings to clinical providers	1	2	3	4	5
n. Identifying structural determinants of mental health and implicit biases in clinical care	1	2	3	4	5
o. Implementing strategies to dismantle structural determinants of care	1	2	3	4	5
p. Using instructional design steps to develop educational content	1	2	3	4	5
q. Implement processes and systems to support lifelong learning	1	2	3	4	5
r. Cultivate habits and strategies to promote efficient and sustainable practice	1	2	3	4	5
s. Implement self-care strategies to foster resilience and reduce risk of burnout	1	2	3	4	5

3. How confident are you in **delivering** the following Brief Behavioral Interventions in a primary care setting?	Not at all	Not very	A little	Some	Very
a. PST	1	2	3	4	5
b. Behavioral Activation					
c. CBT for Anxiety, Depression, Insomnia					
d. Motivational Interviewing	1	2	3	4	5
e. Harm Reduction	1	2	3	4	5
f. Distress Tolerance Skills	1	2	3	4	5
g. Health Behavior Change					
h. Behavioral therapy for ADHD					

4. How confident are you in **supporting** the following Brief Behavioral Interventions in a primary care setting delivered by another provider?	Not at all	Not very	A little	Some	Very
a. PST	1	2	3	4	5

b. Behavioral Activation						
c. CBT for Anxiety, Depression, Insomnia						
d. Motivational Interviewing						
e. Harm Reduction						
f. Distress Tolerance Skills						
g. Health Behavior Change						
h. Behavioral therapy for ADHD						

5. Have you participated in any quality improvement (QI) projects?
   Yes
   No

6. Have you ever used a written, PDSA cycle for a quality improvement (QI) project?
   Yes
   No

7. Rate your level of proficiency in each of the following activities for a QI project:	Not at all	Not very	A little	Some	Very
a. Designing the project	1	2	3	4	5
b. Conducting the project	1	2	3	4	5
c. Collecting data	1	2	3	4	5
d. Analyzing data	1	2	3	4	5
e. Interpreting data	1	2	3	4	5
f. Developing recommendations for change	1	2	3	4	5
g. Implementing changes	1	2	3	4	5

8. Rate your familiarity with the following principles and models applicable to QI:	Not at all	Not very	A little	Some	Very
1. Lean	1	2	3	4	5
2. Six sigma	1	2	3	4	5
3. IHI Model for Improvement	1	2	3	4	5

9. How often do you review aggregate information on clinical care processes and/or patient outcomes for a population of patients?
   Never → Skip to question [10]
   Once a Year
   Twice a Year
   Quarterly
   Monthly or More Frequently

10. How much impact do you feel you have in improving the overall mental health of your patients?
    - None
    - Very Little
    - Some

- A lot
- Absolute

11. Do you have any other comments you would like to make:

Qikat Post

Please read each of the following two clinical scenarios and answer the questions that follow each one. We recognize that there may be many areas to improve in each scenario. We request that you provide a response to each question, even if you are unsure of the single best response.

Scenario #1

You are a general psychiatrist in a three-person practice and have just finished a busy morning clinic session. Your last patient was a 60 year-old man with bipolar disorder, hypercholesterolemia, and type 2 diabetes mellitus. His bipolar disorder is well-controlled with quetiapine 600 mg po qhs and lithium carbonate 300 mg po BID. However, you are frustrated because his hypercholesterolemia and diabetes remain sub-optimally controlled. He is not interested in exercise, and his diet is questionable. Quetiapine and lithium in combination has been the only medication regimen that has sufficiently controlled his mood disorder.

As you sit down to ponder his case, you open a letter from one of the insurance plans that covers many of your patients. Enclosed is a summary of their review of a random number of patients in your practice for whom you prescribe atypical antipsychotics. This was done as part of their annual review for National Committee on Quality Assurance certification of their plan. The data show that on several measures (frequency of fasting glucose and fasting lipid testing, frequency of weight and waist circumference measurement) more than 65% of your patients do not meet their target goals for patients on atypical antipsychotics. This further adds to your level of frustration and ruins your appetite for lunch.

Please answer each of the following questions as if you were developing a program to investigate and improve the problem presented above.

1) What would be the aim?

_____

2) What would you measure to assess the situation?

_____

3) Identify one change that might be worth testing.

_____

Scenario #2

You are a psychiatry intern on a busy inpatient unit and are starting your morning by administering electroconvulsive therapy to three of your patients. You are preparing to administer ECT treatment #1 to your patient Ms. A, who had previously shown a nice response to ECT treatment several years ago. All goes well with the treatment, as Ms. A has a 50-second seizure. However, you notice that she seems to have more oral secretions at the end of the procedure than you normally see in your ECT patients. You worry that she might not have received her pre-ECT glycopyrrolate, and to your horror, you discover that you failed to order it for her when you put in your ECT orders the prior evening. Worse yet, she develops an aspiration pneumonia that requires transfer to the ICU for several days. In talking with another of your intern colleagues, you discover that she too once forgot to order glycopyrrolate for one of her ECT patients, though fortunately that patient did not aspirate.

It has generally been standard practice for psychiatry residents at your hospital to enter into the computerized medical record system a set of individual orders for patients who are to receive ECT. This is usually done on the day prior to their first ECT treatment in a course of ECT. These orders usually include NPO directions, glycopyrrolate orders, and orders to hold benzodiazepines prior to each ECT treatment. It doesn't seem to you that it has ever been too difficult to remember to place all of these orders for each patient about to start ECT, but sometimes, as happened here, things can become very busy on the unit so that you end up hastily putting in orders without the opportunity to double-check them. In thinking further about this, you start to wonder about all the other things you might have forgotten to order for patients this year without even realizing it.

Please answer each of the following questions as if you were developing a program to investigate and improve the problem presented above.

4) What would be the aim?

_____

5) What would you measure to assess the situation?

_____

6) Identify one change that might be worth testing.

_____

QI Scenarios

Please read each of the following two clinical scenarios and answer the questions that follow each one. We recognize that there may be many areas to improve in each scenario. We request that you provide a response to each question, even if you are unsure of the single best response.

Scenario #1

You are a general psychiatrist in a three-person practice and have just finished a busy morning clinic session. Your last patient was a 60 year-old man with bipolar disorder, hypercholesterolemia, and type 2 diabetes mellitus. His bipolar disorder is well-controlled with quetiapine 600 mg po qhs and lithium carbonate 300 mg po BID. However, you are frustrated because his hypercholesterolemia and diabetes remain sub-optimally controlled. He is not interested in exercise, and his diet is questionable. Quetiapine and lithium in combination has been the only medication regimen that has sufficiently controlled his mood disorder.

As you sit down to ponder his case, you open a letter from one of the insurance plans that covers many of your patients. Enclosed is a summary of their review of a random number of patients in your practice for whom you prescribe atypical antipsychotics. This was done as part of their annual review for National Committee on Quality Assurance certification of their plan. The data show that on several measures (frequency of fasting glucose and fasting lipid testing, frequency of weight and waist circumference measurement) more than 65% of your patients do not meet their target goals for patients on atypical antipsychotics. This further adds to your level of frustration and ruins your appetite for lunch.

Please answer each of the following questions as if you were developing a program to investigate and improve the problem presented above.

1) What would be the aim?

_____

2) What would you measure to assess the situation?

_____

3) Identify one change that might be worth testing.

_____

Scenario #2

You are a psychiatry intern on a busy inpatient unit and are starting your morning by administering electroconvulsive therapy to three of your patients. You are preparing to administer ECT treatment #1 to your patient Ms. A, who had previously shown a nice response to ECT treatment several years ago. All goes well with the treatment, as Ms. A has a 50-second seizure. However, you notice that she seems to have more oral secretions at the end of the procedure than you normally see in your ECT patients. You worry that she might not have received her pre-ECT glycopyrrolate, and to your horror, you discover that you failed to order it for her when you put in your ECT orders the prior evening. Worse yet, she develops an aspiration pneumonia that requires transfer to the ICU for several days. In talking with another of your intern colleagues, you discover that she too once forgot to order glycopyrrolate for one of her ECT patients, though fortunately that patient did not aspirate.

It has generally been standard practice for psychiatry residents at your hospital to enter into the computerized medical record system a set of individual orders for patients who are to receive ECT. This is usually done on the day prior to their first ECT treatment in a course of ECT. These orders usually include NPO directions, glycopyrrolate orders, and orders to hold benzodiazepines prior to each ECT treatment. It doesn't seem to you that it has ever been too difficult to remember to place all of these orders for each patient about to start ECT, but sometimes, as happened here, things can become very busy on the unit so that you end up hastily putting in orders without the opportunity to double-check them. In thinking further about this, you start to wonder about all the other things you might have forgotten to order for patients this year without even realizing it.

Please answer each of the following questions as if you were developing a program to investigate and improve the problem presented above.

4) What would be the aim?

_____

5) What would you measure to assess the situation?

_____

6) Identify one change that might be worth testing.

_____

APPPFP Satisfaction, burnout
and lifelong learning survey

Internal Planning Notes

- 1-5 Satisfaction Questions
- 6-24 Copenhagen Burnout Survey
- 25-38 Lifelong Learning Survey Questions

Attitudes and Opinions

1. Working in my practice has allowed me to experience joy in my work.
    a. Very Untrue
    b. Untrue
    c. Neither Untrue nor True
    d. True
    e. Very True
2. Do you feel isolated from or connected to the general medical community?
    a. Very Isolated
    b. Somewhat Isolated
    c. Neither Isolated nor Connected
    d. Somewhat Connected
    e. Very Connected
3. How much ownership do you feel about improving the overall mental health of your patients?
    a. None
    b. Very Little
    c. Some
    d. A lot
    e. Absolute
4. How much impact do you feel you have in improving the overall mental health of your patients?
    a. None
    b. Very Little
    c. Some
    d. A lot
    e. Absolute
5. Do you have any other comments you would like to make:

[Begin Copenhagen Burnout Survey]

	Never/ Almost Never	Seldom	Sometimes	Often	Always
6. How often do you feel tired?	1	2	3	4	5
7. How often are you physically exhausted?	1	2	3	4	5

8. How often are you emotionally exhausted?	1	2	3	4	5
9. How often do you think: “I can’t take it anymore”?	1	2	3	4	5
10. How often do you feel worn out?	1	2	3	4	5
11. How often do you feel weak and susceptible to illness?	1	2	3	4	5

	To a very low degree	To a low degree	Somewhat	To a high degree	To a very high degree
12. Is your work emotionally exhausting?	1	2	3	4	5
13. Do you feel burnt out because of your work?	1	2	3	4	5
14. Does your work frustrate you?	1	2	3	4	5
	Never/Almost Never	Seldom	Sometimes	Often	Always
15. Do you feel worn out at the end of the working day?	1	2	3	4	5
16. Are you exhausted in the morning at the thought of another day at work?	1	2	3	4	5
17. Do you feel that every working hour is tiring for you?	1	2	3	4	5
18. Do you have enough energy for family and friends during leisure time?					

	To a very low degree	To a low degree	Somewhat	To a high degree	To a very high degree
19. Do you find it hard to work with clients?	1	2	3	4	5
20. Do you find it frustrating to work with clients?	1	2	3	4	5
21. Does it drain your energy to work with clients?	1	2	3	4	5
22. Do you feel that you give more than you get back when you work with clients?					

APPPFP Satisfaction, burnout
and lifelong learning survey

	Never/Almost Never	Seldom	Sometimes	Often	Always
23. Are you tired of working with clients?	1	2	3	4	5
24. Do you sometimes wonder how long you will be able to continue working with clients?	1	2	3	4	5

	Strongly disagree	Disagree	Agree	Strongly agree
25. Searching for the answer to a question is, in and by itself, rewarding	1	2	3	4
26. Lifelong learning is a professional responsibility of all healthcare providers	1	2	3	4
27. I enjoy reading articles in which issues of healthcare/medicine are discussed	1	2	3	4
28. I routinely attend student study groups	1	2	3	4
29. I read healthcare/medical literature in journals, websites or textbooks at least once every week	1	2	3	4
30. I routinely search electronic resources to find out about new developments in healthcare/medicine	1	2	3	4
31. I believe that I would fall behind if I stopped learning about new developments in healthcare/medicine	1	2	3	4
32. One of the important goals of health professions' education is to develop students' lifelong learning skills	1	2	3	4
33. Rapid changes in health science/medicine require constant updating of knowledge and development of new professional skills	1	2	3	4
34. I always make time for learning on my own, even when I have a busy class schedule and other obligations	1	2	3	4
35. I recognize my need to constantly acquire new professional knowledge	1	2	3	4
36. I routinely attend **optional** sessions, such as professional meetings, guest lectures, or clinics where I can volunteer to improve my knowledge and clinical skills	1	2	3	4

37. I take every opportunity to gain new knowledge/skills that are important to my discipline	1	2	3	4
38. My preferred approach in finding an answer to a question is to consult a credible resource such as a textbook or electronic resource	1	2	3	4

ii. Program evaluations completed by the fellow
    1. Didactic Session and Teaching Evaluation
    2. Clinical Site Evaluation
    3. Clinical Teaching Evaluation
    4. QI Call Evaluation
    5. Program Goals Evaluation

APPPFP Didactic Session and Teaching Evaluation Form

Version 1.0 08/31/2023

Session Date:

Title of Session:

Faculty:

1. **The strengths of this session:**
2. **How this session could be improved:**

Other comments:

Question	**1**	**2**	**3**	**4**	**5**
Relevance of content (1 = Not at all relevant ; 5= Very relevant)					
Overall quality of session (1 = Poor ; 5= Excellent)					
Relevance of Pre-work materials (1= Not at all relevant; 5= Very relevant)					
Overall quality of Teaching Level (1=Poor; 5= Excellent)					

APPPFP Clinical Rotation Evaluation Form

- Organization
    - Were the clinical duties and assignments clearly presented and readily achievable within the clinic system? (ie, did you feel like you knew what your role was?)
        - Yes/No
        - Free text (optional)
    - Did the clinic site have enough available space for you to perform your clinical duties and obtain evaluation and feedback?
        - Yes/No
        - Free text (optional)
    - Was this rotation an effective use of your time?
        - Yes/No
        - Free text (optional)

- Patient Care
    - How satisfied are you with the variety of clinical experiences encountered at the clinic?
        - 1: very unsatisfied
        - 2: Unsatisfied
        - 3: Neutral
        - 4: Satisfied
        - 5: Very Satisfied
        - Free text (optional)
    - Was the patient volume sufficient to fill your time and meet your learning needs?
        - Yes/No
        - Free text (optional)
    - In your experience, did patient management employ an interdisciplinary approach?
        - Yes/No
        - Free Text (optional)

- Evaluation and Feedback
    - Was your performance regularly reviewed with faculty and preceptors?
        - Yes/No
        - Free text (optional)
    - What did you like best about this rotation?
        - Free Text
    - What was one strength of this rotation?
        - Free text
    - What is one thing you would change about this rotation?
        -

APPPFP Clinical Teaching Evaluation Form

[For questions 1-18, please respond using the following scale]

Scale:

1 = Consistently Failed

2 = About Half the Time

3 = Most of the Time

4 = Almost Always

5 = Consistently

Free text (optional)

Overall, my preceptor/attending . . .

1. Was available when I needed him/her
2. Provided an appropriate balance of supervision and autonomy
3. Devoted an adequate amount of time towards discussing patients and patient care decisions
4. Effectively communicated their thoughts but allowed me to exercise my clinical judgment.
5. Was skilled and knowledgeable
6. Modeled patient interviews/clinical skills for me
7. Observed me interviewing/treating patients (in person/by videotape/by audiotape)
8. Modeled effective interactions with the multidisciplinary treatment team
9. Reviewed my notes and discharge summaries
10. Modeled effective interactions with other providers (e.g. consultants, outpatient providers), and with insurance and managed care companies
11. Provided me with relevant readings and encouraged me to consult the literature to improve patient care
12. Recognized their own limitations and used such situations as opportunities to show life-learning learning principles
13. Gave me clear feedback and specific, constructive suggestions for improvement on at least two occasions (halfway through and at the end of the rotation)
14. Treated me with courtesy and respect
15. Modeled interpersonal qualities of integrity, ethical and professional behavior, empathy, and compassion
16. Was enthusiastic and stimulated the learning process
17. Was helpful, available and responsive
18. Please rate the overall quality of your attending/supervisor's teaching
19. Please comment on the strengths of your attending/supervisor as it related to precepting: [free text]

1. Please provide constructive feedback to your attending/supervisor about areas for improvement as it relates to their role as a preceptor:
   [free text]

APPPFP Quality Improvement
Session Evaluation

1. QI Didactic date:
    a. Free text
2. QI title (e.g quality improvement call # 1)
    a. Free text
3. Facilitator
    a. Denise Chang, MD
    b. Other (free text)
4. Please indicate how relevant the content was to your practice:
    a. 1: Not at all relevant
    b. 2: A little relevant
    c. 3: Somewhat relevant
    d. 4: Mostly relevant
    e. 5: Very relevant
5. Please indicate the quality of the session:
    a. 1: Poor
    b. 2: Fair
    c. 3: Average
    d. 4: Above Average
    e. 5: Excellent

In the next set of questions, please provide feedback on anything from this call, including the videoconference experience (if applicable), session content, and/or instructor feedback.

6. What were the strengths of the session?
    a. Free text
7. How could this session be improved?
    a. Free text
8. Other comments:
    a. Free text

APPPFP Fellow Evaluation of Program

Program level evaluation: This evaluation is tied to the program level goals and is designed for the fellow to provide timely feedback on how effectively the program is meeting these goals. Information from this survey will be used for ongoing program evaluation and improvement.

1. Please rate how effectively the program has met the following goals as it relates to you:
    a. GOAL 1: Expand Washington's behavioral health workforce through advanced psychiatric training for newly graduated advanced practice psychiatric providers that emphasizes clinical competence, confidence, and sustained professional development
        i. Scale: 1=did not meet; 2=mostly unmet; 3=partially met; 4=mostly met; 5=met completely.
    b. GOAL 2: Foster the development of advanced practice psychiatric clinical leaders who are accountable for providing team-based, patient-centered care to all persons in need of behavioral health services in the community
        i. Scale: 1=did not meet; 2=mostly unmet; 3=partially met; 4=mostly met; 5=met completely.
    c. GOAL 3: Increase workforce capacity for delivering data-driven continuous quality improvement as part of a learning behavioral healthcare system
        i. Scale: 1=did not meet; 2=mostly unmet; 3=partially met; 4=mostly met; 5=met completely.
    d. GOAL 4: Enhance advanced practice psychiatric provider career satisfaction and retention in the behavioral health workforce
        i. Scale: 1=did not meet; 2=mostly unmet; 3=partially met; 4=mostly met; 5=met completely.
    e. GOAL 5: Develop a cohort of advanced practice psychiatric provider graduates with skills as clinical educators to contribute to sustainable behavioral health workforce development and mentorship
        i. Scale: 1=did not meet; 2=mostly unmet; 3=partially met; 4=mostly met; 5=met completely.
2. What did the program director do well? What are the suggestions for improvement?
    a. Free text
3. What did the preceptors do well? What are the suggestions for improvement?
    a. Free text
4. What worked well with the workspace and EHR? What are the suggestions for improvement?
    a. Free text
5. The fellowship provided adequate support, supervision and evidence-based behavioral health training to effectively care for diverse adult patient populations.
    a. **Scale:** 1 = strongly disagree 2 = disagree; 3 = Agree a little; 4 = mostly agree; 5 = Fully Agree
6. How much do you agree with the following statement: "I had ample opportunity to provide behavioral health care in a variety of psychiatric settings and subspecialties."

   a. **Scale:** 1 = strongly disagree 2 = disagree; 3 = Agree a little; 4 = mostly agree; 5 = Fully Agree
7. The fellowship provided an opportunity for mastering roles both as a direct care provider and as an indirect psychiatric consultant to balance the needs of caring for the larger Seattle community.
   a. **Scale:** 1 = strongly disagree 2 = disagree; 3 = Agree a little; 4 = mostly agree; 5 = Fully Agree
8. In this fellowship I felt included and was able to participate in interdisciplinary care teams.
   a. **Scale:** 1 = strongly disagree 2 = disagree; 3 = Agree a little; 4 = mostly agree; 5 = Fully Agree
9. Please rate each of the following educational experiences from your rotations over the past year (Poor, inadequate, fair, good, exceptional)
   a. UW primary care Belltown
   b. UW primary care Shoreline
   c. Fred Hutch
   d. Northwest Hospital inpatient consult liaison
   e. Outpatient psychiatric clinic
   f. Geriatric psychiatry inpatient
   g. Psychiatric Emergency rotation at Harborview
   h. Monday didactic topics
   i. Journal entries
   j. QI project
10. For any of the cites you rated as poor or inadequate, please share ways this rotation could be improved (e.g., workload, teaching, etc)
    a. [open response]
11. Please provide your favorite/most educational:
    a. Clinical experience this year. What was it about the experience that made it the best?
       i. (Open response)
    b. Preceptor/didactic faculty: How did this individual facilitate your learning?
       i. (Open response)
12. This fellowship facilitated the development of my personal and organizational well-being and resilience.
    a. **Scale:** 1 = strongly disagree 2 = disagree; 3 = Agree a little; 4 = mostly agree; 5 = Fully Agree
13. This program helped me develop clinical practice strategies and habits that promote efficient care delivery.
    a. **Scale:** 1 = strongly disagree 2 = disagree; 3 = Agree a little; 4 = mostly agree; 5 = Fully Agree
14. How true is the following statement for you: “As a result of my time in the APPPFP fellowship I have a deeper understanding of and commitment to practice improvement through use of continuous quality improvement methods, anti-racism strategies and participation in continuing education formally.”
    a. **Scale:** (Not at all true, somewhat true, mostly true, very true, completely true)

15. How likely are you to pursue the following after the completion of your fellowship?
    a. Leadership opportunities
        i. **Scale (placeholder for now):** 1 = not at all; 2 = not very; 3 = a little; 4 = some; 5 = very
    b. Teaching and academic opportunities
        i. **Scale (placeholder for now):** 1 = not at all; 2 = not very; 3 = a little; 4 = some; 5 = very
    c. Mentorship opportunities for Advanced Practice students/fellows
        i. **Scale (placeholder for now):** 1 = not at all; 2 = not very; 3 = a little; 4 = some; 5 = very
    d. Additional training on a psychiatric specialty
        i. **Scale (placeholder for now):** 1 = not at all; 2 = not very; 3 = a little; 4 = some; 5 = very
        ii. Which speciality or topic? (for example, neuromodulation, DBT, CL, etc)
    e. Clinical Practice in an outpatient setting
        i. **Scale (placeholder for now):** 1 = not at all; 2 = not very; 3 = a little; 4 = some; 5 = very
    f. Clinical Practice in an integrated practice setting such as BHIP
        i. **Scale (placeholder for now):** 1 = not at all; 2 = not very; 3 = a little; 4 = some; 5 = very
    g. Clinical Practice in an inpatient setting
        i. **Scale (placeholder for now):** 1 = not at all; 2 = not very; 3 = a little; 4 = some; 5 = very
16. Please rate your educational experience with curriculum in the past academic year:

Curriculum	Poor	Fair	Good	Very Good	Excellent
a. Clinical Experiences					
b. Rigor and Scholarship					
c. Opportunities to explore individual interests					
d. Mentorship/advising					
e. Teaching interprofessional teamwork skills					
f. Overall satisfaction with the curriculum					

17. How much do you agree with the following statement: “Overall I am satisfied with the process for dealing confidentially with problems and concerns”?
    a. **Scale:** 1 = strongly disagree 2 = disagree; 3 = Agree a little; 4 = mostly agree; 5 = Fully Agree
    b. Free text (optional)
18. How much do you agree with the following statement: “As a result of this fellowship, I feel prepared for fully autonomous practice”
    a. **Scale:** 1 = strongly disagree 2 = disagree; 3 = Agree a little; 4 = mostly agree; 5 = Fully Agree

    b. Free text (optional)

19. If there is anything else you would like to discuss related to your experience of the program, please enter it here:
    a. Free text (optional)

b. Evaluations completed by program faculty
    i. Evaluations of Fellow progress
        1. Clinical Evaluation
        2. Didactic Evaluation
        3. QI Evaluation
        4. Professionalism Evaluation
    ii. Faculty Evaluation of Program

Advanced Practice Psychiatric Provider Fellowship Clinical Evaluation Rubric

Completed by:

1. Patient Care	**Intervention**	**Direction**	**Support**	**Competent**	**Proficient**
	Not capable of completing some or all of the task	Requires significant support or redirection	Require minimal support to ensure safety/competence	Perform independently for safety /minimal competence	Performs with high competence; Able to teach others
a) Conducts comprehensive screening and assessments, including history-taking and examination skills, for patients with a broad range of neuropsychiatric presentations. (1a)	1	2	3	4	5
b) Develops formulations, including differential diagnosis, for patients with a broad range of neuropsychiatric presentations. (1b)	1	2	3	4	5
c) Collaborates with patients to recommend or deliver evidence-based treatment, monitoring treatment adherence and response, and adjusting as needed to meet treatment goals. (1c)	1	2	3	4	5
d) Plans for and coordinates next steps in care, including plans for maintenance treatment or relapse prevention among patients who have responded to care or referral as needed to higher levels of care, or other specialists for additional assessment or intervention. (1d)	1	2	3	4	5
e) Conducts care effectively and safely whether in person or via telehealth. (1e)	1	2	3	4	5
f) Provides patient-centered, evidence-based indirect psychiatric care, including recommendations for assessment, diagnosis, and management. (1f)	1	2	3	4	5

g) Demonstrates efficiency in clinical encounters and practice habits. (1g)	1	2	3	4	5
2. Interpersonal and Communication Skills	**Intervention** Not capable of completing some or all of the task	**Direction** Requires significant support or redirection	**Support** Require minimal support to ensure safety/competence	**Competent** Perform independently for safety /minimal competence	**Proficient** Performs with high competence; Able to teach others
a) Engages patients (and caregivers or family members as applicable) in care, using patient-friendly language, with attention to literacy, culture, patient preferences, and an awareness of patient/family responses. (4a)					
b) Communicates effectively with diverse groups of patients and families, healthcare providers, and staff, with awareness of implicit bias, countertransference, and pro-active participation in strategies to counter biases and ensure positive interactions. (4b)					
c) Understands and fulfills role in interdisciplinary healthcare team and collaborates well with team members to deliver patient-centered, evidence-based mental health care to patients from diverse backgrounds. (4c)					
d) Effectively navigates challenging interactions or conflict with patients or colleagues. (4d)					
e) Demonstrates effective and timely written communication including patient after visit summaries, psychiatric case review recommendations, and EHR notes. (4e)					
3. Professionalism	**Intervention** Not capable of completing some or all of the task	**Direction** Requires significant support or redirection	**Support** Require minimal support to ensure safety/competence	**Competent** Perform independently for safety /minimal competence	**Proficient** Performs with high competence; Able to teach others

a) Employs ethical principles and professionalism into practice, including respect for patients and their autonomy, confidentiality, and consent (5a)					
b) Exhibits accountability to patients and healthcare system for care provided, including effective coordination of care. (5b)					
c) Demonstrates adherence to principles of integrity, accountability, and respect consistently in clinical practice and interactions with patients and colleagues. (5c)					
4. Interdisciplinary Collaboration	**Intervention**	**Direction**	**Support**	**Competent**	**Proficient**
	Not capable of completing some or all of the task	Requires significant support or redirection	Require minimal support to ensure safety/competence	Perform independently for safety /minimal competence	Performs with high competence; Able to teach others
a) Works with other interdisciplinary team members to establish and demonstrate a climate of mutual respect, dignity, diversity, inclusion, ethical integrity, and trust. (7a)					
b) Uses the knowledge of one's own role and roles of other interdisciplinary team members to appropriately assess and address the health care needs of the patients and populations served both virtually and in-person. (7b)					
c) Communicates, delegates, and defers to expertise within the interdisciplinary team in a responsive and responsible manner that supports the maintenance of health and the treatment of disease in individual patients and populations. (7c)					
d) Demonstrates understanding of the interdisciplinary roles and responsibilities that are required to establish, develop, and continuously enhance inter-disciplinary team functioning. (7d)					
5. Systems-based Practice	**Intervention**	**Direction**	**Support**	**Competent**	**Proficient**
	Not capable of completing	Requires significant	Require minimal support to ensure	Perform independently for safety	Performs with high competence;

	some or all of the task	support or redirection	safety/competence	/minimal competence	Able to teach others
a) Obtains, synthesizes, and applies relevant clinical, population, and research data to improve and guide patient and program outcomes. (6a)					
b) Understands and adheres to risk management strategies and all regulatory requirements and participates in practice improvement activities. (6b)					
c) Advocates for optimal care systems and coordinates care effectively to maximize health outcomes with attention to healthcare costs. (6c)					

Advanced Practice Psychiatric Provider Fellowship Didactic Evaluation Rubric

1. Knowledge for Practice	**Intervention** Not capable of completing some or all of the task	**Direction** Requires significant support or redirection	**Support** Require minimal support to ensure safety/competence	**Competent** Perform independently for safety /minimal competence	**Proficient** Performs with high competence; Able to teach others
a) Shows awareness of emerging trends affecting population health and healthcare. (2a)	1	2	3	4	5
b) Recognizes and reflects on systemic and social determinants of health and implicit bias. Actively engages in mitigating impact. (2b)	1	2	3	4	5
c) Uses evidence-based principles in clinical decision-making during case-based discussion, accounting for psychosocial factors as well as individual and population level needs. (2c)	1	2	3	4	5
2. Interpersonal and Communication Skills					
a) Demonstrates respect for others and their contributions to the learning environment. (4f)	1	2	3	4	5
3. Practice-based Learning and Improvement					
a) Uses technology and clinical resources to optimize individual and team-based learning. (3a)	1	2	3	4	5

Advanced Practice Psychiatric Provider Fellowship QI Evaluation Rubric

1. Practice-based Learning and Improvement	Intervention Not capable of completing some or all of the task	Direction Requires significant support or redirection	Support Require minimal support to ensure safety/competence	Competent Perform independently for safety /minimal competence	Proficient Performs with high competence; Able to teach others
a) Employs systems-based thinking and data-driven methods to identify and problem-solve gaps in quality of care or system errors. (3b)	1	2	3	4	5
b) Demonstrates systemic analysis of practice using QI methods to identify and address areas for improvement. (3c)	1	2	3	4	5
2. Systems-based Practice					
a) Obtains, synthesizes, and applies relevant clinical, population, and research data to improve and guide patient and program outcomes. (6a)	1	2	3	4	5
b) Demonstrates active leadership and shared responsibility in designing and executing a QI project in a clinical setting. (6e)	1	2	3	4	5
c) Cultivates active participation and a commitment to respectful collaboration among interdisciplinary team members to address systems-level issues. (6f)	1	2	3	4	5

Advanced Practice Psychiatric Provider Fellowship Professionalism Evaluation Rubric

Program director and fellow self-evaluation

	Intervention	Direction	Support	Competent	Proficient
1. Systems-based Practice	Not capable of completing some or all of the task	Requires significant support or redirection	Require minimal support to ensure safety/competence	Perform independently for safety /minimal competence	Performs with high competence; Able to teach others
a) Coordinates care within the health care system to maximize positive patient outcomes, controls cost, and demonstrates advocacy for optimal care systems. (6g)	1	2	3	4	5
2. Diversity, Equity, and Inclusion					
a) Incorporates principles of DEI in all professional activities, promoting an inclusive workplace culture. (10a)	1	2	3	4	5
b) Employs anti-bias strategies, including anti-racism strategies, throughout clinical and academic settings. (10b)	1	2	3	4	5
3. Personal and Professional Development					
a) Practices self-reflection, including on topics of personal limitations and implicit bias to promote personal growth and resilience. (8a)	1	2	3	4	5
b) Demonstrates growth mindset, including humility and commitment to veracity; shows willingness to embrace change. (8b)	1	2	3	4	5

c) Utilizes leadership skills to enhance team functioning and engender trust as a mentor and resource to other members of the healthcare team, including trainees. (8c)	1	2	3	4	5
d) Embraces ambiguity in clinical care and demonstrates effective means to work with uncertainty and manage. (8d)	1	2	3	4	5

APPPFP Faculty Survey

This anonymous annual faculty survey is designed to give you the opportunity to provide feedback about the Advanced Practice Psychiatric Provider Fellowship Program (APPPFP). The comments tend to provide the most useful information, so please share your thoughts about what is working well and suggestions for improvements. The aggregated anonymous results will be evaluated by program leadership.

Program Administration & Staff

1. Please rate the following:

	Poor	Fair	Good	Very Good	Excellent
a. Support you've received from program administration and staff around coordinating didactics, rotations, etc.					
b. Availability and support from program director and staff around issues with fellows when they arise					

2. Please provide any additional specific feedback about program administration & staff support. [Open response]
3. Please provide any additional specific feedback about the Program Director: __

Committees

4. Did you serve on the Faculty Advisory Committee (FAC) this year?
    a. Yes/No
    a. If yes, what specific feedback do you have about your experience serving on a committee?

Adverse Events

5. Did you have any of the following experiences in the past year with a patient for whom you shared clinical care with a fellow?

	No	Yes
b. Fellow was threatened and/or assaulted by a patient		
c. Fellow experienced racist, sexist, or other discriminatory behavior by patient, staff, or other faculty		
d. Fellow was harassed or treated unprofessionally by patient, staff, or other faculty		
e. A patient attempted suicide (and survived)		
f. A patient died by suicide		

2. If you answered yes to any of the prompts in question 5, did you . . .
    a. debrief with the fellow about the experience? Yes/No
    b. notify the Program Director or other leadership staff? Yes/no
6. Do you know where the residency suicide protocol is located? Yes/No

Faculty Teaching & Supervision

7. What specific feedback do you have about your experience working with residents on rotations, including your perception of their overall preparedness for clinical rotations? __
8. What about teaching is most meaningful to you? [open response]
9. What about teaching is most challenging or difficult for you? [open response]
10. What barriers, if any, to teaching are you experiencing, and how could the program help to reduce these? Please be specific __
11. Did you go to a department faculty development meeting this year? [Yes/No]
    a. If no, what was the barrier? (Select all that apply)
        i. Time
        ii. clinical coverage
        iii. topics did not seem relevant
        iv. Other:
12. What would you most like faculty development on in the next 1-2 years? [Open response]
13. Please add any additional comments or suggestions regarding ways for the program to support faculty development: (Open response)

Didactics

a. How many didactics did you teach during 2022-2023?
b. 0
a. 1-2
b. 3-4
c. 5-6
d. 7+

a. If you taught didactics, how satisfied were you with the current evaluation system? Are there ways you think this could be improved? (open response)
b. If you taught didactics, please provide any additional specific feedback about your experience teaching didactics. (open response)

QI and Scholarly Projects

14. How many fellows did you work with on scholarly projects?
    a. 0
    b. 1
    c. 2
    d. 3

c. If you worked with a fellow on a scholarly project, what type of project was it? Please check all projects that apply:
    i. Research
    ii. Review article
    iii. Case Report
    iv. Poster
    v. Lecture Development
    vi. Curriculum
    vii. National meeting presentation or workshop
    viii. QI Project
    ix. Other:

EDI OTHER

15. What is one thing the program could do to better support you in incorporating EDI into your didactic content?

OTHER

16. Please add any additional comments about strengths and/or areas for improvement in the residency program: [open response]