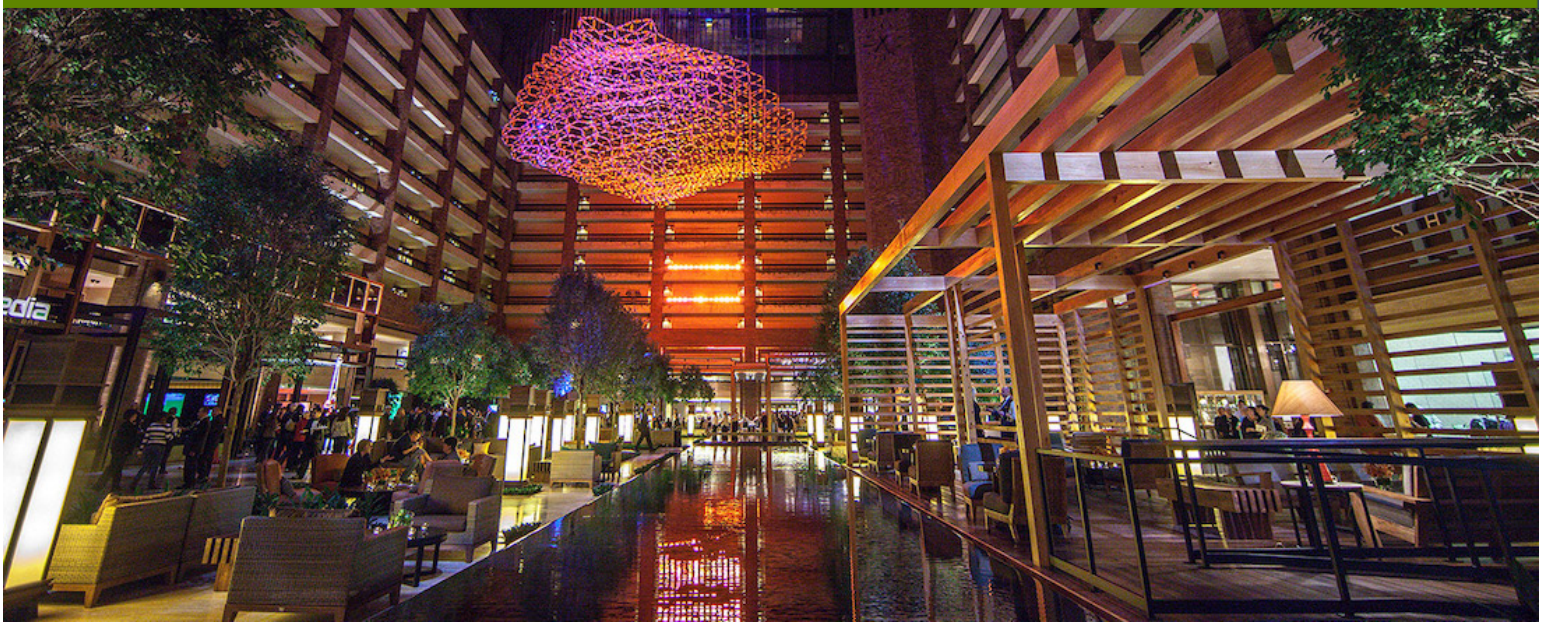
AADPRT

American Association of
Directors of Psychiatric
Residency Training



# 2020 Annual Meeting

## *Reclaim Meaning Through Teaching*

**Wednesday, March 4 (Noon) –**
**Saturday, March 7**

# BRAIN Conference

**Wednesday, March 4**
**7:30am – 12pm**

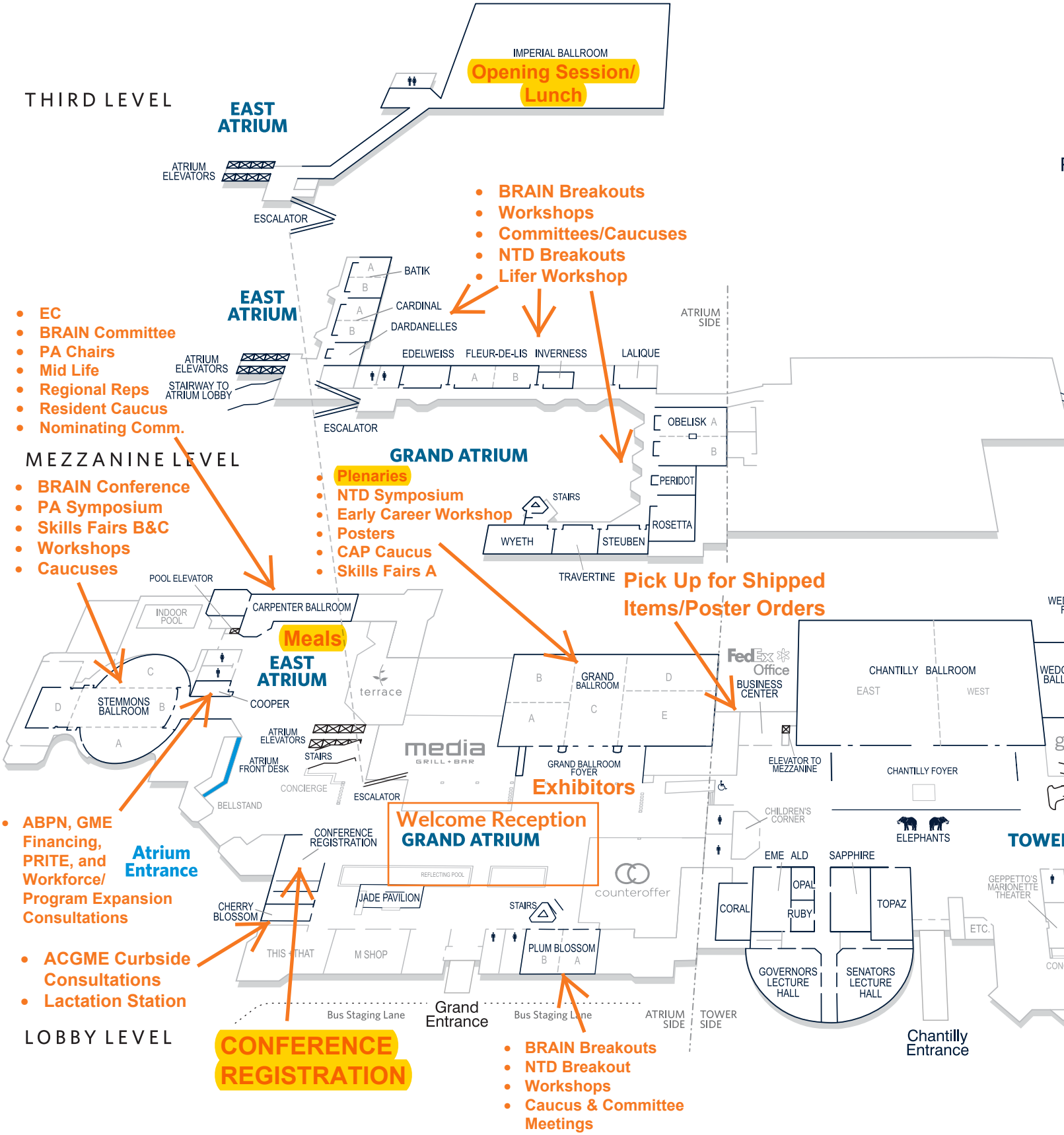
# AADPRT
## 49th Annual Meeting
## *Reclaim Meaning Through Teaching*
## March 4 – 7, 2020
## BRAIN Conference ~ March 4

**ACCREDITATION AND DISCLOSURE STATEMENTS**

**Accreditation Statement:** This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Psychiatric Association (APA) and American Association of Directors of Psychiatric Residency Training (AADPRT). The APA is accredited by the ACCME to provide continuing medical education for physicians. The APA designates this live activity for a maximum of 25 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Disclosure Statement:** It is the policy of the APA to comply with the ACCME Standards for commercial support of CME. Planning committee members and related staff disclosures must be on file annually with disclosures made available on program materials. Faculty participating in sponsored or jointly sponsored programs by APA are required to disclose to the program audience any real or apparent financial relationships with commercial interests related to the content of their presentation. Faculty are also responsible for disclosing any discussion of off-label or investigational use of a product.

# AADPRT
# ANNUAL MEETING MAP



**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| **3 - Tuesday** | **Event** | **Leader** | **Room** |
|---|---|---|---|
| 1:00 – 2:00 pm | Steering Committee Meeting | Adam Brenner, MD | Presidential Suite |
| 2:15 – 7:00 pm | Executive Council Meeting & Dinner | Adam Brenner, MD | Carpenter Ballroom |
| 3:30 – 7:30 pm | Annual Meeting Registration | | Atrium Registration Desk |
| 7:30 - 8:30 pm | BRAIN Conference Committee Meeting | David Ross, MD, PhD, Ashley Walker, MD, Joseph Cooper, MD | Carpenter Ballroom |
| **4 - Wednesday** | **Event** | **Leader** | **Room** |
| 7:00 am – 6:00 pm | Annual Meeting Registration | | Atrium Registration Desk |
| 7:00 – 7:30 am | BRAIN Conference Breakfast | | East Atrium |
| 7:00 - 8:00 am | Meeting of the *Academic Psychiatry Journal* Governance Board | Adam Brenner, MD | Presidential Suite |
| 7:30 am - 12:00 pm | BRAIN Conference | David Ross, MD, PhD, Ashley Walker, MD, Joseph Cooper, MD | Stemmons Ballroom, Batik A/B, Cardinal A/B, Dardanelles, Fleur de Lis A/B, Lalique, Obelisk A, Obelisk B, Plum Blossom A, Plum Blossom B, Rosetta, Steuben, Wyeth |
| 11:00 am - 12:00 pm | PA Committee Chairs Meeting | Kim Kirchner | Carpenter Ballroom |
| 12:00 - 1:15 pm | **Plenary: Lunch and Opening Session** | Adam Brenner, MD, Sallie DeGolia, MD, MPH, Ann Schwartz, MD, Kim-Lan Czelusta, MD, Sourav Sengupta, MD, MPH, Erick Hung, MD, Donna Sudak, MD | Imperial Ballroom |
| 1:30 pm - 3:00 pm | **Educational Workshops Session #1** | | |
| | Don't sue me! – Teaching residents essential principles of malpractice to reduce fear and improve quality of care *(Intended Audience: all annual meeting attendees)* | Cathleen Cerny-Suelzer, MD, Selena Magalotti MD, Victoria Kelly, MD, Michael Greenspan, MD, Brianne Newman, MD | Batik A/B |

| | | | |
|---|---|---|---|
| | Embracing our responsibility for inclusion: Implementing the 2019 ACGME Common Program Requirement on diversity and inclusion *(Intended Audience: all annual meeting attendees)* | Tracey Guthrie, MD, Saira Kalia, MBBS, MD, Francis Lu, MD, Ana Ozdoba, MD | Obelisk A |
| | Screening strategies for the next generation of successful residents – Balancing metrics and holistic review *(Intended Audience: all annual meeting attendees)* | Robert Cotes, MD, Gretchen Gavero, DO, Alan Koike, MD, Amy Addams, Jessica Kovach, MD | Cardinal A/B |
| | Assessing Competency in Psychodynamic Psychotherapy (Intended Audience: all annual meeting attendees) | Randy Welton, MD, Deborah Cabaniss, MD, Erin Crocker, MD, Sindhu Idicula, BA, MD, Bianca Nguyen, MD, MPH | Obelisk B |
| | Innovations for Clinical Teaching on a Busy CL Service *(Intended Audience: all annual meeting attendees)* | Amelia Dubovsky, MD, Thomas Soeprono, MD | Fleur de Lis A/B |
| | The Impact of Patient Suicide on Psychiatry Trainees: How do we respond? *(Intended Audience: all annual meeting attendees)* | Zheala Qayyum, MBBS, MD, Jeffrey Hunt, MD | Plum Blossom A |
| | Curriculum Development: Step By Step From Finish to Start *(Intended Audience: all annual meeting attendees)* | Jacqueline Hobbs, MD, PhD, Paul Lee, MD, MPH | Plum Blossom B |
| | Separating Signal from Noise: Is Your Program being Viewed Accurately by Applicants? *(Intended Audience: all annual meeting attendees)* | Lia Thomas, MD, Anna Kerlek MD, Daniel Gih, MD, Shambhavi Chandraiah, FRCP(C), MD, Marcy Verduin, MD | Lalique |

| | | | |
|---|---|---|---|
| | Once Again, It Wasn't Done!: How to have Professional Accountability Conversations that Promote Learning and Lessen Stress *(Intended Audience: all annual meeting attendees)* | Jane Ripperger-Suhler, MD, Kari Wolf, MD, Charla Clark, Kari Whatley, MD | Stemmons Ballroom |
| | Saving Dr. Caufield: Modeling Vulnerability to Shift Away from a Culture of Maladaptive Perfectionism *(Intended Audience: all annual meeting attendees)* | Sansea Jacobson, MD, Julie Chilton, MD, Colin Stewart, MD, Kayla Isaacs, BA, Andres Martin, MD | Rosetta |
| | The Hidden Factor In Trainee Wellness: Supporting Trainees who Experience Patient Aggression and Discrimination-Based Aggression/Harassment *(Intended Audience: all annual meeting attendees)* | Sarah Mohiuddin, MD, Michael Jibson, MD, PhD, Adrienne Adams, MD, MSc | Steuben |
| | Parenting in Residency: How parent-learners strengthen programs and how programs can best support them *(Intended Audience: all annual meeting attendees)* | Jonathan Homans, MD, Lora Wichser, MD, Sandra DeJong, MD, MSc, Anne Ruble, MD, MPH | Wyeth |
| 3:00 - 3:30 pm | Coffee Break | | East Atrium |
| 3:30 pm - 5:00 pm | **Educational Workshops Session #2** | | |
| | N.O. S.H.A.M.E -- A Framework for Empowering and Supporting Trainees to Manage Mistreatment in Academic Settings *(Intended Audience: all annual meeting attendees)* | John Chamberlain, MD, Tammy Duong, MD, Hannah Potvin, MD, | Batik A/B |

| | | | |
|---|---|---|---|
| | Helping patients plan for a mental health crisis: How to implement the use of psychiatric advance directives within residency training programs. *(Intended Audience: CAP TDs, New TDs, Residents)* | Tristan Gorrindo, MD, John Torous, MD | Obelisk A |
| | Reading Between the Lines: Deciphering Letters of Recommendation in Psychiatry *(Intended Audience: CAP TDs, New TDs* | Anne McBride, BA, MD, William Newman, MD, Alan Koike, MD, MS, Brianne Newman, MD, Paula Wadell, MD | Cardinal A/B |
| | Teaching Relationship-Centered Communication to Psychiatry Trainees *(Intended Audience: all annual meeting attendees)* | Rebecca Rendleman, MD, Oliver Stroeh, MD, Steven Kaplan, MD, Helen Ding, MD, Sara VanBronkhorst, MD | Obelisk B |
| | Assessing an IMG Application: Diamonds and Pearls! *(Intended Audience: all annual meeting attendees)* | Vishal Madaan, MD, Consuelo Cagande, MD, Ellen Berkowitz, MD, Donna Sudak, MD, Manal Khan, MBBS | Fleur de Lis A/B |
| | Managing the Millennial Struggling Learner: Creating a Team Approach *(Intended Audience: all annual meeting attendees)* | Sourav Sengupta, MD, MPH, Elizabeth Sengupta, BS, MA, Cynthia Pristach, MD, Paula DelRegno, MD | Plum Blossom A |
| | Psychological Safety: It's Not Just for Snowflakes *(Intended Audience: all annual meeting attendees)* | Jennifer O'Donohoe, MD, Kristi Kleinschmit, MD, T. Eric Spiegel, MD, Luke Dwyer, MD, Thomas Gethin-Jones, MD | Plum Blossom B |
| | Lights...Camera...Action!: A Lesson on Educating Trainees to Address Social Determinants of Mental Health Through Interactive Theater *(Intended Audience: all annual meeting attendees)* | Margaret Wang, MD, Antara Banik, MD, Evelyn Ashiofu, MD, MPH, Karen Duong, DO, Lia Thomas, MD | Lalique |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| | We get by with a little help from Our PEERS: Developing and implementing a relevant well-being curriculum for trainees *(Intended Audience: all annual meeting attendees)* | Anne Hart, MD, Jordyn Feingold, MA, Shreya Nagula, MD, Asher Simon, MD | Stemmons Ballroom |
| | Grabbing the Third Rail: Race and Racism in Clinical Documentation *(Intended Audience: all annual meeting attendees)* | J. Corey Williams, MA, MD, Jessica Isom, MD, Matthew Goldenberg, MD, Robert Rohrbaugh, MD | Rosetta |
| | Clinical Skills Evaluation: Data-Informed Strategies to Improve Interrater Reliability Within and Across Programs *(Intended Audience: all annual meeting attendees)* | Michael Jibson, MD, PhD, Kaz Nelson, MD, Heather Schultz, MD, MPH | Steuben |
| | Screen Time! Learning to Teach Pediatric Telepsychiatry (PTP) Using a National Curriculum *(Intended Audience: CAP TDs)* | Sandra DeJong, MD, MSc, Shabana Khan, MD, Deborah Brooks, MD, Amy Fehrmann, MD | Wyeth |
| 5:15 - 7:00 pm | Executive Council Meeting | Adam Brenner, MD | Carpenter Ballroom |
| 5:15 - 7:00 pm | Meet with Your Mentor *(AADPRT encourages you to make plans to meet with your mentor during this time)* | | |
| 7:15 PM | Networking Dinners (charges not included in registration) | Sallie DeGolia, MD, MPH | Atrium Entrance |
| **5 - Thursday** | **Event** | **Leader** | **Room** |
| 7:00 - 8:00 am | Steering Committee Breakfast Meeting | Adam Brenner, MD | Presidential Suite |
| 7:30 am - 5:30 pm | Annual Meeting Registration | | Atrium Registration Desk |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| 7:30 – 8:30 am | General Breakfast - consultations available with PRITE, GME Financing, and Workforce/Program Expansion Experts. Appointments not required. | | East Atrium/Cooper |
| 8:00 am – 5:30 pm | Exhibitors | | Grand Ballroom Foyer |
| 8:00 - 11:30 am | PA Symposium | Juliet Arthur, MHA, C-TAGME, Zoellen Murphy, BA, C-TAGME, Amber Pearson, C-TAGME, Georgina Rink, C-TAGME, Chelsea Wimmer, MS | Stemmons Ballroom B/D |
| 8:00 – 9:45am | New Training Director Symposium *(TDs and ATDs with 0-2 years experience)* | Kim-Lan Czelusta, MD, Sourav Sengupta, MD, MPH | Grand Ballroom C |
| 8:00 - 9:00 am | IMG Fellowship Committee Meeting (*Committee Members Only* ) | Ellen Berkowitz, MD | Peridot |
| 8:15 - 9:00 am | Resident Orientation *(Residents and Fellows only)* | Melissa Arbuckle, MD, PhD | Obelisk |
| 8:30 - 9:45 am | *Early Career Workshop: Becoming a Residency Training Director: Identity and a Framework for the Role (TDs/ATDs with 3-5 yrs. experience)* | Adrienne Bentman, MD, Deborah Cowley, MD, Sandra DeJong, MD, MSc, Samira Solomon, MD, Deborah Spitz, MD | Grand Ballroom A/B |
| 8:30 - 9:45 am | Mid-life Workshop: *Utilizing Group Dynamics in Program Director Work (TDs/ATDs with 6-10 years experience)* | Peter Daniolos, MD, Kimberly Kelsay, MD, Sumru Bilge-Johnson, MD | Carpenter Ballroom |
| 8:30 - 9:45 am | Lifer Workshop: *Developmental Stages of Senior Status and Career Opportunities Re: Mentorship (TDs/ATDs with 11+ years experience)* | Gene Beresin, MD, MA, Carlyle Chan, MD, Geraldine Fox, MD, Martin Drell, MD, David Kaye, MD, Christopher Thomas, MD, Sheldon Benjamin, MD | Fleur de Lis A/B and Edelweiss |
| 8:45 - 9:45 am | Henderson Award Committee Meeting | Oliver Stroeh, MD | Dardanelles |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| 9:00 – 10:00 am | IMG Fellow Orientation *(Committee Members and Awardees only)* | Ellen Berkowitz, MD | Peridot |
| 9:15 – 9:45 am | Ginsberg Fellow Orientation *(Committee Members and Awardees only)* | Richard Lee, MD | Travertine |
| 9:45 - 10:00 am | Coffee Break | | Grand Ballroom Foyer |
| 10:00 – 11:30 am | **Plenary: *Avoiding the Curriculum Carousel: Approaches to Curriculum Development*** | Sanjeev Sockalingam | Grand Ballroom D/E |
| 11:45 am – 1:00 pm | PA Working Lunch/Caucus Update | Kim Kirchner, C-TAGME, Sharon Ezzo, MA, C-TAGME | Stemmons Ballroom B/D |
| 11:45 am – 1:00 pm | **Lunch** - pick up lunch here and take it to your lunch meeting location below. **Meetings open to AADPRT members only.** Consultations available with ABPN and PRITE experts. Appointments not required. | | East Atrium/Cooper |
| 11:45 am – 1:00 pm | Triple Board/AACAP Lunch Meeting | Kristi Kleinschmit, MD, Mary Gabriel, MD | Rosetta |
| 11:45 am – 1:00 pm | Curriculum Committee Lunch Meeting | Jacqueline Hobbs, MD, PhD, Paul Lee, MD | Batik B |
| 11:45 am – 1:00 pm | Development Committee Lunch Meeting | Erick Hung, MD | Dardanelles |
| 11:45 am – 1:00 pm | Assessment Committee Lunch Meeting | John Q. Young, MD, MPH, PhD | Steuben |
| 11:45 am – 1:00 pm | Membership Committee Lunch Meeting | Kim-Lan Czelusta, MD, Sourav Sengupta, MD, MPH | Peridot |
| 11:45 am – 1:00 pm | Neuroscience Ed Com Lunch Meeting | David Ross, MD, PhD, Mike Travis, MD, Melissa Arbuckle, MD, PhD | Travertine |
| 11:45 am – 1:00 pm | Psychotherapy Committee Lunch Meeting | Erin Crocker, MD | Plum Blossom |
| 11:45 am – 1:00 pm | Recruitment Committee Lunch Meeting | Jessica Kovach, MD | Cardinal A |
| 11:45 am – 1:00 pm | Addictions Task Force Lunch Meeting | Ann Schwartz, MD, Scott Oakman, MD, PhD | Inverness |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| 11:45 am – 1:00 pm | Information Technology Lunch Meeting | John Luo, MD, Ann Cunningham, DO | Edelweiss |
| 11:45 am – 1:00 pm | Regional Representatives Lunch Meeting | Joy Houston, MD | Cardinal B |
| 11:45 am – 1:00 pm | Workforce Taskforce Lunch Meeting | Art Walaszek, MD | Lalique |
| 11:45 am – 1:00 pm | ACGME Curbside Consultations-by appointment only | | Cherry Blossom |
| 1:15 - 2:45 pm | **Plenary: Input and Awards** | Adam Brenner, MD, Melissa Arbuckle, MD, PhD, Sallie DeGolia, MD, MPH | Grand Ballroom C/D/E |
| 2:45 - 4:45 pm | Lifer PA University | Karla Anderson, C-TAGME, Sally Jones, C-TAGME | Stemmons Ballroom B/D |
| 2:45 – 5:15 pm | New PA University | Kimberly Slavsky, MS, Tiffany Hamilton, BA | Stemmons Ballroom A |
| 2:45 - 3:45 pm | **Plenary: ABPN and ACGME Q/A** | Larry Faulkner, MD – ABPN, Bob Boland, MD – ACGME | Grand Ballroom C/D/E |
| 3:45 - 4:00 pm | Coffee Break | | Grand Ballroom Foyer |
| 4:00 - 5:15 pm | **Caucus Meetings** *(open to all meeting attendees)* | | |
| 4:00 - 5:15 pm | Region I: New England (Canada (Quebec, Toronto, Ontario), Connecticut, Maine, Massachusetts, New Hampshire, Road Island, Vermont) | Christine Wittmann, MD, Lee Robinson, MD | Plum Blossom |
| 4:00 - 5:15 pm | Region II: New York | Paul Rosenfield MD, Cathryn Galanter, MD | Wyeth |
| 4:00 - 5:15 pm | Region III: Mid-Atlantic (Delaware, Maryland, New Jersey, Pennsylvania, Washington D.C.) | Ken Certa, MD, Mansoor Malik, MD | Obelisk A |
| 4:00 - 5:15 pm | Region IV: Midwest (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin) | Brian Evans, DO, Ayame Takahashi, MD | Carpenter Ballroom |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| 4:00 - 5:15 pm | Region V: Southeast (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, West Virginia) | Sandra Batsel-Thomas, MD, Dale Peeples, MD | Batik A/B |
| 4:00 - 5:15 pm | Region VI: California | Alan Koike, MD, MS, Richard Lee, MD | Obelisk B |
| 4:00 - 5:15 pm | Region VII: Far West (Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico. Orgegon, Utah, Washington, Wyoming, Canada (Vancouver, Winnipeg, Manitoba, Alberta, British Columbia, Saskatchewan) | Kristen Dunaway, MD, Funda Bachini, MD | Rosetta |
| 5:15 – 5:30 pm | Coffee Break | | Grand Ballroom Foyer |
| 5:30 - 6:45 pm | **Lifetime Service Award Presentation & Plenary: Enhancing the Joy of Teaching** | Adam Brenner, MD, Melissa Arbuckle, MD, PhD, Sallie DeGolia, MD, MPH, Kelley Skeff, MD, PhD | Grand Ballroom C/D/E |
| 6:45 - 8:30 pm | Welcome Reception | | Grand Atrium |
| **6 - Friday** | **Event** | **Leader** | **Room** |
| 7:00 am - 12:00 pm | Annual Meeting Registration | | Atrium Registration Desk |
| 7:00 - 8:00 am | Breakfast with Executive Council Members (except Program Administrators) or join a focus group on faculty burnout | | East Atrium |
| 7:00 - 8:00 am | Meet with your Mentor *(AADPRT encourages you to make plans to meet with your mentor during this time)* | | |
| | | | |
| | | | |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| 7:00 – 8:00 am | PA Breakfast & Programming | Juliet Arthur, MHA, C-TAGME, Zoellen Murphy, BA, C-TAGME, Amber Pearson, C-TAGME, Georgina Rink, C-TAGME | Stemmons B/D |
| 7:00 – 9:15 am | Poster set up | | Grand Ballroom A/B |
| 7:30 am – 3:15 pm | Exhibitors | | Grand Ballroom Foyer |
| 8:00 - 9:30 am | **Educational Workshops Session #3** | | |
| | Graduate Medical Education Funding Made Less Complex *(Intended Audience: all annual meeting attendees)* | Jed Magen, MD | Batik A |
| | When the supervisor needs a supervisor: your guide to training supervisors in best practices *(Intended Audience: all annual meeting attendees)* | Amber Frank, MD, Aimee Murray, Anne Ruble, MD, MPH, Donna Sudak, MD, David Topor, PhD | Plum Blossom A |
| | Feedback, mentorship, and change: Finding Meaning in the Disciplinary Process *(Intended Audience: all annual meeting attendees)* | Adrienne Bentman, MD, Deborah Spitz, MD, Ann Schwartz, MD | Wyeth |
| | The PGAA Tour: Parenting, Guilt, and Adapting in Academia *(Intended Audience: all annual meeting attendees)* | Esther Lee, MD, Sansea Jacobson, MD, Neha Sharma, DO, Isheeta Zalpuri, MD, Robert Kitts, MD | Cardinal B |
| | Addressing the Shortage of Psychiatry Subspecialists: What Residency Educators Can Do *(Intended Audience: all annual meeting attendees)* | Anna Kerlek, MD, Carrie Ernst, MD, Rebecca Klisz-Hulbert, MD, Kari Wolf, MD, Art Walaszek, MD | Fleur de Lis A |
| | Resident Scholarly Activity: From Citation to Commendation! *(Intended Audience: all annual meeting attendees)* | Rashi Aggarwal, MD, Tanya Keeble, MD, Justin Faden, MD, Amy Burns, MD, Muhammad Zeshan, MBBS | Plum Blossom B |

| | | | |
|---|---|---|---|
| | Putting Entrustable Professional Activities (EPAs) into Action: Implementation Tips and Strategies *(Intended Audience: all annual meeting attendees)* | John Q. Young, MD, MPH, PhD, Erick Hung, MD, Colin Stewart, MD, Andrea Weiss, MD, Julie Sadhu, MD | Lalique |
| | Why (and How) Combined Training? Insights from People Who've Been There to Help People Who Might Like to Go There *(Intended Audience: all annual meeting attendees)* | Shannon Suo, MD, Robert McCarron, DO, Sandra Batsel-Thomas, MD, Amy Kim, MD, Sheldon Benjamin, MD | Obelisk A |
| | Teaching Adolescent SUDs and Co-Occurring Disorders Like an Addictions Expert *(Intended Audience: all annual meeting attendees)* | Kelly Blankenship, DO, Sandra DeJong, MD, MSc, Ray Hsiao, MD, Kenneth Zoucha, MD | Obelisk B |
| | Firearms and Suicide Prevention: Why We Should Ask About Guns and How To Train Residents To Have These Conversations *(Intended Audience: all annual meeting attendees)* | Lindsey Pershern, MD, Meagan Whitney, MD, Theresa De Freitas Nicholson, MD | Rosetta |
| | The Evolving Composition of the Psychiatry Residency Trainee Workforce: Analysis of matching trends of International Medical Graduates *(Intended Audience: all annual meeting attendees)* | Sanya Virani, MD, Souparno Mitra, MD, Robert Cotes, MD, Jessica Kovach, MD, Vishal Madaan, MD | Steuben |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| | Diverse Perspectives and Practical Strategies in URM Psychiatry Recruitment, Retention and Development *(Intended Audience: CAP TDs, New TDs, Program Administrators)* | Jaela Barnett, MD, Denese Shervington, MD, Arden Dingle, MD, Danielle Hairston, MD, Sarah Vinson, MD | Cardinal A |
| 9:30 – 10:15 am | Poster Session 1 & Coffee Break | | Grand Ballroom A/B |
| 9:45 - 10:30 am | PA Symposium: ACGME Updates/Web Ads | Louise Castille, MS | Stemmons B/D |
| 10:15 – 11:30 am | **Plenary: Shein Lecture - *Ending Sexual Harrassment and Gender Inequity in Medical Training*** | Reshma Jagsi, MD, D.Phil | Grand Ballroom C/D/E |
| 10:45 - 11:30 am | PA Workshop Session 1: Behind the Scenes of Starting a New Residency Program | Traci Wooden, MHA, Krystal Hernandez, Elizabeth Rashid | Stemmons A |
| 10:45 - 11:30 am | PA Workshop Session 1: When the REAL Kind of Tornado Hits | Regina Boeve | Stemmons B/D |
| 11:45 am - 12:45 pm | **Lunch** - pick up lunch here and take it to your lunch meeting location below. **Regional Reps meeting open to Regional Reps ONLY. NTD breakout assignment is on back of name badge.** Consultations available with ABPN experts. Appointments not required. | | East Atrium/Cooper |
| 11:45 am - 12:45 pm | Posters available to view but presenters may not be available. | | Grand Ballroom A/B |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Sheldon Benjamin, MD | Inverness |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Kari Wolf, MD | Peridot |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Cathleen Cerny-Suelzer, MD | Edelweiss |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Deb Cowley, MD | Dardanelles |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Sandra DeJong, MD, MSc | Travertine |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Ahmad Hameed, MD | Plum Blossom A |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Erick Hung, MD | Steuben |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Michael Jibson, MD, PhD | Fleur de Lis A |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Jessica Kovach, MD | Plum Blossom B |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Lindsey Pershern, MD | Lalique |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Jane Ripperger-Suhler, MD | Wyeth |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Robert Rohrbaugh, MD | Cardinal B |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Ann Schwartz, MD | Batik A |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Deborah Spitz, MD | Batik B |
| 11:45 am - 12:45 pm | NTD Breakout & Lunch | Kaz Nelson, MD | Fleur de Lis B |
| 11:45 am - 12:45 pm | Assistant/Associate TD Caucus Lunch Meeting | Asher Simon, MD | Stemmons A |
| 11:45 am - 12:45 pm | Regional Representatives Committee Lunch Meeting (Regional Representatives ONLY) | Joy Houston, MD | Carpenter Ballroom |
| 11:45 am - 12:45 pm | IMG Caucus Lunch Meeting | Vishal Madaan, MD | Cardinal A |
| 11:45 am - 12:45 pm | ACGME Curbside Consultations-by appointment only | | Cherry Blossom |
| 11:45 am - 12:45 pm | Nominating Committee (committee members only) | Donna Sudak, MD | Presidential Suite |
| 1:00 – 2:30 pm | **Educational Workshops Session #4** | | |
| | Let's Talk About Sex: Improving Sexuality Education for Trainees *(Intended Audience: all annual meeting attendees)* | Cathleen Cerny-Suelzer, MD, Stephen Levine, MD, Victoria Kelly, MD | Batik A |
| | Teaching Addictions: You can do it! (We can help) (Intended Audience: all annual meeting attendees) | Ann Schwartz, MD, Sandra DeJong, MD, MSc, Amber Frank, MD, Scott Oakman, MD, PhD, Ray Hsiao, MD | Plum Blossom A |
| | Professionalism: It ain't what it used to be *(Intended Audience: all annual meeting attendees)* | Randy Welton, MD, Suzie Nelson, MD, Kelly Blankenship, DO | Wyeth |

| | | | |
|---|---|---|---|
| | "Social Media Rounds": Enhancing Resident Competencies in Web 2.0, Social Media and Digital Technologies To Improve Psychiatry Education, Leadership and Patient Care. *(Intended Audience: all annual meeting attendees)* | Carlos Salgado, MD, Sohrab Mosaddad, MD, Xenia Aponte, MD, Tamara Zec, MD | Cardinal B |
| | Take the pain out of planning: Design a highly effective learning session in 10 minutes *(Intended Audience: all annual meeting attendees)* | Kaz Nelson, MD, Jonathan Homans, MD, Lora Wichser, MD | Fleur de Lis A |
| | Optimizing your Leadership Style *(Intended Audience: CAP TDs, New TDs, Program Administrators)* | Rachel Russo, MD, Lia Thomas, MD, Heather Schultz, MD, MPH | Lalique |
| | Listening to All Voices: Cultural Humility in Psychiatry Resident Supervision *(Intended Audience: all annual meeting attendees)* | Raziya Wang, MD Poh Choo How, MD, PhD, Takesha Cooper, MD, MS, Ryan Harris, MD | Obelisk A |
| | Real Change: Approaching physician trainee well-being through evidence-based individual, structural, and systems-level initiatives *(Intended Audience: all annual meeting attendees)* | Aaron Reliford, MD, Sansea Jacobson, MD, Misty Richards, MD, Anne Glowinski, MD, Colin Stewart, MD | Obelisk B |
| | Engaging junior faculty and residents: a comprehensive model for effectively supporting scholarship in early academic careers *(Intended Audience: all annual meeting attendees)* | Anne Penner, MD, Merlin Ariefdjohan, MPH, PhD, Kimberly Kelsay, MD | Rosetta |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| | Creating a Healthy Program: Shifting the Onus of Residency Wellness from the Individual to the Program *(Intended Audience: all annual meeting attendees)* | Julie Wolfe, MD, Heather Murray, MD, MPH, Alyssa Tran, DO, Robert Davies, MD | Steuben |
| | Workforce Development through Psychiatry Residency Tracks and Expansion *(Intended Audience: all annual meeting attendees)* | Deborah Cowley, MD, Rashi Aggarwal, MD, Lindsey Pershern, MD, Kirsten Aaland, MD, Melanie Drake, MD | Cardinal A |
| 1:15 – 2:00 pm | PA Workshop Session 2: How to Get Written Learner Feedback that is Perceived as Helpful Rather than as Retaliatory | Charla Clark, Kari Whatley, MD | Stemmons A |
| 1:15 – 2:00 pm | PA Workshop Session 2: 360 Degrees in Recruitment: Using Your "RAD" to Develop "Winning Formula" | Juliet Arthur, MHA, C-TAGME, Romain Branch, MD, Rishab Gupta, MBBS | Stemmons B/D |
| 2:00 – 2:45 pm | PA Workshop Session 3: What is Your EI? Why Emotional Intelligence is Crucial for Program Coordinator Success! | Jessie Skriner, MS, CHES, Jaime Christensen, C-TAGME, Pamela Carpenter, MEd, C-TAGME | Stemmons A |
| 2:00 – 2:45 pm | PA Workshop Session 3: Finding Your Fire: Professional Development for Program Administrators | Kimberly Slavsky, MS | Stemmons B/D |
| 2:30 - 3:15 pm | Poster Session 2 & Coffee Break | | Grand Ballroom A/B |
| 2:45 - 6:00 pm | CAP Caucus Meeting *(CAP TDs/ATDs only)* | | Grand Ballroom C/D/E |
| 3:15 – 4:45 pm | **Educational Workshops Session #5** | | |

| | | | |
|---|---|---|---|
| | Maintaining a Sense of Wellness Following an Adverse Event: The Development of a Pilot Committee for Resident Safety *(Intended Audience: all annual meeting attendees)* | Vanessa Padilla, MD, Cody Bryant MD, Jessica Healey, MD, Julia Salinas, MD, Omar Munoz, MD | Batik A |
| | Teaching Case Formulation, or, How to Make Meaning Central to Treatment *(Intended Audience: all annual meeting attendees)* | David Mintz, MD, Deborah Cabaniss, MD, David Ross, MD, PhD | Plum Blossom A |
| | Protecting your Trainees and your Program: How to deal with Trainee Unprofessionalism *(Intended Audience: all annual meeting attendees)* | Ahmad Hameed, MD, Ken Certa, MD | Wyeth |
| | Community Based Psychiatry Program Development: A Practical Primer *(Intended Audience: all annual meeting attendees)* | Tanya Keeble, MD, Ann Cunningham, DO, Kelly Blankenship, DO, Bill Sanders, DO, MS, Areef Kassam, MD | Cardinal B |
| | Competency-Based Behavioral Interviewing: Using a structured interview method to enhance residency and fellowship interviews *(Intended Audience: all annual meeting attendees)* | Ashley Walker, MD, Kristy Griffith, MD, Christine Langner, DO | Fleur de Lis A |
| | Adventures in Active Learning: Active Learning Resources to Fit Any Budget *(Intended Audience: all annual meeting attendees)* | Lillian Houston, MD, Cesar Cardenas, Jr., MD | Plum Blossom B |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| | ***WITHDRAWN*** -- To Retreat or Not to Retreat: Strategic Use of Resident Retreats as a Wellness Tool with Cues from the Corporate World *(Intended Audience: all annual meeting attendees)* | Victoria Kelly, MD, Thomas Roach, DO, Nathan Massengill, MD, Zoellen Murphy, BA, C-TAGME, Kristi Williams, MD | Lalique |
| | No More Sitting and Staring at Powerpoint! Using Interactive Teaching Techniques to Enhance Meaning-Making in Trainee Didactics *(Intended Audience: all annual meeting attendees)* | David Hankins, MD, MS, Julie Penzner, MD, Mark Sullivan, MD, Susan Samuels, MD | Obelisk A |
| | Recruitment vs. Selection: Minimizing Systematic Bias During the Match Process *(Intended Audience: all annual meeting attendees)* | Christin Drake, MD, Deepti Anbarasan, MD, D Bhatt, MD, PhD, Tyra Bailey, MA | Obelisk B |
| | Reclaiming Meaning for Everyone: exploring power, privilege, and allyship with psychiatry residents *(Intended Audience: all annual meeting attendees)* | Jackie Wang, MD, Isela Pardo, MD, Belinda Bandstra, MD, MA | Rosetta |
| | Being a Peer Reviewer: Why and How? *(Intended Audience: all annual meeting attendees)* | Rashi Aggarwal, MD, Adam Brenner, MD Richard Balon, MD, Ann Tennier, BA, BS | Steuben |
| | How to become a Journal Club Superstar! *(Intended Audience: all annual meeting attendees)* | Lindsey Pershern, MD, Adriane Dela Cruz, MD, PhD | Cardinal A |
| 3:15 – 4:00 pm | Poster & Exhibitor Tear Down | | Grand Ballroom A/B, Grand Ballroom Foyer |
| 5:00 – 6:00 pm | **Caucuses** *(open to all meeting attendees)* | | |
| 5:00 – 6:00 pm | New Programs Caucus | Daniel Gih, MD | Obelisk B |
| 5:00 – 6:00 pm | Combined Programs Caucus | Sheldon Benjamin, MD | Plum Blossom B |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| 5:00 – 6:00 pm | Director of Small Programs Caucus | Jessica Nelson, MD | Obelisk A |
| 5:00 – 6:00 pm | Global Psychiatry Caucus | | Fleur de Lis A |
| 5:00 – 6:00 pm | Integrated Care Caucus | Anna Ratzliff, MD, PhD | Cardinal A |
| 5:00 – 6:00 pm | Subspecialty Training Directors Caucus | William Newman, MD | Rosetta |
| 5:00 – 6:00 pm | VA Training Director Caucus | Christina Girgis, MD, Alana Iglewicz, MD | Batik A |
| 5:00 – 6:00 pm | Community Programs Caucus | Theadia Carey, MD, MS, Scott Oakman, MD, PhD | Plum Blossom A |
| 5:00 – 6:00 pm | Resident Caucus | Rana Elmaghraby, MD | Carpenter Ballroom |
| 5:00 – 6:00 pm | Vice Chair Caucus | Ahmad Hameed, MD | Steuben |
| 5:00 – 6:00 pm | Teichner Award Interest Group | Gene Beresin, MD, MA, Sherry Katz-Bearnot, MD | Lalique |
| 6:00 – 7:30 pm | President's Reception (Invitation Only) | Adam Brenner, MD | SER Restaurant (27th floor - Tower) |
| **7 - Saturday** | **Event** | **Leader** | **Room** |
| 7:30 – 8:45 am | Executive Council Breakfast Meeting (Council members only) | Adam Brenner, MD | Carpenter Ballroom |
| 7:30 – 8:45 am | PA Breakfast and Symposium | Juliet Arthur, MHA, C-TAGME, Zoellen Murphy, BA, C-TAGME, Amber Pearson, C-TAGME, Chelsea Wimmer, MS, Georgina Rink, C-TAGME | Stemmons B/D |
| 7:30 - 8:45 am | Breakfast and Meet with Your Mentor (AADPRT encourages you to make plans to meet with your mentor during this time) | | East Atrium |
| 9:00 - 9:30 am | **Plenary: Milestones 2.0** | Deb Cowley, MD, Laura Edgar, EdD, CAE | Grand Ballroom C/D/E |
| 9:30 - 10:30 am | **Plenary: President's Symposium: *Creating Solutions to Faculty Burnout*** | William Greenberg, MD, Lillian (Joy) Houston, MD, Kari Wolf, MD | Grand Ballroom C/D/E |
| 10:30 - 10:40 am | **Plenary: Closing Session** | Adam Brenner, MD, Melissa Arbuckle, MD PhD, Donna Sudak, MD Randy Welton, MD | Grand Ballroom C/D/E |
| 10:45 am - 12:00 pm | Meeting of the *Academic Psychiatry* Journal Editorial Board (board members only) | Adam Brenner, MD | Carpenter Ballroom |

**AADPRT ANNUAL MEETING BRAIN CONFERENCE**
**MEETING AT A GLANCE - MARCH 4-7, 2020 (all times central)**

| | | | |
|---|---|---|---|
| 10:50 am - 12:00 pm | **Skills Fair: participants may choose one track or may move between rooms** | | Grand Ballroom C/D/E and Stemmons Ballroom A/B/D |
| | **Skills Fair A: *Fostering a Flourishing Climate for Diversity and Inclusion: From Intention to Action*** | Belinda Bandstra, MD, MA | Grand Ballroom C/D/E |
| 10:50 – 11:10 am | Practical Tips for Promoting Diversity in Recruitment | Belinda Bandstra, MD, MA | Grand Ballroom C/D/E |
| 11:15 – 11:35 am | Practical Tips for Facilitating Real Conversations About Culture and Diversity | Raziya Wang, MD | Grand Ballroom C/D/E |
| 11:40 am - 12:00 pm | Practical Tips for Supervising Across Cultures | Tracey Guthrie, MD | Grand Ballroom C/D/E |
| | | | |
| | **Skills Fair B: *Self-Study: A Survival Guide in Three Stages*** | Erick Hung, MD | Stemmons A |
| 10:50 – 11:10 am | Oh No, What's a Self-Study | Alissa Peterson, MD | Stemmons A |
| 11:15 – 11:35 am | Let the SWOT be Your Guide | Ann Schwartz, MD | Stemmons A |
| 11:40 am - 12:00 pm | We Submitted the Self-Study, Now What? | Erick Hung, MD | Stemmons A |
| | | | |
| | **Skills Fair C: *Upgrade Your Assessment and Feedback*** | Randy Welton, MD | Stemmons B/D |
| 10:50 – 11:10 am | Setting Meaningful Objectives | Kelly Blankenship, DO | Stemmons B/D |
| 11:15 – 11:35 am | Using Structured Assessments | Allison Cowan, MD | Stemmons B/D |
| 11:40 am - 12:00 pm | Providing Actionable Feedback | Suzie Nelson, MD | Stemmons B/D |
| 12:15 – 1:15 pm | Steering Committee Lunch Meeting | Melissa Arbuckle, MD, PhD | Presidential Suite |

# 2020 AADPRT Program Administrator Symposium

| Day | Date | Time | Event | Leader/Presenter | Abstract | Objectives |
|---|---|---|---|---|---|---|
| Wednesday | 3/4/20 | 11:00am - 12:00pm | PA Committee Chairs Meeting | **Kim Kirchner, C-TAGME** | | |
| *Wednesday* | *3/4/20* | *12:00 - 1:15pm* | *Plenary: Lunch, Opening, Business Meeting* | | | |
| *Wednesday* | *3/4/20* | *1:30 - 3:00pm* | *Educational Workshops Session #1* | | | |
| *Wednesday* | *3/4/20* | *3:30 - 5:00pm* | *Educational Workshops Session #2* | | | |
| Wednesday | 3/4/20 | 6:30 - 9:00pm | OPTIONAL Social Gathering | **MetroDemic** | | |
| **Day** | **Date** | **Time** | **Event** | **Leader/Presenter** | **Abstract** | **Objectives** |
| *Thursday* | *3/5/20* | *7:30 - 8:00am* | *General Breakfast* | | | |
| Thursday | 3/5/20 | 8:00 - 8:10am | Welcome and Program Overview | **Planning Committee**<br>Juliet Arthur, MHA, C-TAGME<br>Zoellen Murphy, BA, C-TAGME<br>Amber Pearson, C-TAGME<br>Chelsea Wimmer, MS<br>Georgina Rink, C-TAGME | | |
| Thursday | 3/5/20 | 8:10 - 8:25am | ACGME Updates | **Robert Boland, MD**<br>Chair, ACGME Psychiatry Review Committee | | |
| Thursday | 3/5/20 | 8:25 - 8:30am | AADPRT Introduction/Welcome | **Adam Brenner, MD**<br>President, AADPRT<br>**Sallie DeGolia, MD, MPH**<br>Program Chair, AADPRT<br>**Sara Stramel-Brewer, MA**<br>Executive Director, AADPRT | | |
| Thursday | 3/5/20 | 8:30 - 9:30am | Keynote:<br>Residents are from Venus; Program Administrators are from Mars | **Vicki Dennis, MHA, FACHE**<br>Department Adminstrator,<br>UT Southwestern | | 1. Using the abbreviated DiSC assessment tool, identify your Adapted and Natural style.<br>2. Understand the basic characteristics of each DiSC style.<br>3. Recognize which DiSC styles work best together.<br>4. Identify some tips for using the DiSC style tool to improve communications with residents. |
| Thursday | 3/5/20 | 9:45 - 10:05am | ABPN Updates | **Patti Vondrak, MBA**<br>Vice President, ABPN Operations<br>**Jessica Huber**<br>Manager, ABPN Credentials | | |
| Thursday | 3/5/20 | 10:05 - 10:09am | Lucille Fusaro Meinsler Program Administrator Recognition Award | **Nancy Lenz, BBA, C-TAGME**<br>Chair, AADPRT Lucille Fusaro Meinsler Program Administrator Award Committee | | |

NOTE: All times listed are in CST. During times without PA Symposium-specific events, PAs are encouraged to participate in other annual meeting activities including plenaries, workshops, caucuses, skills fair, etc.

# 2020 AADPRT Program Administrator Symposium

| | | | | | | |
|---|---|---|---|---|---|---|
| Thursday | 3/5/20 | 10:10 - 10:18am | Five Minute Tips:<br>Fostering Psychological and Emotional Well-Being of Residents | **Ryan Flynn, BA**<br>Program Administrator<br>Albert Einstein Medical Center | Given the fast-paced and stressful nature of Psychiatry, both residents and faculty members alike are at risk for burnout and depression. Residency programs, as well as their Sponsoring Institutions, hold the responsibility to address psychological and emotional well-being just as much as other aspects of resident competence (e.g. medical knowledge and professionalism). This presentation aims to provide a clear picture of what is expected from the ACGME regarding resident well-being, and to offer helpful resources and program policies that program coordinators can adopt. | 1. Defining ACGME common program requirements and expectations for resident well-being<br>2. Provide suggestions for practical resources and programming that can help foster resident well-being |
| Thursday | 3/5/20 | 10:19 - 10:27am | Five Minute Tips:<br>FaceCards: Documented Evaluations of Resident's Performance from Patients | **Debbie Bibeau, C-TAGME**<br>Program Administrator<br>Baystate Medical Center | Our institutions Program Administrators (all programs) collectively came up with a solution to patient evaluations of residents given the challenges of computer access for patients and providing feedback from them prior to leaving the hospital/outpatient office. My presentation will offer another way for Program Administrators to provide feedback from patients on resident's performance that helps us meet the ACGME requirement. | 1. Provide another option for obtaining patient evaluations of residents to meet the ACGME requirements |
| Thursday | 3/5/20 | 10:28 - 10:36am | Five Minute Tips:<br>Residency Newsletter | **Regina Boeve**<br>Program Administrator<br>University of South Dakota | A weekly newsletter sent to residents, PDs and acquired faculty including birthdays, outstanding evaluations, reminders, things to do in city, announcements, etc. | 1. To decrease email flow but still get all important information to the appropriate places<br>2. Wellness, program communication |
| Thursday | 3/5/20 | 10:37 - 10:44am | Five Minute Tips:<br>The 3 P's: Public Speaking, Presentations, Persuasion | **Sharon Ezzo, MA, C-TAGME**<br>Program Manager<br>Cleveland Clinic Foundation | From minor meetings, to making a boardroom presentation or delivering a presentation at a national conference. Advice and guidance for planning, practicing, and putting together something that will be effective and memorable. Sharing techniques to develop this important skill is a great way to empower program administrators. | 1. Getting comfortable in public speaking situations<br>2. Tips for making effective presentations<br>3. Developing the ability to influence other people |
| Thursday | 3/5/20 | 10:45 - 11:30am | Questions and Answers Panel | **Roopali Bhargava**<br>Program Administrator<br>Cambridge Health Alliance | Everyday coordinators face hard problems or questions that we just don't know what to do with. We deal with problem residents, communication issues, technology frustrations, etc. This panel will offer attendees a chance to present problem scenarios before our meeting, and have our panelists, in real time at the conference, discuss their proposed solutions or what they would do in the situation. | 1. Equip coordinators with solutions to the tough problems that they face in residency training<br>2. Have seasoned training directors and coordinators share their history and knowledge about residency training with attendees |
| Thursday | 3/5/20 | 11:45am - 1:00pm | Program Administrators Working Lunch/Caucus Update on Caucus Activities | **Kim Kirchner, C-TAGME**<br>Caucus Chair, AADPRT<br>**Sharon Ezzo, MA, C-TAGME**<br>Caucus Chair Elect, AADPRT | | |
| *Thursday* | *3/5/20* | *1:15 - 2:45pm* | *Plenary: Input and Awards* | ***Adam Brenner, MD***<br>***Melissa Arbuckle, MD, PhD***<br>***Sallie DeGolia, MD, MPH*** | | |

NOTE: All times listed are in CST. During times without PA Symposium-specific events, PAs are encouraged to participate in other annual meeting activities including plenaries, workshops, caucuses, skills fair, etc.

# 2020 AADPRT Program Administrator Symposium

| | | | | | | |
|---|---|---|---|---|---|---|
| Thursday | 3/5/20 | 2:45 - 5:15pm | New Program Administrators University | **Kimberly Slavsky, MS**<br>Program Administrator<br>University of Colorado<br>**Tiffany Hamilton, BA**<br>Program Administrator<br>University of Colorado | This workshop offers a comprehensive review of administrative tasks for all new program administrators in order to master their program's management and accreditation requirements. The workshop will be interactive with the new coordinators, giving different perspectives, from years of the presenters' experience. This workshop will give tips and advice on how build a successful relationship as an administrator with their program leadership and trainees. Participants will be provided with documentation that can be altered to fit individual training programs including a yearly calendar of events, an acronym list and other program management tools. | 1. Gain an understanding of structure for the academic year and how to plan for efficiency to meet deadlines<br>2. Understand the different organizations that programs interact with during the academic year<br>3. Start to learn how to develop institutional knowledge as a program resource |
| Thursday | 3/5/20 | 2:45 - 4:45pm | Lifers Program Administrators University: Scheduling Your Non-Negotiable Time | **Karla Anderson, C-TAGME**<br>Program Administrator<br>University of Kentucky<br>**Sally Jones, C-TAGME**<br>Medical Education Specialist<br>University of Kentucky | As program administrators we are the core-person everyone comes to with questions and concerns on the daily basis. We stop what we are doing to help others. Creating time in your weekly schedule to focus on your wellness and not allowing anything to interfere with this time helps make me a more productive and satisfied program administrator. | 1. Identify the times and days of the week that is least interruptive to program<br>2. Create a schedule that maximizes your time for wellness<br>3. Commit to following the schedule |
| **Day** | **Date** | **Time** | **Event** | **Leader/Presenter** | **Abstract** | **Objectives** |
| Friday | 3/6/20 | 7:00 - 8:00am | Breakfast | | | |
| Friday | 3/6/20 | 7:15 - 7:20am | Program Overview | **Planning Committee**<br>Juliet Arthur, MHA, C-TAGME<br>Zoellen Murphy, BA, C-TAGME<br>Amber Pearson, C-TAGME<br>Chelsea Wimmer, MS<br>Georgina Rink, C-TAGME | | |
| Friday | 3/6/20 | 7:20 - 7:45am | Mentoring, Professional Development and TAGME | **Sharon Ezzo, MA, C-TAGME**<br>Program Manager<br>Cleveland Clinic Foundation<br>**Tracy Hendershot**<br>Program Administrator<br>Geisinger Health System<br>**Jaime Christensen, C-TAGME**<br>Education Director<br>University of Utah | This session will encompass the mentoring and networking resources available to program administrators through AADPRT. We will also review the professional development opportunities that align with mentorship, and review the application process for TAGME certification. | 1. Utilizing mentorship to assist with your own personal and professional development<br>2. Preparing for TAGME certification: eligibility and application process |
| *Friday* | *3/6/20* | *8:00 - 9:30am* | *Educational Workshops Session #3* | | | |
| Friday | 3/6/20 | 9:45 - 10:30am | ACGME Updates/WebADS | **Louise Castile, MS**<br>Executive Director, ACGME Psychiatry Review Committee | | |

NOTE: All times listed are in CST. During times without PA Symposium-specific events, PAs are encouraged to participate in other annual meeting activities including plenaries, workshops, caucuses, skills fair, etc.

# 2020 AADPRT Program Administrator Symposium

| | | | | | | |
|---|---|---|---|---|---|---|
| Friday | 3/6/20 | 10:45 - 11:30am | PA Workshop Session 1A: Behind the Scenes of Starting a New Residency Program | **Traci Wooden, MHA**<br>Program Administrator<br>University of Central Florida (Gainesville)<br>**Krystal Hernandez**<br>Program Administrator<br>University of Central Florida (Osceola)<br>**Elizabeth Rashid**<br>Program Administrator<br>University of Nebraska | During this workshop, we will split up the stages of building a new program into the following- Stage 1, Stage 2 and Stage 3. Stage 1 will focus on applying for initial accreditation, gathering faculty and sites, the first recruitment season, building/creating a curriculum, program planning and the first full cycle of GME including match, onboarding, orientation, CCC/PEC, wellness and more. Stage 2 will focus on more program planning, including building a new clinic, building electives, adding faculty, faculty development, continued accreditation site visit, building a senior curriculum and chief resident selection. Stage 3 will discuss board prep and board passing rates, graduation, preparing residents for job searches, having a chief resident, recruiting own residents, expanding the residency/adding fellowships or a rural track, the transition for faculty and residents in a growing program. We plan to provide program administrators with the knowledge they need to build a new program and discuss some key factors that specifically affect a new and upcoming psychiatry residency program. | 1. Obtain knowledge on how to build a new program from the ground up<br>2. Obtain a clear understanding of the 3 different stages of building a new program<br>3. Provide with easy tips on how prepare residents and faculty for the transitioning periods of new and growing programs |
| Friday | 3/6/20 | 10:45 - 11:30am | PA Workshop Session 1B: When the REAL Kind of Tornado Hits | **Regina Boeve**<br>Program Administrator<br>University of South Dakota | On September 10th, 2019, our main training facility got hit by a tornado that left our facility patient less. (No one was seriously injured!) Patients got moved all over to various hospitals with open beds, Residents/Fellows had to be rescheduled, state cars needed to be reserved, daily per diem rates needed to be reviewed, call schedules etc. Even though the tornado didn't even touch my office/desk, it sure feels like it did something to my brain! | 1. Natural disaster rotation<br>2. Schedule changes<br>3. Teamwork |
| *Friday* | *3/6/20* | *11:45am - 12:45pm* | *General Lunch* | | | |
| Friday | 3/6/20 | 1:15 - 2:00pm | PA Workshop Session 2A: How to Get Written Learner Feedback That is Perceived as Helpful Rather Than as Retaliatory | **Charla Clark**<br>Program Administrator<br>University of Texas Austin<br>**Kari Whatley, MD**<br>CAP Fellow<br>University of Texas Austin | Evaluations have been a struggle for many years to get completed evaluations with useful information. We are going to conduct research for the best ways to increase completion of written fellow evaluations. We are also comparing diverse ways to receive constructive and useful written feedback as opposed to personal, offensive and retaliatory comments. We will then be taking the information from the research and will use the results to incorporate in to our written fellow evaluations for this year. We will discuss the cycle of evaluations from the beginning to what is done with the information. | 1. Differentiate the various purposes of the diverse types of written evaluations<br>2. Identify and summarize potential barriers on receiving quality written feedback from evaluations<br>3. Compare ways to improve the quantity and quality of written evaluations<br>4. Develop solutions for overcoming potential barriers to receiving quality written feedback from evaluations |
| Friday | 3/6/20 | 1:15 - 2:00pm | PA Workshop Session 2B: 360 Degrees in Recruitment: Using your "RAD" to Develop a "Winning Formula" | **Juliet Arthur, MHA, C-TAGME**<br>Program Administrator<br>SUNY Downstate Health Sciences<br>**Romain Branch, MD**<br>Residency Program Director<br>Nassau University<br>**Rishab Gupta, MBBS**<br>Chief Psychiatry Resident<br>SUNY Downstate Health Sciences | For a PD, running a residency program is very complicated. There is a direct dependency on the Program Administrator and the Chief Resident(s). In this presentation, we will demonstrate how the use of RAD as a team can improve your recruitment process(es) and the overall program from a 360 degree(s) (perspective). | 1. Understand how collaboration between the Residents, Administrator, and (Program) Director can be maximized to facilitate recruitment of the 'best' applicants<br>2. Understand how to utilize residents (particularly, chief residents) throughout the recruitment (interview and evaluation) process<br>3. Understand how to complete a 360–degree evaluation process through the application/utilization of "RAD" |

NOTE: All times listed are in CST. During times without PA Symposium-specific events, PAs are encouraged to participate in other annual meeting activities including plenaries, workshops, caucuses, skills fair, etc.

# 2020 AADPRT Program Administrator Symposium

| | | | | | | |
|---|---|---|---|---|---|---|
| Friday | 3/6/20 | 2:00 - 2:45pm | PA Workshop Session 3A: What is your EI? Why Emotional Intelligence is Crucial for Program Coordinator Success! | **Jessie Skriner, MS, CHES**<br>Program Administrator<br>University of Utah<br>**Jaime Christensen, C-TAGME**<br>Education Director<br>University of Utah<br>**Pamela Carpenter, MEd, C-TAGME**<br>Education Director<br>University of Utah | Emotional Intelligence is the ability to manage one's emotions and the emotions of others. This is a vital key to guiding communication and professional relationships. As program administrators, our role can be seriously complicated by managing emotional relationships with our peers, leadership, and trainees. Skills in assessing not only our response to interpersonal obstacles but also coaching others to similarly react are invaluable. | 1. Define Emotional Intelligence and its importance in the workplace, specifically as it pertains to the program coordinator role<br>2. Utilize tools to assess individual EI and discuss the components of EI in workplace relationships<br>3. Practice EI tenets for increased self-awareness and demonstrate coaching techniques for others |
| Friday | 3/6/20 | 2:00 - 2:45pm | PA Workshop Session 3B: Finding Your Fire: Professional Development for Program Administrators | **Kimberly Slavsky, MS**<br>Program Administrator<br>University of Colorado Denver | This presentation will discuss how program administrators can find opportunities within their institutions for professional development and how to incorporate those opportunities into their roles with potential for changing positions within graduate medical education or outside of the system. This program will also discuss advocacy for program administrators and building better relationships with the program's leadership and department teams. | 1. Identify areas of interest for professional development<br>2. Develop implementation plans<br>3. How to network with others within similar interests |
| *Friday* | *3/6/20* | *3:15 - 4:45pm* | *Educational Workshops Session #5* | | | |
| **Day** | **Date** | **Time** | **Event** | **Leader/Presenter** | **Abstract** | **Objectives** |
| Saturday | 3/7/20 | 7:30 - 8:45am | Breakfast | | | |
| Saturday | 3/7/20 | 7:30 - 7:40am | Program Overview | **Planning Committee**<br>Juliet Arthur, MHA, C-TAGME<br>Zoellen Murphy, BA, C-TAGME<br>Amber Pearson, C-TAGME<br>Chelsea Wimmer, MS<br>Georgina Rink, C-TAGME | | |
| Saturday | 3/7/20 | 7:40 - 8:40am | Wellness:<br>Attitude of Gratitude | **Britany Griffin**<br>Program Administrator<br>University of Florida<br>**Cynthia Medina, C-TAGME**<br>Program Administrator<br>Citrus Health Network | The word gratitude comes from the Latin word gratia, which means gratefulness. Gratitude encompasses an appreciation for all the things an individual receives. Gratitude can improve one's overall happiness and wellbeing by providing lasting benefits to one's health, emotions, personality, career, and social life. This workshop will explore practices for incorporating an "Attitude of Gratitude" into everyday life. | |
| Saturday | 3/7/20 | 8:40 - 8:45am | Wrap-Up | **Planning Committee**<br>Juliet Arthur, MHA, C-TAGME<br>Zoellen Murphy, BA, C-TAGME<br>Amber Pearson, C-TAGME<br>Chelsea Wimmer, MS<br>Georgina Rink, C-TAGME | | |
| *Saturday* | *3/7/20* | *9:00 - 9:30am* | *Plenary: Milestones 2.0* | ***Deb Cowley, MD*** | | |
| *Saturday* | *3/7/20* | *9:30 - 10:30am* | *Plenary: President's Symposium: Creating Solutions to Faculty Burnout* | | | |
| *Saturday* | *3/7/20* | *10:30 - 10:40am* | *Plenary: Closing Session* | ***Adam Brenner, MD***<br>***Melissa Arbuckle, MD, PhD***<br>***Donna Sudak, MD***<br>***Randy Welton, MD*** | | |
| *Saturday* | *3/7/20* | *10:50 - 12:00pm* | *Skills Fair* | | | |

NOTE: All times listed are in CST. During times without PA Symposium-specific events, PAs are encouraged to participate in other annual meeting activities including plenaries, workshops, caucuses, skills fair, etc.

# Welcome Important Information for Registrants

## Internet Access

Complimentary wireless Internet is available in the hotel lobby, restaurants, and conference areas. The login below is for the conference space. Complimentary guest room internet access information will be provided at check-in to Hilton Honors Members.

**Network**: **AADPRT2020 (case sensitive)**

**Access Code: AADPRT2020 (case sensitive)**

## Silence your Devices

As a courtesy to all meeting attendees, please remember to silence all electronic devices.

## Poster Sessions

Attendees may view posters Friday, March 6, 9:30 am - 10:15 am and 2:30 - 3:30 pm. All sessions will take place inside Grand Ballroom A&B located on the lobby level.

## Poster and Workshop Materials Presenters

Share your workshop/poster materials with colleagues. Upload them to:.

**https://xsimple.formstack.com/forms/aadprt20materials**

## Meeting Evaluation and CME Credit/Certificates

**To get your CME:**

1. **You must have signed in at registration.**
2. You will receive an email immediately following the close of the meeting on Saturday, March 7 that will include a link to APA's website where the evaluation will be.
3. **The evaluation must be completed no later than May 7, 2020 (no exceptions).**
4. Upon completing your evaluation, your certificate will be generated. You must print or save it at this time. We suggest you do not complete the evaluation on phone or tablet for this reason.

## New! Annual Meeting Virtual Journal

Springer publishing developed a unique journal issue for the AADPRT Annual Meeting. It's full of articles pertaining to this year's meeting topics.
Go to: **https://www.springer.com/journal/40596/updates/17649844**

## Have suggestions for the 2022 Pre-meeting?

If you have topic and leader ideas for the meeting that precedes the Annual Meeting, let us know! Go to: **https://tinyurl.com/rhjdfpq**

# 2020 CME Credit Hour Breakdown

| | | | |
|---|---|---|---|
| **Wednesday, March 4** | | | |
| 7:30am - 12:00pm | BRAIN Conference Breakout Groups, Wrap-up | 4.00 | |
| 12:15-1:15pm | Opening Session, Business Meeting | 1.00 | |
| 1:30-3:00pm, 3:30-5:00pm | Educational workshops sessions 1 & 2 | 3.00 | |
| | | | |
| **Thursday, March 5** | | | |
| 8:00-9:45am | New Training Directors Symposium | 1.75 | |
| OR | | | |
| 8:30-9:45am | Early Career Workshop | | 1.25 |
| OR | | | |
| 8:30-9:45am | Midlife Career Workshop | | 1.25 |
| OR | | | |
| 8:30-9:45am | Lifers' Workshop | | 1.25 |
| 10:00-11:30am | Faculty Development | 1.50 | |
| 1:15 - 2:45 pm | Input Session | 0.75 | |
| 2:45-3:45pm | ABPN Q&A, ACGME Q&A | 1.00 | |
| 5:45-6:45pm | Plenary Session | 1.00 | |
| | | | |
| **Friday, March 6** | | | |
| 8:00-9:30am | Educational Workshop Session 3 | 1.50 | |
| 9:30-10:15am | Poster Session 1 | 0.75 | |
| 10:15-11:30am | Plenary Session: Shein Lecture | 1.25 | |
| 11:45am-12:45pm | New Training Director Breakout | 1.00 | |
| 1:00-2:30pm | Educational Workshop Session 4 | 1.50 | |
| 2:30-3:15pm | Poster Session 2 | 0.75 | |
| 3:15-4:45pm | Educational Workshop Session 5 | 1.5 | |
| | | | |
| | | | |
| **Saturday, March 7** | | | |
| 9:00 - 10:30 am | President's Symposium | 1.50 | |
| 10:30 - 10:45 am | Closing Session | 0.25 | |
| 10:45 am - 12:00 pm | Skills Fair | 1.00 | |
| | 10:50-11:10a | | |
| | 11:15-11:35a | | |
| | 11:40a-12:00p | | |
| **Maximum hours to be earned** | | **25.00** | |

## ACCREDITATION AND DISCLOSURE STATEMENTS

**Accreditation Statement:** This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the American Psychiatric Association (APA) and AADPRT. The APA is accredited by the ACCME to provide continuing medical education for physicians. The APA designates this live activity for a maximum of 25 AMA PRA Category 1 Credit ™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Disclosure Statement:** It is the policy of the APA to comply with the ACCME Standards for commercial support of CME. Planning committee members and related staff disclosures must be on file annually with disclosures made available on program materials. Faculty participating in sponsored or jointly sponsored programs by APA are required to disclose to the program audience any real or apparent financial relationships with commercial interests related to the content of their presentation. Faculty are also responsible for disclosing any discussion of off-label or investigational use of a product.

**Messages for Attendees**
Messages for attendees can be left at the front desk of the Hilton Anatole.

## Registration Check-in

Attendees who have pre-registered should sign in and pick up name badges/materials at the Meeting Registration Desk during the times listed below. For those registering on site, please be aware:

1) Credit card payment is due at time of registration.
2) The onsite fee will be $25 higher than the highest posted rate.

| | | |
|---|---|---|
| **Tuesday** | **Lobby Level**<br>Atrium Regisration Desk | 3:30 pm - 7:30 pm |
| **Wednesday** | **Lobby Level**<br>Atrium Regisration Desk | 7:00 am - 6:00 pm |
| **Thursday** | **Lobby Level**<br>Atrium Regisration Desk | 7:30 am - 5:30 pm |
| **Friday** | **Lobby Level**<br>Atrium Regisration Desk | 7:00 am - 12:00 pm |

**Exhibitors**

AACAP (American Academy of Child & Adolescent Psychiatry)
Academic Psychiatry - Springer American Physician Institute
APA (American Psychiatric Association)
APA, Inc (American Professional Agency)
APAP (American Psychiatric Association Publishing)
Menninger Clinic
Neuroscience Education Institute
PRMS (Professional Risk Management Services, LLC)
Rosh Review
True Learn

**Exhibitor Schedule**
**Grand Ballroom Foyer (lobby level)**

| | |
|---|---|
| **Thursday** | 8:00 am - 5:30 pm |
| **Friday** | 7:30 am - 3:15 pm |

## Executive Council > March 2019 – 2020

| Position | Name |
|---|---|
| President | Adam Brenner, MD |
| President-elect | Melissa Arbuckle, MD, PhD |
| Secretary | Mike Travis, MD |
| Treasurer | Ann Schwartz, MD |
| Program Chair | Sallie DeGolia, MD, MPH |
| **CHAIRS** | |
| ACGME Liaison Committee | Adam Brenner, MD |
| Child & Adolescent Caucus | Erica Shoemaker, MD, MPH |
| Curriculum | Jacqueline Hobbs, MD, PhD<br>Paul Lee, MD, MPH |
| Development | Erick Hung, MD |
| Diversity and Inclusion | Adrienne Adams, MD, MSc |
| IMG Caucus | Vishal Madaan, MD |
| Information Management | John Luo, MD<br>Ann Cunningham, DO |
| Membership | Kim-Lan Czelusta, MD<br>Sourav Sengupta, MD, MPH |
| Neuroscience Education (BRAIN Conference) | David Ross, MD, PhD |
| Psychotherapy | Erin Crocker, MD |
| Recruitment | Jessica Kovach, MD |
| Regional Representatives | Joy Houston, MD |
| Subspecialty Caucus | Will Newman, MD |
| **APPOINTED MEMBERS** | |
| Workforce Task Force<br>Addictions Task Force<br>Presidential Appointee | Art Walaszek, MD<br>Ann Schwartz, MD<br>Tracey Guthrie, MD |
| **LIAISONS** | |
| Governance Board, *Academic Psychiatry* | Sheldon Benjamin, MD |
| APA Council on Medical Education | Richard Summers, MD |
| Liaison, Residency Explorer Project with the NRMP/AAMC | Jessica Kovach, MD |
| **PAST PRESIDENTS** | Donna Sudak, MD<br>Sandra DeJong, MD, MSc |

## The American Association of Directors of Psychiatric Residency Training wishes to express its sincere gratitude to:

The American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) for their grant support for this year's Victor J. Teichner Award

Professional Risk Management Services, Inc. (PRMS). Thanks to their generosity, our 2020 resident recipients of the IMG and Henderson awards are able to attend the AADPRT Annual Meeting so they may be recognized in front of their peers for their notable accomplishments. We extend our sincere gratitude to PRMS for this outstanding gesture of support for the future of psychiatry.

---

## In 2011, AADPRT began requesting member support for its fellowship and award programs. We are grateful to this year's contributors for their support:

Melissa Arbuckle, MD, PhD
Sheldon Benjamin, MD
Adam Brenner, MD
E. Cabrina Campbell, MD
Erin Crocker, MD
Ann Cunningham, DO
Kim-Lan Czelusta, MD
Sallie DeGolia, MD, MPH
Sandra DeJong, MD, MSc
Tracey Guthrie, MD
Joy Houston, MD
Erick Hung, MD
Jessica Kovach, MD
Mara Pheister, MD
David Ross, MD, PhD
Sourav Sengupta, MD, MPH
Erica Shoemaker, MD
Donna Sudak, MD
Richard Summers, MD
Art Walaszek, MD

We ask for your continued help funding our highly beneficial fellowship and award programs: AADPRT/George Ginsberg, MD Fellowship, Nyapati Rao and Francis Lu International Medical Graduate in Psychiatry (IMG) Fellowship, Peter Henderson, MD Memorial Paper Award, Lucille Fusaro Meinsler Psychiatric Residency Program Administrator Award.

Your contribution will be used exclusively to support the educational experience of the trainee award recipients. The cost of administering these fellowships is borne by our organization, so 100% of your donation is used for educational purposes. **Give to build the future of AADPRT** today!

# BRAIN Conference

| | |
|---|---|
| **Your name** | Ashley Walker, MD |
| **Abstract title** | 2020 BRAIN CONFERENCE: Navigating Modern Neuroscience |
| **Your role in this abstract** | Co-leader |
| **Educational Objectives** | This year's BRAIN Conference will continue to focus on strategies to teach neuroscience and incorporate a modern neuroscience perspective into clinical care. This half-day conference will include a series of workshops designed to:<br><br>1) Empower faculty with or without a neuroscience background to feel confident that they can teach neuroscience effectively;<br>2) Engage conference attendees to participate as both student and instructor using new and innovative teaching methods; and<br>3) Provide programs with resources for how they might address, teach, and assess neuroscience-specific milestones.<br><br>Through large and small group activities, attendees will receive training in various new and creative approaches to teaching neuroscience.<br><br>The registration fee for the BRAIN Conference will cover all sessions, hand-outs, and breakfast. Sign up online when registering for the AADPRT meeting. We hope you will join us for a fun and exciting morning! |
| **Practice Gap** | Psychiatry is in the midst of a paradigm shift. The diseases we treat are increasingly understood in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry. Yet most psychiatrists have a relatively minimal knowledge of neuroscience. This may be due to many factors, including the difficulty of keeping pace with a rapidly advancing field or a lack of exposure to neuroscience during training. To date, neuroscience has generally not been taught in a way that is engaging, accessible, and relevant to patient care. Much of neuroscience education has remained lecture-based without employing active, adult learning principles. It is also frequently taught in a way that seems devoid of clinical relevance, disconnected from the patient's story and life experience, and separated from the importance of the therapeutic alliance. Regardless of the reason, what has resulted is an enormous practice gap: despite the central role that neuroscience plays in psychiatry, we continue to under-represent and fail to integrate this essential perspective in our work. |

| | |
|---|---|
| **Scientific Citations** | 1. Insel, T. The future of psychiatry (= Clinical Neuroscience). April 20, 2012. https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2012/the-future-of-psychiatry-clinical-neuroscience.shtml. Accessed October 24th, 2017.<br>2. Ross, DA, Travis, MJ, Arbuckle, MR. "The future of psychiatry as clinical neuroscience: Why not now?" JAMA Psychiatry, 2015; 72(5):413-414. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5347976/<br>3. Arbuckle, MR, Travis, MJ, Ross, DA. "Integrating a neuroscience perspective into clinical psychiatry today". JAMA Psychiatry, 2017; 74(4):313-314. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5501322/ |
| **Workshop Abstract** | Each year, the impact of modern neuroscience on psychiatry becomes increasingly clear. While biological models of mental illness once emphasized "chemical imbalances", modern perspectives increasingly incorporate the role of genetics and epigenetics, a more nuanced understanding of molecular pathways, the importance of neuroplasticity, functional dynamics of neural circuits, and a range of novel therapeutic approaches.<br><br>But the challenge of integrating this content into our practice - and into the curricula that will train the next generation of psychiatrists - remains massive. Which content should be emphasized? And, critically, how can we bring this material to life in a compelling and engaging manner?<br><br>In this year's BRAIN conference, participants will have the opportunity to define their own personal learning objectives - both as a teacher and as a student. They will then select from sessions that are designed to bring a wide range of neuroscience content to life, employing a diverse set of teaching methods.<br><br>BRAIN 2020: Navigating Modern Neuroscience. |
| **Additional presenter 1** | David Ross, MD, PhD |
| **Additional presenter 2** | Joseph Cooper, MD |

# Opening Session

| | |
|---|---|
| **Your name** | Sallie DeGolia, MD, MPH |
| **Abstract title** | Opening Session |
| **Your role in this abstract** | Co-leader |
| **Educational Objectives** | - Provide AADPRT members with important, up to date information about AADPRT Committees and Task Forces relevant to achieving AADPRT's mission and to improving psychiatry residency training.<br>- Describe national issues in psychiatric education. |
| **Practice Gap** | Training Directors need to be aware of the work of our organization. Feedback from past meetings continues to reinforce the need for transparency within the organization and a pathway to involvement and leadership. |

# New Training Director Symposium

| | |
|---|---|
| **Your name** | Kim-Lan Czelusta, MD |
| **Abstract title** | New Training Director Symposium |
| **Your role in this abstract** | Co-leader |
| **Educational Objectives** | 1) To provide new Program Directors with basic information and important tools to succeed in the administration and coordination of their programs;<br>2) To provide a framework that helps new Program Directors advance their academic careers by networking and seizing opportunities within local and national organizations and regulatory agencies (e.g., AADPRT, ACGME, ABPN);<br>3) To provide a forum for interactive discussion in small groups led by senior Program Directors to discuss common problems new directors face. |
| **Practice Gap** | In many instances, new Program Directors are introduced into their new role with insufficient training about the highly demanding managerial aspect of their jobs and a lack of mentorship (1). They quickly need to learn the numerous administrative requirements and expectations set by regulatory agencies. Program directors and associate program directors need administrative leadership development and resources, separate from general faculty development to meet their role-specific needs for orientation and development and to better equip them to meet GME leadership challenges (2). With this challenging task, it is not uncommon for new training directors to lose track of their own professional and career goals. This workshop intends to provide a roadmap of how to advance their careers at the same time they maintain and enhance their training programs. |
| **Scientific Citations** | 1. Arbuckle MR, DeGolia SG, Esposito K, Miller E, Weinberg M, Brenner AM. Associate Residency Training Directors in Psychiatry: Demographics, Professional Activities, and Job Satisfaction. Academic Psychiatry 36(5):391- 394, 2012.<br>2. Haan CK, Zenni EA, West DT, Genuardi FJ. Graduate Medical Education Leadership Development Curriculum for Program Directors. J of Grad Med Ed 3(2):232-235, 2011. |

| | |
|---|---|
| **Workshop Abstract** | Program Directors (PDs) are in the unique position of certifying that each graduate is competent to practice independently in the community. This privileged position comes with significant responsibilities and requires substantial expertise to ensure that training is effective and that each graduate has gained the requisite knowledge, skills, and professionalism for independent practice. Success as a PD relies on developing a practical, organized approach to daily demands while relying on the support of colleagues, mentors, and the Program Coordinator. Ultimately, career satisfaction derives from watching your trainees develop into leaders in advocacy, research, education, and patient care in the field.<br><br>The workshop has two parts:<br><br>1) Brief didactics: Designed to orient the new Program Directors (and Associate/Assistant PDs) to the position, to career opportunities, to new challenges, and to AADPRT as an organization. The didactic portion includes "nuts and bolts" of being a new training director<br>2) Small Break-Out Groups: Led by senior PDs and Assistant/Associate PDs in general and child and adolescent psychiatry, these groups will offer their new peer group members the opportunity to meet, network and discuss practical solutions to challenges and opportunities faced. An experienced director will facilitate discussion of issues confronting the group's new directors. Participants are invited to present current problems in their own programs. Group members will work together to develop constructive responses and solutions. In the spirit of teaching the teachers, we hope to enhance the knowledge and skills of each training director as they approach their new role, to facilitate long-term working relationships, and to promote the organizational philosophy of joint collaboration in the interest of training the next generation of superior psychiatrists. |
| **Additional presenter 1** | Sourav Sengupta, MD |

# Early-Career Workshop

| | |
|---|---|
| **Your name** | Adrienne Bentman, MD |
| **Abstract title** | Becoming a Residency Training Director:  Identity and a Framework for the Role |
| **Your role in this abstract** | Leader |
| **Educational Objectives** | At the end of the workshop, participants will be able to:<br>1. Recognize the import of "role and task" to the work of the program director<br>2. Appreciate the function of creating a "holding environment" which supports learning<br>3. Identify the role of the training director in facilitating the residents' development of their identity as psychiatrists<br>4. Discuss the development of their own identity as program director<br>5. Address the challenges to an early career program director's identity development |
| **Practice Gap** | After a new program director learns the ACGME Psychiatry Review Committee's requirements and begins to translate them into programs, rotations and courses, what comes next?  Is there a unifying context in which we conduct our work?  We propose that that context is provided by developing one's identity as a program director and suggest that this provides not only a framework for our decisions but provides meaning for us, and for the faculty, residents, and organizational leadership. |
| **Scientific Citations** | 1. Wald HS.  Professional Identity (Trans)Formation in Medical Education: Reflection, Relationship, Resilience.  Academic Medicine. 2015; 90:701-706.<br>2. Van der Zwet J, Zwietering PJ, Teunissen PW, van der Vleuten CP, Scherpbier AJ.  Workplace Learning from a Scio-cultural Perspective: Creating Developmental Space during the General Practice Clerkship.  Adv Health Sci Educ Theory Pract.  2011; 16:359-373.<br>3. Epstein RM.  Reflection, Perception, and Acquisition of Wisdom. Medical Education.  2008; 42:1048-1050.<br>4. Coles R.  Lives of Moral Leadership.  New York, NY:  Random House; 2000. |

| | |
|---|---|
| **Workshop Abstract** | The first years of a program director's (PD) career are spent learning what the initials of residency education's alphabet soup - ABPN, PreCERT, ACGME, WebADS, NRMP, ERAS - stand for and what one's obligations are to each one. And inevitably there are emergencies in one part of the program on another. As the PD/APD gets a few orientation -recruitment -graduation cycles under their belt, the PD/APD can begin to think about specific rotations, didactics, and supervision. Left at this, the work may seem lifeless, a complex checklist of items completed and fires doused. So what are the constructs which make sense of and give meaning to this work?<br><br>This workshop is designed for program directors and their assistant/associates who have been in these roles for 2 - 5 years. Training Director co-leaders will discuss: a) the links of developmental identity to a similar line of development in PD/APDs, b) the import of a PD/APD's role and task identification in routine work and in the management of strife, c) the import of developing a "holding environment" which supports learning, d) the import of ownership in a program director's role, and e) the import of reflection and curiosity in the work of a program director.<br><br>Attendees will have the chance to listen to these ideas, and then break into groups to discuss the challenges to identity which they have confronted and new means of anticipating and confronting these challenges. New ideas will be shared with the larger group. |
| **Additional presenter 1** | Deborah Cowley, MD |
| **Additional presenter 2** | Sandra DeJong, MD, MSc |
| **Additional presenter 3** | Samira Solomon, MD |
| **Additional presenter 4** | Deborah Spitz, MD |

# Mid-life Workshop

| | |
|---|---|
| **Your name** | Kimberly Kelsay |
| **Abstract title** | Mid-Life Workshop.  Building a super team within your fellowship/residency: Applying the science of group dynamics to save your sanity, maximize trainee success, live long and prosper |
| **Your role in this abstract** | Co-leader |
| **Educational Objectives** | Mid-Career training directors will<br>1) Explore the science of group dynamics (from industrial, clinical psychology and medical education) and apply this to training programs through case discussions<br>2) Identify factors that impact development of a mature group<br>3) Practice tenets and skills as PD to successfully intervene when group process has gone awry.<br>4) Understand how to effectively utilize chief resident to facilitate group success.<br>5) Identify next steps to support healthy groups from orientation to infinity. |
| **Practice Gap** | 1) Group dynamics can cause problems or lead to meaningful successes within training programs, yet this is not an area that most program directors have much expertise.<br>2) Literature from industrial psychology and clinical psychology regarding group dynamics and processes can inform group dynamics within training programs yet translation to educational literature has mostly been limited to small group teaching. |
| **Scientific Citations** | Barsade, S. G. (2002). The Ripple Effect: Emotional Contagion and Its influence on group behavior. Administrative Science Quaterly, 47, 644-675.<br>Franz, T. M. (2012). Group dynamics and team interventiuons understanding and improving team performance. Malden, Ma: Blackwell Publishing.<br>Munich, R. L. (1993). Varieties of learning in an experiential group. Int J Group Psychother, 43(3), 345-361.<br>Rahmani, M. (2019). Using Group Psychotherapy Skills for Small Group Teaching. Acad Psychiatry, 43(1), 96-100. doi:10.1007/s40596-018-0896-4 |

| | |
|---|---|
| **Workshop Abstract** | Psychiatry residencies and fellowships are settings where group dynamics can hinder educational objectives or conversely help a group maximize success. Mid-career program directors have likely had the sustaining experiencing of a group of trainees/faculty that have surpassed individual potential and the distressing experience of a group that has decreased the level of function of its members. Although there is a substantial literature from industrial psychology regarding factors that promote formation of successful groups and studies from group therapies regarding processes that promote group health, most program directors are not experts in group dynamics. Translational work from these fields into medical education has largely focused on PBL groups within medical school training. Surprisingly, this work has not been translated or applied to group dynamics within training programs. We argue that successfully translating this knowledge to dynamics within training programs can be critical to career satisfaction.<br>Agenda:<br>1) 5 minutes Introduction of leaders and attendees.<br>2) 10 minutes explanation of tenets of successful group formation.<br>3) 10 minutes-The group will be divided into 3-4 small groups. All groups will receive 2 case scenarios and are tasked with generating ideas to improve group dynamics and relate these to information presented.<br>4) 10 minutes-Each group will report their ideas during which workshop directors will record themes on large sheets of papers<br>5) 10 minutes-Themes will be used generate ideas to build successful groups as they begin to form.<br>6) 5 minutes wrap up, feedback regarding workshop, |
| **Additional presenter 1** | Sumru Bilge-Johnson, MD/Associate Professor, NEOMED |
| **Additional presenter 2** | Rakin Hoq, MD/Chief Resident, NEOMED |
| **Additional presenter 3** | Peter Daniolos, MD/Clinic Professor, University of Iowa |

# Lifer Workshop

| | |
|---|---|
| **Your name** | Gene Beresin, MD, MA |
| **Abstract title** | Senior Faculty Trajectories: Retirement, Re-invention or Status Quo? |
| **Your role in this abstract** | Co-leader |
| **Educational Objectives** | Goals and Objectives: At the conclusion of this workshop, participants will:<br><br>1) Recognize the developmental stages that may accompany senior faculty status<br>2) Discuss potential threats and opportunities inherent in achieving senior status<br>3) Examine professional career opportunities, including new academic and/or clinical positions and ways to foster mentorship. |
| **Practice Gap** | Gap:<br><br>The average age of medical school faculty in 2007 was 48.5 and the percentage over 55 was 29%. A survey of 787 Society of Teachers of Family Medicine members aged 50 or older revealed concerns of work and personal time balance (67%), maintaining health (66%) and retirement planning (60%). About one third considered reducing full-time employment. Two thirds were planning to retire but three quarters of those individuals wanted to remain active in teaching. Half had reported receiving no mentoring of any kind. (1) 60% of all practicing psychiatrists are age 55 and over, third among US medical specialties. (2) The literature on how age impacts senior psychiatric academic faculty is non-existent. |
| **Scientific Citations** | Scientific Citations:<br><br>1. Understanding the needs and concerns of senior faculty in academic medicine: building strategies to maintain this critical resource. Stearns J; Everard KM; Gjerde CL; Stearns M; Shore W.Academic Medicine. 88(12):1927-33, 2013 Dec.<br><br>2. https://www.aamc.org/data/workforce/reports/458494/1-4-chart.html<br><br>3. Ingram, D; Stine, J (2016) "How Senior Psychodynamic Psychiatrists Regard Retirement" Psychodynamic Psychiatry, 44(2), 211-238 |

**Workshop Abstract**

Workshop Abstract: Achieving the rank of full professor and/or tenure is a mark of academic achievement and survivorship. And there are other markers of seniority depending on your system.

The question then becomes, what next?

The purpose of this year's Lifer's Workshop is to provide senior faculty the opportunity to explore and discuss what it means to have a successful academic career, what is life like after being a program director, fellowship director, service chief, or any senior leadership position and what options might there be for future career trajectories. Erik Erikson's adulthood stage of generativity vs stagnation begins to overlap into the older adult stage of integrity vs despair. We suspect that generativity and integrity remain issues for senior faculty.

We will explore some of the unconscious (and conscious) bias towards senior faculty status on the part of some trainees, junior faculty and even leadership. It is not uncommon for senior faculty to be dismissed as having outdated practices, and some elderly faculty have to work harder to be "seen" as serious contributors or leaders.

Facilitators in small groups will lead discussions of some exit strategies or new positions which include retirement, exploring new opportunities, dealing with a new Chair, becoming Chairs, moving to the Dean's Office in some capacity and other novel work situations, including part-time employment, and other, perhaps new career opportunities, such as writing, consulting, or changing career paths even having reached a senior level in an academic environment. We expect that, with their experience and expertise, participants will share their stories and wisdom.

Teaching Methodologies:

Each small group leader to take a few minutes to relate their career paths and directions and/or relate considerations or dilemmas they are dealing with. Some key issues that play into what comes next might include questions about what contributes to generativity, engagement or detachment from your place of work, self-esteem, morale, enthusiasm, search for new meaning, the joys of mentorship, wanting to start something new; or it might involve talking about how one deals with uncertainty, getting older, or working part time.

This should set the stage for others to comment, and relate their own personal experiences and/or questions

Note: Additional Presenters: Christopher Thomas, MD, John Sargent, MD, Joan Anzia, MD, Sheldon Benjamin, MD

| | |
|---|---|
| **Additional presenter 1** | Carl Chan, MD (Co-Leader) |
| **Additional presenter 2** | Geri Fox, MD |
| **Additional presenter 3** | Martin Drell, MD |
| **Additional presenter 4** | David Kaye, MD |

# Plenary: Thursday, 10-11:30am

| | |
|---|---|
| **Your name** | Sanjeev Sockalingam, MD, MHPE, FRCPC |
| **Abstract title** | Avoiding the Curriculum Carousel: Approaches to Curriculum Development |
| **Your role in this abstract** | Leader |
| **Educational Objectives** | 1. List each step in the 6-step approach to curriculum design<br>2. Identify common resources and barriers in curriculum implementation<br>3. Apply a model of curriculum design to your own curricula |
| **Practice Gap** | Psychiatry educators and leaders are often asked to develop new or reform existing curricula. Although curriculum development is a common request and expected competency amongst psychiatry educators and leaders, faculty are not commonly provided with resources or approaches to respond to these requests and expectations. Literature also identifies that curriculum development is often not aligned with intended goals or responsive to needs of keystakeholders including society (references below). This workshop also was identified as a faculty need by the AADPRT conference leadership. |
| **Scientific Citations** | 1. Thomas PA, Kern DE, Hughes MT, Chen BY. Curriculum development for medical education: A six-step approach. John Hopkins University Press, United Stated, 2015<br>2. Whitehead CR. Getting off the carousel: De-centring the curriculum in medical education.<br>3. Klasegaram K, Mylopoulos M, Tonin P, Bernsetin S, Bryden P, Law M, Lazor J, Pitini R, Sockalingam S, Tait GR, Houston P. The alignment imperative in curriculum renewal. Med Teach 2018; 40: 443-448<br>4. Abrahamson S. Diseases of the curriculum. J of Med Education 1978; 53: 951-957. |

**Workshop Abstract**

A common request of psychiatry educators is curriculum development or curriculum reform. Despite this being a common expectation of psychiatry educators and education leaders, the process of curriculum design can be challenging. How does one begin by designing a new courses or seminars for trainees? If changing curricula, what are the goals and guiding principles? The development of new curricula requires a systematic approach considering aims, instructional methods and approaches to curriculum evaluation. The following workshop provides participants with a framework for curriculum development based on a 6-step model for curriculum design. Participants will have an opportunity to use this framework to develop a curriculum from their local setting starting with identification of needs and proceeding to implementation. Approaches to evaluating curricula will be discussed including approaches to data collection and evaluation methods. However, many individuals may be lacking a common framework for curriculum development and evaluation. References and key articles on curriculum development will be shared.

# Input Session

| | |
|---|---|
| **Your name** | Sallie DeGolia, MD, MPH |
| **Abstract title** | Input Session |
| **Your role in this abstract** | Co-leader |
| **Educational Objectives** | • Provide AADPRT members with important, up to date information relevant to psychiatry residency training, such as changes in requirements for accreditation of residency programs and Board certification.<br>• Describe national trends in psychiatric education.<br>• List new developments in the field of psychiatry, as well as mental health care policy and funding. |
| **Practice Gap** | Training Directors need to be aware of the work of our allied associations. Feedback from past meetings continues to reinforce the need for this discussion. |

# ABPN Q&A

| | |
|---|---|
| **Your name** | Larry Faulkner, MD |
| **Abstract title** | ABPN and ACGME Workshop |
| **Your role in this abstract** | Co-leader |
| **Educational Objectives** | By the end of this session, attendees will be able to describe:<br><br>1. The common mistakes program directors make with respect to following ABPN credentialing requirements for their residents.<br><br>2. The structure and content outline of the ABPN certification examination.<br><br>3. ABPN certification fees.<br><br>4. Special ABPN programs, included combined programs and PPPPs, Senior Resident Administrative Fellowship, Innovation ion Education Award, Research Award, and Crucial Issues Forums. |
| **Practice Gap** | Current Practice: Based upon the experience of ABPN staff, not all training directors understand their role in ensuring that their residents meet the requirements for ABPN certification, appropriately document resident training experiences, or provide residents with accurate information about the ABPN's special education and research opportunities.<br><br>Optimal Practice: All training directors would appropriately document training for their residents and provide them with up-to-date information on the ABPN's certification processes and its special education and research opportunities. |
| **Scientific Citations** | The need for this program was brought to my attention by questions asked by current training directors and by feedback from ABPN staff who interact on a regular basis with residents, fellows, program directors and program coordinators.<br><br>Citations:<br><br>1. ABPN Website (www.abpn.com): Become Certified: Information About Initial Certification Exams, 2019<br><br>2. ABPN Website (www.abpn.com): Access Residency Info: Residency Training Information, 2019 |

**Workshop Abstract**

In this annual session for residency training directors, coordinators, and other meeting attendees, the ABPN President and CEO will review 10 common mistakes made by training directors as they assist their residents with the credentialing process for ABPN certification.  Recent changes in the design of the certification examinations will be reviewed as will recent certification examination results and fees for certification. Special ABPN educational and research funding opportunities will be described.

# ACGME Q&A

| | |
|---|---|
| **Your name** | Robert Boland, MD, Chair, Review Committee, Psychiatry, ACGME |
| **Abstract title** | The Accreditation Process for Psychiatry Residency Programs - THE RRC ESSENTIALS |
| **Your role in this abstract** | Leader |
| **Educational Objectives** | 1. Provide information regarding the accreditation requirements for residency programs in Psychiatry and psychiatric subspecialties.<br>2. Describe in detail recent modifications in these requirements.<br>3. Describe the ongoing process of revision of the requirements, and likely changes that will result from this process. |
| **Practice Gap** | Training program directors and coordinators must be aware of recent changes and revisions to ACGME Program Requirements in order to improve training and maintain the necessary accreditation of their programs. The transition to the Next Accreditation System is a major change in the accreditation process and program directors and coordinators must understand and continue to adopt best practices to assure continued improvement in residency training. |
| **Scientific Citations** | 1. Nasca TJ, Philibert I, Brigham T, Flynn TC. The next GME accreditation system--rationale and benefits. N Engl J Med. 2012 Mar 15;366(11):1051-6. doi: 10.1056/NEJMsr1200117. Epub 2012 Feb 22. PubMed PMID: 22356262.<br>2. Thomas CR, Keepers G. The milestones for general psychiatry residency training. Acad Psychiatry. 2014 Jun;38(3):255-60. doi: 10.1007/s40596-014-0102-2. Epub 2014 May 7. PubMed PMID: 24800729.<br>3. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf |
| **Workshop Abstract** | This is an annual session for Residency Directors and other AADPRT meeting attendees, given by the Chair of the Accreditation Council for Graduate Medical Education's (ACGME's) Residency Review Committee for Psychiatry, to provide information about the current requirements for accreditation of a Psychiatry Residency program. The session will review the major revision of the Common Program Requirements. |
| **Additional presenter 1** | Louise Castille, MS, Executive Director, Review Committee for Psychiatry ACGME |

# Plenary: Thursday, 5:30-6:45 pm

| | |
|---|---|
| **Your name** | Kelley Skeff, MD, PhD |
| **Abstract title** | Enhancing the Joy of Teaching |
| **Your role in this abstract** | Leader |
| **Educational Objectives** | Participants will be able to:<br><br>1) Identify multiple sources for joy in medical teaching<br>2) Consider the current impediments to the joy of teaching<br>3) Identify new approaches for medical teachers and learners to experience joy in teaching |
| **Practice Gap** | The literature on medical education and medical practice documents that medical practitioners and trainees are facing major challenges of burnout, depression, and even suicide. Approaches are needed to reinstill the joy of practice and teaching to help alleviate this issue. |
| **Scientific Citations** | Numerous citations describe physician burnout in the current environment.<br><br>Articles by Shanafelt et al are examples. |
| **Workshop Abstract** | In this lecture/workshop, Dr. Skeff will lead the audience through a series of educational models and schemes that will enable them to identify areas for improvement for themselves and their institutions.<br>These models are built on the methods incorporated in the Stanford Faculty Development Center for Medical Teachers as well as ongoing research on physician challenges. The workshop is intended to both inform the participants and enable them to consider opportunities to access additional sources of professional joy. |

# Shein Lecture

| | |
|---|---|
| **Your name** | Reshma Jagsi, MD, DPhil |
| **Abstract title** | Ending Sexual Harassment and Gender Inequity in Medical Training |
| **Your role in this abstract** | Leader |
| **Educational Objectives** | 1. To understand the nature and causes of gender inequity in medicine and psychiatry<br>2. To define what constitutes sexual harassment<br>3. To appreciate how to target systems-level interventions to target root causes of inequity and harassment |
| **Practice Gap** | Inequity and harassment rob the profession of the documented benefits of diversity and access to the full talent pool entering medical school today. Evidence-based interventions to promote equity are important to address this gap. This lecture will establish the evidence base and discuss what interventions can practicably be implemented by members of the audience at their home institutions. |

**Scientific Citations**


Mangurian C, Linos E, Sarkar U, Rodriguez C, Jagsi R. What's Holding Women in Medicine Back from Leadership. Harvard Business Review 2018 June 19.

Jagsi R, Guancial EA, Worobey CC, Henault LE, Chang Y, Starr R, Tarbell NJ, Hylek EM. The "gender gap" in authorship of academic medical literature--a 35-year perspective. N Engl J Med 2006;355(3):281-7.

Jagsi R, Motomura AR, Griffith KA, Rangarajan S, Ubel PA. Sex differences in attainment of independent funding by career development awardees. Ann Intern Med 2009;151(11):804-11.

Jagsi R. Perspective. Sexual Harassment in Medicine: #MeToo. New England Journal of Medicine, 2017.

Bates CK, Jagsi R, Gordon LK, Travis E, Chatterjee A, Gillis M, Means O, Chaudron L, Ganetzky R, Gulati M, Fivush B, Sharma P, Grover A, Lautenberger D, Flotte TR. It is Time for Zero Tolerance for Sexual Harassment in Academic Medicine. Acad Med 2017

Jagsi R, Griffith K, Jones R, Perumalswami C, Ubel P, Stewart A. Sexual harassment and discrimination experiences of academic medical faculty. JAMA 2016.

Cortina LM, Jagsi R. What Can Medicine Learn From Social Science Studies of Sexual Harassment? Ann Intern Med. 2018 Nov 20;169(10):716-717

Choo E, Byington C, Lubin-Johnson N, Jagsi R. From #MeToo to #TimesUp: the clock has run out on fundamental change in the culture of inequity and harassment in science, medicine, and global health. Lancet 2019, 393(10171):499-502.

Jagsi R, Griffith KA, Stewart A, Sambuco D, DeCastro R, Ubel PA. Gender differences in the salaries of physician researchers. JAMA 2012;307(22):2410-7

Magudia K, Bick A, Cohen J, Ng TSC, Weinstein D, Mangurian C, Jagsi R. Childbearing and Family Leave Policies for Resident Physicians at Top Training Institutions. JAMA. 2018 Dec 11;320(22):2372-2374.

Jolly S, Griffith KA, DeCastro R, Stewart A, Ubel P, and Jagsi R. Gender Differences in Time Spent on Parenting and Domestic Responsibilities by High-Achieving Young Physician-Researchers. Ann Intern Med 2014;160(5):344-53.

DeCastro R, Sambuco D, Ubel PA, Stewart A, Jagsi R. Batting 300 is good: perspectives of faculty researchers and their mentors on rejection, resilience, and persistence in academic medical careers. Acad Med 2013;88:497-504.

**Workshop Abstract**

In the wake of the #metoo movement, Dr. Jagsi's publications in JAMA and the New England Journal of Medicine on sexual harassment in medicine are widely cited and have been featured by numerous media outlets. In her presentation, Dr. Jagsi will begin by providing an overview of definitions to ensure common understandings, grounded in both behavioral/ psychological research and in relevant laws. She will next provide a brief summary of the literature in organizational psychology that has demonstrated the impact of harassment on employee well-being and retention more generally. She will then discuss in detail the research she and others have led to evaluate the frequency and nature of sexual harassment and discrimination experiences of academic medical faculty-and the barriers to reporting and remediation in this context. She will conclude with a discussion of how institutional leaders can not only react to individual incidents but also proactively begin to transform culture to address these challenges.

# Plenary: Milestones 2.0

| | |
|---|---|
| **Your name** | Deborah Cowley, MD |
| **Abstract title** | Psychiatry Milestones 2.0 Update |
| **Your role in this abstract** | Leader |
| **Educational Objectives** | At the conclusion of this session, participants will be able to:<br><br>1. Describe the major changes between the 1.0 and 2.0 versions of the ACGME's Psychiatry Milestones.<br><br>2. Discuss substantive changes made to the draft version of the Psychiatry Milestones 2.0 in response to feedback from AADPRT and program directors. |
| **Practice Gap** | The ACGME's Psychiatry Milestones were implemented in 2015 and were intended to be revised as needed. Currently, the Psychiatry Milestones 2.0 Workgroup is finalizing the revised milestones, informed by input from the public comment process, including input from AADPRT and program directors. General psychiatry program directors and programs, including teaching faculty, will need to become familiar with, and prepare for using, the revised milestones and Psychiatry subspecialties will be revising their milestones in the near future. This session aims to provide a general overview of the principles underlying the revision process, the major differences between Psychiatry Milestones 1.0 and 2.0 versions, and responses to input from AADPRT leadership and members, in order to prepare participants to implement revised milestones. |

**Scientific Citations**

The Psychiatry Milestones 2.0 are being finalized and will be implemented in 2020. Psychiatry subspecialties will also be developing revised milestones. Thus, there is a need to inform program directors about the new milestones and general principles that will also apply to subspecialty revisions. References within the literature regarding the overall ACGME Milestones Project and providing evidence and background for the revisions include:

1. Nasca TJ, Philibert I, Brigham T, et al. The next GME accreditation system-rationale and benefits. N Engl J Med. 2012;366(11):1051-1056.
2. Leep Hunderfund AN, Reed DA, Starr SR, et al. Ways to write a milestone: approaches to operationalizing the development of competence in graduate medical education. Acad Med. 2017;92(9):1328-1334.
3. Thomas C, Keepers G. The milestones for general psychiatry residency training. Acad Psychiatry 2014; 38: 255-260.
4. Edgar L, Roberts S, Yaghmour N, et al. Competency crosswalk: a multispecialty review of the ACGME milestones across four competency domains. Acad Med. 2018; 93 (7):1035-41.
5. Edgar L, Roberts S, Holmboe E. Milestones 2.0: A step forward. J Grad Med Educ 2018; 10 (3): 367-369.

**Workshop Abstract**

Milestones were first developed as part of the Accreditation Council for Graduate Medical Education (ACGME) Next Accreditation System. They provide an outcomes-based assessment framework based on the 6 core competencies of patient care (PC), medical knowledge (MK), interpersonal and communication skills (ICS), practice-based learning and improvement (PBLI), professionalism (PROF), and systems-based practice (SBP). For each specialty and subspecialty, a workgroup of stakeholders including program directors, representatives of specialty societies, and residents or fellows identified subcompetencies and a developmental progression of milestones within each subcompetency. The Psychiatry Milestones were first implemented in 2015.

The original intent was to revise Milestones based on evidence and feedback from the field. Currently, the Milestones 2.0 project is engaged in revisions specific for each medical specialty and subspecialty (PC and MK subcompetencies and milestones), as well as across-specialty harmonized milestones for ICS, PBLI, PROF, and SBP. The ACGME, working with a Psychiatry Milestones 2.0 Workgroup, has developed a draft of the revised version and a supplemental guide, and has solicited feedback from stakeholders including specialty organizations such as AADPRT and individual program directors. The draft has been modified based on this feedback.

This session aims to provide an overview of the rationale for revisions, major differences between the 2.0 and original versions of the Psychiatry Milestones, and changes made in response to feedback from AADPRT leadership and members.

**Additional presenter 1**

Laura Edgar, EdD, CAE

# President's Symposium

| | |
|---|---|
| **Your name** | Adam Brenner, MD |
| **Abstract title** | Creating Solutions for Faculty Burnout |
| **Your role in this abstract** | Leader |
| **Educational Objectives** | 1. Attendees will share their ideas about how academic systems can prevent, mitigate, and eliminate burnout.<br>2. Attendees will learn from panelists a proposed set of 'best practices' that institutions can employ to prevent, mitigate, and eliminate faculty burnout. |
| **Practice Gap** | There is a growing awareness of burnout among psychiatry department faculty, based on both the growing literature, the efforts of national organizations such as AAMC and ACGME, and our own listserv discussions. The roots of faculty burnout lie in systemic issues, but how these can be most effectively addressed remains a very real question. |
| **Scientific Citations** | 1. Shah, Darshana T. PhD; Williams, Valerie N. PhD, MPA; Thorndyke, Luanne E. MD; Marsh, E. Eugene MD; Sonnino, Roberta E. MD; Block, Steven M. MB BCh; Viggiano, Thomas R. MD. . Restoring Faculty Vitality in Academic Medicine When Burnout Threatens Academic Medicine: July 2018 - Volume 93 - Issue 7 - p 979-984<br>doi: 10.1097/ACM.0000000000002013<br><br>2. Pololi, Linda H. MBBS; Evans, Arthur T. MD, MPH; Civian, Janet T. EdD; Gibbs, Brian K. PhD; Coplit, Lisa D. MD; Gillum, Linda H. PhD; Brennan, Robert T. EdD. Faculty Vitality-Surviving the Challenges Facing Academic Health Centers: A National Survey of Medical Faculty. Academic Medicine: July 2015 - Volume 90 - Issue 7 - p 930-936<br>doi: 10.1097/ACM.0000000000000674<br><br>3. 5. Shanafelt T, Trockel M, Ripp J, Murphy ML, Sandborg C, Bohman B. Building a program on well-being: key design considerations to meet the unique needs of each organization. Acad Med. 2019;94:156-161. |

| | |
|---|---|
| **Workshop Abstract** | Faculty burnout is a major problem for academic health centers and can lead to significant mental health problems for faculty and to deterioration of clinical morale and the learning environment. While individual physicians can work to increase their personal resilience, the root causes of burnout do not lie in individual deficits but in systemic stressors. This symposium will seek to explore and present solutions to faculty burnout that are rooted in system change. The symposium will begin with an introduction followed by the use of Poll Everywhere to elicit the attendees ideas of what could reduce or prevent their own burnout, or the burnout of their colleagues. This will be followed by presentations from three panelists who will speak from their perspective as program directors and chairs of departments about various models for system interventions to address burnout. Time will be left for audience questions, discussion, and generation of additional solutions. |
| **Additional presenter 1** | Joy Houston, MD |
| **Additional presenter 2** | Kari Wolf, MD |
| **Additional presenter 3** | William Greenberg, MD |

# Closing Session

| | |
|---|---|
| **Your name** | Sallie DeGolia, MD, MPH |
| **Abstract title** | Closing Session |
| **Your role in this abstract** | Co-leader |
| **Educational Objectives** | • Provide AADPRT members with important, up to date information relevant to the next AADPRT Annual Meeting.<br>• Remind members to submit Whova and APA Evaluation forms to provide feedback for developing the subsequent year's annual programming and to obtain CME credits.<br>• Thank members for their input, donations and commitment to residency/fellowship training. |
| **Practice Gap** | Training Directors need to be aware of the work of AADPRT.<br>Feedback from past meetings continues to reinforce the need for this discussion. |

# Skills Fair

| | |
|---|---|
| **Your name** | Sallie DeGolia, MD, MPH |
| **Abstract title** | Skills Fair |
| **Your role in this abstract** | Co-leader |
| **Educational Objectives** | At the end of this session, participants will:<br>1) Have new or improved proficiency in one of 3 core skill areas essential to efficient and effective functioning as a program director<br>2) Be able to identify at least two ways in which they could use these improved/acquired skills to improve their functioning as a program director |
| **Practice Gap** | Psychiatry program directors are trained in psychiatry and, to some extent, graduate medical education. Few are trained in the administrative skills needed to function successfully and efficiently as a program director. The kinds of skills needed have changed significantly over time, particularly given the advent of technology, the changing landscape of healthcare and graduate medical education, and new accreditation processes aligned with continuous process improvement. |
| **Scientific Citations** | 1. Lieff SJ, Zaretsky A, Bandiera G, Imrie K, Spadafora S, Glover Takahashi S. What<br>do I do? Developing a competency inventory for postgraduate (residency) program<br>directors. Med Teach. 2016 Oct;38(10):1011-1016.<br>2. Philibert I, Lieh-Lai M. A practical guide to the ACGME self-study. J Grad Med Educ. 2014;6(3):612-614. |

**Workshop Abstract**

Program directors need quick, efficient updates in several key skills, particularly how to: (1) how to assess and provide effective feedback to learners to ensure effective learning; (2) prepare for, implement and submit the ACGME self study and then plan the gap between this and the site visit; (3) respond to diversity issues sensitively and effectively to ensure a safe learning climate and a feeling of belonging for both learners and educators. Sessions will be offered in all three of these areas:

1. Fostering a Flourishing Climate for Diversity and Inclusion: From Intention to Action. These presentations will address specific strategies for nurturing a training program community that effectively supports diversity and inclusion. Specific topics will include: how to promote diversity in recruitment, how to have fruitful program-wide conversations about culture and diversity, and how to supervise trainees who come from different cultural contexts.

2. "Self-Study - a survival guide in three stages": These presentations will take participants through the three stages of the self study. Phase I: "Oh no, what's a Self-Study?!" How to structure the Self-Study period. Phase II: "Let the SWOT be your guide!" Performing an effective SWOT analysis. Phase III: "We submitted the Self-Study, now what?!" Continuous process improvement after the self-study and preparation for the site visit.

3. Upgrade your Assessment and Feedback - This session is designed to help residency programs improve the quality of the feedback they provide by integrating rotation objectives and assessment strategies into the feedback process. Programs will be challenged to create meaningful objectives that capture the essence of the rotation. Evaluations of residents can be made more significant by assessing performance on specific objectives. Feedback is then tailored to acknowledging which objectives have been met and then identifying specific strategies to meet the remaining objectives.

Room 1
Fostering a Flourishing Climate for Diversity and Inclusion: From Intention to Action - Belinda Bandstra, MD, MS
"Practical tips for promoting diversity in recruitment" Belinda Bandstra, MD, MS
"Practical tips for facilitating real conversations about culture and diversity" Raziya Wang, MD
"Practical tips for supervising across cultures" Tracey Guthrie, MD

Room 2

Self-Study - a survival guide in three stages - Erick Hung, MD

- "Oh no, what's a Self-Study?!" Alissa Peterson, MD
- "Let the SWOT be your guide!" Ann Schwartz, MD
- "We submitted the Self-Study, now what?!" Erick Hung, MD

Room 3
Upgrade your Assessment and Feedback - Randon Welton M.D.
- Setting Meaningful Objectives - Kelly Blankenship D.O.
- Using Structured Assessments - Allison Cowan M.D.
- Providing Actionable Feedback - Suzie Nelson M.D.

| | |
|---|---|
| **Additional presenter 1** | Belinda Bandstra, MD, MS |
| **Additional presenter 2** | Erick Hung, MD |
| **Additional presenter 3** | Randon Welton, MD |

# Educational Workshops Session 1

## Don't sue me! – Teaching residents essential principles of malpractice to reduce fear and improve quality of care

**Presenters**
Cathleen Cerny-Suelzer, MD
Selena Magalotti MD
Victoria Kelly, MD
Michael Greenspan, MD
Brianne Newman, MD

**Educational Objective**

1. By the end of the presentation portion of the workshop, participants will be able to explain and discuss the basics of malpractice with their trainees.
2. Participants will be able to recognize ways in which technology might be altering the standard of care and introducing potential new causes of legal action.
3. Participants will analyze fictional example(s) to detect the elements of malpractice and debate whether the standard of care was met.
4. Participants will solidify their learning by applying their knowledge to the appraisal of case examples, which they can in turn discuss with their trainees as part of teaching.

**Practice Gap**

In our increasingly litigious society, getting sued is a major concern of residents. Even though the risk of malpractice is often on the minds of trainees, this topic may not be a formal part of the residency curriculum. Teaching residents about malpractice early on in their training not only helps to dispel fears, but also helps trainees to reflect on why they do what they do. It is also important for trainees to be aware of how technology is changing the standard of care and subsequently impacting a physician's level of medicolegal risk. To address these gaps, this interactive workshop is aimed at preparing faculty to teach about malpractice, risk management, and the related use of technology in the ever-changing clinical learning environment.

**Abstract**

"Like spouses in a dysfunctional marriage, we can't live with lawyers, but we can't live without them" [1].

The AMA has cited that 16.1% of psychiatrists practicing in the United States report facing at least one medical liability claim in their careers [2]. Although the topic of malpractice connects to various ACGME core competencies [3-5], there are no ACGME general psychiatry training milestones directly assessing knowledge of medical malpractice and related risk management [6]. Further, the ACGME description of the required forensic psychiatry experience in general training makes no mention of malpractice [7]. Thus, this leaves training programs with little

guidance on what to teach about malpractice, or how to assess trainee mastery of this essential knowledge base.

Malpractice issues are often taught to residents informally or through anecdotes by people with their own biases and varying levels of expertise [1]. This lack of adequate understanding can increase fear, but it does not provide the tools to know how to decrease one's risk of litigation. Put aptly, "In light of today's litigious medical practice environment, graduating newly fledged psychiatrists from residency without specific education and training about malpractice and the standard of care is in our view educational malpractice" [8]. With growing awareness of this issue, some training programs have published on their initiatives to teach about medical malpractice and risk management in their curriculum [5, 9-11]. Further, it is important for programs to include education about how technology can be an aide in decreasing risk of malpractice, but also has the potential to change the standard of care and introduce new causes of legal action (12-13).

For all of these reasons, an increased focus on training residents about basic principles of law and malpractice is of vital importance. In this workshop, faculty will be trained on how to teach residents about the basic principles of medical malpractice law, the four Ds of malpractice, risk management, and the related use of technology. Teaching will be interactive through small and large group discussion of cases. The goal of this workshop is for faculty to leave feeling prepared to train residents on these important topics at their institutions. The intended audience includes general program directors, fellowship program directors, teaching faculty, and trainees. This workshop will help to bridge the gap on training residents for a medicolegally sound career.

**Agenda**

1. 5 minutes – Speaker introductions
2. 5 minutes – Large group discussion of the challenges to educating trainees on the topic of malpractice
3. 15 minutes - Presentation on basic malpractice concepts that are important to be taught to general trainees, including the role of the psychiatrist, basic legal terminology, the four "D"s of malpractice, defining the standard of care, and causes of action in psychiatric malpractice lawsuits
4. 10 minutes – Small group discussion involving patient scenario, resident's note, and giving feedback on malpractice related risks
5. 5 minutes – Presentation on the Do's and Don'ts of documentation
6. 5 minutes – Presentation on tips for speaking in court
7. 15 minutes – Small group discussions of case involving technology and malpractice risk
8. 20 minutes – Mock-Trial
9. 10 minutes – Summary and final discussion

**Scientific Citations**

1. Tellefsen C. Commentary: Lawyer Phobia. J Am Acad Psychiatry Law. 2009; 37:162-4.

2. Guardado JR. Policy Research Perspectives: Medical Liability Claim Frequency Among U.S. Physicians. 2017. https://www.ama-assn.org/sites/default/files/media-browser/public/government/advocacy/policy-research-perspective-medical-liability-claim-frequency.pdf. Accessed 19 Oct 2018.
3. American Board of Psychiatry and Neurology. Psychiatry Core Competencies Outline. 2011. https://www.abpn.com/wp-content/uploads/2015/02/2011_core_P_MREE.pdf. Accessed 19 Oct 2018.
4. Frierson RL, Campbell NN. Commentary: Core Competencies and the Training of Psychiatric Residents in Therapeutic Risk Management. J Am Acad Psychiatry Law. 2009; 37:165-167.
5. Nissen K, Angus SV, Miller W, et al. Teaching Risk Management: Addressing ACGME Core Competencies. J Grad Med Edu. 2010; 2:589-94.
6. Accreditation Council for Graduate Medical Education, American Board of Psychiatry and Neurology. The Psychiatry Milestone Project. 2015. https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf?ver=2015-11-06-120520-753. Accessed 19 Oct 2018.
7. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. 2017. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf?ver=2017-05-25-083803-023. Accessed 19 Oct 2018.
8. Rogers JE, Neumann CL, Myers WC. Commentary: Bringing Order to Chaos - How Psychiatrists Know the Standard of Care. J Am Acad Psychiatry Law. 2015; 43:451-5.
9. Ping Tsao CI, Layde J. Three-Session Psychiatric Malpractice Curriculum for Senior Psychiatry Residents. Acad Psychiatry. 2009; 33:160-2.
10. Hochberg MS, Seib CD, Berman RS, et al. Perspective: Malpractice in an Academic Medical Center: A Frequently Overlooked Aspect of Professionalism Education. Acad Med. 2011; 86:365-68.
11. Schlicher NR, Ten Eych RP. Medical Malpractice: Utilization of Layered Simulation for Resident Education. Acad Emer Med. 2008; 15:1175-80.
12. Sokol AJ, Molzen CJ. The Changing Standard of Care in Medicine. J Legal Med. 2002; 23:449-90.
13. Cooke BK, Worsham E, Reisfield GM. The Elusive Standard of Care. J Am Acad Psychiatry Law. 2017; 45:358-64.

## Embracing our responsibility for inclusion: Implementing the 2019 ACGME Common Program Requirement on diversity and inclusion

**Presenters**
Tracey Guthrie, MD
Saira Kalia, MBBS, MD
Francis Lu, MD
Ana Ozdoba, MD

**Educational Objective**

1. Understand the meaning and significance of the new ACGME Common Program Requirement (CPR) on diversity and inclusion that is an accreditation standard for all residencies and fellowships of all specialties effective July 1, 2019.
2. Define and identify the important relationship between the terms “diversity” and “inclusion.”
3. Recognize that the creation of an inclusive environment is not a “one size fits all” approach, but must be tailored to the specific institution, mission, and community.
4. List and describe specific action steps that training(residency/fellowship) programs, departments, and sponsoring institutions including hospital systems can take towards inclusion.

**Practice Gap**

On June 29, 2018, the ACGME released its new Common Program Requirements (CPR) effective July 1, 2019 including a new one on diversity and inclusion that applies to all residencies and fellowships of all specialties:

“I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)”

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution’s mission and aims. The program’s annual evaluation must include an assessment of the program’s efforts to recruit and retain a diverse workforce, as noted in V.C.1.c). (5). (c).”

Until now, ACGME has not had a diversity/inclusion accreditation standard, although it has had ones that related to cultural competence, which is a related, but not synonymous topic. This action closes the gap between the 2009 LCME accreditation standard on diversity/inclusion for U.S. and Canadian medical schools and the ACGME graduate medical education accreditation standards for all residencies/fellowship programs of all specialties in the U.S. This is the relevant LCME accreditation standard effective July 1, 2019; note the similarity in language of 3.3 and the new ACGME CPR on diversity and inclusion:

“Standard 3: Academic and Learning Environments

A medical school ensures that its medical education program occurs in professional, respectful, and intellectually stimulating academic and clinical environments, recognizes the benefits of diversity, and promotes students’ attainment of competencies required of future physicians.

3.3 Diversity/Pipeline Programs and Partnerships

A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.”

Both the LCME accreditation standard and the new ACGME CPR on diversity and inclusion advance diversity/inclusion as a driver for health equity and disparities reduction (Nivet, 2011). Since this is a new ACGME accreditation standard effective July 1, 2019, that all residencies and fellowships must implement, this general session will help attendees understand the new CPR on diversity and inclusion and how to take concrete action steps towards meeting the accreditation standard. Evaluating the inclusive nature of one's institution is one such concrete action. The Diversity and Engagement Survey (DES) is a survey tool that can be used to evaluate and assess institutions for engagement and inclusion (Sharina, et al., 2015)

**Abstract**
This workshop will first describe the meaning and significance of the new ACGME Common Program Requirement (CPR) on diversity and inclusion that is an accreditation standard for all residencies and fellowships of all specialties effective July 1, 2019. Secondly, the general session presenters will summarize a checklist of concrete specific action steps that residency and fellowship programs can take towards meeting this new accreditation standard based on the work of the AADPRT Diversity and Inclusion Committee's review of the literature. Recruitment of a diverse physician workforce is a necessary step, but it is not the only step that programs and organizations should undertake. Recruitment and retention will only occur if there are culturally competent, welcoming and safe environments for individuals to thrive within. Many programs are grappling with how to attain and adhere to this standard of inclusion in an effective and meaningful way. Everyone, including department chairs, hospital administration, residency leadership, faculty, staff, and other allies have a role in this mission of attaining a diverse and inclusive environment. We will define and describe action steps institutions have taken to increase the eight inclusion factors that form the framework for the Diversity Engagement Survey (DES) to highlight the behaviors necessary for an inclusive environment: common purpose, trust, appreciation of individual attributes, sense of belonging, access to opportunity, equitable reward and recognition, cultural competence, and respect. An interactive audience-response exercise will allow participants to assess their own institution for these eight inclusion factors. Finally, the general session will engage the participants in focused small group discussions to identify opportunities, challenges, and resources for increasing inclusion factors in their own institutions.

**Agenda**
0:00: Introduction to workshop and presenters: Chair Tracey Guthrie
0:05: Presentation on the meaning and significance of the new ACGME Common Program Requirement on diversity and inclusion: Francis Lu
0:13: Review of a framework for a strategic plan on diversity and inclusion: Francis Lu
0:20: Review of the DES (Diversity and Engagement Survey) and the 8 inclusion factors that form the framework of the DES: Tracey Guthrie
0:40: Assessing your institution's climate for inclusion: Interactive experience with the DES for participants using poll everywhere: Ana Ozdoba and Saira Kalia
0:45: Discussion of the results of the interactive experience: Ana Ozdoba and Saira Kalia
0:55: Small group with each presenter leading a small group
0:80: Report back and Large group discussion: Tracey Guthrie

**Scientific Citations**

1. ACGME Common Program Requirements, effective July 1, 2019: https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements. Note that the same CPR accreditation standard on diversity and inclusion exists in both the "Residency" and "Fellowship" documents.
2.. LCME Functions and Structure of a Medical School - (contains the LCME Standards), effective July 1, 2019: http://lcme.org/publications/
3. AAMC Roadmap to Diversity: Integrating Holistic Review Practices into Medical School Admission Processes, 2010 https://members.aamc.org/eweb/upload/Roadmap%20to%20Diversity%20Integrating%20Holistic%20Review.pdf
4. Nivet, M. Commentary: Diversity 3.0: A Necessary Systems Upgrade. Acad Med. 2011;86:1487–1489.
5. University of California Office of the General Counsel. Guidelines for Addressing Race and Gender Equity in Academic Programs in Compliance with Proposition 209, July 2015: https://www.ucop.edu/general-counsel/_files/guidelines-equity.pdf
6. Lim, R.F., Luo, J.S., Suo, S. et al. Diversity Initiatives in Academic Psychiatry: Applying Cultural Competence. Acad Psychiatry (2008) 32: 283. https://doi.org/10.1176/appi.ap.32.4.283
7. Stewart, A. Diversity and Inclusion Matter in Continuing Education Efforts. Published Online:12 Oct 2018 https://doi.org/10.1176/appi.pn.2018.10b15
8. Measuring Diversity and Inclusion in Academic Medicine: The Diversity Engagement Survey Sharina Person;C. Jordan;Jeroan Allison;Lisa Fink Ogawa;Laura Castillo-Page;Sarah Conrad;Marc Nivet;Deborah Plummer; Academic Medicine. 90(12):1675–1683, December 2015. https://www.ncbi.nlm.nih.gov/pubmed/26466376

## Screening strategies for the next generation of successful residents – Balancing metrics and holistic review

**Presenters**

Robert Cotes, MD
Gretchen Gavero, DO
Alan Koike, MD
Amy Adams
Jessica Kovach, MD

**Educational Objective**

1. Identify a program-specific definition of the "successful resident" and describe potential predictors of success at the screening stage of the interview process
2. Consider how and which metrics (i.e. USMLE scores, class rank, medical school ranking) play a role in the screening process

3. Define the term holistic review and describe the AAMC's Experience-Attributes-Metrics Model
4. Identify practical, program-specific methods of incorporating metrics with holistic review when screening applicants

**Practice Gap**

The average ACGME-accredited Psychiatry Residency received over 1000 applications in each of the last three years. Data from the 2018-2019 recruitment season indicate that the number of US and Canadian graduates applying to psychiatry has more than doubled since 2012, and, by traditional metrics, such as USMLE scores and AOA status, the quality of applicants is rising. Many programs struggle to find the resources to adequately screen the large number of applications they receive each year, and programs may be tempted to increasingly rely on a metric-driven approach. Per the 2018 NRMP Program Director Survey, psychiatry programs identified the USMLE Step 1 score and the Medical Student Performance Evaluation (MSPE) as the two most frequently cited factors in selecting an applicant to interview (each at 91%). While evaluating and prioritizing metrics can save time, program directors could miss well-qualified applicants, as it is unclear to what extent USMLE scores predict residency performance in psychiatry. Furthermore, beginning in July 2019, Common Program Requirements now require that programs, in partnership with their sponsoring institutions, engage in "mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce." When faced with this growing number of applications, how can program directors approach each applicant in a holistic way?

**Abstract**

This workshop will present strategies for programs to help select the applicants that are the best fit for an individual program at the screening stage. The audience will initially reflect inward about how a successful resident is defined, and what may be the predictors of success at their individual program.

The workshop will consist of the following components: 1) participants will reflect inward about the predictors of success at one's own program, 2) presenters will discuss an ongoing, multi-site project to identify possible predictors of success among psychiatry trainees, 3) presenters will introduce the concept of holistic review, and 4) presenters will provide an example of a holistic review being utilized at two programs and discuss how other programs may implement these concepts.

According to the AAMC, "Holistic review is a flexible, individualized way of assessing an applicant's capabilities by which balanced consideration is given to experiences, attributes, and academic metrics and, when considered in combination, how the individual might contribute value as a medical student and physician." In fact, 91% of medical schools self-reported in 2013 that they utilized a holistic review process. While this review process may be more time-intensive than that utilized by most Psychiatry residency programs, the AAMC reports that it has been successful in achieving more diverse undergraduate medical classes.

Beginning in July 2019, Common Program Requirements now require that programs, in partnership with their sponsoring institutions, engage in "mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce."

By contrast, the AAMC reported that 91% of schools self-reported in 2013 that they utilized a "holistic review" process. According to the AAMC, "Holistic review is a flexible, individualized way of assessing an applicant's capabilities by which balanced consideration is given to experiences, attributes, and academic metrics and, when considered in combination, how the individual might contribute value as a medical student and physician." While this review process may be more time-intensive than that utilized by most Psychiatry residency programs, the AAMC reports that it has been successful in achieving more diverse undergraduate medical classes.

**Agenda**

0:00 – 00:10: Introductions, goals & objectives

00:10 – 00:15: Individual exercise - Define program-specific definition of resident success. On a worksheet, participants will identify what experiences, attributes, and metrics they think best predict their program-specific definitions of success.

00:15 – 00:25: Group exercise - Discuss potential top 5 predictors of success in applicants and list 3 ways that programs try to screen for each predictor in the recruitment process

0:25 – 0:35: Large group debrief

0:35 – 0:45: Presentation of the "Predictors of Success" research project. We will discuss the methodology, preliminary results, and limitations.

0:45 – 0:55: The presenters will introduce the holistic review process at the undergraduate medical education level, including potential impact of this process on mission-specific diversity outcomes.

0:55 – 1:15: Application of holistic review at two psychiatry residency programs.

1:15 – 1:25: Large Group Debrief, focused on the practical application of holistic review.

1:25 – 1:30: Conclusion

**Scientific Citations**

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf
https://www.aamc.org/services/eras/stats/359278/stats.html
https://www.aamc.org/initiatives/holisticreview/

# Assessing Competency in Psychodynamic Psychotherapy

**Presenters**
Randon Welton, MD
Deborah Cabaniss, MD
Erin Crocker, MD
Sindhu Idicula, BA, MD
Bianca Nguyen, MD, MPH

**Educational Objective**
By the end of this workshop participants will be able to:
- Discuss what priorities, attitudes, and techniques define competency in psychodynamic psychotherapy
- Describe psychodynamic psychotherapy evaluation forms created by the American Association of Directors of Psychiatry Residency Training's (AADPRT) Psychotherapy Committee
- Practice using AADPRT tools to evaluate the conduct of psychodynamic psychotherapy
- Evaluate the usefulness of the AADPRT tools to evaluate psychodynamic psychotherapy

**Practice Gap**
Psychodynamic Psychotherapy has long been a cornerstone of psychiatric practice. The ACGME requires that psychiatry residents demonstrate competency in psychodynamic psychotherapy. The ACGME's Psychiatry Milestones include "providing psychodynamic psychotherapy to patients with moderately complicated problems" as one of the Level 4 anchor points for Patient Care 4 - Psychotherapy. Measuring competence in psychodynamic psychotherapy presents a challenge to psychiatry residency programs. This challenge has increased as fewer psychiatrists have extensive training or experience in psychodynamic psychotherapy. There are no widely available tools to assist in directly measuring competence in psychodynamic psychotherapy.

**Abstract**
The Accreditation Council for Graduate Medical Education requires that all graduating psychiatry residents are competent in managing and treating patients using brief and long-term cognitive behavior therapy, supportive psychotherapy, and psychodynamic psychotherapy. Developing didactics covering the basics of psychotherapy is relatively straightforward. Evaluating knowledge about psychotherapy can be conducted through simple multiple-choice questions. Measuring competency in psychotherapy is more difficult. Cognitive Behavior Therapy can be assessed using the Cognitive Therapist Rating Scale. AADPRT's Psychotherapy Committee has previously created tools to assess competency in Supportive Therapy. Assessing competency in psychodynamic psychotherapy, however, presents a new challenge. Often competency is merely assumed based on the number of hours a resident spends providing therapy. Assessment of psychodynamic psychotherapy competency is often relegated solely to the individual psychotherapy supervisor based on discussions of the care provided or observing video/audio recordings of therapy sessions. This interactive workshop presents new assessment tools created by the AADPRT Psychotherapy Committee. One of the tools evaluates the resident's demonstrations of the priorities and attitudes of a psychodynamic

psychotherapist while the other assesses the resident's use of psychodynamic interventions. The tools will be explained and then participants will practice using the tools to evaluate video examples of psychodynamic psychotherapy. Participants will then share ideas for improving the usefulness of these tools.

**Agenda**

Introduction and goals (Didactic presentation)
5 minutes
The difficulties in demonstrating competency in psychodynamic psychotherapy (Didactic presentation)
15 minutes
How might competency in psychodynamic psychotherapy be demonstrated? (Large Group Discussion)
10 minutes
Introducing the tools (Didactic presentation)
- Psychodynamic Psychotherapy – Priorities
- Psychodynamic Psychotherapy – Interventions
15 minutes
Video presentations of psychodynamic psychotherapy (video)
15 minutes
Using the Psychodynamic Psychotherapy Tools to rate psychodynamic psychotherapy (Small group discussion)
15 minutes
Improving the tools (Large Group Discussion)
10 minutes
Closing comments (Large Group Discussion)
5 minutes

**Scientific Citations**


- Bienenfeld D., Klykylo W., Lehrer D. Closing the Loop: Assessing the Effectiveness of Psychiatric Competency Measures. Academic Psychiatry. 2003; 27: 131-135.
- Liston EH., Yager J., Strauss G.D. Assessment of Psychotherapy Skills: The Problem of Interrater Agreement. American Journal of Psychiatry. 1981; 138: 1069-1074.
- Manring J., Beitman B.D., Dewan M.J. Evaluating Competence in Psychotherapy. Academic Psychiatry. 2003; 27: 136-144.
- Ravitz P., Lawson A., Fefergrad M., Rawkins S., Lancee W., Maunder,R., Leszcz M., Kivlighan D.M. Psychotherapy Competency Milestones: an Exploratory Pilot of CBT and Psychodynamic Psychotherapy Skills Acquisition in Junior Psychiatry Residents. Academic Psychiatry. 2019; 43: 61-66.
- Weerasekera P., Manring J., Lynn D.J. Psychotherapy Training for Residents: Reconciling Requirements With Evidence-Based Competency-Focused Practice. Academic Psychiatry. 2010; 34: 5-12.
- Yager J., Bienenfeld D. How Competent Are We to Assess Psychotherapeutic Competence in Psychiatric Residents. Academic Psychiatry. 2003; 27:174-183.

# Innovations for Clinical Teaching on a Busy CL Service

**Presenters**
Amelia Dubovsky, MD
Thomas Soeprono, MD

**Educational Objective**
By the end of this workshop, learners will be able to:
1. Identify barriers to education in the unique confines of a busy CL service.
2. Apply strategies necessary to foster a healthy learning environment in a complex setting.
3. Practice multimodal approaches of education grounded in learning theory specific to CL clinical work.

**Practice Gap**
Providing education on a busy psychiatric consultation service is challenging due to complex patient and provider schedules and frequent interruptions necessary to provide urgent medical attention. The team is often fractured, covering multiple cases at once to ensure timely patient care. The rapid turnover of patients, team members, and students presents a need for redundancy in reviewing common consult-liaison educational topics. Despite attempts to incorporate teaching into clinical practice, education is often separated in space and time from relevant clinical cases, and at times neglected entirely when a service is busy.

**Abstract**
Providing education on a busy psychiatric consultation service is challenging due to complex patient and provider schedules and frequent interruptions necessary to provide urgent medical attention. The team is often fractured, covering multiple cases at once to ensure timely patient care. The rapid turnover of patients, team members, and students presents a need for redundancy in reviewing common consult-liaison educational topics. Despite attempts to incorporate teaching into clinical practice, education is often separated in space and time from relevant clinical cases, and at times neglected entirely when a service is busy.

This workshop will address these unique challenges in clinical education by proposing 4 alternate educational strategies for incorporating teaching into a busy clinical practice. First, helping learners approach difficult consult subjects requires an environment of safety and a growth-mindset. Dr. Dubovsky will demonstrate and explain the methods and principles she has used to open the minds of her learners in the midst of the chaos of a busy consult service.

Second, Dr. Soeprono has developed the “Layered Teaching Model” which is method of teaching that incorporates clinical education into practice using brief video lectures, clinical guidelines summarized in flowchart maps, and questions to help learners assess their knowledge and to facilitate larger medical team discussions. Learners utilize this multimodal teaching model through the use of technology which enables just-in-time education based on Adult Learning Theory principles. Learners are able to optimize their education in real time with real clinical patient encounters.

Third, we will describe and exhibit ultra-brief chalk talks and Socratic questioning techniques specific to the CL setting. While bedside teaching remains a critical form of resident teaching, a new generation of learners has become accustomed to a more systematized teaching approach. Attendees will learn Dr. Dubovsky's use of the "Daily Pearl" to both ground education and provide a framework for teaching points. Lastly, Dr. Soeprono's "Patient-Centered Clinical Didactics" will be described and put to use. This is an innovative way to provide relevant patient focused education for those seeking CL educational approaches for the outpatient setting.

**Agenda**

1. Current state of CL education EXERCISE: Groups of 3 will discuss the ways that residents and medical students are currently educated on the CL service at their home institution. (10 min)
2. Unique barriers to CL education DIDACTIC: Explanation of how CL is different in its learning environment and subject matter. Discussion of CL clinical pedagogical knowledge and the implications thereof. (10 min)
3. Proposals for learner barrier solutions EXERCISE: Groups of 3 will create proposals for solutions to the previously discussed barriers to CL education. (15 min)
4. Layered Teaching Model DEMONSTRATION (10 min)
5. Role play with Dr. Dubovsky and Dr. Soeprono presenting the "Daily Pearl" DEMONSTRATION (10 min)
6. Patient-Centered Clinical Didactics DEMONSTRATION (10 min)
7. CL education change commitment EXERCISE: Groups of 3 will formulate plans for implantation and practice of newly acquired methods of education for their home CL service. We will ask that learners provide support and accountability for one another in these efforts though a point of contact at a deadline beyond the AADPRT meeting. (15 min)
8. QUESTIONS (10 min)

**Scientific Citations**

Asher A, Kondziolka D, Selden NR. Addressing deficiencies in American healthcare education: a call for informed instructional design. Neurosurgery. 2009 Aug;65(2):223-9; discussion 229-30. doi: 10.1227/01.NEU.0000348010.12339.1E.

Goldman S. The Educational Kanban: promoting effective self-directed adult learning in medical education. Acad Med. 2009 Jul;84(7):927-34. doi: 10.1097/ACM.0b013e3181a8177b.

Gonzalez CM, Bussey-Jones J. Disparities education: what do students want? J Gen Intern Med. 2010 May;25 Suppl 2:S102-7. doi: 10.1007/s11606-010-1250-z.

Irby, David M. Excellence in clinical teaching: knowledge transformation and development required. Medical Education 48: 776-784; 2014.

Kassirer JP. Teaching clinical reasoning: case-based and coached. Acad Med. 2010 Jul;85(7):1118-24.

Kern, David E. et al. Curriculum Development for Medical Education: A Six-Step Approach. Johns Hopkins University Press: Baltimore and London, 2006.

Ruiz J, Mintzer M, Leipzig R. The Impact of E-Learning in Medical Education. Academic Medicine, Vol. 81, No. 3 / March 2006.

Shulman, Lee S. Knowledge and Teaching: Foundations of the New Reform. Harvard Educational Review Vol. 57, No. 1 Feb 1987.

Sisson SD1, Hill-Briggs F, Levine D. How to improve medical education website design. BMC Med Educ. 2010 Apr 21;10:30. doi: 10.1186/1472-6920-10-30.

Wei, Marlynn H. et al. Teaching Trainees about the Practice of Consultation-Liaison Psychiatry in the General Hospital. Psychiatr Clin N Am 34, 689-707, 2011.

## The Impact of Patient Suicide on Psychiatry Trainees: How do we respond?

**Presenters**
Zheala Qayyum, MBBS, MD
Jeffrey Hunt, MD

**Educational Objective**

- Participants will understand the impact of patient suicide on trainees in psychiatry, with a focus on appreciating the expected emotional and psychological responses.
- Participants will explore how academic and non-academic medical settings respond to patient suicide.
- Participants will be better prepared to respond to the needs of trainees as supervisors, in the event the trainee's patient dies by suicide.
- Participants will appreciate the challenges of transition into independent practice in the context of completed suicides during the early years out of training.

**Practice Gap**

Suicide is now the second leading cause of death in adolescents and young adults. Center for Disease control and National Institute for Mental Health have reported continued rise of 24 % in the suicide rates over the last fifteen years. Many of our trainees will experience this during their General Psychiatry residency years or during their Child and Adolescent Fellowship training. However, the supervision and guidance around managing the emotional burden is highly variable. The impact of patient loss is often unrecognized and many training institutions do not have formal programmatic supports in place for such an occurrence. Timely oversight and support from supervisors can provide a safe place to explore and process the difficult

experience of patient loss due to suicide. The improved comfort and knowledge of supervisors around providing this type of supervision in particular can have a positive impact on trainee experience and learning. Furthermore, focus on adolescent cases will better prepare trainees to respond to the current increase in suicidal behavior in that population. However, there are no formal guidelines that indicate what should be expected in supervision by the trainee.

**Abstract**
Background:

Suicide has become the second leading cause of death in adolescents and young adults ages 15-34 and the third leading cause of death in individuals between the ages of 10-14 in the US. About 30-60% of General Psychiatry Residents experience patient suicide during their training; however, currently there are no formal guidelines for either the supervisor or supervisee in educational practice.

Methods:

This study is a qualitative research project and utilized individual semi-structured interviews of trainees and supervisors identified by criterion sampling. Participants were recruited from General Psychiatry resident training and Child & Adolescent Psychiatry fellowship programs in New England. Eligible participants included: current psychiatry trainees and trainees who graduated in the last 2 years who have experienced the death of a patient they cared for from suicide; participants also included supervisory psychiatrists of psychiatry trainees when their patient committed suicide. Inductive thematic analysis of the transcribed interviews was performed to identify emerging themes.

Results:

Thematic analysis of the interview data identified a central theme of patient suicide being a life changing event for a psychiatrist. This was impacted by a sense of general unpreparedness at multiple levels, and affected by several medicating and complicating factors such as shared loss, supervisor credibility, patient characteristics and societal expectations.

Conclusions:

There is a significant lack of preparation on the part of institutions, on how to deal with the aftermath of a patient suicide. Key factors appear to influence the distress associated with the experience, and these findings together may inform the development of educational, programmatic and mentorship interventions to best support this process.

**Agenda**
1.Introduction
2.Physician experiences of patient suicide
3.Presentation of pertinent research and available data

4.Discussion regarding the impact of patient suicide on trainees and early career psychiatrists
5.Small group discussions of strategies for improving supports for trainees (15 min discussion + 10 mins to report out and discuss). Depending on the number of attendees, we will divide the audience into small groups or do a large-group discussion if needed.
- 3-5 small groups (or a large group) facilitated by presenters
- ask the groups to discuss the following question:
a) What would be helpful to you when dealing with patient suicide? What would work in your institution?
b) Is there anything that the training program could do to help anticipate the impact of suicide on trainees and early career psychiatrists?
- in the last 10 min, ask each group to share their answer with the large audience
6.Proposed recommendations & Concluding remarks
7. Questions

**Scientific Citations**

1) Balon, R. (2007). Encountering patient suicide: The need for guidelines. Academic Psychiatry. https://doi.org/10.1176/appi.ap.31.5.336
2) Biermann, B. (2003). When depression becomes terminal: the impact of patient suicide during residency. The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 31(3), 443–457. https://doi.org/10.1521/jaap.31.3.443.22130
3) Cazares, P. T., Santiago, P., Moulton, D., Moran, S., & Tsai, A. (2015). Suicide Response Guidelines for Residency Trainees: A Novel Postvention Response for the Care and Teaching of Psychiatry Residents who Encounter Suicide in Their Patients. Academic Psychiatry. https://doi.org/10.1007/s40596-015-0352-7
4) Deringer, E., & Caligor, E. (2014). Supervision and responses of psychiatry residents to adverse patient events. Academic Psychiatry, 38(6), 761–767. https://doi.org/10.1007/s40596-014-0151-6

## Curriculum Development: Step By Step From Finish to Start

**Presenters**

Jacqueline Hobbs, MD, PhD
Paul Lee, MD, MPH

**Educational Objective**

Upon completion of this workshop, participants will be able to 1) (re-)define curriculum, 2) apply different models of curriculum design and development, 3) conceptualize short and comprehensive residency/fellowship curricula, 4) identify and discuss goals for short- and long-term curriculum development.

**Practice Gap**

Curriculum development can be a daunting challenge for any program director, whether new to the job or seasoned. The AADPRT Curriculum Committee's goal is to empower and assist

program directors and other teaching faculty in their efforts to develop new curricula or re-design existing curricula by providing foundational education, skills and resources.

**Abstract**
Curriculum development is both an art and science that many program directors and teaching faculty in academia likely were not taught during their medical education. Curriculum development is often thrust upon training directors and may have to be learned in a very random way via on-the-job learning and training. The AADPRT Curriculum Committee seeks to encourage and assist members in their curriculum development journey. In this workshop, graduate medical education curriculum will be broadly defined. Participants will receive an overview of two major and well-known curriculum development models: Wiggins and McTighe's backward design and Kern's 6-step approach. The co-leaders will elaborate on their own curriculum development journeys that are each based off the two major models and elicit participants' similar and different experiences.

Curriculum development goal-setting will be demonstrated and practiced. Practical suggestions as well as textbook, journal, and web-based resources (including the AADPRT Virtual Training Office curricular offerings) for curriculum development will be shared with participants. This workshop and the leaders will provide guidance, support, templates, resources, and encouragement for members to reach their goals for developing their curricula that can be submitted for peer review to the AADPRT Curriculum Committee. Each participant will have produced overall short- and long-term goals and plans for their own curriculum development by the end of the session for their professional use.

**Agenda**
This workshop will be interactive with individual and small-group participation and feedback. Participants are strongly encouraged to bring their ideas for areas they would like to consider for curriculum development to this workshop, but an open mind and blank slate are welcome as well. Participants are encouraged to bring a laptop computer, tablet, or their phones for taking notes and reviewing web-based information.

- Introduction/Didactic: 25 minutes
- Individual/Small-Group Discussion:10 minutes
- Goal-Setting Demonstration and Practice: 20 minutes
- Interactive demonstration of online and other resources: 15 minutes
- Q&A: 15 minutes
- eedback and evaluation: 5 minutes

**Scientific Citations**
Benson NM, Puckett JA, Chaukos DC, Gerken AT, Baker JT, Smith FA, Beach SR: Curriculum overhaul in psychiatric residency: an innovative approach to revising the didactic lecture series. Acad Psychiatry 42:258-261, 2018.

Sexton JM, Lord JA, Brenner CJ, Curry CE, Shyn SI, Cowley DS: Peer mentoring process for Psychiatry Curriculum Revision: Lessons Learned from the "Mod Squad". Acad Psychiatry 40:436-440, 2016.
Thomas PA, Kern DE, Hughes MT, Chen BY (Eds). (2016). Curriculum Development for Medical Education: A Six-Step Approach (3rd ed). Baltimore,MD: Johns Hopkins University Preess.
VanLehn K: Cognitive skill acquisition. Annu Rev Psychol 47:513-539, 1996.
Wiggins G, McTighe J: Understanding by Design, 2nd Edition. Alexandria, VA, Association for Supervision and Curriculum Development, 2005.

## Separating Signal from Noise: Is Your Program being Viewed Accurately by Applicants?

**Presenters**

Lia Thomas, MD
Anna Kerlek MD
Daniel Gih, MD
Shambhavi Chandraiah, FRCP(C), MD
Marcy Verduin, MD

**Educational Objective**

1. Describe and assess the various tools and resources that are currently available to residency applicants for learning about psychiatric residency programs (eg. ApplySmart, Residency Explorer, and third party programs like Doximity, Reddit, podcasts, etc.)
2. Analyze potential proactive use of social media in residency recruitment.
3. Develop a promising plan to bolster one's online presence in order to market a program's unique missions and attributes.

**Practice Gap**

There are numerous sites and programs that now offer applicants information about how to apply to residency programs. It is important for psychiatry program directors and coordinators to be aware of this information of how this information is being accessed and viewed by medical students, medical student deans, and graduate medical education leadership. Awareness of this information can allow a program to better assess their program's image, and to provide correction to better reflect the program. In addition, program directors and coordinators may need to actively manage program perceptions and promote more accurate information.

Coupled with the growth of new ways to look at psychiatry programs, the number of new accredited psychiatry residency programs has been increasing rapidly in recent years. According to the Accreditation Council for Graduate Medical Education, twelve new psychiatry residencies were accredited between 2012 and 2015, while fifty-six new programs were accredited between 2015 and 2018. Newer programs may have a disadvantage over more established ones as there is not a track record to reference. However both new and established programs

can benefit from strategic marketing and identifying novel ways to present their programs to applicants.

**Abstract**
The AAMC notes that medical student enrollment has been increasing at a far greater pace than residency positions. With the recent elevation in interest in Psychiatry as a career choice, competition for residency slots has amplified. Students and advisors thus want more nuanced information to help students better determine program fit. Similarly program directors may want to better identify applicants with genuine interest by highlighting specific aspects of their program. Programs need to carefully attend to the various venues in which information is being obtained, shared, and exchanged about their programs, and how applicants might utilize this in decisions to apply or interview.

Participants will be encouraged to bring laptops and their programmatic mission statement to the workshop for active group work. They will examine their program's data on at least one external site during this workshop.

This workshop will describe the existing websites and sources commonly used by students. Presenters will review advantages and disadvantages of each current method of information dissemination and describe program directors' experiences attempting to edit such information. Participants will also be asked to share their experiences in editing data as well. A demonstration of Twitter and a new program's plan to highlight their unique features will be shared for group discussion.

Finally, participants will be asked to identify a new plan for enhancing their presence on websites and social media. There will be small group and large group discussion so that all attendees can identify resources and resolve potential barriers.

**Agenda**
Presentation: 15 min - Advantages/disadvantages of various existing websites commonly used by students to gather information about programs. (Specific institutions may be selected for these searches)
Small group activity: 20 min - Established programs and newer programs will discuss and share the pros and cons of the current resources and practices.
Large group: 5 min - presentation of small group summaries
Presentation: 15 min - New program's plan to highlight their unique aspects on social media
Small group activity: 20 min - Identify barriers and ways to promote your program on websites and social media.
Large group: 5 min - presentation of small group summaries
Summary & Homework: 10min - Each person identifies one task and a partner to be held accountable to enhance their own program presence on websites/social media.

**Scientific Citations**
Agapoff JR 4th1, Tonai C2, Eckert DM2, Gavero G2, Goebert DA2. Challenges and Perspectives to the Rise in General Psychiatry Residency Applications. Acad Psychiatry. 2018 Oct;42(5):674-676. doi: 10.1007/s40596-018-0923-5. Epub 2018 Jul 5
Apply Smart :Data to Consider when applying to Residency, American Association of Medical Colleges. https://students-residents.aamc.org/applying-residency/apply-smart-residency/.html, Accessed October 16, 2019
Guide to Applying for Psychiatric Residency. https://www.psychiatry.org/residents-medical-students/medical-students/apply-for-psychiatric-residency Accessed 10/16/19

Sterling et al. "The Use of Social Media in Graduate Medical Education: A Systematic Review" Academic Medicine 2017, 2(7): 1043–1056

## Once Again, It Wasn't Done!: How to have Professional Accountability Conversations that Promote Learning and Lessen Stress

**Presenters**
Jane Ripperger-Suhler, MA, MD
Kari Wolf, MD
Charla Clark
Kari Whatley, MD

**Educational Objective**

- Prepare yourself for a productive accountability conversation
- Create a safe environment in which to have an accountability conversation
- Determine a plan which includes WWWF (who, what, when, follow up)

**Practice Gap**
Physicians have many responsibilities for which they must account. Part of the development of professionalism in residents involves learning to balance and a willingness to be held accountable for those responsibilities. At the same time, residents are employees of an organization and provide a crucial segment of the workforce. Their actions have an impact on the success of the organization. Program directors often find themselves in conflict between their role as a support for residents' growth and learning and as the manager with expectations for performance and as such sometimes find it challenging to hold residents accountable for their actions without resorting to punitive means.

**Abstract**
Holding others accountable for actions or lack of actions can often involve conversations that seem awkward and confrontational and therefore is a task often avoided. The development of accountability skills is a crucial component of the leadership toolbox. Kerry Patterson and his colleagues in the book, Crucial Accountability: Tools for Resolving Violated Expectations, Broken Commitments, and Bad Behavior present a framework for developing these skills that

we will share with participants as we practice and strengthen our skills together. There are three main parts to having successful accountability conversations. In this workshop, we will explore how to prepare oneself for a productive accountability conversation, when and if to have a conversation and how to plan for an honest discourse when emotions are high. We will discuss and practice creating a safe environment in which to have an accountability conversation. And finally we will learn to finish the conversation by determining a plan with who, what, when, and follow up actions.

**Agenda**
Self assessment - warm up
Intro ppt 5 min
1-2-4-all discussion of accountability situations 15 min
“Work on me first” ppt 5 min
1-2 discussion of getting your story straight 10 min
"Creating safety” ppt 5 min
Scripted role play practice - 20 min (10 min each)
“Move to action”ppt 5 min
Role play practice eliciting an action plan using template 15 min
Wrap-up with discussion and re-assessment - 10 min

**Scientific Citations**
Patterson K, et al: Crucial Accountability: Tools for Resolving Violated Expectations, Broken Commitments, and
Bad Behavior, McGraw-Hill, 2014.
Sanfey H et al: Pursuing professional accountability: An evidence-based approach to addressing residents with behavioral problems, Arch Surg 147(7):642-647, 2012.
Bhatt A, et al: Improving compliance: Pediatric resident accountability using peer pressure, Academic Pediatrics, 19(6): E33, 2019

## Saving Dr. Caufield: Modeling Vulnerability to Shift Away from a Culture of Maladaptive Perfectionism

**Presenters**
Sansea Jacobson, MD
Julie Chilton, MD
Colin Stewart, MD
Kayla Isaacs, BA
Andres Martin, MD

**Educational Objective**
1. Participants will examine their own implicit bias related to perfectionism, making medical errors, and physician mental health struggles

2. Participants will be able to describe positive and negative consequences related to self-disclosures of their own vulnerabilities at different stages within one's career
3. Participants will learn how to counsel physician trainees and colleagues on how and when they might choose to engage in self-disclosure as a means to promote the acceptance of our own humanity and to normalize self-care
4. Participants will be introduced to practical evidence-based approaches to destigmatize physician mental illness and stress-related conditions and decrease obstacles to care within their home institutions

**Practice Gap**

Physicians have long held themselves to unattainable standards. With ever increasing systemic pressures, our resiliency as a professional body is being tested. Furthermore, there are growing concerns about untreated physician mental illness given increasing rates of physician depression, substance use disorders, and death by suicide. It is critical that physicians are able to access care confidentially and easily with as little disruption to their careers, professional identities, and personal lives as possible. Furthermore, there needs to be a focus on changes to healthcare systems and the culture of medicine to improve physician and trainee well-being, but systemic change will take time. In the meantime, we need to increase the likelihood that the growing numbers of struggling physicians and trainees access care and confront the inevitability that we will all make mistakes and all have personal flaws. Medical errors or even the perception of having made an error is a significant risk factor for physician suicide, yet senior physicians do not commonly discuss their own mistakes and imperfections to trainees. It is not surprising, then, that study after study show that stigma-related concerns are the oft-cited reasons physicians and trainees do not seek help for mental health and stress-based issues. In a recent survey of almost 900 medical students, only one-third sought help for burnout, and more than half of those trainees believed that residency directors would pass over their application and supervisors would see them in a less favorable way if they were aware the student had an emotional and/or mental health problem. These findings are not only discouraging, they are dangerous. It is known that transitioning from medical school to residency is a period of heightened risk with one study showing suicidal ideation increasing 370% over the first 3 months of internship. In response to growing concerns related to burnout and factors threatening physician wellness, the Accreditation Council for Graduate Medication Education (ACGME) updated the Core Program Requirements to include language related to resident and faculty well-being. While these new requirements exist, there continues to be a lack of best practices for program directors to follow in order to address physician well-being comprehensively or in an evidence-based fashion. Program directors invested in leading such well-being initiatives need specific evidence-based approaches and guidance to do so safely.

**Abstract**

By promoting physician vulnerability and self-care as the norm, rather than something to be ashamed of, physicians and trainees would be more likely to get help when they begin to struggle, preventing progression to impairment. Preliminary findings in a recent study show that more than 90% of medical students surveyed agreed with the statement that "knowing doctors further along in their careers (residents, deans, attendings, professors) who struggled

with mental health issues, got treatment, and are now doing well, would make me more likely to access care if I needed it." Fortunately, residency program directors are uniquely positioned to help. Given their bridging role between training and practice, program directors are more likely to be aware of physician leaders within their academic communities who may be willing to serve as such wellness role models. In this workshop, we propose a method to enact meaningful change within a residency wellness initiative by teaching local physician leaders how to judiciously self-disclose overcoming personal, professional, and/or mental health struggles. This will in turn serve to decrease maladaptive perfectionism, destigmatize mental illness and promote self-care and help-seeking behaviors among physicians where such change is implemented. During the session, we will define "self-disclosure" in the context of physician well-being education and advocacy. Audience members will then be guided in an examination of their own implicit biases related to vulnerabilities like making medical errors and physician mental illness. We will then explore the potential positive and negative consequences of physician self-disclosure at different stages of one's career. Lastly, self-disclosure will be modeled, and participants will have an opportunity to learn how to be an effective mentor to individuals who are contemplating self-disclosure at their home institutions. By the end of the workshop, participants will have a practical understanding of an easy-to-implement intervention to promote a shift in perceptions and a more humane and accepting culture within their own academic community.

**Agenda**

During this interactive workshop, we will provide a summary of the prevalence of mental health and stress-related issues that physicians and trainees face as perfectionistic individuals in a high-pressure system, within a culture that historically has not encouraged help-seeking. We will then define the concept of physician "self-disclosure" as it pertains to overcoming personal and professional struggles and/or seeking treatment for mental illness. Presenters from different institutions and at every level of professional development (from medical student, to resident, to attending, to national physician leaders) will help provide a framework and facilitate small-group interactive exercises: (1) exploring implicit bias related to imperfection and mental illness, (2) determining the pros and cons of different methods of self-disclosure at different stages of one's career, (3) learning how to counsel physicians on productive self-disclosure in order to improve self-care and help-seeking behaviors among colleagues and trainees. Finally, we will engage our audience in a panel discussion. Topics likely to be discussed during the panel include: how to assure appropriate services are in place to support the changing culture, discussion of other evidence-based methods to improve access to mental health care for physicians, and next steps for sharing ideas, resources and best practices going forward.

The format of the 90min session will be organized as follows:

1. Introduction (5min)
2. Why don't Physicians Seek Mental Health Care? (10min)
3. Exercise 1 – Explore your own implicit bias related to physician mental illness (10min)
4. Self-Disclosure: How can we assure self-disclosure narratives are intentional and safe (10min)
5. Exercise 2 – Examine the natural consequences of self-disclosure (10min)

6. A case example: How a prominent physician leader recognizes their radar is broken (10min)
7. Exercise 3 – Practice coaching physicians who intend to self-disclose (15min)
8. Panel Discussion (15min)
9. Wrap-up (5min)

**Scientific Citations**

Dyrbye, LL, Eacker, A, Durning, SJ, Brazeau, C, Moutier, C, Massie, FS, Satele, D, Sloan, JA & Shanafelt, TD 2015, 'The Impact of Stigma and Personal Experiences on the Help-Seeking Behaviors of Medical Students with Burnout', Academic Medicine, vol. 90, no. 7, pp. 961-969. https://doi.org/10.1097/ACM.0000000000000655

Javier FG, Chilton J, Martin A: Wellbeing: Identification and prevention of burnout, depression and suicide among clinicians. J.M. Rey's IACAPAP e-Textbook of Child and Adolescent Mental Health 2019: J.12: 1-11

Martin A, Chilton J, Gothelf D, Amsalem D. Physician self-disclosure of lived experience improves mental health attitudes among medical students: a randomized study. Journal of Medical Education and Curriculum Development (in press).

S Rees, D Cohen, N Marfell, M Robling, Doctors' decisions when disclosing their mental ill-health, Occupational Medicine, Volume 69, Issue 4, June 2019, Pages 258–265, https://doi.org/10.1093/occmed/kqz062

van Uum RT, de Groot E, Mol SSL. Physician, disclose thyself! Self-disclosure as an educational tool (2018). Ned Tijdschr Geneeskd. 2018 Aug 30;162. pii: D2977. PMID: 30212004

NA Yaghmour, TP Brigham, T Richter, et al. Causes of Death of residents in ACGME-accredited programs 2000 through 2014: implications for the learning environment. Acad Med, 92 (2017), pp. 976-983. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5483979/

## The Hidden Factor In Trainee Wellness: Supporting Trainees who Experience Patient Aggression and Discrimination-Based Aggression/Harassment

**Presenters**

Sarah Mohiuddin, MD
Michael Jibson, MD, PhD
Adrienne Adams, MD, MSc

**Educational Objective**

1. Attendees will review the frequency and types of patient-related aggression that occur towards psychiatric trainees.
2. Attendees will identify risk factors for verbal aggression and harassment from patients including female gender and racial and ethnic minority status
3. Attendees will identify the role that faculty and training directors play in supporting trainees from minority populations following an episode of aggression
4. Attendees will design training and didactics around discrimination-based aggression

**Practice Gap**

Patient aggression and violence is a serious and unfortunate reality experienced by psychiatrists as well as psychiatric trainees over the course of their careers. Though aggression and violence directed towards psychiatrists have been addressed in the literature, few studies study the intersection of aggression from patients towards trainees and discrimination/harassment of minority trainees. As such, training programs and faculty often lack an understanding of how to prepare and support minority trainees when these events occur. There are even fewer programs that provide specific training in the assessment and management of discrimination-based aggression in psychiatric settings.

**Abstract**

Patient aggression towards training physicians is a well-known phenomenon. Despite a focus on physical aggression and assault, verbal aggression and harassment is reported as the most common form of aggression from patients towards trainees, with up to 86% of psychiatry residents reporting being verbally threatened by a patient. However, few studies have looked at the intersection of patient aggression and discrimination-based harassment and aggression. This is of particular importance as up to 60% of residents describe experiencing harassment or discrimination during their training. Verbal harassment is the most commonly cited type of discriminatory behavior, including high rates of reported harassment and discrimination from patients or patients' families. Current studies suggest under-reporting of aggressive episodes given that it may not be clear to trainees which behaviors warrant reporting or notification, as well as perceived risk for negative outcomes from training program. Residents also describe aggression-based harassment impacting decision-making related to program continuation and an overall sense of well-being. Recently, educational interventions focusing on addressing discrimination from patients have been described, but no current interventions specifically address harassment-based aggression. This workshop seeks to help educate training directors on the intersection of patient-aggression and discriminatory behavior towards trainees and help to design training and didactics around harassment-based aggression that meet the needs of our trainees.

**Agenda**

15 minutes Mohiuddin – Presentation on available data on patient aggression towards trainees in psychiatry

10 minutes Adams - Presentation on discrimination-based harassment towards trainees from supervisors, staff, and patients

10min - Small group discussion: Participants will break into groups and detail events related to aggression a that have taken place at their own institutions

10 Minutes Jibson – Presentation on addressing patient aggression/harassment as residency/fellowship programs and as program directors

45 minutes (all presenters): Two-part active learning session, will break into small groups with facilitators

Part 1: Specific scenarios of discrimination-based aggression are given to each group for discussion. We will plan to have each group discuss one scenario and describe acute safety

management, reporting strategies, debriefing, and how to support the trainee. Each group will then report their findings and thoughts to the larger group.
Part 2: Each person will then be given an opportunity to reflect on their own program, events that have occurred in the past, and their current state for training and education around harassment-based aggression towards trainees. They will then brainstorm ideas together on how to address barriers to the implementation of safety protocols and educational programming. Each group will then report their findings and thoughts to the larger group.

**Scientific Citations**

1) Schwartz, T. L., & Park, T. L. (1999). Assaults by patients on psychiatric residents: a survey and training recommendations. Psychiatric Services, 50(3), 381-383.
2) Whitgob, E. E., Blankenburg, R. L., & Bogetz, A. L. (2016). The discriminatory patient and family: strategies to address discrimination towards trainees. Academic Medicine, 91(11), S64-S69.
3) Wheeler, D. J., Zapata, J., Davis, D., & Chou, C. (2019). Twelve tips for responding to microaggressions and overt discrimination: When the patient offends the learner. Medical teacher, 41(10), 1112-1117.
4) Wasser, TD. (2015).How do we keep our residents safe? An educational intervention. Academic psychiatry, 39(1), 94-98.
5) Kwok, S., Ostermeyer, B., & Coverdale, J. (2012). A systematic review of the prevalence of patient assaults against residents. Journal of graduate medical education, 4(3), 296-300.
6) Coverdale, J., Gale, C., Weeks, S., & Turbott, S. (2001). A survey of threats and violent acts by patients against training physicians. Medical education, 35(2), 154-159.
7) Dvir, Y., Moniwa, E., Crisp-Han, H., Levy, D., & Coverdale, J. H. (2012). Survey of threats and assaults by patients on psychiatry residents. Academic psychiatry, 36(1), 39-42.
8) Goldenberg, M. N., Cyrus, K. D., & Wilkins, K. M. (2019). ERASE: a new framework for faculty to manage patient mistreatment of trainees. Academic Psychiatry, 43(4), 396-399.
9) Brenner, A. M., Coverdale, J., Guerrero, A. P., Balon, R., Beresin, E. V., Louie, A. K., & Roberts, L. W. (2019). An Update on Trainee Wellness: Some Progress and a Long Way to Go.

## Parenting in Residency: How parent-learners strengthen programs and how programs can best support them

**Presenters**

Jonathan Homans, MD
Lora Wichser, MD
Sandra DeJong, MD, MSc
Anne Ruble, MD, MPH

**Educational Objective**

1) Recognize the strengths parents bring to educational environments
2) Identify systematic approaches to improve educational environments for parent trainees
3) Develop program structures and policies that support parent-learners

**Practice Gap**

There is a knowledge gap about how to best support trainees during residency who are parents or who will become parents. There is a growing body of literature on the impact of parenting on practicing physicians, but limited exploration of the same areas amongst trainees. There has been one small study of 14 family medicine residents who collected qualitative data on the experience of being a parent in residency and potential recommendations to training programs2. In addition, surveys of program directors in family medicine indicate that there are not adequate system supports in place, and that a majority of trainees who take parental leave are required to extend their training3. Related equity and diversity concerns continue as parenting responsibilities disproportionately impact women in medicine at multiple points in their career1. A second practice gap, is that existing literature focuses predominantly on negatives, whereas it has been established that parenting is actually protective against burnout4. Apart from burnout, there has been limited investigation of the potential benefits of having children during medical training. This workshop seeks to address this gap by focusing on understanding the benefits of having children during medical training and how training programs can implement policies to support these learners.

**Abstract**

Reproduction is a biological necessity for humans. Medical training often occurs during eight consecutive years of peak fertility. Given these facts, we should expect pregnancy, birth and parenting to be a normal part of the medical training experience. Despite this, pregnancy, parental leave, and parenting are often described as barriers or complications that interfere with medical training. This workshop seeks to recast the trainee-as-parent narrative by highlighting the positives of having parent-trainees in our educational programs and what programs can do to support such learners. We will examine the current state of parenting while in medical training, work on reframing common 'problems' with being a parent during training, and finally aim towards participants leveraging the content of this workshop into practical steps to improve their programs. The content of this workshop is drawn from contemporary scientific literature, lived experience of having children during training, and also from experience as directors of training programs. Participants will be actively engaged throughout the workshop with opportunities to learn from other programs and leave with concrete action steps to improve the parent-learner experience in their own programs.

**Agenda**

0-10 min: Introduction of presenters and parenting journey in training
10-25 min: Participants think, then pair to discuss their parenting journey and/or other goals that brought them to the workshop, including struggles with parent trainees.
25-30 min: Large group share general themes, specific goals
30-40 min: Brief didactic on the data, population changes, personal and institutional benefits, challenges with parenting in training
40-55 min: small group work on participants' educational settings, opportunities to benefit from trainee parents, opportunities in implementing support structures

55-65 min: large group share of specific goals from the beginning of the workshop, specific examples of opportunities.
65-75 min: small group work on challenges and strategies to overcome
75-85 min: large group share and discussion
85-90 min: wrap up, participants make commitment to next steps in implementing opportunities for their educational setting.

**Scientific Citations**

Adesoye, T., Mangurian, C., Choo, E. K., Girgis, C., Sabry-Elnaggar, H., & Linos, E. (2017). Perceived discrimination experienced by physician mothers and desired workplace changes: A cross-sectional survey. JAMA Internal Medicine, 177(7), 1033–1036. https://doi.org/10.1001/jamainternmed.2017.1394

Chan, M. K., Chew, Q. H., & Sim, K. (2019). Burnout and associated factors in psychiatry residents: a systematic review. International Journal of Medical Education, 10, 149–160. https://doi.org/10.5116/ijme.5d21.b621

Frank, E., Zhao, Z., Sen, S., & Guille, C. (2019). Gender Disparities in Work and Parental Status Among Early Career Physicians. JAMA Network Open, 2(8), e198340. https://doi.org/10.1001/jamanetworkopen.2019.8340

Morris, L., Cronk, N. J., & Washington, K. T. (2016). Parenting during residency: Providing support for Dr mom and Dr dad. Family Medicine, 48(2), 140–144.

Morris, L. E., Lindbloom, E., Kruse, R. L., Washington, K. T., Cronk, N. J., & Paladine, H. L. (2018). Perceptions of Parenting Residents Among Family Medicine Residency Directors. Family Medicine, 50(10), 756–762. https://doi.org/10.22454/FamMed.2018.978635

# Educational Workshops Session 2

## N.O. S.H.A.M.E--A Framework for Empowering and Supporting Trainees to Manage Mistreatment in Academic Settings

**Presenters**
John Chamberlain, MD
Tammy Duong, MD
Hannah Potvin, MD

**Educational Objective**
At the conclusion of this workshop, participants will be able to:

1. Describe common forms of mistreatment experienced by trainees in academic settings.
2. Explain factors in and characteristics of academic settings that increase the risk of trainees being subjected to mistreatment
3. Discuss responses to reports of mistreatment that fail to appropriately support trainees
4. Describe steps that faculty and training programs can take to empower trainees to lower the risk of mistreatment and to encourage trainees to report instances of mistreatment
5. Explain how faculty and training programs can properly support trainees who have experienced mistreatment

**Practice Gap**
Mistreatment of trainees (e.g. physical violence, bullying, discrimination, sexual harassment, verbal abuse, etc) in academic settings and the negative impacts of such experiences have been recognized for decades. However, in spite of this recognition and associated efforts to address the issue, mistreatment continues to be an all too common experience among trainees in academic settings. Trainees may be subjected to mistreatment by supervisors (e.g. faculty members, senior residents), administrative staff, clinical staff, peers, patients, friends and family members of patients, strangers, and other hospital staff. Trainees are often unsure of how to respond to such behavior and what resources are available to them following the experience of mistreatment. They may hesitate to discuss mistreatment with colleagues and supervisors due to fears of being perceived negatively. Moreover, they may not receive education on relevant skills (e.g. de-escalation, limit setting, interpersonal efficacy, etc). At the same time, supervisors are often ill-equipped to provide effective and appropriate support to trainees who experience mistreatment. Acquiring skills to recognize factors that increase the risk of mistreatment, to identify forms of mistreatment, and to minimize the risk of experiencing mistreatment are critical career development skills for trainees and faculty. Likewise, fostering an understanding of the negative impacts of mistreatment on personal and professional well-being as well as developing an awareness of resources and strategies available to support trainees who experience mistreatment are vital skills for the career growth of trainees and faculty. This workshop will address these gaps in academic practice.

**Abstract**
Mistreatment of trainees (e.g. physical violence, bullying, sexual harassment, verbal abuse, etc) in academic settings and the negative impacts of such experiences have been recognized for decades. In spite of this recognition and associated efforts to address the issue, mistreatment continues to be an all too common experience among trainees in academic settings. Further, the problem of trainees' suffering mistreatment in academic settings is an issue of international concern. For example, studies from Peru, the United States, Saudi Arabia, Europe, and Australia have demonstrated high rates of mistreatment during training. Such experiences have been associated with substance use, poorer mental health, burn-out, lower self-esteem, and decreased career satisfaction.

Trainees may be subjected to mistreatment by supervisors (e.g. faculty members, senior residents), administrative staff, clinical staff, peers, patients, friends and family members of patients, strangers, and other hospital staff. Trainees are often unsure of how to respond to such behavior and what resources are available following the experience of mistreatment. Trainees may feel they must tolerate what would otherwise be viewed as unacceptable behaviors from patients because they are ill and under stress. Moreover, they may believe that, in the high stress environment of academic settings, inappropriate behavior by faculty, staff, and other trainees is expected. Faculty, more senior trainees, and peers may implicitly or explicitly communicate expectations that trainees tolerate or excuse mistreatment.

Trainees may hesitate to discuss mistreatment with colleagues and supervisors due to fears of being perceived negatively. For example, they may fear being perceived as thin-skinned, overly sensitive, or incompetent. Moreover, they may not receive education on relevant skills (e.g. de-escalation, limit setting, interpersonal efficacy, etc) that would better equip them to manage inappropriate behavior. At the same time, supervisors are often ill-equipped to provide appropriate support to trainees who experience mistreatment. For instance, supervisors may not understand their responsibilities to support and protect trainees who have experienced mistreatment. Further, they may struggle with finding the time to talk with trainees about these issues. They may also be unaware of the local resources in their institution to which they can refer trainees for additional support. Lastly, they may feel uncomfortable discussing issues related to mistreatment with trainees.

Acquiring skills to recognize factors that increase the risk of mistreatment, to identify forms of mistreatment, to support victims of mistreatment, and to minimize the risk of experiencing mistreatment are critical career development skills for trainees and faculty. Likewise, fostering an understanding of the negative impacts of mistreatment on personal and professional well-being are vital skills for the career growth of trainees and faculty. This workshop will provide an overview of a framework developed at the University of California San Francisco for helping faculty, staff, and trainees recognize mistreatment; to empower trainees to manage and report mistreatment; and to support trainees who have experienced mistreatment. Participants will have an opportunity to apply this framework to relevant examples of trainee mistreatment. In

addition, participants will share how this framework could be applied to their home institutions in facilitated group discussions.

**Agenda**
0:00 – 0:10: Introductions
0:10 – 0:20: PowerPoint facilitated overview of common forms of mistreatment in academic settings, common mistakes when mistreatment is reported by trainees, and framework for H.A.L.T.S.
0:20 – 0:50 Small group application activity (review vignettes; discuss types of mistreatment identified in the vignettes; analyze responses to mistreatment; examine systemic issues contributing to the occurrence of mistreatment)
0:50 – 1:20: Small group experiential activity (use the H.A.L.T.S. framework to identify steps that could have been taken to both empower trainees to manage inappropriate behavior, facilitate trainees' reporting of mistreatment, and support trainees who were subjected to mistreatment; discuss how this framework may be applied at participants' home institutions)
1:20 – 1:30: Facilitated Group Discussion and Q&A

**Scientific Citations**
Ayyala MS, Chaudhry S, Windish D, et al. (2018) Awareness of Bullying in Residency: Results of a National Survey of Internal Medicine Program Directors. Journal of Graduate Medical Education, April: 209 - 213.

Chadaga AR, Villines D, Krikorian A. (2016) Bullying in the American Graduate Medical Education System: A National Cross-Sectional Survey. PLoS ONE 11(3): e0150246.

Cook AF, Arora VM, Rasinki KA, et al. (2014) The Prevalence of Medical Student Mistreatment and Its Association with Burnout. Acad Med. 89(5): 749–754.

Crebbin W, Campbell G, Hillis DA, et al. (2015) Prevalence of bullying, discrimination and sexual harassment in surgery in Australasia. ANZ J Surg. 85: 905–909.

Fnais N, al-Nasser M, Zamakhshary M, et al. (2013) Prevalence of harassment and discrimination among residents in three training hospitals in Saudi Arabia. Ann Saudi Med. 33(2): 134-139.

Fnais N, Soobiah C, Chen MH, et al. (2014) Harassment and Discrimination in Medical Training: A Systematic Review and Meta-Analysis. Acad Med. 89: 817–827.

Forel D, Vandepeer M, Duncan J, et al. (2018) Leaving surgical training: some of the reasons are in surgery. ANZ J Surg. 88: 402–407

Hamblin LE, Essenmacher L, Ager J, et al. (2016) Worker-to-Worker Violence in Hospitals: Perpetrator Characteristics and Common Dyads. Workplace Health Saf. 64(2): 51–56.

House JB, Griffith MC, Kappy MD, et al. (2018) Tracking Student Mistreatment Data to Improve the Emergency Medicine Clerkship Learning Environment. West J Emerg Med. 19(1): 18–22.

Johansen IH, Baste V, Rosta J, et al. (2017) Changes in prevalence of workplace violence against doctors in all medical specialties in Norway between 1993 and 2014: a repeated cross-sectional survey. BMJ Open. 7: e017757.

Kulaylat AN, Qin D, Sun SX, et al. (2017) Perceptions of mistreatment among trainees vary at different stages of clinical training. BMC Medical Education. 17:14.

Leisy HB and Ahmad M. (2016) Altering workplace attitudes for resident education (A.W.A.R.E.): discovering solutions for medical resident bullying through literature review. BMC Medical Education. 16: 127.

Nieto-Gutierrez W, Toro-Huamanchumo CJ, Taype-Rondan A, et al. (2018) Workplace violence by specialty among Peruvian medical residents. PLoS ONE 13(11): e0207769.

Price O and Baker J. (2012) Key components of de-escalation techniques: A thematic synthesis International Journal of Mental Health Nursing. 21: 310–319.

Price O, Baker J, Bee P, et al. (2015) Learning and performance outcomes of mental health staff training in de-escalation techniques for the management of violence and aggression. The British Journal of Psychiatry. 206: 447–455.

Robertson T, Daffern M, Thomas S, et al. (2012) De-escalation and limit-setting in forensic mental health units. Journal of Forensic Nursing. 8: 94–101.

Siller H, Tauber G, Komlenac N, et al. (2017) Gender differences and similarities in medical students' experiences of mistreatment by various groups of perpetrators. BMC Medical Education. 17: 134.

Volz NB, Fringer R, Walters B, et al. (2017) Prevalence of Horizontal Violence Among Emergency Attending Physicians, Residents, and Physician Assistants. West J Emerg Med. 18(2): 213-218.

## Helping patients plan for a mental health crisis: How to implement the use of psychiatric advance directives within residency training programs.

**Presenters**
Tristan Gorrindo, MD
John Torous, MD

**Educational Objective**

1. Describe psychiatric advance directives and how they promote patient autonomy

2. Demonstrate use of tools which facilitate the creation of psychiatric advance directives
3. Create a plan for implementing an educational activity on psychiatric advance directives within a residency training program

**Practice Gap**

A psychiatric advance directive (PAD) is a legal tool recognized in the majority of U.S. states that allows a person with mental illness to state their preferences for treatment and hospitalization in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. They are similar to living wills and other medical advance planning documents used in palliative care, times of intubation, and times of resuscitation. Individuals with serious mental illness (SMI) such as bipolar disorder, schizophrenia, and recurrent major depression may have limited ability to express their wishes for the types of care that they receive during times of high symptoms burden. PADs can include advance instructions, establish power of attorney, or both. Without such information, clinicians are often times left to make surrogate decisions for a patient — often through a complicated court-ordered process — without knowing if a patient would make those same decisions for himself/herself during times of clearer cognition and decisional capacity. There is a national effort to ensure that all patients being discharged from an inpatient psychiatric unit have a valid PAD. Given that PADs are a relatively new construct and that the role of completing PADs with patients may fall to trainees rotating on inpatient unites, trainees need knowledge and tools to complete these documents with patients.

**Abstract**

This workshop will focus on the hands-on implementation of psychiatric advance directives within residency training programs using: 1) a new app created by the American Psychiatric Association's SMI Adviser initiative, and 2) a training module which can be used by program directors in their residency programs. A relatively new construct in psychiatry, a psychiatric advance directive (PAD) is a legal tool recognized in the majority of U.S. states that allows a person with mental illness to state their preferences for treatment and hospitalization in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. They are similar to living wills and other medical advance planning documents used in palliative care, times of intubation, and times of resuscitation. Individuals with serious mental illness (SMI) such as bipolar disorder, schizophrenia, and recurrent major depression may have limited ability to express their wishes for the types of care that they receive during times of high symptoms burden. Efforts are underway to ensure every psychiatric inpatient has an opportunity to create a psychiatric advance directive. This workshop will walk attendees through the process of how a clinician would work with a patient to create advance instructions within a digital PAD with a focus on the use of medication, willingness to be hospitalized, and consent to share information with individuals outside of a treatment team (such as a family member). Lesson plans and slide decks will also be provided to assist program directors in providing PAD-related education to trainees. At the end of this workshop, attendees will have the knowledge and tools to implement PAD related education within their institutions.

**Agenda**
This workshop will focus on the hands-on use of a digital app that can be used to create a psychiatric advance directive. The agenda below promotes kinetic and action-oriented learning of attendees, especially training program directors who are looking implement similar training in their residency programs.
10 Minutes – Review purpose and structure of psychiatric advance directives (PAD)
40 Minutes – Download a psychiatric advance directive app and walk through the steps of creating a PAD
20 Minutes – Review tools designed for program directors to teach residents about PADs
10 Minutes – Complete an action plan for implementing PAD training within training programs
10 Minutes – Questions and answers with faculty, Whova app

**Scientific Citations**
The Substance Abuse and Mental Health Services Administration (SAMHSA) released a PAD toolkit for mental health clinicians in 2019. The toolkit and background information can be found at:
Substance Abuse and Mental Health Services Administration: A Practical Guide to Psychiatric Advance Directives. Rockville, MD: Center for Mental Health Services. Substance Abuse and Mental Health Services Administration, 2019.
https://www.samhsa.gov/sites/default/files/a_practical_guide_to_psychiatric_advance_directives.pdf

## Reading Between the Lines: Deciphering Letters of Recommendation in Psychiatry

**Presenters**
Anne McBride, BA, MD
William Newman, MD
Alan Koike, MD, MS
Brianne Newman, MD
Paula Wadell, MD

**Educational Objective**
1. Gain knowledge regarding the challenges and limitations involved in reviewing and writing letters of recommendation.
2. Identify significant LOR features, applicant abilities, and commonly used phrases.
3. Receive feedback on whether the participant's written LOR is consistent with how other readers interpret the LOR.

**Practice Gap**
The ACGME requires program directors to recruit and select appropriate applicants for general psychiatry residency and subspecialty fellowships. A typical program may receive numerous applications for each available residency position, and program directors are often tasked with

reviewing hundreds of applications during each recruitment cycle. With multiple ACGME-accredited and non-accredited fellowships available to trainees, fellowship directors must also review substantial numbers of fellowship applications. The ability to accurately and efficiently decipher an applicant's letters of recommendation (LOR) becomes critical. Of equal importance, program directors and faculty in general are often asked to write LORs for prospective applicants. Given that LORs can serve as such important sources of information to round out an individual's application portfolio, writing LORs that are both meaningful and accurate is imperative. Careful and deliberate reading and writing of LORs is not typically a skill taught to new (and sometimes more seasoned) faculty including program directors. This workshop is a first step in closing the gap in this necessary skill.

**Abstract**
Acceptance into a psychiatric residency has become increasingly competitive. A typical program may receive numerous applications for each available residency position, and program directors are often tasked with reviewing hundreds of applications during each recruitment cycle. With multiple ACGME-accredited and non-accredited fellowships available to trainees, fellowship directors must also review substantial numbers of fellowship applications. The ability to accurately and efficiently decipher an applicant's letters of recommendation (LOR) becomes critical. Of equal importance, program directors and faculty in general are often asked to write LORs for prospective applicants. Given that LORs can serve as such important sources of information to round out an individual's application portfolio, writing LORs that are both meaningful and accurate is imperative. Careful and deliberate reading and writing of LORs is not typically a skill taught to new (and sometimes more seasoned) faculty including program directors. This workshop is a first step in closing the gap in this necessary skill.

In this workshop, participants will be asked to bring in two to three de-identified LORs that they have previously written. Ideally this would include LORs regarding a variety of applicants who range from exceptional to mediocre to problematic. Upon arrival to the workshop, participants will fill out a one-item survey for each LOR they bring, evaluating on a scale from 1 (lowest) - 10 (highest) their own perception of the quality of the applicant. LORs will then be collected and shuffled. After a brief overview on the challenges and limitations associated with reading and writing LORs, participants will break into smaller groups. Each group will review multiple LORs. As a group, participants will identify significant letter features, applicant abilities, and commonly used phrases. Each group member will rate each letter on the overall quality (scored 1-10) of the applicant described in the LOR and generate comments on why they arrived at each score. The overall quality (scored 1-10) of each applicant as viewed by the LOR author will be revealed and the group will identify letters that were consistent with the intent of the author and letters that were discrepant.

Finally, the large group will come back together to compare and consolidate findings in order to identify overall significant letter features, applicant abilities, and commonly used phrases (for the basis of a future survey).

**Agenda**
00:00 Lecture format by presenters to provide overview on LORs including challenges and limitations in writing and deciphering LORs.
00:10 Small groups will be tasked with two challenges. As a group, a review of individual LORs will yield: 1. Significant letter features, applicant abilities, and commonly used phrases, and 2. Each group member will rate each letter on the overall quality (scored 1-10) of the applicant described in the LOR.
00:40 The overall quality (scored 1-10) of each applicant as viewed by the LOR author will be revealed and the group will identify letters that were consistent with the intent of the author and letters that were discrepant.
01:10 Large group discussion to compare and consolidate findings in order to identify overall significant letter features, applicant abilities, and commonly used phrases (for future survey).
01:20 Q&A
01:25 Evaluation

**Scientific Citations**
The ACGME requires program directors to recruit and select appropriate applicants for general psychiatry residency and subspecialty fellowships. (Common requirement. 11.A.4.)

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf

The number of psychiatry positions has grown every year since 2008 and the 98.9% fill rate is among the highest on record. From NRMP's 2019 Main Residency Match, Results and Data, accessed at: https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/04/NRMP-Results-and-Data-2019_04112019_final.pdf

## Teaching Relationship-Centered Communication to Psychiatry Trainees

**Presenters**
Rebecca Rendleman, MD
Oliver Stroeh, MD
Steven Kaplan, MD
Helen Ding, MD
Sara VanBronkhorst, MD

**Educational Objective**
At the end of the workshop, participants will be able to:
1. Recognize communication as a fundamental skill that can be explicitly taught and deliberately practiced
2. Appreciate the relevance of communication training in psychiatry residency
3. Identify relationship-centered communication as one model of communication training
4. Communicate more effectively diagnosis and treatment recommendations to patients using a relationship-centered communication skill

5. Consider strategies for implementing communication training in psychiatry residency

**Practice Gap**

Communication is a fundamental skill and is one of the six Core Competencies identified by the Accreditation Council of Graduate Medical Education (The Milestone Project, 2014). Effective communication improves patient outcomes and enhances patient, family and caregiver satisfaction (Chou et al, 2014). Increased provider satisfaction helps mitigate burn-out and improve wellbeing (Krasner et al, 2009). Historically, limited attention has been given during residency to explicit training in effective communication (Ericsson, 2004). While psychiatry training frequently focuses on psychotherapeutic techniques, competence in the more fundamental and universal physician-patient communication skills is often assumed.

**Abstract**

Communication is a fundamental skill and is one of the Accreditation Council of Graduate Medical Education's six Core Competencies (The Milestone Project, 2014). It is a procedure in which the average clinician engages approximately 200,000 times during an average practice lifetime. Effective communication has been associated with improved outcomes, including greater patient and provider satisfaction, increased likelihood of adherence to a treatment plan, and reduced malpractice risk (Chou et al, 2014; Levinson et al, 1997; Levinson et al 2010). However, other than addressing some circumscribed domains such as "delivering bad news" or "managing the angry patient," few graduate medical education programs' curricula incorporate formal communication skills training. In 2013, leadership at NewYork-Presbyterian (NYP) collaborated with the Academy of Communication in Healthcare to develop a relationship-centered communication (RCC) workshop to enhance providers' skills and improve patient experience. Relationship-centered communication (in contrast to patient- or provider-centered communication) recognizes explicitly the importance of the patient-provider relationship to the delivery of care, and emphasizes the providers' abilities to empathize with patients and understand their perspectives. To date, over 1,000 NYP healthcare providers have completed the NYP RCC workshop. Feedback collected through 2016 indicated that, immediately following the workshop, participants regarded the training positively and, six weeks later, endorsed significant improvements in their self-efficacy, attitudes, and behaviors related to communication with patients (Saslaw et al, 2017). Since 2016 and as part of their first-year summer orientation, over 50 residents in the NYP Child and Adolescent Psychiatry (CAP) Residency Training Program have completed the RCC workshop. Eighty-five percent of those CAP residents who completed a follow-up survey agreed or strongly agreed that the RCC workshop was useful to their education. The aims of this AADPRT workshop are to increase recognition that communication is a fundamental skill that can be taught and practiced, and that communication training is relevant to psychiatry residency education. This workshop will utilize (1) a brief overview of the RCC workshop's three modules, (2) live demonstration of targeted communication skills, and (3) opportunities for participants to practice one RCC skills through observed role-play with real-time feedback. A debrief will allow participants to share their experiences and address potential barriers to the use of the skill. As a result of this workshop, participants will learn about and experience first-hand through active learning one

model by which to teach psychiatric residents communications skills and to consider how to potentially bring communication skills training to their home institutions.

**Agenda**

1. Welcome and introductions – 5 minutes
2. Presentation of evidence in support of communication skills training – 10 minutes
3. Overview of relationship-centered communication (RCC) workshop at NewYork-Presbyterian (NYP) – 15 minutes
4. Interactive skill-building exercise (demonstration by workshop leaders and role play by participants) – 45 minutes
5. Debrief/discussion – 10 minutes
6. Wrap-up – 5 minutes

**Scientific Citations**


1. The Psychiatry Milestone Project. J Grad Med Educ. 2014 Mar;6(1s1):284-304.
2. Chou CL, Cooley L, Pearlman E et al., Enhancing patient experience by training local trainers in fundamental communication skills. Patient Experience Journal. 2014;1(2);36-45.
3. Ericsson KA. Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains. Acad Med. 2004;79:S70-S81.
4. Krasner MS, Epstein RM, Beckman H et al., Association of an education program in mindful communication with burnout, empathy, and attitudes among primary care physicians. JAMA. 2009;302(12):1284-1293.
5. Levinson W, Lesser CS, Epstein RM. Developing physician communication skills for patient-centered care. Health Affairs. 2010:29:1310-1318.
6. Levinson W, Roter KL, Mullooly JP et al., Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. JAMA. 1997:277:553-559.
7. Saslaw M, Sirota DR, Jones DP et al., Effects of a hospital-wide physician communication skills training workshop on self-efficacy, attitudes and behavior. Patient Experience Journal. 2017;4(3);48-54.


## Assessing an IMG Application: Diamonds and Pearls!

**Presenters**


Vishal Madaan, MD
Consuelo Cagande, MD
Ellen Berkowitz, MD
Donna Sudak, MD
Manal Khan, MBBS

**Educational Objective**

1. Recognize the nuances of assessing an International Medical Graduate (IMG) residency application
2. Employ techniques to assess communication skills and cultural competence
3. Identify features of IMG applications that predict success in psychiatry training
4. Develop an assessment tool/check list specific to IMG application

**Practice Gap**

There is a paucity of literature and training, including in Psychiatry, on how to assess IMGs for a residency, with majority of the focus on the certification and immigration process. IMGs are vital to the provision of care to the underserved and enrich the diversity of practicing psychiatrists. Given the increasing number of United States Medical Graduates (USMG), it is even more competitive for IMGs to obtain residency positions. In 2018, the American Medical Association (AMA) listed Pathology, Internal Medicine, Neurology and Family Medicine as the top four medical specialties that matched the most IMGs, and yet IMGs constitute about 30% of trainees in general psychiatry and sub-specialties. Psychiatry training directors must thoroughly review applications beyond USMLE scores to find IMGs who will be a good fit and successful in training.

**Abstract**

"What do I look for in an IMG application?" This is one of the most common questions a program director (PD) may have when reviewing hundreds of applications. There is a paucity of literature on guiding PDs regarding this issue. Most of the focus is on certification and immigration process for IMG applicants, and not recommendations for the PDs. PDs must assess the quality of the medical school to the quality of work experience in the United States. In addition, how do their medical school grades translate into the US context. Furthermore, how do IMGs compare to US medical graduates? How do you define IMG success? What value would the IMG(s) add to your program? This session aims to answer many similar questions. Utilizing interactive polling Dr. Cagande will discuss the nuances of assessing an IMG application. Dr. Berkowitz will review techniques to assess communication skills and cultural competence. Dr. Sudak will point out highlights of the application that predict success in training. Based on these topics, the audience will review sample applications and develop their own check list specific to their program needs. Ultimately, the session will provide the audience an understanding of IMG applications and a skill set and tool to use when assessing t. As residency program leaders, we know good fit with a diverse pool of applicants is essential for the success of the trainee (diamond) and the program (pearl).

**Agenda**

1) Welcome/overview of agenda/introduction of speakers: Dr. Madaan (5 min)
2) Learn the nuances of assessing an IMG residency application: Dr. Cagande (10 min)
3) Employ techniques to assess communication skills and cultural competence: Dr. Berkowitz (10 min)
4) Identify features of IMG applications that predict success in psychiatry training: Dr. Sudak (10 min)

5) A chief resident's perspective: Dr. Khan (5 min)
6) Pair-Think-Share: Develop an assessment tool/check list specific to IMG application in small groups (45 min)
7) Regroup, feedback and questions: Dr. Madaan (5 min)

**Scientific Citations**


1. Kokosis G, Leto Barone AA, Grzelak MJ, et al. International Medical Graduates in the US Plastic Surgery Residency: Characteristics of Successful Applicants. Eplasty. 2018;18:e33. Published 2018 Nov 27.PMC6263251
2. Cardenas Lara F, Naik ND, Pandian TK, Gas BL, Strubel S, Cadeliña R, Heller SF, Farley DR. A Comparison of Objective Assessment Data for the United States and International Medical Graduates in a General Surgery Residency. Journal of Surgical Education. Volume 74, Issue 6, November–December 2017, Pages e1-e7
3. https://www.yousmle.com/img-guide/
4. https://www.ama-assn.org/residents-students/specialty-profiles/4-medical-specialties-among-friendliest-img-pgy-1-matches


## Managing the Millennial Struggling Learner: Creating a Team Approach

**Presenters**


Sourav Sengupta, MD, MPH
Elizabeth Sengupta, BS, MA
Cynthia Pristach, MD
Paula DelRegno, MD


**Educational Objective**

1. Participants will be able to discuss results of several studies regarding millennial attitudes toward training and feedback.
2. Participants will be able to describe key components of Hauer's model for remediation of physician learners.
3. Participants will consider how the use of Milestones may help programs meet the changing needs and expectations of millennial learners.
4. Participant will be introduced to the way that two programs (one smaller fellowship program and one larger general psychiatry program) use Milestones to create a team-based approach to addressing the needs of struggling millennial learners.
5. Participants will discuss the unique features of their home programs and brainstorm ways to design and implement a team-based approach to defining learning targets and monitoring the progress of struggling learners.

**Practice Gap**

Programs are required to hold bi-annual clinical competency committee meetings to assess resident performance using the ACGME Milestones. But what do we do when a resident isn't making sufficient progress? Several studies have been published offering practical tips for

aiding learners struggling with specific Milestones but there is a lack of practical implementation tips to create a programmatic system to address these issues as a teaching team. Furthermore, we have been witnessing a generational shift in the way residents interpret, respond to and expect feedback. Millennials have been shown to value mentorship, personalized learning, and teamwork as well as continuous, explicit, direct feedback (Desy 2017). Milestones can be used not only as a way to identify struggling learners, but also as a tool to create a team-based, comprehensive approach to remediation that plays to the expectations and preferences of this new generation of learners.

**Abstract**

The goal of this workshop is to aid programs in designing a team-based, comprehensive approach to addressing struggling learners that incorporates the expectations and preferences of millennials while working within the context of the individual program.

We will begin by considering the results of several studies surveying millennial attitudes toward motivation, training and achievement, as well as millennial expectations regarding mentorship and feedback. We will then consider the implications of these unique attitudes and expectations on residency training. Furthermore, we will examine research on current best practices to address struggling learners, focusing on Hauer's model of assessment, diagnosis of deficiency, development of individualized learning plan, remediation via deliberate practice, feedback and reflection, and reassessment (2009), and illustrate how Milestones can be used not only as a tool to identify learning gaps, but also as a way to address these gaps while addressing the needs and expectations of millennial trainees.

We will discuss how the unique pre-existing features of individual programs can be leveraged to create a team-based approach to identify targeted learning goals by outlining the process used in two different programs. The first approach is used in a small, two-year fellowship program whose faculty work at many sites around the city. The second approach is used in a larger, four-year general psychiatry program whose faculty meet more regularly in one location. Both programs utilize the Milestones as a tool both to create individualized learning plans for struggling trainees, and to keep all members of the team focused on the targeted learning goals. Participants will then be given time to consider the unique features of their individual programs and begin to design a team-based, Milestones-driven approach to remediation that fits within their program's structure and addresses the needs and expectations of millennial learners.

**Agenda**

10 minutes: The generational change in expectations and attitudes in residency training
10 minutes: What we already know about best practices in remediation (Hauer's model)
5 minutes: The application of Milestones in addressing millennial feedback expectations
20 minutes: The application of a systematic, team-based approach to addressing resident learning gaps in two different programs
15 minutes: Small group breakout: leveraging pre-existing features of your training program in designing a systematic, team-based approach to aiding struggling learners

20 minutes: Discussion and troubleshooting
10 minutes: Wrap-up

**Scientific Citations**

1. Desy, J., Reed, D., & Wolanskyj, A. (2017). Milestones and Millennials: A Perfect Pairing—Competency-Based Medical Education and the Learning Preferences of Generation Y. Mayo Clinic Proceedings, 92(2), 243–250. https://doi.org/10.1016/j.mayocp.2016.10.026
2. Rumack, C., Guerrasio, J., Christensen, A., Aagaard, E., & Rumack, C. (2017). Academic Remediation: Why Early Identification and Intervention Matters. Academic Radiology, 24(6), 730–733. https://doi.org/10.1016/j.acra.2016.12.022
3. Ketteler, E., Auyang, E., Beard, K., Mcbride, E., Mckee, R., Russell, J., … Nelson, M. (2014). Competency Champions in the Clinical Competency Committee: A Successful Strategy to Implement Milestone Evaluations and Competency Coaching. Journal of Surgical Education, 71(1), 36–38. https://doi.org/10.1016/j.jsurg.2013.09.012
4. Hauer, K. E., Ciccone, A., Henzel, T. R., Katsufrakis, P., Miller, S. H., Norcross, W. A., Papadakis, M. A., Irby, D. M. (2009). Remediation of the deficiencies of physicians across the continuum from medical school to practice: a thematic review of the literature. Academic Medicine, 84(12), 1822-32. https://doi.org/10.1097/ACM.0b013e3181bf3170
5. Wu, J., Siewert, B., & Boiselle, P. (2010). Resident evaluation and remediation: a comprehensive approach. Journal of Graduate Medical Education, 2(2), 242–245. https://doi.org/10.4300/JGME-D-10-00031.1

## Psychological Safety: It's Not Just for Snowflakes

**Presenters**

Jennifer O'Donohoe, MD
Kristi Kleinschmit, MD
T. Eric Spiegel, MD
Luke Dwyer, MD
Thomas Gethin-Jones, MD

**Educational Objective**

1. Define the primary tenants of psychological safety
2. Describe several ways to assess the psychological safety of trainees and faculty
3. Practice implementing strategies that improve psychological safety
4. Explore obstacles and solutions to enhancing psychological safety in each participants' setting

**Practice Gap**

Psychological safety is a critical part of optimizing the learning environment. For learning to occur, trainees must feel safe to take risks and make mistakes. If they feel that they will be punished, humiliated or unfairly remediated for making mistakes, this can lead to burnout, depression, lack of empathy, and decreased career satisfaction [1]. The ACGME tasks GME programs with creating an appropriate and safe environment for trainees to learn

competencies. It has been shown that psychological safety is an important factor for residents in their assessment of their learning environment/program [2]. The ACGME also makes it clear that psychological safety is something that they value. One of the reported responses on the Annual Resident Survey is, “Residents can raise concerns without fear.” In 2018, 82% of adult and child psychiatry programs were compliant with this metric. It is troubling that 1 out of 5 trainees does not feel that they can raise concerns without fear. Program directors need a systematic way to describe and assess the psychological safety of their departments. They also need strategies for addressing any deficits in psychological safety with faculty and trainees.

**Abstract**

The goal of this workshop is to help attendees address the importance of psychological safety in the training environment within their home departments in a systematic way. The workshop will be co-led by senior child psychiatry and general psychiatry trainees who have first-hand experience with psychological safety within training. The workshop will start with an ice breaker designed to engage the participants and simultaneously build psychological safety within the group. We will have the group define the important factors that contribute to psychological safety and create our own ground rules for the workshop. Next, using an interactive and anonymous tool (Poll Everywhere), we will have the participants take the Psychological Safety Survey. We will also identify common obstacles to psychological safety using the interactive tool and discuss other assessments for psychological safety that participants can utilize to assess their own programs. We will then have interactive breakout sessions where we will use previously recorded videos of scenarios experienced by the residents in their training during which there was an absence of psychological safety. The small groups will reenact the scenarios using the tenants of psychological safety and process the differences. Large group discussion will focus on the experiences of the participants. There will be a brief presentation of practical strategies to strengthen psychological safety in a department and resident work environments. We will have the participants make a commitment to themselves to trial one of the strategies. Then we will conclude with a review of the importance of psychological safety, obstacles to it and commitments to assess it and intervene when necessary.

**Agenda**

1. Introduction: Interactive ice breaker (5 min)
2. Group definition of psychological safety and setting norms (5 min)
3. Interactive assessment of psychological safety and obstacles (20)
4. Small Groups role play scenarios (30 min)
5. Large Group Report Back (10 min)
6. Presentation of practical ways to actively create psychological safety (10 min)
7. Conclusion (10min)

**Scientific Citations**

1. Bynum WE, Haque TM. Risky business: psychological safety and the risks of learning medicine. J Grad Med Edu. 2016; 8 5:780-782.

2. Torralba KD, Loo LK, Byrne JM, et al. Does Psychological safety impact the clinical learning environment for resident physicians? Results from the VA's Learners' Perception Survey. J Grad Med Educ. 2016; 8 5:699-707.

## Lights...Camera...Action!: A Lesson on Educating Trainees to Address Social Determinants of Mental Health Through Interactive Theater

**Presenters**
Margaret Wang, MD
Antara Banik, MD
Evelyn Ashiofu, MD, MPH
Karen Duong, DO
Lia Thomas, MD

**Educational Objective**

1. Recognize common social factors that play a role in individuals' mental health statuses and experiences across the life span
2. Practice identifying how these social factors manifest in patient interactions and how to address them using scripted scenes, interactive theater, and role play
3. Learn how to incorporate discussion regarding "social determinants of (mental) health" with patients, and how this can be incorporated into daily clinical practice
4. Identify specific resources that can be used with patients with mental health disorders from disadvantaged backgrounds
5. Encourage implementation of a social determinants of mental health topics into general residency education curriculum

**Practice Gap**

"Social determinants of mental health" refer to social and environmental factors that interact with and influence the genetics and life experiences of individuals with mental health disorders, and the systems in place to deal with mental illness. Understanding the social factors allows for population-level interventions for primary and secondary prevention of mental illness. Teaching of this topic is not uniform throughout residency training programs and clinicians often feel unequipped to address mental illness from this angle. Current literature shows that individuals who experience adverse environmental effects, from living in low-income neighborhoods, having inadequate access to healthcare or quality education, living with food insecurity, to being of a minority race, have a higher likelihood of mental health conditions but also have poorer mental health treatment outcomes. Examples include experiencing race-based major discrimination as a predictor of lifetime depressive and mood disorders, neighborhood depravation and poverty being associated with higher incidence of overdose, schizophrenia, depression and worse mental health outcomes. If psychiatrists could be taught about these social and environmental factors and ways to mitigate them during patient interactions early in residency training, these skills could then be incorporated into clinical practice as a tool to help improve patients' mental health. Health care disparities may be touched on, especially at the

medical school education level, and are typically taught through the teachings of cultural competency. As medical students transition into the resident level and are now directly working with different patient populations, it is important that lessons are taught that go beyond cultural competency and take a deeper look at the structural factors in place that affect the delivery of mental health care. There have been very few reports in the literature describing how often these topics are taught during residency, how to teach these topics, or a standardized method of teaching.

**Abstract**
For psychiatrists in training, it is important to understand how the social determinants of mental health play an important role in the diagnosis and treatment of individuals who are faced with such challenges. This workshop aims to showcase the importance of shedding light on these influential factors of mental health and to also provide an approach on how to effectively teach psychiatry residents about the topic of social determinants of mental health in an innovative and interactive way: through theater and role-play. Interactive theater has been used to facilitate discussion and train trainees on patient interactions. Scenes can be frozen and audience members can engage in dialogues with the characters regarding their experiences, thoughts and motivations. Audience members can help direct alternative endings to the scenes with their input, therefore allowing for audience discussion and teaching. This session is based on a special seminar created at the University of Texas Southwestern Medical Center to teach residents about social determinants of mental health. Concepts from this session may be adapted to help teach this topic in other residency programs. Our session will teach common "social determinants" that affect mental health and use interactive theater to help teach participants about the experiences and contexts of, and approach to, patients whose mental health are affected by environmental factors through enacting a scripted patient-doctor scene with underlying "social determinants" themes. These themes include discrimination, limited income, poor access to health care and poor education. Moderators will facilitate discussion around addressing these issues in clinical care and provide participants with resource tools. Participants will then be able to practice addressing these issues with patients through role-play, while incorporating reflections from the large group audience discussion and the provided resource tools into their interactions. By the end of the session, participants will have learned strategies to teach colleagues on how to address some social determinants of mental health in clinical practice.

**Agenda**
0:00 Introductions / Objectives
0:05 Overview of social determinants of mental health
0:20: Presenters enact scene with indicated pauses/pauses in scene to discuss with audience and characters regarding themes in the scene and moderate alternative endings/how they would respond to the scenario presented.
0:40: Each group assigned scripted scene and roundtable discussion regarding social determinants themes with group with guiding questions
1:10: Groups share with larger group their responses and larger group discussion

1:20 Wrap up/Tools to address social determinants of mental health, including resource handouts to use with patients
1:25: Participant review of session via Whova app

**Scientific Citations**

1) Compton, M.T. and Shim, RS (2015). The Social Determinants of Mental Health. Arlington, VA: American Psychiatric Publishing.
2) King, T.E. (2007). Medical Management of Vulnerable and Underserved Patients: Principles, Practice, and Populations. Chicago, IL: McGraw-Hill Companies, Inc.

3) Patel et al (2014). Global Mental Health Principles and Practice. New York, NY: Oxford University Press.

4) Skye, E. P., Wagenschutz, H., Steiger, J. A. & Kumagai, A. K. Use of Interactive Theater and Role Play to Develop Medical Students' Skills in Breaking Bad News. J. Cancer Educ. 29, 704–708 (2014).

5) Hansen, H., Braslow, J., & Rohrbaugh, R. M. (2018). From Cultural to Structural Competency—Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism. JAMA Psychiatry, 75(2), 117. doi: 10.1001/jamapsychiatry.2017.3894
6) O'Brien, M. J., Garland, J. M., Murphy, K. M., Shuman, S. J., Whitaker, R. C., & Larson, S. C. (2014). Training medical students in the social determinants of health: the Health Scholars Program at Puentes de Salud. Advances in medical education and practice, 5, 307–314. doi:10.2147/AMEP.S67480

## We get by with a little help from Our PEERS: Developing and implementing a relevant well-being curriculum for trainees

**Presenters**

Anne Hart, MD
Jordyn Feingold, MA
Shreya Nagula, MD
Asher Simon, MD

**Educational Objective**

This workshop has been produced by trainees with two faculty mentors/AADPRT members.

- Understand the process of engaging trainees in developing an effective wellness program
  - Conducting a needs assessment
  - Identifying stress points throughout training
  - Establishing a method of delivery
  - Discussing barriers to buy-in
- Understand the value of positive psychology interventions in residency training

- Discuss the importance of focusing on mental health in wellness, as a distinct entity from mental illness
- Experience a PEERS intervention as a participant and a leader
- Learn how to establish a PEERS program at your home institutions, for your residents as well as for other disciplines and levels of trainees

**Practice Gap**

Adequate ability to achieve a state of well-being (beyond the absence of depression, disease, and other etiologies that limit function) is essential for the sustainable practice of medicine and optimal patient care delivery. Physician burnout begins as early as medical school, increases over the course of training, and affects young physicians at higher rates than their more senior counterparts. Over the last decade, the necessity for emphasizing physician well-being has become increasingly appreciated, and the demand for well-being initiatives is on the rise. The pursuit of well-being has been recognized under the Institute for Healthcare Improvement's Quadruple Aim as an essential part of quality healthcare, we now have an ICD-10 code for burnout in the workplace, and the ACGME is mandating wellness requirements in every accredited training program across the country. While the problem of burnout and pursuit of well-being are being discussed at a national level, solutions have lagged behind. The problem is complex, and largely attributable to systemic failures of medical practice in the 21st century. Solutions must address the system, and simultaneously support the individual operating within this broken system with necessary skills to cope and even thrive through adversity. Within this system that is necessarily lacking in resources, we have found a way to implement an effective, scalable, trainee-driven well-being program that helps trainees maximize their sense of meaning and foster connections among peers and mentors.

**Abstract**

It is well-established that peer support is protective among medical professionals. The Practice Enhancement, Engagement, Resilience, and Support (PEERS) curriculum at the Icahn School of Medicine at Mount Sinai (ISMMS) is a trainee-led longitudinal well-being and resilience curriculum that provides peer-to-peer support, leading to reduced levels of burnout and increased levels of resilience in over 500 trainees in the past 3 years. Developed by trainees who are involved in its dissemination alongside faculty advocates, our program embodies the sentiment of "nothing about us without us," maximizing relevance and buy-in. PEERS teaches critical skills in mindfulness, positive psychology, cognitive behavioral therapy, and other therapeutic modalities, while prioritizing and fostering a sense of community and support among learners. Importantly, skills learned can be employed in real time in clinical settings.

The basic principles inform the name. Practice Enhancement: self-care is not just a moral imperative but a critical clinical skill and prerequisite to sustainable patient-care and optimal patient safety. Engagement: learners can deliberately reflect on their sense of meaning in day-to-day life, maximizing the ability to live by their values and use the best parts of themselves in the medical workplace and personal endeavors. Resilience: mistakes and adversity are inevitable in medicine, and one's ability to bounce forward and grow through challenges can be learned and developed. Highly resilient when they begin medical training, learners can explore

and deliberately cultivate effective mechanisms for dealing with inevitable stress. Support: a strong sense of community can be a powerful antidote to burnout, and no learner should feel alone in their experiences.

Originally designed as a mandatory program for medical students, PEERS is now being customized and expanded for four residency programs (Psychiatry, Pediatrics, OBGYN, Neurology) and PhD graduate students. The PEERS program has been recognized by both the APA (poster won the 2019 Student/Resident Curriculum Development and Education Award) and the ACGME (David C. Leach Award recognizing innovation and improvement in residency programs, advancing humanism in medicine, and increasing efficiency and emphasis on educational outcomes.)

In this workshop we provide a brief overview before engaging all participants in a PEERS-like experience, rejuvenating that connection to others that is a key component of these groups. A facilitation manual will guide participants. Reflecting the ease with which PEERS can be customized for inclusion in curricula and disseminated to different training populations, workshop participants will utilize an operationalized worksheet to begin conceptualizing a program relevant to their institutions. We will review all phases of the process, from needs-assessment, to facilitator recruitment, scheduling, and implementation.

Ultimately, PEERS fills a necessary gap between ACGME requirements, the dangers of burnout, and actual practices within a residency program. We aim to provide program directors with a framework to improve trainee well-being while taking into account institutional culture and utilizing local resources in order to maximize their residents' ability to find meaning and a community within training.

We are excited to share this model and the steps to developing a scalable program with the AADPRT community.

**Agenda**

5 min: Welcome & Introductions
15 min: What is the PEERS program?
40 min: Engage in an abbreviated PEERS session in small groups
15 min: Strategize how to bring PEERS home
10 min: Questions & Discussion
5 min: Evaluation Form

**Scientific Citations**


1. Charlton, J. I. (1998). Nothing About Us Without Us. University of California Press.
2. Dyrbye, LN, Thomas, MR, Massie Jr., FS. et al. (2008). Burnout and suicidal ideation among U.S. medical students. Ann Intern Med, 149, 334-341
3. Muller, D. (2017). "Kathryn." N Engl J Med 376(12): 1101-1103.

4. Lopez-Gomez, I., et al. (2017). "Comparing the acceptability of a positive psychology intervention versus a cognitive behavioural therapy for clinical depression." Clin Psychol Psychother 24(5): 1029-1039.
5. Rathert, C., et al. (2018). "Evidence for the Quadruple Aim: A Systematic Review of the Literature on Physician Burnout and Patient Outcomes." Med Care 56(12): 976-984.
6. Rotenstein, L. S., Ramos, M. A., Torre, M., Segal, J. B., Peluso, M. J., Guille, C., ... & Mata, D. A. (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: a systematic review and meta-analysis. JAMA, 316(21), 2214-2236.
7. Shanafelt, TD, Hasan, O, Dyrbye, LN et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc, (90), 1600-1613.
8. Wallace, J. E. and J. Lemaire (2007). "On physician well being-you'll get by with a little help from your friends." Soc Sci Med 64(12): 2565-2577.
9. Wallace, J. E., et al. (2009). "Physician wellness: a missing quality indicator." Lancet 374(9702): 1714-1721.
10. Wasson, L. T., et al. (2016). "Association Between Learning Environment Interventions and Medical Student Well-being: A Systematic Review." JAMA 316(21): 2237-2252.
11. West, CP Shanafelt, TD, Kolars, JC. (2011). Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. JAMA, (306)952-960.

## Grabbing the Third Rail: Race and Racism in Clinical Documentation

**Presenters**

J. Corey Williams, MA, MD
Jessica Isom, MD
Matthew Goldenberg, MD
Robert Rohrbaugh, MD

**Educational Objective**

1. List at least three of the most common current practices and rationales around the use of race in clinical documentation.
2. Explain how the current practices of identifying race are connected to a history of scientific racism.
3. Identify at least three ways in which the common use of race in clinical documentation may be problematic and lead to deleterious consequences for patients.
4. Define race as a social construct as opposed to a biological reality.
5. Examine health disparities as a function of institutional racism as opposed to inherent biological differences.
6. Demonstrate an alternative practice that more appropriately places race in its social context as a risk marker of exposure to racism through a guided role play scenario.

**Practice Gap**

Studies indicate that a large proportion of physicians routinely identity the race of the pa-tient (Black, White, Hispanic, Asian, etc.) alongside other variables (e.g. age, sex, medical his-tory) in their oral presentations and clinical documentation, often as one of the first descrip-tive elements of a case. Many clinicians and educators are uncritical of their use of race in clin-ical care. Scholars have cited several problems with this casual practice of identifying race in-cluding: (1) reinforcing the false idea of race as a biological category (as opposed to a social construct), (2) potential activation of biases that may affect clinical care and/or lead to dis-counting of clinical nuances, (3) justification for unwarranted differential treatment, (4) failure to examine racism as opposed to race as an important risk exposure. Critically, clinicians need guidelines and a framework for how and when to discuss and document a patient's race. In this workshop, we encourage participants to critically analyze the use of race in our clinical care as well as whether and how we teach residents to engage race in the clinical setting. Such analysis serves the goals of the ACGME milestones and Common Program Requirements that task programs with preparing residents to recognize disparities and understand the social determinants of health of the populations they serve. To meet the ultimate goal of address-ing these needs and health disparities, programs must attend to the misuse of race in clinical documentation and respond to the benign neglect of racism as a key social determinant of health.

**Abstract**

"An elderly African-American woman with a history of diabetes brought in by her daughter for increased forgetfulness"; "A 24 year-old Caucasian male with a 2-week history of worsening mood"; "An age-appearing Asian woman in no acute physical distress." Physicians, including psychiatrists, frequently employ phrases that bring attention to a patient's race, often in the opening line of oral presentations or clinical documentation. In many cases, this casual identification of a patient's race is a taken-for-granted routine without conscious rationale. In other instances, physicians may believe the race of the patient directly pertinent to the diagnosis or treatment for the patient.

A robust body of literature has demonstrated that racially identifying patient's has important diagnostic and treatment implications, many of which may be deleterious to the patient. A key aspect of misuse of race in clinical documentation and communication is the failure to name and address racism as a social determinate of health. This lack of recognition contributes to the perpetuation of racial health disparities. As a professional community, physicians rarely engage in critical analysis of when and how race is useful to the care of the patient and the potential implications, if any. We will briefly discuss the history of the scientific inventions of race as a biological construct and how this legacy continues to operate in contemporary medical practice. By giving race a misplaced salience in clinical practice, physicians are complicit in perpetuating the myth of distinct biologically-based racial categories. Further-more, invoking racial categories potentially activates bias and negative stereotypes towards racial minority patients.

**Agenda**
0:00 Introduction
0:05 Case Vignettes with Interactive Questions (using audience polling software)
0:35 Small Group Activity: we will provide prompts to discuss issues of patients' race and experiences of racism.
0:20 Brief historical overview of scientific racism
Background on Race, Racism and Health Disparities
0:55 Large Group Debrief of Small Group
1:05 Cultural Formulation Review and Practical Tips (focusing on Race and Discrimination)
1:20 Concluding comments/Questions and Answers
Last 5 minutes: Workshop evaluation

**Scientific Citations**
Smedley, B. D. (2012). The Lived Experience of Race and Its Health Consequences. American Journal of Public Health, 102(5), 933–935. http://doi.org/10.2105/AJPH.2011.300643

Braun L, Fausto-Sterling A, Fullwiley D, Hammonds EM, Nelson A, Quivers W, et al. (2007) Racial Categories in Medical Practice: How Useful Are They? PLoS Med 4(9): e271. https://doi.org/10.1371/journal.pmed.0040271

Acquaviva KD, Mintz M. Perspective: are we teaching racial profiling? The dangers of subjective determinations of race and ethnicity in case presentations. Acad Med. 2010;85:702–705

Jones CP, LaVeist TA, Lillie-Blanton M. "Race" in the epidemiologic literature: an examination of the American Journal of Epidemiology, 1921–1990. Am J Epidemiol. 1991;134:1079–1084.

Pálsson G. How deep is the skin? The geneticization of race and medicine. BioSocieties. 2007;2:257.

## Clinical Skills Evaluation: Data-Informed Strategies to Improve Interrater Reliability Within and Across Programs

**Presenters**
Michael Jibson, MD, PhD
Kaz Nelson, MD
Heather Schultz, MD, MPH

**Educational Objective**
- Attendees will review and discuss a large, multisite database on CSE performance, including data on inter-rater reliability between faculty members and across programs.
- Attendees will review and sample tools available on the AADPRT website to improve inter-rater reliability.

- Attendees will discuss and outline methods to improve inter-rater reliability in their own programs.

**Practice Gap**

Since its implementation in 2006, the Clinical Skills Evaluation (CSE; aka CSV) has been a requirement both for programs and individual residents. Initial training experiences were conducted at AADPRT in 2009, 2010, and 2012, and a variety of training materials have been on the AADPRT website. Since then, a large, multisite study of validity and interrater reliability has been conducted that provides useful information to assist program directors in assessing the reliability of their assessments internally and compared with other training programs. In addition, new training materials are being developed for the AADPRT website. Issues of validity and interrater reliability have not been addressed at AADPRT since a workshop in 2013, leaving a significant group of newer program directors unfamiliar with these issues and how to address them and more experienced directors without current data to inform their evaluation processes.

**Abstract**

Since its implementation in 2006, the Clinical Skills Evaluation (CSE; aka CSV) has been a requirement both for programs and individual residents, with program directors responsible for training faculty to conduct the assessments. In order to assess the validity and interrater reliability of this process in actual practice, a series of studies has looked at (1) 1,183 CSEs conducted in 4 residency programs between 2008 and 2014, (2) interrater reliability data from more than 200 AADPRT members rating multiple interview videos, and (3) 195 CSEs conducted on 51 practicing psychiatrists by experienced and novice evaluators. These data show strong similarities in CSE performance across programs, with a scoring pattern consistent with a valid measure of competency in the skills measured. This pattern was robust across programs despite significant differences in the timing and frequency of the CSEs between programs. These studies also showed distinct patterns of scoring for individual faculty and demonstrated the impact of 3 types of training experience: immediate feedback on scores in large groups observing video interviews, small group discussion of video interviews, and side-by-side training of novice evaluators by experienced colleagues. With these data in mind, a set of training materials for the AADPRT website is being prepared. These data may also be used by individual programs to assess the interrater reliability of their CSE assessments among their own faculty and compared to other programs. The purpose of this workshop is to review these data and tools, and use them to assist attendees to design and implement training for faculty in the conduct of CSEs.

**Agenda**

10 min: Large group review and discussion of validity data.
40 min: Large group review and discussion of interrater reliability and training data.
20 min: Large group review and discussion of AADPRT training tools.
20 min: Small group discussion of implementation issues in individual programs.

**Scientific Citations**

Juul D, Brooks BA, Jozefowicz R, Jibson M, Faulkner L. Clinical skills assessment: the effects of moving certification requirements into neurology, child neurology, and psychiatry residency training. Journal of Graduate Medical Education 2015; 7:98-100.

Jibson MD, Broquet K, Anzia JM, Beresin EV, Hunt JI, Kaye DL, Rao NR, Rostain A, Sexson SB, Summers RF. Clinical skills verification in general psychiatry: recommendations of the ABPN task force on rater training. Academic Psychiatry 2012; 36, 363-68. PMID: 22983466.

Dalack GW, Jibson MD. Clinical skills verification, formative feedback, and psychiatry residency trainees. Academic Psychiatry 2012; 36, 122-25. PMID: 22532202.

Rao NR, Kodali R, Mian A, Ramtekkar U, Kamarajan C, Jibson MD. Psychiatric Residents' Attitudes towards and Experiences with the Clinical Skills Verification Process - A Pilot Study of US and International Medical Graduates. Academic Psychiatry 2012; 36, 316-22. PMID: 22851030.

## Screen Time! Learning to Teach Pediatric Telepsychiatry (PTP) Using a National Curriculum

**Presenters**

Sandra DeJong, MD, MSc
Shabana Khan, MD
Deborah Brooks, MD
Amy Fehrmann, MD

**Educational Objective**

1) Describe a systematic, competency-based approach to PTP education
2) Review key content areas and current resources for PTP education and ways to incorporate them into child fellowship training
3) Learn how to teach PTP using the Collaborative Care setting as a simulated example
4) Develop an individual learning plan for becoming an effective teacher and supervisor of telepsychiatry

**Practice Gap**

The United States currently faces a dire shortage of child and adolescent psychiatrists (CAPs). Although effective treatments are available, a significant percentage of youth with psychiatric disorders do not receive any treatment; for those that do, there is often a significant delay from symptom onset to diagnosis and treatment initiation.

Telepsychiatry, which has been shown to be effective with children and youth, offers a critical opportunity to improve access to pediatric behavioral health.

In a survey of all U.S. ACGME-accredited CAP fellowship programs conducted in April 2019, 100% of respondents felt that it is “somewhat” or “very” important for telepsychiatry to be part of their program; yet 35% reported offering no telepsychiatry experience to their fellows. Of the 65% who reported having “some” or “a lot” of telepsychiatry experience, 60% reported they had no formal didactic curriculum.

Programs identified lack of faculty with expertise in PTP as an important obstacle. Without relevant education, clinical experience, and exposure to technology, psychiatrists may be hesitant to integrate telepsychiatry into their practice.

**Abstract**
This interactive session will begin with an overview of the ongoing effort to develop a national Pediatric Telepsychiatry (PTP) Curriculum. Key content areas, model didactics and assessment tools, and demos of the curriculum will be presented. Participants will then try out and discuss a variety of online resources for PTP education and training, including the joint American Academy of Child and Adolescent Psychiatry (AACAP) and American Psychiatric Association (APA) Telepsychiatry toolkit videos.

Participants will then engage in a simulated training session on “PTP in Collaborative Care.” In this experiential learning exercise, participants will learn how to structure and teach didactic and clinical sessions using existing resources. Testimonials from CAP fellows with experience in telepsychiatry will be shared for discussion. Finally, participants will work in small groups to develop their own individual learning plan for becoming teachers and supervisors of telepsychiatry.

This work is supported by an ABPN Faculty Innovation in Education award to Dr. DeJong.

**Agenda**
0:00 Introduction
0:05 Overview of the Development of a National Pediatric Telepsychiatry Curriculum
0:20 Review of PTP Core Content and Training Resources with Audience Participation
0:35 “Pediatric Telepsychiatry in the Collaborative Care Model” – A simulated example
1:00 Small Group Breakouts: Developing a Learning Plan for Becoming PTP Teachers and Supervisors
1:20 Q&A Discussion

**Scientific Citations**
1 Clinical Update: Telepsychiatry With Children and Adolescents. J Am Acad Child Adolesc Psychiatry. 2017;56(10):875-93.
2 Boydell KM, Hodgins M, and Pignatiello A et al. Using technology to deliver mental health services to children and youth: A scoping review. Can Acad Child Adolesc Psychiatry, 23:2, May 2014
3 Flaum M. Telemental health as a solution to the widening gap between supply and demand for mental health services. In: Myers K, Turvey C, eds. Telemental Health:

Clinical, Technical and Administrative Foundation for Evidence-Based Practice. London: Elsevier Insights; 2013:11-25.
4 DeJong SM et al. (2019). Unpublished data.
5 AACAP-APA Child and Adolescent Telepsychiatry Toolkit. 2019. https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent. Accessed September 3, 2019.

# Educational Workshops Session 3

## Graduate Medical Education Funding Made Less Complex

**Presenters**
Jed Magen

**Educational Objective**
Training Directors will understand:
1) Basics of current Graduate Medical Education funding mechanisms
2) How hospitals and programs may respond to regulatory and other changes that affect funding
3) The state mechanisms currently used across the US to fund residency program positions that they may be a model for other states

**Practice Gap**
1)From discussion and feedback from past workshops, program directors report that they do not have easily accessible or understandable information regarding how hospitals, states and the Federal Government fund graduate medical education and their own programs.
2) Many program directors report that they do not have program budgets and thus do not understand their own costs.
3) Evidence from the Teaching Health Center GME program is consistent with the view that may program directors do not understand how this funding mechanism might be used by their programs to add positions.

**Abstract**
Graduate Medical Education programs rely heavily on Medicare funding. Direct and indirect medical education funding levels continue to decrease based on earlier legislation mandating continued cuts. Caps on hospital residency numbers decrease flexibility to change numbers and other regulations increasingly constrain programs. Health care reform legislation resulted in some changes in GME regulations. This seminar will help program directors to:
1) understand basic mechanisms of GME funding
2) review GME regulatory changes
3) various Federal GME funding recommendations

The following topics will be discussed:

The basics of GME funding
a) direct and indirect GME costs/reimbursement
b) caps on housestaff numbers and years of training
c) workforce issues
d) changes in Medicare payment for services and where does all the money go?

2) Possible responses
a) resident generated revenue
b) other funding sources (state, local)
c) uncompensated residencies
d) outsourcing, consortiums, other novel responses
e) Federally Qualified Health Centers and Teaching Health Center grants

3) Health care reform, past, present

**Agenda**
The objective of this workshop is to help program directors better understand and function in the current very uncertain and complex health care environment that makes maintaining quality in training programs difficult.

**Scientific Citations**
Graduate Medical Education Financing: Sustaining Medical Education in Rural Places
http//depts.washington.edu/uwrhrc/uploads/RTT_Finances_PB.pdf

Accountability and Transparency in Graduate Medical Education Expenditures
Saima I. Chaudhry, MD, MSHS, Sameer Khanijo, MD, Andrew J. Halvorsen, MS, Furman S. McDonald, MD, MPH, Kavita Patel, MD, MSH
American Journal of Medicine. May 2012 Volume 125, Issue 5, pages 517-522

## When the supervisor needs a supervisor: your guide to training supervisors in best practices

**Presenters**
Amber Frank, MD
Aimee Murray
Anne Ruble, MD, MPH
Donna Sudak, MD
David Topor, PhD

**Educational Objective**
By the end of the session, participants will be able to
1) Briefly describe common challenges in psychotherapy supervision faced by residency and fellowship programs.

2) Identify several potential approaches to manage these common challenges.
3) Identify at least one supervisory challenge relevant to their home programs, and develop a preliminary action plan to address it.

**Practice Gap**

Individual supervision of psychotherapy cases is a cornerstone of psychotherapy education for residency and fellowship programs. Program Directors and Directors of Psychotherapy Training are tasked with oversight of their trainees' psychotherapy supervision, including recruiting supervisors, helping address problems in supervision, and providing ongoing faculty development for psychotherapy supervisors. However, training directors may feel less equipped to manage aspects of psychotherapy supervision that fall outside of their personal areas of expertise. This workshop will provide participants with the opportunity to increase their confidence in managing common supervision challenges faced by training directors and faculty supervisors , including recruiting and developing a supervisor pool, managing problems in the supervisor-supervisee dyad, and special issues in psychotherapy supervision, e.g. interdisciplinary collaboration and diversity, equity, and inclusion.

**Abstract**

Despite the importance of the supervisory relationship, there has been little uniformity in its implementation and a paucity of evidence about the most effective supervisory behaviors. Nevertheless, there exists a literature about principles of adult learning that may be applied to supervision to enrich and make the experience more robust. Several recent studies point to supervision as vital to the process of psychotherapy adherence and quality, as well as improvement in patient outcomes.

This workshop is derived from the work of a subgroup of the AADPRT Psychotherapy Committee, which has generated a list of common challenges and core issues in psychotherapy supervision, with the goal of creating a series of practical guides for the membership on these topics. This workshop will review a subset of these common challenges and core issues, and attendees will also discuss specific roadblocks to effective supervision in their program and determine an action plan. Participants will have the opportunity to explore challenges within the supervisor-supervisee dyad as well as systems-level supervision concerns relevant to training directors, such as recruiting and developing your psychotherapy supervisor pool. The workshop will be active in nature, utilizing scenarios and discussion to review key points.

**Agenda**

- Welcome and Introductions - 5 min
- Overview of Challenges in Supervision - 10 min
- Small group scenarios and discussion - 45 min
- Individual program action planning - 10 min
- Large Group Discussion and questions - 15 min
- Evaluations - 5 min

**Scientific Citations**


1. Bambling, MW, King, R, Raue, P, Schweitzer, R, Lambert, M. Clinical supervision: Its influence on client-rated working alliance and clinical symptom reduction in the brief treatment of major depression. Psychotherapy Research 16(3):317-331, 2006.
2. Sholomskas, DE, Syracuse-Siewert, G., Rounsaville, BJ, Ball, SA, Nuro, KE, Carroll, KM. We don't train in vain:A dissemination trial of three strategies of training clinicians in cognitive-behavioural therapy. Journal of Consulting and Clinical Psychology 73: 106-115, 2005
3. Crocker E, Sudak M. Making the Most of Psychotherapy Supervision: A Guide for Psychiatry Residents. Academic Psychiatry. 2017;41(1):35-39. doi:10.1007/s40596-016-0637-5
4. De Golia, GS, Corcoran KM. Supervision in Psychiatric Practice: Practical Approaches across Venues and Providers. American Psychiatric Association Publishing; 2019.
5. Grant J, Schofield MJ, Crawford S. Managing difficulties in supervision: Supervisors perspectives. Journal of Counseling Psychology. 2012;59(4):528-541. doi:10.1037/a0030000.
6. Hutman H, Ellis MV. Supervisee nondisclosure in clinical supervision: Cultural and relational considerations. Training and Education in Professional Psychology. 2019. doi:10.1037/tep0000290.
7. Jacobsen CH, Tanggaard L. Beginning therapists' experiences of what constitutes good and bad psychotherapy supervision: With a special focus on individual differences. Nordic Psychology. 2009;61(4):59-84. doi:10.1027/1901-2276.61.4.59
8. Shanfield SB, Hetherly VV, Matthews KL. Excellent supervision: the residents' perspective. The Journal of Psychotherapy Practice and Research. 2001;10(1):23-27.
9. Watkins CE. Educating Psychotherapy Supervisors. American Journal of Psychotherapy. 2012;66(3):279-307. doi:10.1176/appi.psychotherapy.2012.66.3.279.


## Feedback, mentorship, and change: Finding meaning in the Disciplinary Process

**Presenters**


Adrienne Bentman, MD
Deborah Spitz, MD
Ann Schwartz, MD


**Educational Objective**

1) Identify the time line of the disciplinary process
2) Recognize the key elements of a remediation plan and disciplinary letter
3) Develop tools to address common challenges and missteps in the disciplinary process
4) Identify means to limit collateral damage among residents

**Practice Gap**

Feedback on prior disciplinary workshops suggests that new program directors and even those with some experience are challenged by the complexities of the disciplinary process and need

basic, step-by-step instructions in order to make the process work effectively. This workshop is designed to meet that need while containing the impact of the process on fellow residents.

**Abstract**
For all program directors, the disciplinary process is challenging. Initial faculty assertions of misbehavior or incompetence may evaporate, arrive after submission of a passing evaluation, or become lost in the shuffle among rotations and sites. When confronted, the resident may be scared, misrepresent the issues, or be entirely unaware of the concerns. In spite of guidelines that seem clear, implementing the disciplinary process can leave the program director in a "grey zone" of confusion, surprises and difficult choices which can challenge even the most seasoned among us.

Following a brief overview and outline of the disciplinary process, we will discuss the process of writing letters of deficiency and developing remediation plans. Samples of both will be shared and discussed. The workshop will also address common challenges in the disciplinary process including:

1) Addressing concerns with resident performance including poor insight, difficulty receiving feedback, executive dysfunction, poor boundaries, underlying psychiatric or substance use disorder to name a few.
2) The case of poor performance but limited written documentation (though lots of verbal feedback from faculty in the hallway)
3) Challenges in implementing a plan to address deficiencies (which requires intensive resources, faculty time, mentoring)
4) Problematic structural issues in the Department (low faculty morale, complex institutional requirements)

We will discuss solutions to these problems and share techniques and experiences that have worked! The role of mentorship and coaching will be emphasized as there is something to be gained in the process, often by everyone involved.

In a discussion about pitfalls and collateral damage, we will address the effects of disciplinary actions on other residents in the program and discuss how to manage the challenging and complicated feelings of vulnerability and fear that may arise in the context of remediation or dismissal of a fellow resident.

**Agenda**
5 min, Introduction
5 min, The basics of the disciplinary process (discovery to resolution) (Schwartz)
10 min, Remediation plan and the contents of a disciplinary letter (Spitz)
15 min, Challenges and missteps in the Disciplinary Process (Schwartz)
25 min, Pitfalls and Collateral Damage (Spitz and Bentman)
30 min, Discussion, QA and wrap-up (all)

**Scientific Citations**

Paglia MJ, Frishman. The trainee in difficulty: a viewpoint from the USA. The Obstetrician and Gynecologist 2011: 13:247-251.

Ratan RB, Pica AG, Berkowitz RL. A model for instituting a comprehensive program of remediation for at-risk residents. Obstetrics and Gynecology 2008; 112:1155-1159.

Schwartz AC, Kotwicki RJ, McDonald WM. Developing a modern standard to define and assess professionalism in trainees. Academic Psychiatry 2009: 33:442-450.

## The PGAA Tour: Parenting, Guilt, and Adapting in Academia

**Presenters**

Esther Lee, MD
Sansea Jacobson, MD
Neha Sharma, DO
Isheeta Zalpuri, MD
Robert Kitts, MD

**Educational Objective**

Upon completion of this session, participants will be able to:
1. Understand the impact of parenting challenges upon professional growth, performance, and advancement as an early career psychiatrist.
2. Adopt a more empowered attitude about being or becoming a parent in academia.
3. Demonstrate knowledge of resources, skills, and tools that provide support for parents trying to adapt and thrive in academia.

**Practice Gap**

Physician surveys have revealed that physician mothers are responsible for a disproportionate amount of household duties (1) and childcare (2) compared to their male peers, and that this "second shift" is a contributor to burnout (3). In the general population, motherhood has been associated with greater incidence of burnout, feelings of parental inadequacy, and high levels of anxiety (4). For physicians, there is also significant concern from trainees about the negative impact that having children and taking parental leave might have on their professional reputation and career (5,6). A literature review from 1984-2001 also suggested an increased risk of medical complications, especially adverse late-pregnancy events, with pregnant residents finding the physical demands of training and lack of support to be the most stressful factors (7). While mid-career physicians (11-20 years of experience) were more vulnerable to work-family conflict, the productivity of female faculty members in the later stages of their career (even surpassing that of their male colleagues) is attributed to the decreased burden of family responsibilities at this stage (8).

1- Marital and parental satisfaction of married physicians with children. Warde CM, Moonesinghe K, Allen A, and Gelberg L. J Gen Intern M. 1999 March; 14 (3): 157-165.
2- Effectively mentoring physician-mothers. Lechner BE, Gottlieb AS, Taylor LE. Acad Med. 2009 Dec;84(12):1643-4. doi: 10.1097/ACM.0b013e3181bee79a. PMID: 19940561
3- Marriage, children cause more burnout for female physicians. Bernard R. Medical Economics (BLOG). April 15, 2017. https://www.medicaleconomics.com/medical-economics-blog/marriage-children-cause-more-burnout-female-physicians#_edn5
4- Parental Burnout Crisis in Corporate America – The Incidence of Weary and Work Out Parents in America. BPI Network and PollFish. http://bpinetwork.org/pdf/studies/Parental-Burnout_Report_Final.pdf June 2018
5- Do women residents delay childbearing due to perceived career threats? Willett LL et al. Academic medicine. 2010 April; 85(4).
6- Female trainees believe that having children will negatively impact their careers: results of a quantitative survey of trainees at an academic medical center. Kin C, Yang R., Desai P, Mueller C, and Girod S. BMC Medical Education. 2018; 18:260.
7- Pregnancy during Residency: A Literature Review. Finch S.J. Academic Medicine. 2003 April; 78(4).
8- Balancing motherhood, career, and medicine. Mezu-Chukwu U. JAMA Cardiology. 2017 July; 2(7).

**Abstract**
The transition into parenthood is one of the most life-altering and challenging in any individual's life, yet one for which medical learners and early career psychiatrists are often underprepared. Despite the recently increasing focus on resiliency and burnout, there is a dearth of education and resources on how developing physicians, especially those in academia, can better adapt to this major change. The hidden curriculum of academic parenting is broad and includes the following:
1. The challenges facing new parents in academia (e.g., barriers, impact of leave, career compromise)
2. Internal struggles (e.g., guilt, conflicting priorities, increased pressure for perfection in multiple professional and personal realms)
3. The effect on personal relationships (e.g., depletion of empathy/patience, shifting priorities, reduced time for connection)
4. Effects on professional work (e.g., burnout, impact on productivity/efficiency, chronic sleep deprivation)
This workshop aims to explore this hidden curriculum within the context of the academic realm through discussion and proactive engagement. Created by four academic child & adolescent psychiatrists with diverse parenting backgrounds (e.g., married mother of three, gay father, divorced mother, first-generation American-born parent), this workshop will include an assessment of needs/interest, the establishment of a career development framework/map with resources, and suggested actions and next steps for the future.

**Agenda**
20 minutes: Introductions and ice-breaker

10 minutes: Strength-based exercise identifying the advantages of parenting in academia
45 minutes: The workshop will introduce the following four themes:

1. The challenges of becoming a parent in academia
2. The internal struggles that come with being a parent in academia
3. The effects on personal relationships
4. The effects on professional work

After conducting a needs assessment as a larger group, identifying the challenges presented by parenting in academia, participants will break in smaller groups by theme. With the use of flip charts, handouts, and group think/pair-share, each group will focus on identifying ways, resources and/or tools to target some of the identified challenges for their assigned theme. The goals for each group will be as follows:

1. Conducting an informal needs/interest assessment of parenting challenges and how they are prioritized in the academic setting
2. Working on a career development framework/map and discussing how the aforementioned challenges might be accommodated
3. Generating solutions, resources, and "lessons learned" to help promote adaptation
4. Creating personal, training, and/or institutional goals, action items, and next steps

Each group will then summarize their identified solutions for the larger group and brainstorm ways in which to keep one another accountable for their action plan.

**Scientific Citations**

The inspiration for this topic came when four child & adolescent psychiatrists, including three current fellowship program directors, started a discussion on the impact of parenting upon developing academic careers. As parents of young children in diverse contexts, we still found common concerns regarding the general lack of support, inconsistent institutional policies regarding parental leave, and inflexible expectations for career advancement that exist in our current medical system. After conducting a literature search on this subject, we found that the impact of parenting on an academic career is one that is well-recognized but inadequately addressed as discussed above. The parenting experience is one that is common to a significant proportion of our profession at a time when the importance of physician wellness is being increasingly recognized and prioritized. Our purpose in creating this workshop is to start and carry forward a much-needed dialogue on how to truly obtain a reasonable and compassionate work-life balance in academic psychiatry.

## Addressing the Shortage of Psychiatry Subspecialists: What Residency Educators Can Do

**Presenters**

Anna Kerlek, MD
Carrie Ernst, MD
Rebecca Klisz-Hulbert, MD
Kari Wolf, MD
Art Walaszek, MD

**Educational Objective**

1. Understand and interpret the scope of the shortage of psychiatry subspecialists in the U.S. and the recruitment challenges that psychiatry fellowships face.
2. Describe strategies that general residency programs can implement to help promote subspecialty training and thereby help address the shortage of subspecialists.
3. Identify and generate other strategies for promoting workforce development in psychiatry subspecialties.
4. Select one such strategy to implement in their own residency programs.

**Practice Gap**

While the shortage of psychiatrists in the U.S. is significant, the shortage of psychiatry subspecialists is especially dire. Out of nearly one million physicians in the country, serving a population of 330 million, there are fewer than 10,000 child and adolescent psychiatrists (CAP), roughly 1300 geriatric psychiatrists, and just over 800 addiction psychiatrists. Psychiatry subspecialists are also distributed inequitably, with many areas (especially rural ones) experiencing shortages. For example, 41 states are reported to have "severe" shortages of CAP, defined as 17 or fewer child and adolescent psychiatrists per 100,000 children. 72% of U.S. counties do not have a single CAP. Two states do not have a single geriatric psychiatrist. There are no addiction psychiatrists in four states, and none in 92% of counties.

At the same time, recruitment into fellowships has plateaued or declined. For the 2018-2019 academic year, many fellowship positions went unfilled: an estimated 10% of CAP positions, 28% of addiction psychiatry positions, 39% of forensic psychiatry positions, 42% of consultation-liaison psychiatry positions, and a staggering 57% of geriatric psychiatry positions. The number of CAP fellows has remained flat over time (855 in 2012, 869 in 2018), whereas the number of geriatric psychiatry fellows has declined (67 in 2012, 52 in 2018) – despite the projection that 20% of the U.S. population will be over 65 by 2030.

**Abstract**

More medical students are matching into psychiatry than at any point in the past, and psychiatry programs continue to expand. Despite this increased interest in psychiatry, recruitment into subspecialty fellowships has plateaued. Recruitment into general programs may have an impact on recruitment into fellowships. Historically, international medical graduates (IMGs) have made up a significant proportion of psychiatry fellows (for example, approximately half of geriatric psychiatry fellows). However, as more U.S. medical school graduates have applied to and entered psychiatry residencies, the number of IMGs in residency training has decreased – which may in turn further hamper efforts to recruit into fellowships. Without efforts to promote subspecialty recruitment, it may fall on general residencies to increase the amount of training in subspecialty topics.

This workshop is a joint presentation by the AADPRT Recruitment Committee and the Work Force Task Force. The Work Force Task Force surveyed subspecialty program directors to determine trends in fellowship program establishment, expansion and reduction, as well as

funding, resources and recruitment challenges. Presenters will provide data on the shortage of subspecialists and on recruitment into fellowships, and will then present outcomes of the Work Force Task Force survey of fellowship program directors. Participants will break into small groups for a guided discussion of barriers to subspecialty recruitment. We will discuss strategies that educators in general residency programs can deploy to aid fellowship recruitment and thereby help address the shortage of subspecialists. Finally, participants will consider approaches that they can use in their own programs to increase the number of trainees entering subspecialty training.

**Agenda**

| | |
|---|---|
| 0:00-0:05 | Introduction |
| 0:05-0:20 | Presentation of subspecialty recruitment statistics and results of AADPRT Work Force Task Force survey of fellowship directors |
| 0:20-0:40 | Breakout #1: Facilitated discussion on barriers to subspecialty recruitment |
| 0:40-0:55 | Presentation of strategies for promoting recruitment of fellows |
| 0:55-1:15 | Breakout #2: Facilitated discussion on strategies to promote subspecialty recruitment |
| 1:15-1:30 | Q&A and feedback via Whova |

**Scientific Citations**

Agapoff J, Olson D. Challenges and Perspectives to the Fall in Psychiatry Fellowship Applications. Academic Psychiatry 43: 425-428, 2019.

American Psychiatric Association: Resident Census 2018. https://www.psychiatry.org/residents-medical-students/medical-students/resident-fellow-census, Accessed October 20, 2019.

Balon R. Subspecialty training: time for a change. Academic Psychiatry 41 (4): 558-560, 2017.

University of Michigan Behavioral Health Workforce Research Center: Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH; 2018.

Wayeed A, Sadhu J, Kerlek A, Lee P. The Biopsychosocial Model of Program Self-Evaluation: an Innovative and Holistic Approach to Enhance Child and Adolescent Psychiatry Training and Recruitment. Academic Psychiatry 43 (5): 542-546, 2019.

## Resident Scholarly Activity: From Citation to Commendation!

**Presenters**

Rashi Aggarwal, MD
Tanya Keeble, MD
Justin Faden, MD
Amy Burns, MD
Muhammad Zeshan, MBBS

**Educational Objective**
At the end of the workshop, participants will be able to:

1. Identify barriers to productivity in the scholarly activity process during residency training.
2. Describe strategies to enhance scholarly activity for residents
3. Describe concrete steps towards instituting a mentorship program to boost scholarly activity
4. Identify the next step to boost scholarly activity in their own program.

**Practice Gap**
Although resident scholarly activity is encouraged for all psychiatry residents, few guidelines exist for residency training programs with regards to delineating a practical process for assisting residents with accomplishing this goal. In this workshop, we aim to discuss the initiative at two programs, both of which were very successful. We also intend to discuss the generalizability of barriers and insights from other programs and participants via discussion and group participation. In particular, we plan to stress common barriers to the scholarly process, mechanisms for tackling barriers, and suggestions for instituting a more formal process of assigning and guiding guiding mentors, and helping residents and mentors become familiar with the process of taking an idea or case to a scholarly project. We hope that participants gain insights and ideas from this educational and didactic experience to assist in instituting similar initiatives at their respective programs.

**Abstract**
Resident scholarly activity is encouraged for all psychiatry residents as per the 2007 ACGME program requirements. Studies have repeatedly showed that engaging in scholarly projects during training helps residents to interpret the literature, apply evidence to patient care, demonstrate competency in research methods, pursue a career in academic medicine, and ultimately achieve higher academic ranks. It also adds to the program's ranking and enhances its profile by increasing the departmental publications, poster and oral presentation at conferences, and nomination of their residents for regional and national awards.

Despite the overarching benefits, residents find it challenging to pursue scholarly work due a myriad of factors including limited number of formal research training opportunities, increasing pressure on mentors to maintain revenue based clinical activities, trainee attitudes, lack of clarity and consistency among programs about setting scholarly goals and providing protected scholarly/research time. The National Institute of Mental Health has also noted a decline in the number of psychiatrist-researchers as compared to other medical specialties.

In this workshop we highlight two different ways programs have been successful in addressing this gap. The medical center academic program developed a scholarly activity initiative in 2010 in which residents were provided with guidelines on how to identify novel and relevant cases, undertake a literature search, find the most appropriate format for conveying ideas (poster, case report, letter), and start the writing process. Since instituted, this initiative produced significant scholarly activity output, which is evidenced by production of 3 posters and 2

publications from 2008-2010, to 170 posters, 93 publications, and 25 workshops between 2011-2019.

The second, newer community based program was motivated to address scholarly activity gaps after receiving two ACGME citations in this area in 2017, one of which was focused on resident participation in scholarly activity, the other on faculty scholarly activity. They developed an alternative strategy, designed to address the emerging new common program requirement focus on program accomplishments in quality improvement and/or patient safety initiatives, resident engagement in quality improvement activities and faculty support of resident scholarly activity. They developed a resident AI and patient safety and QI curriculum that threads through all 4 years of the categorical program, and includes expectations for scholarly production and dissemination in regional and national settings. This approach has been successful in fully resolving the citation, and garnering an ACGME commendation for taking an active and creative effort in generating participation in scholarly activity in a sustained and supported manner.

The goal of this workshop is to facilitate adoption of the scholarly activity process in other programs by engaging the workshop audience in group discussion, role playing, and various interactive sessions to identify barriers to lack of engagement and productivity. We will delineate specific techniques for tackling these barriers. We will also focus on scholarly activities most attainable for busy residents and departments without significant grant support, including translation of daily clinical activities and quality improvement projects into poster presentations, and publications.

**Agenda**

Introduction and understanding the needs of the audience- 10min
Small Groups to discuss barriers (15min)
Large Group Discussion to discuss barriers (10min)
Role Play (5min)
Solution at an Academic program with many affiliate sites (20min)
Role Play (5min)
Solution at a new community based program (10 min)
Pairing to identify one useful strategy and Large Group Discussion- 15min

**Scientific Citations**


1. Accreditation Council for Graduate Medical Education. ACGME program requirements for graduate medical education in psychiatry. 2007. http://www.acgme.org/acWebsite/down loads/RRC progReq/400 psychiatry 07012007 u 04122008.pdfCaren B, Robert M. Research tracks during psychiatry residency training. Acad Psychiatry 2018
2. Fenton W, James R, Insel T. Psychiatry residency training, the physician-scientist, and the future of psychiatry. Acad Psychiatry. 2004; 28(4):263–6. [PubMed: 15673819] 5.
3. Kupfer DJ, et al. Recruiting and retaining future generations of physician scientistsin mental health. Arch Gen Psychiatry. 2002; 59(7):657–60. [PubMed: 12090819]

4. Josette R, Rachel L, Scott W. Brief Report: Completing a scholarly project during residency training, Perspective of residents who have been successful. J Gen Internal Med 2005;20:366-369

## Putting Entrustable Professional Activities (EPAs) into Action: Implementation Tips and Strategies

**Presenters**
John Q. Young, MD, MPH, PhD
Erick Hung, MD
Colin Stewart, MD
Andrea Weiss, MD
Julie Sadhu, MD

**Educational Objective**
1. Appreciate how the framework of Entrustable Professional Activities (EPAs) complements and enhances a Milestones-based assessment program.
2. Locate the EPA Implementation Toolkit on the AADPRT Website
3. Compare and contrast practical approaches to implementing EPAs

**Practice Gap**
A number of RRCs, the AAMC, and specialty societies in other countries have endorsed EPAs as framework for milestone-based assessment. In 2018, the AADPRT Assessment Committee published their proposed end-of-training EPAs for psychiatry in Academic Medicine. Many programs have expressed interest in the EPA framework but are not sure how to take the next step. This workshop will address this gap.

**Abstract**
With the emergence of the competency- and now milestone-based frameworks for graduate medical education, residency programs must develop new methods for assessment. The AAMC and a number of GME specialties in the U.S. and Canada have embraced Entrustable Professional Activities (EPAs) as a helpful framework with which to build a program of assessment. EPAs focus assessment on residents' performance of the essential work activities in a specialty, and are assessed by determining how much supervision is needed, and how much independence residents have earned, to perform these activities. Psychiatry now has end-of-training EPAs. The main focus of this workshop will focus on implementation of EPAs in psychiatry residency programs. We will introduce the EPA framework, share examples and practical tools for incorporating EPAs into a program of assessment, and help participants identify next steps for their home institutions.

**Agenda**
1. Introduction (LG group discussion, 5 min)
2. Brief orientation to EPAs (Instructional, 10 min)

3. Implementing EPAs: Key Choices (Instructional/Interactive plus Small Group, 15 min)
4. Practical Tools (Demonstration, 10 minutes)
5. Identifying Next Steps (Small Group, 35 minutes)
6. Wrap Up (15 min)

**Scientific Citations**

Young JQ, Hasser C, Hung EK, et al. Developing End-of-Training Entrustable Professional Activities for Psychiatry: Results and Methodological Lessons. Acad Med. 2018;93(7):1048-1054.

## Why (and How) Combined Training? Insights from People Who've Been There to Help People Who Might Like to Go There

**Presenters**

Shannon Suo, MD
Robert McCarron, DO
Sandra Batsel-Thomas, MD
Amy Kim, MD
Sheldon Benjamin, MD

**Educational Objective**

Participants attending the workshop will:

1) Be able to describe the background, history and evolution of combined training programs (internal medicine-psychiatry, family practice-psychiatry, neurology-psychiatry, pediatrics-psychiatry-child psychiatry) and ABPN approved alternative pathway (post-pediatric portal program).
2) Determine benefits and drawbacks to a combined training approach
3) Develop strategies for approaching institutional and external logistics in creating a new combined training program

**Practice Gap**

As physicians dedicated to shaping the future of psychiatry, it is important to consider the growing evidence that patients with psychiatric needs frequently have challenging comorbid medical conditions. Corollaries to this statement include observations (1) that treating patients' behavioral health needs can improve their quality of life while decreasing their expenditures and (2) a psychiatrist may be the only physician a patient with severe mental illness sees. (McCarron et al., 2015).

Though combined training programs have been in existence for over 20 years, common perceptions persist that graduates will pursue one or the other (but not both) specialty and/or that training is lacking. A 2012 survey (Jain et al., 2012) of graduates of combined training programs revealed a high degree of job satisfaction, ability to address complicated interplay between medical and psychiatric illnesses, and tendency to practice in integrated care settings. Given the uncertainty in future of the healthcare system and the evidence that a comprehensive approach to healthcare (including behavioral health considerations) will be

cost-effective, integrated behavioral health models have started to proliferate; combined-trained physicians will be well poised to facilitate, educate and promulgate further alignment of medical and mental health services (Kroenke and Unutzer, 2017).

At present there are 15 internal medicine-psychiatry, 6 family practice-psychiatry, 10 pediatrics-psychiatry-child psychiatry, 5 neurology-psychiatry and 4 post-pediatric portal training programs. Residency training directors for combined programs have witnessed a doubling in the number of applications to combined training programs over the last 5 years, and medical student involvement in organizations dedicated to combined training and practice has grown as well (records from the Association of Medicine and Psychiatry), with some students vowing to pursue sequential training if there is insufficient space in the combined programs. The ABPN has reopened the process for institutions to apply for combined training programs, and new programs are being developed.

Many psychiatrists are unaware of the history and evolution of combined training, and creating a combined training program can seem daunting. The goal of this workshop is to facilitate a discussion about what combined training is and to provide general and specific information to encourage would-be combined training directors. Even if not interested in starting up a combined training program, psychiatry residency training directors may benefit from increased awareness of options (including combined training options) that may be appropriate for medical students who seek career advice.

**Abstract**
There are nearly 30 combined training programs in the country, and new programs coming on line. Combined trained physicians may be in a useful position to help align medical and mental health services to improve patient care, and the majority of combined trained physicians find ways to practice and lead healthcare in both medical and psychiatric disciplines. As educators strive to find ways to incorporate integrated behavioral healthcare curricula in their training programs there may be opportunities to consider the merits of combined training. This workshop will provide information, background, and opportunity to discuss combined training, including logistics, advantages, disadvantages, and possible strategies in starting a new program.

**Agenda**

| | |
|---|---|
| 10 minutes | Introductions, background, history of combined training |
| 20 minutes | Interactive discussion – WHY and WHY NOT combined training |
| 30 minutes | How to start a new combined program |
| | - Ingredients |
| | - Practical considerations |
| | - Starting the program |
| 15 minutes | Mythbusters / Q&A |
| 15 minutes | Develop an Action Plan |

**Scientific Citations**

McCarron RM, Bourgeous JA, Chwastiak LA, et al. Integrated medicine and psychiatry curriculum for psychiatry residency training: A model designed to meet growing mental health workforce needs. Academic Psychiatry 2015; 39(4): 461-465.
Jain G, Dzara K, Gagliardi JP, Xiong G, Resch DS, Summergrad P. Assessing the practices and perceptions of dually-trained physicians: A pilot study. Acad Psychiatry 2012; 36(1): 72-74.
Kroenke K, Unutzer J. Closing the false divide: Sustainable approaches to integrating mental health services into primary care. J Gen Intern Med 2017; 32(4): 404-410.

## Teaching Adolescent SUDs and Co-Occurring Disorders Like an Addictions Expert

**Presenters**

Kelly Blankenship, DO
Sandra DeJong, MD, MSc
Ray Hsiao, MD
Kenneth Zoucha, MD

**Educational Objective**

1. Know how to teach common presentations of complex Co-Occurring Disorders (COD) in adolescent patients in psychiatric residency/fellowship didactics
2. Understand treatment options for adolescent Substance Use Disorders and CODs and how to teach about them to psychiatry residents/fellows
3. Identify ways of teaching the use of combining psychopharmacological and psychosocial interventions to achieve optimal treatment outcome for COD in adolescent patients

**Practice Gap**

The United States in an addiction crisis, and not just among adults. With increasing marijuana legalization, many adolescents feel it is “safe” despite research indicating otherwise. Data from 2016 estimated that 4.3% of all adolescents (ages 12-17 years) have a diagnosable substance use disorder. The same report estimated that 23% of adolescents have a history of lifetime illicit drug use, with 7.9% report using illicit drugs in the previous month (1). Despite increasing substance use disorders (SUDs) in the adolescent population, psychiatrists who feel comfortable diagnosing and treating SUDs and co-occurring disorders in teens are lacking. In addition, psychiatry residency and fellowship training in adolescent addiction is often sparse. In a recent survey of child and adolescent psychiatry fellowships, 63.4% of respondents reported no exposure to inpatient or outpatient specialized addiction training settings in their program (2). With the increased need for trained child and adolescent psychiatrists to diagnose and treat co-occurring substance use disorders in adolescents, improved training and didactics for psychiatry residents and child and adolescent psychiatry fellows in this area is imperative. Teaching the teachers and training the trainers is an important model.

**Abstract**

With the rise of marijuana legalization and the current opioid epidemic plaguing the United States, more and more psychiatrists are encountering adolescent patients with complex co-

occurring disorders. However, many practitioners feel under-prepared to handle such challenging cases based on their residency/fellowship training and their sentiments were recently confirmed in a survey of psychiatry training directors conducted by the American Association of Directors of Psychiatry Residency Training (AADPRT). In an effort to educate current residents/fellow and develop a workforce capable of meeting the needs of the growing number of COD patients, AADPRT has convened a Taskforce on Addictions consisted of experts from various psychiatric organizations including the American Psychiatric Association (APA), American Academy of Addiction Psychiatry (AAAP) and the American Academy of Child and Adolescent Psychiatry (AACAP). The Taskforce is in the process of developing various resources for training residents/fellows on co-occurring disorders and this proposed session is one of the model educational activities aimed at training residents/fellows on management of common co-occurring disorders in adolescent patients. During our session, we will have participants divide into 5 small groups to conduct three case studies of common co-occurring disorders in adolescent patients. Each small group will be facilitated by a member of the AADPRT Taskforce on Addictions, and participants will be given a series of prompts and questions that could be used during didactics to teach residents/fellows to diagnose and treat adolescent patients with co-occurring disorders.

**Agenda**

0:00 Introduction
0:05 Overview of SUDs and Co-Occurring Disorders in Adolescents
0:10 Small Case #1: Major Depressive Disorders and Alcohol Use Disorders in Adolescents
1. Identify Alcohol Use vs. Misuse in adolescents vs. Alcohol Use Disorders
2. Common Laboratory Tests for Adolescent COD patients
3. Treating Alcohol Use Disorders in Adolescents
4. Recognizing Safety and other Risk Management issues
5. Managing Major Depressive Disorder in Adolescents

0:35 Small Group Case #2: Bipolar Disorder and Stimulant/Methamphetamine Use Disorders
1. Recognize early warning signs of Bipolar Disorder in adolescents in the context of Substance Use Disorders
2. Managing Bipolar Disorder and co-morbid substance use in adolescents
3. Managing treatment non-adherence in COD adolescent patients

0:55 Small Group Case #3: Anxiety Disorders and Cannabis Use Disorders
1. Identify Cannabis Use Disorders
2. Managing Cannabis Use Disorders
3. Managing Anxiety Disorders in Adolescent Patients with Cannabis Use Disorder

1:15 Small Group Report Out/Large Group Discussion of Cases and Q&A

**Scientific Citations**

1. Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: results from the 2016 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm Published September 2017.
2. Welsh JW, Schwartz AC, DeJong SM. Addictions Training in Child and Adolescent

Psychiatry Fellowships. Acad Psychiatry. 2018 Jul 31. doi: 10.1007/s40596-018-0959-6. [Epub ahead of print] PubMed PMID: 30066242.
3. Mark TL, Meinhofer A. The Extent to Which Psychiatrists Diagnose and Treat Substance Use Disorders. Psychiatr Serv. 2018 Mar 1;69(3):250. doi: 10.1176/appi.ps.201700457. Epub 2018 Jan 16. PubMed PMID: 29334879.
4. Schwartz AC, Frank A, Welsh JW, Blankenship K, DeJong SM. Addictions Training in General Psychiatry Training Programs: Current Gaps and Barriers. Acad Psychiatry. 2018 Aug 2. doi: 10.1007/s40596-018-0950-2. [Epub ahead of print] PubMed PMID: 30073538.

## Firearms and Suicide Prevention: Why We Should Ask About Guns and How To Train Residents To Have These Conversations

**Presenters**
Lindsey Pershern, MD
Meagan Whitney, MD
Theresa De Freitas Nicholson, MD

**Educational Objective**
By the end of this workshop, participants will be able to:
Learning Objective 1: Describe the role of firearms in patient suicides.
Learning Objective 2: Demonstrate a basic understanding of firearms, how firearms operate and safe gun storage options.
Learning Objective 3: Develop training experiences in non-threatening, culturally competent ways to discuss firearm access and safety with patients.

**Practice Gap**
Suicides are currently twice as prevalent as homicides in the United States. Additionally, over half of suicides are committed with firearms. A study done in Ohio provided a questionnaire to 422 practicing psychiatrists consisting of barriers, anticipatory guidance on firearms and counseling practices, among other topics. This study found that the majority of responding psychiatrists perceived firearm safety issues to be an important issue for mental health patients. However, only one fourth reported that they had a routine system for identifying patients with firearms and almost half had never thought seriously about discussing firearm safety issues with their patients. Another study performed a questionnaire for psychiatry residency program directors to assess their perceptions and beliefs regarding firearm injury prevention training. The vast majority (79%) of responders reported they had not seriously thought about providing firearm injury prevention training. Given the importance of educating physicians regarding firearm safety, a study was done to search for reviews on firearm safety training programs. This study was able to identify only four programs that met their criteria. In one of the studies cited, practitioners who participated in training discussed gun access and storage significantly more than those who did not. Additionally, residents who participated in training reported feeling more confident when making referrals. This is further evidence that

psychiatric residency programs are inadequately training residents and thereby keeping them from maximizing their roles as mental health professionals. This prevents psychiatrists from being truly effective at preventing patient suicide and keeping patients alive.

**Abstract**

Firearms are a hot-button issue that many trainees do not want to discuss with friends and family, let alone with patients. However, psychiatrists need to learn to discuss firearms and firearm safety with patients and establish this as a part of practice. Despite evidence that counseling from a provider effects a patient's gun safety, in one study nearly half of psychiatrists surveyed never thought seriously about discussing gun safety with patients. Two main barriers to doing so are a lack of specific training in residency in having these conversations and an overall unfamiliarity with firearms. In order to address this practice gap, we developed and implemented a curriculum to train residents on firearm safety counseling. In this workshop, we will:
1. Provide participants with a firm understanding of the significant role firearms play in completed suicides and increase awareness of the need for formalized training of residents using an interactive platform.
2. Demonstrate an education platform on firearm basics including types of firearms, how firearms operate and recommended firearm safety practices.
3. Present our curriculum for resident training aimed at increasing comfort discussing firearms with patients and addressing barriers to these conversations.
4. Demonstrate a role-play exercise to develop non-threatening, culturally competent ways to discuss firearm safety.

Conclusion: This workshop will establish an understanding of the impact firearms have on suicide rates and methods of training in this area. Participants will gain literacy on firearm safety and learn how to better train residents to confidently discuss firearms with patients.

**Agenda**

0:00-0:25- Introduction and self-assessment: We will use a game-based interactive quiz platform to establish the role of firearms in suicide and importance of discussing firearm access and safety with patients
00:25-00:40 - presentation on firearm basics, focusing on developing audience member's literacy with various gun terms, knowledge of how guns operate and understanding of firearm safety including recommended storage options.
00:40-00:50 - Brief review of presenters' experiences with teaching residents about counseling patients on gun safety and review preliminary results of research
00:50-01:10- Role play activity - participants will pair up to role-play scenarios in which a psychiatrist discusses firearms with a patient focusing on developing comfortable, non-threatening and culturally competent ways to assess firearm access and discuss safety practices.
01:10-01:25- Large group discussion including reflection on role-play activity and reactions to educational format
01:25-01:30- Participants will use the Whova app to review the workshop

**Scientific Citations**

1. Price JH, Kinnison A, Dake JA, Thompson AJ, Price JA. Psychiatrists' practices and perceptions regarding anticipatory guidance on firearms. Am J Prev Med. 2007; 33: 370–373.h https://www.ncbi.nlm.nih.gov/pubmed/17950401
2. Price JH , Thompson AJ, Khubchandani Jet al. . Firearm anticipatory guidance training in psychiatric residency programs. Acad Psychiatry . 2010;34(6):417–423. https://www.ncbi.nlm.nih.gov/pubmed/21041464
3. Puttagunta R, Coverdale TR, Coverdale J. What is taught on firearm safety in undergraduate, graduate, and continuing medical education? A review of educational programs. Acad Psychiatry. 2016;40(5):821–824 https://link.springer.com/article/10.1007/s40596-016-0490-6

## The Evolving Composition of the Psychiatry Residency Trainee Workforce: Analysis of matching trends of International Medical Graduates

**Presenters**

Sanya Virani, MD
Souparno Mitra, MD
Robert Cotes, MD
Jessica Kovach, MD
Vishal Madaan, MD

**Educational Objective**

1. At the end of this session participants should be able to:
2. Understand the recent trends of resident recruitment in Psychiatry and the subsequent decline in numbers of matching international medical graduates (IMGs)
3. Gain insight into the impact of declining IMG numbers within the general and subspecialty psychiatric workforce
4. Engage in discussions (especially program directors) about uniform methods of reviewing candidate applications, whether US medical graduates or IMGs
5. Participate in making recommendations for the future of diversified resident recruitment in Psychiatry

**Practice Gap**

Recruitment trends in Psychiatry have been changing over the last decade. Residency programs are experiencing higher application numbers, both from US and International Medical Graduates (IMGs). The increase in residency positions and programs however has been modest and not kept up with the growing applicant pool, with unmatched spots going down from 16% in 1996 to 1% in 2018.1 The ratio of applicants per spot in psychiatry (1.53) is the second highest among all specialties.2

IMGs contribute to a third of the psychiatric workforce3, are often employed in underserved areas and make up a large proportion of the fellowship trainee pool. They come from diverse social and cultural backgrounds but are at a disadvantage when it comes to residency

recruitment, carrying with them the burden of differential training backgrounds and visa sponsorship requirements. It is likely that the increase in applications from US medical graduates has resulted in a downward trend in IMG match rates, with only 123 out of 321 applicants matching in 2018.

The shortage of psychiatrists is estimated to only increase over the next decade, and as the inclusion of IMGs continues to decline, a direct impact could be seen on the numbers of residents entering subspecialty training. Underserved areas could also potentially bear the brunt of this impending shortage.

**Abstract**

Our workshop will focus on aggregate data analysis of the American Psychiatric Association's five year (2014-2018) resident census report4, which panel members have worked on collaboratively to compile. Data for this report was synthesized from the following sources:

1. Graduate Medical Education Survey data available publicly
2. National Resident Matching Program Data
3. Association of American Medical College (AAMC) special data reports

The workshop will begin with the panel engaging participants in an open discussion about their evaluation criteria with respect to resident recruitment, and their perceived challenges with reviewing applications from IMGs. This will be followed by a presentation by Drs. Cotes, Virani and Mitra on the findings of our study, with particular focus on the current geographic and temporal trends of IMG trainee distribution, in topographical and tabular formats. Subsequently, participants will engage in small-group interactive sessions moderated by Dr. Kovach to zone in on the proportion of IMGs in their own programs and share insights about the changing trends over the past five years in light of the data presented. The groups will also elaborate upon their perceptions of special mentoring needs of IMGs if any, after matching into residency programs.

The panel will then regroup the audience to participate in a discussion about the perceived benefits of IMG inclusion in residency programs and broadly, the workforce, keeping in mind elements of cultural competency and diversified recruitment needs. The final wrap up will be preceded by a group activity conducted by Dr. Madaan, to design succinct, inclusive and broadly applicable evaluation criteria to uniformly evaluate applications. A model set of criteria would be proposed by the panel for participants to review and add on to. A brief Q&A session will subsequently close out the workshop leaving participants informed about varied perceptions of the issue of IMG recruitment and an awareness of the impact that these changing trends could have in the following decade.

**Agenda**

0:00- Introduction
0:05- Open discussion: Perceived and real challenges with IMG recruitment
0:15- Presentation of data and analysis results of the study, including APA resident census report

0:25- Small group sessions: Individual experiences with IMG recruitment, perceptions of mentoring needs for IMGs in residency programs
0:35- Open discussion: Benefits of diverse culturally competent IMG recruitment
0:45- Small group activity: Exercise of designing ideal application criteria
1:05- Cumulative presentation of group ideas to develop unified application evaluation model
1:15- Q&A from participants
1:25- Conclusions

**Scientific Citations**

1 Balon, R., Mufti, R., Williams, M., M.D., Riba, M. (1997). Possible Discrimination in Recruitment of Psychiatry Residents? American Journal of Psychiatry, 154 (11), 1608-09. https://doi.org/10.1176/ajp.154.11.1608
2 National Resident Matching Program (2019). Results and Data: 2019 Main Residency Match®. National Resident Matching Program, Washington, DC. 2019.
3 Ahmed, A.A., Hwang, W.T., Thomas, C.R., Deville, C. (2018). International Medical Graduates in the US Physician Workforce and Graduate Medical Education: Current and Historical Trends. Journal of graduate medical education, 10(2), 214–218. doi:10.4300/JGME-D-17-00580.
4 Isom, J., Virani, S. (2019). American Psychiatric Association Resident Census 2012-2017. APA

## Diverse Perspectives and Practical Strategies in URM Psychiatry Recruitment, Retention and Development

**Presenters**

Jaela Barnett, MD
Denese Shervington, MD
Arden Dingle, MD
Danielle Hairston, MD
Sarah Vinson, MD

**Educational Objective**

Educational Objectives:

1. Identify strategies for addressing the ACGME psychiatry core competency of recruitment and retention of a diverse and inclusive workforce of residents, fellows and faculty members.
2. Review the literature regarding the workplace environment and workforce benefits of the inclusion of underrepresented minorities and diversity.
3. Identify barriers limiting underrepresented minorities from pursuing careers in psychiatry
4. Discuss ways in which leaders with experience in education at both predominantly white institutions and historically black college and university medical schools have successfully recruited, retained and developed under-represented minority trainees.

**Practice Gap**

The road to diversifying medicine is complex and continues to evolve. There are various factors that influence individuals to pursue a career in medicine. Within medicine, there has been an increased awareness in mental health. As the field of psychiatry continues to grow with a population that continues to expand and diversify, psychiatrist from minority backgrounds is essential. Yet, there are barriers that limit underrepresented minorities to pursue a career in psychiatry. Those URM who do matriculate into psychiatry residency programs choose and rank programs based on certain criteria. Residency programs themselves base their selection of residents on numerous criteria. This workshop will focus on the recruitment and retainment of URM's in psychiatry

**Abstract**

The need for underrepresented minorities in psychiatry is pronounced. In 2018 there were roughly 330,000,000 people living in the United States. Less than 10 years ago the U.S. population was approximately 308,000,000. The rate of growth has been exponential. According to the U.S. Census Bureau in 2010, Hispanics made up 16.3% of the population, African-American 12.6%, American-Indian 0.9% and Native Hawaiian 0.2%. In 2018, the percentage increased to 18.3% for Hispanics, 13.4% for African-Americans, 1.3% for American Indian, and Native Hawaiian stayed the same at 0.2%. This emphasizes the increasing diversity in the U.S. One can suspect that these numbers will continue to rise. Despite the increase, it is apparent that various problems continue to persist. Health care disparities continue to be prevalent affecting health outcomes and quality of care. It's imperative that the disparities be

addressed as the population becomes more diverse. Specific to the field of psychiatry is the need for more providers from minority backgrounds to aid in decreasing the stigma associated with mental illness within minority communities, increase access to culturally competent mental health care and inform the provision of care to underserved minority communities. This workshop will address actionable strategies for the recruitment, retention and development of underrepresented minorities in psychiatry. African-Americans constitute roughly 6.6% of psychiatry residents yet African-Americans make up 13.2% of the general population. Additionally, an estimated 8.3% of U.S. psychiatry residents are Hispanic but represent 17.1% or more of the U.S. census. After identifying potential causes of this disparity, the presenters will provide the workshop participants with tools to tackle the critical issue of diversity in the field of psychiatry. The presenters have diverse perspectives and experience levels and include two full professors and leaders in psychiatric education who have successfully recruited and developed URMs at PWIs and HBCUs; two URM mid-career psychiatrists with first-hand experience working at HBCUs and PWISs and are current Program Directors at HBCU residency training programs; and a psychiatry resident at a HBCU training program.

**Agenda**

0:03 Introduction & Disclosures

0:07 Dr. Sarah Vinson- Discussion on structural barriers and stigma medical students and residents face pursuing a career in medicine and psychiatry.

0:10 Dr. Jeala Barnett- A URM resident's perspective on factors influencing her choice in residency programs.

0:10 Dr. Arden Dingle – Discussion on educational program development

0:10 Dr. Danielle Hairston - Utilization and Benefit of Pipeline Programs

0:40 Breakout sessions – Participants can choose 1 of 3 breakout groups that will be led by the panelists and include self-assessment, group problem solving, and identification of smart goals.

Break out-topics/groups (groups of 4-5):

- Medical student engagement and recruitment
- Brainstorm ways to increase URM medical student recruitment into the field of psychiatry at your institution.
- Program development
- Discuss ways in which your program or institution can address the ACGME psychiatry core competency of recruitment and retention of a diverse and inclusive workforce of residents, fellows and faculty members.
- Professional development and sponsorship
- Develop a proposal that focuses on ways programs/institutions can foster an environment that supports inclusion and diversity to recruit and retain URM's.

0:10: Questions and discussion

**Scientific Citations**

Pierre, J.M., Mahr, F., Carter, A. et al. Acad Psychiatry (2017) 41: 226.
https://doi.org/10.1007/s40596-016-0499-x

ACGME Program Requirements for Graduate Medical Education in Psychiatry

# Educational Workshops Session 4

## Let's Talk About Sex: Improving Sexuality Education for Trainees

**Presenters**

Cathleen Cerny-Suelzer, MD
Stephen Levine, MD
Victoria Kelly, MD

**Educational Objective**

1. Recognize the gap between patient sexual difficulties and trainee preparation to deal with them 2. Distinguish between the myriad of negative consequences that can result from sexual behavior and psychiatric concepts of sexual disorder 3. Provide residency and fellowship training directors with a coherent curriculum to prepare trainees for the complex dilemmas that often lay hidden behind traditional psychiatric diagnosis

**Practice Gap**

Sexuality is a force in every person's life throughout the lifecycle. While some develop and maintain a relatively problem-free and satisfying sexual life, prevalence data on defined sexual problems is remarkably high. Adolescence, young adulthood, middle age, early older age and advanced age each pose sexual challenges that may cause distress. Regardless of a residents' future area of concentration, sexual issues of their population age group will confront them. The privacy of individual sexual experience forms a barrier that prevents many trainees from responding with comfort, interest, and knowledge to their patients' concerns. Curriculum in sexuality during child and adolescent psychiatry, adult psychiatry and geriatric psychiatry training is limited, inconsistent and omits many of the major life cycle issues that create significant emotional disruptions in individuals, couples, and family lives. The lack of curricular time and perceived lack of teaching expertise limit programs' offerings in this arena. For these reasons, programs may instead focus teaching on only one or two sexual issues, for example, transgender affirmative care, rather than providing a more comprehensive view of sex and the lifecycle. Helping patients with their diverse sexual concerns is beyond the employment of a particular psychiatric ideology. It requires a thoughtful, psychotherapeutic inquiry that appreciates the personal and interpersonal developmental tasks at stake. This workshop aims to improve the standardization of what in existing sexuality curricula.

**Abstract**

The varied assumptions of training directors about the importance of sexuality to understanding human psychology and its role in creating mental distress might be a key to shaping the training curriculum concerning sexual identity, dysfunction, and other concerns. Sex, a universal functional activity for self-discovery, bonding, pleasure, mutual nurturance, and reproduction, which ultimately reflects the capacity to love a partner, is not always given its due by training directors. The number of didactic hours devoted to the topic and the content vary considerably from program to program. An agreed upon, basic sexuality curriculum is lacking. In this workshop, we hope to impress upon training directors the importance of talking about sex with trainees. This workshop will begin with a long list of issues that are relevant to patient's emotional experiences, provide a review of DSM-5 diagnoses and dwell heavily on the recurrent patterns that are not covered by our nosology. These matters, including infertility, infidelity and incompatible sexual interests, often form the background for many presentations of depression, anxiety, and addictions. Consideration of the breadth of sexual problems in any population will be emphasized in order to understand the goals of an improved curriculum. We will then present what is currently being taught and tested on in board examinations. A major goal of this workshop is to prepare trainees for what they will encounter beyond training both

in the heteronormative and sexual minority segments of the population. A template will be offered for the education of advanced residents and fellows. It will move from basic knowledge of three components of sexual identity and the dysfunctions to the more complex sexual dilemmas and conundrums that often lurk behind conventional psychiatric chief complaints. Suggestions for integrating the curricular education with clinical experiences will be provided and we will reinforce the need to teach basic psychotherapy skills in order to organize the treatment of what can be ameliorated in this private domain. Small and large group exercises will enhance learning and engagement.

**Agenda**

• 5 minutes: Speaker introductions and interests in this topic • 10 minutes: Topic introduction - The problems sexuality brings to medical-psychiatric settings • 10 minutes: Literature review of current sexuality education in psychiatry training and review of ABPN focus on this area • 10 minutes: Small group discussion – What is YOUR program teaching about sexuality? Who is teaching it? What topics? How (what methods) is it being taught? 1. General training group 2. Child & Adolescent training group 3. Fellowship training: Geriatric, CL, Forensic, Addiction • 10 minutes: Basic Sexuality Seminar - concepts to be covered for PGY3/4 trainees • 10 minutes: Advanced Sexuality Seminar - concepts to be covered for late PGY3/PGY4/fellow trainees • 15 minutes: Large group exercise – Brainstorm innovative educational methods, address any barriers to effective education, with both trainees and faculty • 5 minutes: Small group exercise - Define your local sexuality experts: Divide into groups by the seven AADPRT regions • 15 minutes: Summary and interactive final discussion

**Scientific Citations**


1. Levine SB, Why Sex Is Important: Background for Helping Patients with Their Sexual Lives., British Journal of Psychiatry Advances (2017), vol. 23(5)300-306; DOI: 10.1192/apt.bp.116.016428 2. Levine SB, Scott D. (2010) Sexual Education of Psychiatric Residents. Academic Psychiatry, 34(5) 349-352. 3. Osborne LM MacLean JV Barzilay EM Meltzer-Brody S, Miller L Yang SN. (2016). Reproductive Psychiatry Residency Training: A Survey of Psychiatric Residency Program Directors. Academic Psychiatry. 2018 Apr;42(2):197-201. doi: 10.1007/s40596-017-0672-x. Epub 2017 Feb 13. 4. Donald CA1, DasGupta S, Metzl JM, Eckstrand KL. Queer Frontiers in Medicine: A Structural Competency Approach Acad Med. 2017 Mar;92(3):345-350. doi: 10.1097/ACM.0000000000001533. 5. Ard KL, Keuroghlian AS. Training in Sexual and Gender Minority Health—Expanding Education to Reach All Clinicians. NEJM 379(25): 2388-2393, 2018. 6. Levine SB. (2019). Psychotherapeutic Approaches to Sexual Problems: An essential guide for mental health professionals. American Psychiatric Association Publications, Washington, D.C.

# Teaching Addictions: You can do it! (We can help)

**Presenters**
Ann Schwartz, MD
Sandra DeJong, MD, MSc
Amber Frank, MD
Scott Oakman, MD, PhD
Ray Hsiao, MD

**Educational Objective**

1) Briefly describe challenges and barriers to teaching about substance abuse and dependence in psychiatry residencies
2) Discuss innovative teaching methods and existing resources for teaching addictions psychiatry
3) Discuss educational needs for training future providers to care for patients with substance use disorders

**Practice Gap**

Despite the high prevalence of substance use disorders in almost all fields of medicine, particularly psychiatry, in which up to half of patients with a mental health diagnosis will be found to meet criteria for a substance use disorder, addiction medicine and addiction psychiatry are woefully under-represented in both undergraduate and graduate medical education programs. Through discussions with educational leaders, we have brought together interested educators to share experiences and resources to assist others in enhancing the teaching of addiction in residency programs. We seek to discuss and develop resources in Addiction Psychiatry to those who wish to apply them their own training programs and improve addiction education to psychiatric trainees.

**Abstract**

Although half of patients with a mental health diagnosis meet criteria for a substance use disorder, addiction psychiatry is woefully under-represented in both undergraduate and graduate medical education programs. There continues to be an insufficient number of subspecialty trained addiction physicians to meet the current national crisis in opiate and other addictions. Given the prevalence and frequent presentation as co-morbidities of psychiatric disorders, additional training in substance use disorders will need to be a core domain of psychiatric residency training to ensure that psychiatric graduates are competent and prepared to treat addictions.

This workshop will utilize educationally-based vignettes to highlight and problem solve common barriers to optimal teaching of addictions in residency programs. Scenarios will review frequently encountered challenges, including programs having limited number of faculty/staff with time to supervise the experiences, limited faculty/staff with expertise, and insufficient clinical sites specializing in addictions/dual diagnosis. During our session, participants will work

in small groups to discuss the various challenges presented in the cases. Each small group discussion will be facilitated by a member of the AADPRT Taskforce on Addictions.

After reconvening as a large group, we will discuss the cases. Workshop presenters will share innovative strategies and initiatives designed to improve the teaching of addiction psychiatry and application to programs' educational needs. In addition, presenters will provide information regarding resources already developed and available to training programs to enhance addictions education, e.g. Project ECHO, free online buprenorphine waiver training, and instructional videos.

**Agenda**

Welcome - 10 minutes - presenters and participants introduce themselves; participants indicate what they hope to gain from attending the workshop

Brief overview of current gaps and barriers in addictions training - 10 minutes (include buprenorphine waiver and the limited faculty time for teaching)

Small Group discussion re: vignettes that present challenges in teaching additions and the group will be asked to discuss strategies to address the lapse - 30 minutes (1 group for 15 minutes and then switch)

Large Group discussion to share ideas about the vignettes and presentations from the presenters – 20 minutes

Discussion about available resources (provide resources on national trainings and conferences) – 10 minutes

Wrap-up and questions – 10 minutes

**Scientific Citations**

Avery J, Zerbo E, Ross S. Improving Psychiatrists' Attitudes Toward Individuals with Psychotic Disorders and Co-Occurring Substance Use Disorders. Acad Psychiatry. 2016;40:520-522

Renner J. How to train residents to identify and treat dual diagnosis patients. Biol Psychiatry. 2004;56:810-816.

Patil D, Andry T. Letter to the Editor: Molding young minds: The importance of Residency Training in Shaping Residents' Attitudes Toward Substance Use Disorders. Am J Addict.2017:26(1):80-82

Schwartz AC, Frank A, Welsh J, Blankenship K, DeJong SM. "Addictions training in general adult psychiatry training programs: Current gaps and barriers." Academic Psychiatry 2018; 42:642-647.

# Professionalism: It ain't what it used to be

**Presenters**
Randon Welton, MD
Suzie Nelson, MD
Kelly Blankenship, DO

**Educational Objective**
By the end of this training attendees will be able to:
1. Discuss professionalism as a developmental task of psychiatry residents
2. Critique competing models of professionalism
3. Define professional conduct and attitudes when faced with conflicting value systems
4. Develop professionalism training experiences for resident using tools that will be provided

**Practice Gap**
As professionalism has been incorporated into the psychiatry milestones, psychiatry residencies have been obligated to develop means of promoting and assessing professionalism among their residents. Unfortunately this ACGME-driven approach has tended to lead to overly reductionistic and simplistic views of professionalism. Often professionalism in residency is boiled down to a series of forbidden behaviors. Residents are led to consider professionalism as an all-or-nothing trait intrinsic to all physicians. A broader view of professionalism would include attitudes and styles of thinking in addition to behavior. It would involve discussions of the many separate, and sometimes competing, facets of professionalism and would describe professionalism more as a spectrum than a black/white dichotomy. A more complex understanding of professionalism would consider the possibility that standards of professionalism may change over time and vary by location and job description.
Residency programs have a limited array of educational strategies and techniques to promote professionalism. The simplest strategies involve hectoring residents to accept lists of unchanging and unchangeable values or to discuss egregious examples of misconduct. Few of the strategies address complex and competing systems of professionalism.

**Abstract**
This workshop challenges the notion that "Being a Professional" is a one-size-fits-all concept. Since professionalism is partly defined by the standards of conduct within the local community, professional standards vary over time and may be partly dependent on the venue in which the psychiatrist works. This workshop will examine the aspects of professionalism that are less observable than behaviors. We will discuss what residencies can do to promote professional attitudes and styles of thinking.

We will start by describing a developmental view of professionalism, which asserts that individuals become more professional as they observe, interpret and mimic the standards of care in the community. This leads naturally to conclusions that professionalism is a malleable quantity and defies simple descriptions. As a large group we discuss various theoretical systems

of professionalism that vary depending on practice. These include the Nostalgic System, the Entrepreneurial System, the Academic System, Social Justice system, and others. Each of these distinct systems meets the needs of a specific niche of psychiatrists.

Attendees will be asked to review the Professional Commitments found in the Medical Professionalism In The New Millennium: A Physicians' Charter which has been promulgated by the American Board of Internal Medicine and other prominent organizations. In small groups they will discuss the relative value of these commitments and be asked to generate a prioritized list of these commitments. Within their groups they will be asked to report and defend their rankings.

When some consensus has been reached within the small groups they will be given a series of scenarios describing residents' conduct and attitudes. They will be asked to evaluate the residents in light of their list of professional commitments. Lessons learned in the small group will be shared with the large group. Finally we will discuss how these exercises could be adapted for their institutions.

This process mimics a professionalism-training seminar used at our institution. This interactive seminar will provide opportunities for small group discussion, large group discussion, and peer based discussion and learning.

**Agenda**

- Introduction of Speakers – 5 minutes
- Models of Professionalism (Didactic)– 10 minutes
- Competing Systems of Professionalism (Didactic) – 15 minutes
- Competing Systems of Professionalism (Large Group Discussion) – 5 minutes
- Reviewing Professional Commitments from Medical Professionalism In The New Millennium: A Physicians' Charter (Didactic) – 10 minutes
- Small Group Discussion of Professional Commitments (15 minutes)
- Small Group Discussion of Professionalism scenrios (20 minutes)
- Applying this workshop to your residency (Large Group Discussion) - 10 minutes

**Scientific Citations**

- ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. Annals of Internal Medicine, 2002; 136: 243-246.
- Castellani B., Hafferty F.W. (2006) The Complexities of Medical Professionalism. In: Wear D., Aultman J.M. (eds) Professionalism in Medicine. Springer, Boston, MA
- Irby, D.M., Hamstra, S.J. Parting the Clouds: Three Professionalism Frameworks in Medical Education. Academic Medicine, 2016; 91: 1606-1611.
- Paauw, D.S., Papadakis, M., Pfeil, S. (2017) Generational Differences in the Interpretation of Professionalism. In Byyny, R.L., Paauw, D.S., Papadakis, M., Pfeil, S (eds) Medical

Professionalism Best Practices: Professionalism in the Modern Era. Alpha Omega Alpha Honor Medical Society .
- Swing, S.R. The ACGME outcome project: retrospective and prospective. Medical Teacher, 2007; 29: 648-654.

## "Social Media Rounds": Enhancing Resident Competencies in Web 2.0, Social Media and Digital Technologies To Improve Psychiatry Education, Leadership and Patient Care.

**Presenters**
Carlos Salgado, MD
Sohrab Mosaddad, MD
Xenia Aponte, MD
Tamara Zec, MD

**Educational Objective**

1. Appreciate the value and clinical relevance of enhancing trainee and faculty competencies in Web 2.0 and digital media.
2. Develop a greater understanding of the intersection of digital technologies with psychiatry from the view of both patient and clinician.
3. Practice and plan implementation of "Social Media Rounds" as an interactive didactic exercise into the Graduate Medical Education curriculum at one's own institution.
4. Improve familiarity with topics surrounding psychiatry and Web 2.0, such as maintaining a professional online presence, ethical boundaries, Internet addiction, digital health apps, online medical education and more.

**Practice Gap**

Today's children and adolescents live and grow in the digital age, faced with daily challenges that impact their mental health and contribute to interactions with health care and psychiatry. Clinicians and parents often struggle to keep pace with the rapidly changing virtual landscape where our patients exist. Additionally, professional understanding of such technologies as social media, digital health apps and new trends in their use lags behind current technology. As the number of stressors associated with the use of digital technologies grows, there is a growing need for psychiatry trainees to acquire skills, resources and knowledge to discuss the risks of digital media use with patients and their families, to take a pertinent virtual media history and provide guidelines to help parents set limits and support their children. In recent years, the use of Web 2.0- online technologies with interactive user-generated content such as social media, has also gained popularity in medical education. While fields such as emergency medicine and radiology have embraced use of such technologies in Graduate Medical Education (GME), psychiatry has largely lagged behind, potentially due to a lack of integration at the training level.

**Abstract**
The field of psychiatry is uniquely positioned to gain from an enhanced understanding of online technologies due to the proximity of our patient population and often their psychopathologies to the virtual world. This workshop aims to demonstrate that competency in Web 2.0 is a valuable tool for psychiatric Graduate Medical Education to develop professional use standards, guidelines for patients, new diagnostic measures and opportunities for intervention. A set of interactive exercises attempt to immerse the participant with an understanding of key issues such as cyberbullying, sexting, screen time, privacy, gambling, online human trafficking, self-injurious behaviors, social media isolation, public shaming, drug use, gamification of social media, the "dark web", etc. in order to equip future generations of psychiatrists to conduct healthy and informed conversations with parents and their children as they navigate the virtual landscape.

We modeled the workshop after a dynamic series titled "Social Media Rounds" which we have integrated into our own fellowship curriculum. Social Media Rounds or "So Me" Rounds consist of a monthly gathering of trainees, faculty, and program leadership to tackle topics surrounding the new landscape and digital language of our patient population via an experiential and immersive approach, with guidance from assigned exercises. The series is designed to be led by trainees, who are often early adopters of newer online technologies. The exercises are dynamic in that they may change annually as technologies evolve and may be adapted to each program's needs based on geographic, cultural and/or demographic trends. As a secondary goal, this project aims to provide an opportunity for faculty to fill gaps in knowledge, identify clinical challenges and develop strategies to grow the training program's own online presence. As the impact of social media and Web 2.0 grows, psychiatrists are increasingly relied upon to provide guidance to children, families, politicians and even technology firms on healthy use and design practices. Improving trainees' competency in Web 2.0 technologies will also help to alleviate the existing practice gap and improve the therapeutic alliance between patients and psychiatrists, while laying the groundwork for a smooth transition toward a professional online presence, leadership and advocacy for the psychiatrist.

**Agenda**
Minute 0-9 – Introduction
Minute 10-29 – Social Media interactive exercises & discussion groups
Minute 30-49 – Digital Health Apps interactive exercises & discussion groups
Minute 50-69 – Medical Education interactive exercises & discussion groups
Minute 70-84 – Ethics, Privacy & the Law interactive exercises & discussion groups
Minute 85-90 – Participant Review

**Scientific Citations**
Appelbaum PS, Kopelman A. Social media's challenges for psychiatry. World Psychiatry. 2014;13:21–3.
Giordano C, Giordano C. Health professions students' use of social media. J Allied Health. 2011;40(2):78–81.Cheston CC, Flickinger TE, Chisolm MS. Social media use in medical education: a systematic review. Acad Med. 2013;88:893– 901.

Galiatsatos P, Porto-Carreiro F, Hayashi J, Zakaria S. The use of social media to supplement resident medical education - the SMART-ME initiative. Med Educ Online. 2016
Hollinderbaumer A, Hartz T, Uckert F. Education 2.0 – how has social media and Web 2.0 been integrated into medical education? A systematical literature review. In: GMS Z Med Ausblid; 2013.
Jones KB, Sanyer O, Fortenberry K, Van Hala S. Resident education through blogging and other social media platforms. J Grad Med Educ. 2017;9:256.
O'Hagan TS, Roy D, Anton B, Chisolm MS. Social media use in psychiatric graduate medical education: where we are and the places we could go. Acad Psychiatry. 2016;40:131–5.
Peters ME, Uible E, Chisolm MS. A Twitter education: why psychiatrists should tweet. Curr Psychiatry Rep. 2015;17:94.

## Take the pain out of planning: Design a highly effective learning session in 10 minutes

**Presenters**
Kaz Nelson, MD
Jonathan Homans, MD
Lora Wichser, MD

**Educational Objective**
Upon completion of this session, participants will be able to:
Learning Objective 1: Apply the "Minnesota Arc" as a conceptual framework for effective learning.
Learning Objective 2: Learn skills to evaluate learners' receptiveness to learning objectives for any given educational activity.
Learning Objective 3: Efficiently create an effective education session which incorporates evidence-based learning theory.

**Practice Gap**
The consequences of "cognitive overload" in medical training are becoming more apparent. Passive learning strategies involving a traditional hour lecture consisting of multiple PowerPoint slides filled with facts and figures have been demonstrated to be ineffective and potentially contribute to stress and negative health. [1,2] While educators may embrace the theory underlying active learning, many educators struggle with the actual facilitation and structuring of active learning sessions.

**Abstract**
The "Minnesota Arc" is a conceptual framework, originally developed to rapidly teach early learners the skills of interacting with distressed or "difficult" patients. [3] This framework has also been applied in leadership to facilitate interactions with distressed stakeholders. [4] This workshop extends the basic "Minnesota Arc" concept even further to support and equip educators to effectively engage with distressed and potentially cognitively overloaded learners.

The “Interview Arc integrates the science of human cognition and educational theory which allows for quick translation of these concepts to educators of all levels. Application of this framework facilitates highly efficient and effective planning and implementation of learning sessions.

**Agenda**
In this 90 minute workshop, we will conduct a 20 minute needs assessment through small and large group discussion (think/pair/share), 10 minutes of large group discussion summarizing key themes and clarifying learning objectives. We will then show a 2 minute video illustrating a key concept, followed by 10 minutes of presented material. The remaining 45 minutes will be spent in a combination of large and small group work where participants will be able to create a learning session through application of the Minnesota Arc.

**Scientific Citations**
1. Brown, Peter C. Make It Stick : the Science of Successful Learning. Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 2014.
2. Young, JQ, J Van Merrienboer, S Durning, and O Ten Cate. “Cognitive Load Theory: Implications for Medical Education: AMEE Guide No. 86.” Article. Medical Teacher 36 (5): 371–84. https://doi.org/10.3109/0142159X.2014.889290.
3. [Redacted]. The Interview Arc 2.0: A Model for Engaging Learners in the Patient Interview Through Both Virtual Self-Directed Training and Direct Coaching. Association for Academic Psychiatry Annual Meeting, Milwaukee, WI. September 7, 2018.
4. [Redacted]. Teaching Teachers the Interview Arc: A Concise and Elegant Model for Engaging Learners in the Patient Interview. Association for Academic Psychiatry. Denver, CO. September 7, 2017.

## The Self-Compassionate Healer: An interactive curriculum for fostering greater resilience and well-being in medical education (WITHDRAWN)

**Presenters**
Kristin Leight, MD
Mary Yaden, MD, MSc
E Cabrina Campbell, MD

**Educational Objective**
- Define self-compassion and review the evidence for its role in clinician/trainee resilience and well-being
- Engage participants in various self-compassion practices, including a brief guided meditation, writing exercise, and other techniques to engender greater self-compassion
- Provide guidance/materials for participants to adapt or recreate this intervention at their home institution

**Practice Gap**

Over the last several years, the number of academic citations that include self-compassion has risen exponentially and currently surpasses over 20,000. While there is a robust literature on positive outcomes associated with self-compassion, we are at the vanguard of implementing and measuring self-compassion interventions in both clinical and psychiatric educational contexts. Our workshop joins a first wave of interventions to focus on self-compassion within medical or psychiatric education. Although mindfulness has been readily assimilated in both therapeutic and educational practices, self-compassion is still a novel personal resource for both patients and clinicians. Our goal is to bridge this practice gap by providing foundational information about self-compassion and to offer active coping strategies for working directly with emotions like shame that arise in the context of burnout by employing self-compassionate techniques.

**Abstract**

Although mindfulness has become ubiquitous throughout clinician wellness initiatives, self-compassion is a rising star of wellness education. While incorporating the foundations of mindfulness, self-compassion moves beyond non-judgmental awareness to provide skills for transforming one's own suffering into compassion and connection. In fact, a recent large-scale study of residents demonstrated that self-compassion had a unique role in predicting burnout above the effects of mindfulness. increasingly, Self-compassion is comprised of three primary components: awareness of when suffering or burnout arises, a recognition that suffering is a shared human experience, and finally a willingness to meet suffering with warmth and kindness instead of resistance or shame. Psychiatric training values cultivating compassion for the suffering of others; however, it rarely teaches the skills of meeting one's own failures or losses with warmth and understanding. Moral injury, an increasingly salient topic in medical education, is especially impacted by self-compassion, and we believe that training in self-compassion equips educators to address this dimension of burnout head-on. In fact, malignant perfectionism remains a prevalent cultural norm within clinical medicine. Our workshop aims to introduce participants to the science of self-compassion through a didactic introduction, as well as to guide them through contemplative practices, writing exercises, and other techniques aimed at developing greater emotional resilience. This workshop will not only offer a language for medical educators looking to talk about loss, failure, and moral-injury but also orient participants to tools to be used within their own curriculum, including handouts, scripts, and scales. Our workshop adapts evidence-based practices in cultivating self-compassion specifically for use in psychiatric residency programs across trainee level.

**Agenda**

Agenda:
0:00 Introduction
0:05 Didactic Presentation: Science of self-compassion
0:20 Discussion: Self-compassion in the psychiatry residency training
0:35 Exercise: Cultivating self-compassion through contemplative practice or journaling
0:50 Discussion: Self-compassion as an antidote to moral injury
1:00 Exercise: Recovering values as a vehicle for self-compassion

1:10 Debriefing self-compassion exercises
1:15 Discussion: Teaching self-compassion for patients and colleagues
1:20 Question and Answer Session

**Scientific Citations**

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. Clinical Psychology Review, 32, 545-552.

Zessin, U., Dickhauser, O., & Garbade, S. (2015). The relationship between self-compassion and well-being: A meta-analysis. Applied Psychology: Health and Well-Being. doi:10.1111/aphw.12051

Kirby, J. N. (2017). Compassion interventions: the programmes, the evidence, and implications for research and practice. Psychology and Psychotherapy: Theory, Research and Practice, 90(3), 432-455.

Finlay?Jones, A., Kane, R., & Rees, C. (2016). Self?Compassion Online: A Pilot Study of an Internet?Based Self?Compassion Cultivation Program for Psychology Trainees. Journal of Clinical Psychology.

Atkinson, D. M., Rodman, J. L., Thuras, P. D., Shiroma, P. R., & Lim, K. O. (2017). Examining Burnout, Depression, and Self-Compassion in Veterans Affairs Mental Health Staff. The Journal of Alternative and Complementary Medicine.

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Measuring relationships between self?compassion, compassion fatigue, burnout and well?being in student counsellors and student cognitive behavioural psychotherapists: a quantitative survey. Counselling and Psychotherapy Research, 16(1), 15-23.PDF

## Optimizing your Leadership Style

**Presenters**

Rachel Russo, MD
Lia Thomas, MD
Heather Schultz, MD, MPH

**Educational Objective**

By the end of this workshop,
Attendees will be able to:

- Compare and contrast leaders and managers
- Discuss maximizing leadership to followership styles in situational leadership

- Describe the core principles of leadership including self-development, core values, communicating purpose, accountability, and organizational culture

Attendees will also develop an individualized action plan for the next step on their leadership path.

**Practice Gap**

While relevant at any point in a career, leadership training is important as physicians may feel unprepared when moving from clinical work to education and administrative work. Our goal is to use this workshop to help attendees learn about leadership styles (objectives 1-3) and come up with a personalized action plan for the next step in their leadership process (objective 4). Several Level 5 elements of the current Psychiatry Milestones speak to residents being able to lead teams.

**Abstract**

Being an effective leader can magnify our impact as educators on the individuals and communities that we serve. One aspect of effective leadership is self-awareness of leadership style, which is a composite of the styles of role models and others in medicine, business and society. Another key aspect is alignment with those aspects of "followership" (or characteristics) of those we lead, as we provide service, advocate and inspire others to lead.

We are often called to be leaders, usually without any formal leadership training, or opportunity to identify our own leadership styles. Education on domains of leadership must be combined with opportunities to reflect and identify personal leadership styles and a longitudinal approach to adjust over time, preferably with team, peer and/or mentor input.

**Agenda**

This 90-minute workshop will use individual reflection and needs assessment followed by small and large group sharing and is appropriate for trainees and all levels of faculty from early to late career.

5 min – Introductions and setting the objectives of the workshop

20 min- Leader vs. Manager explorations: We will present a case and participants will complete a self-reflection worksheet focused on leader and manager roles, educational tasks as they relate to these roles, and their struggles as a leader and manager. They will then pair and share to explore responses and reactions

10 min – Facilitated large group discussion to brainstorm characteristics of high-quality leaders and managers

20 min - Review of leadership styles, theory, social power framework, characteristics of leaders with pair share and then large group discussion of important characteristics for medical educators.

15 min – Action plan worksheet

10 min- Large group discussion/small group reporting on discussions and synthesis of workshop activities, with emphasis on next steps in working within structure of leadership and followership alignment strategies

5 min – Conclusions and questions

5 min – Participant review using WHOVA app

**Scientific Citations**


1. Bennis W. Managing People is like Herding Cats. Provo, UT: Executive Excellence Publishing, 1999.
2. Bjugstad, Thach, Thompson, Morris (2006). A Fresh Look at Followership: A Model for Matching Followership and Leadership Styles. J Behv Applied Management 304-316.
3. Collins-Nakai (2006) Leadership in Medicine. McGill Journal of Medicine 9:68-73.
4. Harolds (2004) Selected Important Characteristics of Enlightened Medical Leaders. J Am Coll Radiol 1: 338-342.
5. Helitzer DL, Newbill SL, Morahan PS, et al. (2014) Perceptions of skill development of participants in three national career development programs for women faculty in academic medicine. Acad Med 89(6):896-903.
6. Houpt, Gilkey, Ehringhaus. Learning to Lead in the Academic Medical Center: A Practical Guide. Switzerland. Springer International Publishing, 2015.
7. Talmon & Beck Dallghan. Mind the Gap: Generational Differences in Medical Education. Gegensatz Press, 2017.
8. Wiseman. Multipliers: How the Best Leaders make Everyone Smarter. New York: HarperCollins Publishers, 2017.
9. Jardine, D et al. The Need for a Leadership Curriculum for Residents. JGME. http://dx.doi.org/10.4300/JGME-07-02-31. Accessed 10/26/19


## Listening to All Voices: Cultural Humility in Psychiatry Resident Supervision

**Presenters**


Raziya Wang, MD
Poh Choo How, MD, PhD
Takesha Cooper, MD, MS
Ryan Harris, MD


**Educational Objective**

1) To introduce residency program directors to cultural humility concepts
2) To prepare residency program directors to implement cultural humility approaches to supervision at their home institutions

**Practice Gap**

The new ACGME accreditation standards for psychiatry residency training programs state that "Residents must demonstrate competence in respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation." Many psychiatry supervisors recognize that cultural and diversity issues may play an important role in the supervisory relationship as well as in resident interactions with patients. Yet, supervisors often feel ill-equipped to address these concerns directly. The complexity of addressing core

psychiatric concepts while recognizing issues of bias or structural determinants can be challenging. Cultural humility offers a structured approach to integrating concepts of culture and diversity within the context of medical education and may facilitate teaching faculty and residents to work effectively with patients from diverse backgrounds.

**Abstract**

The Surgeon General's Supplement to the Report on Mental Health entitled, Mental Health: Culture, Race and Ethnicity underscored significant disparities in mental health care for racial and ethnic minorities and a study by LeCook demonstrated that these disparities increased further for African Americans and Hispanics between 2004 and 2012. Residency training programs have struggled to train psychiatrists to adequately address this issue. Cultural Competency and more recently, Structural Competency, have emerged as approaches to educate psychiatry residents regarding mental health disparities and have been implemented with varying consistency. The term "competency" is often used in medical education and may imply a concrete set of facts that can be mastered by the learner. However, in their 1998 paper, Drs. Tervalon and Murray-Garcia, two pediatricians at the Oakland Children's Hospital, proposed that an approach of cultural humility would better serve diverse patient populations. They describe four components of cultural humility including 1) a lifelong process of self-reflection and self-critique to identify bias on the part of the provider 2) action to redress the power imbalance between patient and provider 3) developing, on a systems level, beneficial partnerships with communities on behalf of individuals and defined populations and 4) advocating and maintaining institutional accountability for the above principles. Cultural Humility approaches are now used in many aspects of medicine as well as in other fields although with some heterogeneity and to varying degrees of success. For the budding psychiatrist, one-to-one supervision with a designated faculty member is a deeply impactful and even "imprinting" process. Therefore, it is paramount that supervisors be comfortable with cultural humility in order to help train the next generation of psychiatrists to have the skills and motivations to address inequity. In this workshop, we will demonstrate the use of experiential methods to teach cultural humility in our own programs, discuss ways to use this approach in supervision, and provide an opportunity for participants to practice a brief experiential exercise.

**Agenda**

Workshop Agenda:

- 5 min ice breaker activity: "health disparity quiz"
- 25 min Introduction to cultural humility concepts
- 15 min partner/small group activity: "cultural identity pie"
- 15 min large group discussion
- 15 min small group activity: supervision scenario role play
- 15 min audience discussion and group generation of plans for their own curricula

**Scientific Citations**

ACGME Program Requirements for Graduate Medical Education in Psychiatry, Editorial Revision: effective July 1, 2019. Accreditation Council for Graduate Medical Education.

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_Psychiatry_2019.pdf?ver=2019-08-26-134127-827

Hook JN, Watkins CE, Davis DE, et al. Cultural Humility in Psychotherapy Supervision. American Journal of Psychotherapy. June 2016; 70(2): 149-166
https://www.researchgate.net/publication/304070808_Cultural_Humility_in_Psychotherapy_Supervision

LeCook B, Trinh M, Li Z, Hou, SS, Progovac AM. Trends in Racial-Ethnic Disparities in Access to Mental Health Care, 2004-2012. Psychiatric Services, 68:1, 9-16, 2017
https://www.ncbi.nlm.nih.gov/pubmed/27476805

Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General. Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, 2001.
https://www.ncbi.nlm.nih.gov/books/NBK44243/

Smedley BD, Stith AY, Nelson AR, editors. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Washington (DC), National Academies Press (US); 2003
https://www.ncbi.nlm.nih.gov/books/NBK220358/

Tervalon M, Murray-Garcia J. Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. Journal of Health Care for the Poor and Underserved. 1998 May; 9(2): 117-125.
https://melanietervalon.com/wp-content/uploads/2013/08/CulturalHumility_Tervalon-and-Murray-Garcia-Article.pdf

## Real Change: Approaching physician trainee well-being through evidence-based individual, structural, and systems-level initiatives

**Presenters**
Aaron Reliford, MD
Sansea Jacobson, MD
Misty Richards, MD
Anne Glowinski, MD
Colin Stewart, MD

**Educational Objective**
1) Describe the benefits and challenges to early identification of burnout and supporting wellbeing of psychiatry trainees.

2) Differentiate individual & organizational drivers to psychiatry trainee burnout and assist participants to identify such drivers at their home institutions

3) Identify and develop targeted interventions to promote trainee wellbeing at the individual trainee level, but beyond it on a departmental & institutional level.

4) Work with participants to identify perceived barriers to making positive change and help participants create an individualized plan to generate sustainable change at the individual and organizational level

**Practice Gap**

Evidence shows increased rates of physician burnout beginning during medical school and continuing through residency and fellowship. This has led to concerning issues of decreased productivity, medical errors, and compromised patient care. Even worse, burnout has been correlated to growing rates of mental illness in physicians. The Accreditation Council for Graduate Medical Education (ACGME) has since prioritized trainee wellness across all training programs, introducing new core program requirements related to physician wellness. Despite best efforts, there remain no gold-standard approaches to how to approach these issues. Furthermore, most existing initiatives are implemented in an untargeted way in the hopes of combating burnout through targeting personal resilience only. Now that there are new ACGME requirements, all programs now must systematically educate trainees and faculty about the warning signs of burnout and mental illness, how to address early warning signs, and how to promote trainee wellness in the midst of intense learning and clinical care. Even fewer programs have worked to identify institutional and local systemic drivers of burnout for targeted change. Enhancing knowledge of differential contributors to burnout and empowering program directors to navigate systems contributors would greatly enhance the effectiveness of such wellbeing initiatives. Consequently, there is a need to examine innovative methods of assessing stress and wellbeing in trainees and model curriculum developed towards delivering high quality resiliency training. Finally, and perhaps most challenging, departmental and institutional cultures must be examined and changed refocusing on the wellbeing of its physicians and trainees.

**Abstract**

There are varying dimensions of physician wellbeing. These are represented in the realms of physician burnout, physician engagement, professional fulfillment/satisfaction, fatigue, emotional health & stress, and quality of life1. More recently, the issue of physician burnout - the syndrome of emotional exhaustion, depersonalization, & decreased sense of personal accomplishment2 - has received renewed attention, particularly in the realm of physician training. This in response to significantly increased rates of burnout in physicians and physicians in training (as much as 50% in medical students, 75% in residents and fellows, and 50% in the physician workforce3,4). Burnout in physicians and physicians in training is associated with negative consequences in patient care (e.g., medical errors, increased mortality rates, longer recovery times, lower patient satisfaction), workforce productivity & costs (e.g., decreased job satisfaction, decreased work effort, higher physician turnover & associated

costs), and directly on the physicians themselves6. Rates of physician suicide are four fold higher than the general population despite the same rates of depression7. The causes of burnout are multi-determined, arising from individual factors and characteristics of the physician or medical culture, and also from problems in the healthcare systems and the working and learning environments5-7. To address burnout, the approach needs to target the driving factors within the individual clinician as well as in the health care system (e.g., residency training, clinical sites, departmental & institutional levels) shown to be significant contributors to this problem1,6.

The ACGME's Clinical Learning Environment Review (CLER) currently outlines an expectation that institutions both educate residents about burnout and measure burnout regularly. Most recent common program requirements have gone further, mandating that programs collaborate with their sponsoring institution and have the same responsibility to address well-being as another aspect of resident competence. They recommend that efforts include work to enhance the meaning of physicianhood, attention to scheduling, and workplace safety focus. Policies and programs must be created to educate and assess burnout, depression and substance abuse, and provide timely means of addressing them when present.

Our goal is to educate training directors on the need to focus on wellbeing and burnout, how to assess for it locally (e.g., beyond the ACGME wellness survey), and to provide a practical framework for creating a meaningful wellbeing curriculum for their trainees. However, most importantly, we endeavor to help our participants evaluate systems drivers that may be contributing to burnout, and how to engage & navigate their department and institution to promote meaningful, sustainable change. In our session, we will elaborate how to engage leadership within health care systems to enhance the trainee wellbeing. Specifically we will briefly review the literature and highlight examples of innovative systems-level approaches to addressing wellbeing at our own home institutions.

**Agenda**

We plan to highlight the wellbeing curricula and structural program changes to address burnout that have been implemented at the NYU, UCLA, Pittsburg, Georgetown, & Washington University CAP fellowships.

1. Introduction to the concept of wellbeing & assessment of wellbeing in Psychiatry training programs (10 min)
2. Participants will learn about how to assess both well-being and stress levels of residents using a variety of evidence based scales. This will be done through an activity in which the participants will followed by completion of the PERMA wellbeing self-assessment tool (5 min)
3. Break-out: Complete, discuss and review the PERMA wellbeing tool, its utility of this augmented assessment for their trainees, individual strategies they have implemented in their programs to address wellbeing locally in their programs. (10 min)

4. Introduction to the drivers of burnout and how to systematically engage their departments and institutions in addressing these in the development of a comprehensive wellbeing program (15 min)
5. Reviewing examples of structural change at 5 training programs designed to enhance the wellbeing of their trainees. Attention will be paid to the necessary steps and challenges to systematically engage the institution and departments for this purpose. Outcome measures of success will also be reviewed (30 min)
6. Break out: Participants will review examples of how their different institutions have attempted to integrate wellness activities and education into their cultures, including the challenges of engaging their departments and institutions to institute meaningful wellbing intiatives. (15 min)
7. Wrap up with discussion of examples from participants (5 min)

**Scientific Citations**


1. Shanafelt TD, Noseworthy J. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. Mayo Clin Proc. 2017;92(1):129-146
2. Maslach C. The measurement of experienced burnout. Journal of Occupational Behavior, 1981; 2:99-113
3. Dyrbye LN et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med. 2014;89(3):443-451
4. West CP et al. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. JAMA 2011;306(9):952-960
5. Botha E, Gwin T. The effectiveness of mindfulness based programs in reducing stress experienced by nurses in adult hospital settings: a systematic review of quantitative evidence protocol. JBI Database System Rev Implement Rep. 2015 Oct;13(10):21-9
6. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences, and solutions J Intern Med. 2018 Jun;283(6):516-529
7. Rothenberger D. Physician Burnout and Well-Being: A Systematic Review and Framework for Action. Dis Colon Rectum. 2017 Jun;60(6):567-576


## Engaging junior faculty and residents: a comprehensive model for effectively supporting scholarship in early academic careers

**Presenters**


Anne Penner, MD
Merlin Ariefdjohan, MPH, PhD
Kimberly Kelsay, MD


**Educational Objective**

Attendees will

1. Understand training gaps for psychiatry trainees and junior faculty engaging in scholarship

2. Appreciate how training programs may engage in this specific scholarship training through mentorship, skill-based trainings, and engaging departmental support
3. Consider a new support model that enables junior psychiatry faculty to be productive academically while concurrently managing their clinical workload
4. Generate next steps for implementation into their academic program accounting for institutional needs, current resources and programmatic experiences

**Practice Gap**

1. Formalized training tracks for specific skills in academic psychiatry have been described, but they continue to be underutilized, and the benefit to junior faculty underrecognized.
2. Junior faculty practicing in academic medicine face the challenge of managing both clinical commitments and the requirement to be productive academically. Concurrently, they may not have the funds to hire their own research staff.
3. A scholarship training program for fellows and junior faculty that incorporates a culture of mentorship, along with the development of research skills through didactics and skill building, has not been described.
4. There has been a lack of emphasis on how to capitalize on the collaboration between residents and junior faculty for completing scholarly work.

**Abstract**

Early career psychiatrists practicing in academic medicine are passionate about education and dissemination of best practices through scholarship. These scholarly products may include evaluating and disseminating training curricula and conducting projects related to quality improvement or program evaluations; all of which should result in professional presentations and/or publication of manuscripts. However, individuals early in their career often find it difficult to engage in meaningful scholarly activities due to demanding clinical commitments, and are therefore at a disadvantage for promotion1,2. Further, many early career psychiatrists lack formal research training. As such, they may not be sufficiently informed on how to formulate and manage a study that can be performed efficiently from start to completion during their appointment. Fellows and junior faculty alike may find resources on campus confusing or costly to maneuver, making them seem unattainable. Meeting scholarship requirements through research and other academic products can be seen as a major stressor of practicing in an academic medicine setting and contributes to problems with retention. Educational and academic work are passions for psychiatrists choosing to be in academic medicine, so creating a formal curriculum for increasing scholarship is a natural fit and a necessary one. Such programs can increase the number of fellows who engage in successful scholarship, create a pipeline into academic programs, and promote junior faculty development3. Our scholarship program focuses on a culture of mentorship, practical skill-based sessions open to all, and broader departmental support through an in-house research support center. Through these efforts, our program saw a more active and productive collaboration between faculty and trainees, an increase in the number of fellows and junior faculty presenting at national meetings, and an increase in the number of newly initiated projects and publications. In this session, we will discuss our initiatives to promote scholarship by outlining the need for specific training in academic medicine, gaps among psychiatrists as

junior faculty, and then provide specific interventions that worked at our institution. For example, we will talk about a multi-faceted approach to mentorship that includes pairing fellows with junior faculty supervisors, project-based mentors, and senior faculty "meta-mentors" on the scholarship committee4-6. We will also discuss the set-up of our in-house research support center including scholarly outcomes and other challenges. In summary, formalized training in academic psychiatry benefits both resident trainees and junior faculty. This type of initiative is feasible, and such a curriculum can be integrated into programs seeking to boost scholarship in their department.

**Agenda**

1. Introduction to the specific training components of our program, a brief review of training tracks for academic psychiatry, and a description of our in-house research support center for junior faculty (25 minutes)
2. Open discussion of gaps in scholarship for junior faculty and trainees, and then pivot to a discussion what has worked in other programs (15 minutes)
3. Outline the successes associated with the in-house research support center and lessons learned associated with the initiative (10 minutes)
4. Break-out session to discuss practical, specific steps that could be employed by programs. Groups will divide based on their program's experience with this type of formalized training. (20 minutes)
5. Return for final discussion as a group and questions (15 minutes)
6. Feedback on workshop using the app (5 minutes)

**Scientific Citations**


1. Jeffe DB, Yan Y, Andriole DA. Competing Risks Analysis of Promotion and Attrition in Academic Medicine: A National Study of U.S. Medical School Graduates. Acad Med. 2019;94(2):227-236.
2. Ries A, Wingard D, Gamst A, Larsen C, Farrell E, Reznik V. Measuring faculty retention and success in academic medicine. Acad Med. 2012;87(8):1046-1051.
3. Penner AE, Lundblad W, Azzam PN, Gopalan P, Jacobson SL, Travis MJ. Assessing Career Outcomes of a Resident Academic Administrator, Clinician Educator Track: A Seven-Year Follow-up. Acad Psychiatry. 2017;41(2):278-281.
4. Ayyala MS, Skarupski K, Bodurtha JN, et al. Mentorship Is Not Enough: Exploring Sponsorship and Its Role in Career Advancement in Academic Medicine. Acad Med. 2019;94(1):94-100.
5. Kashiwagi DT, Varkey P, Cook DA. Mentoring programs for physicians in academic medicine: a systematic review. Acad Med. 2013;88(7):1029-1037.
6. Lis LD, Wood WC, Petkova E, Shatkin J. Mentoring in psychiatric residency programs: a survey of chief residents. Acad Psychiatry. 2009;33(4):307-312.

# Creating a Healthy Program: Shifting the Onus of Residency Wellness from the Individual to the Program

**Presenters**
Julie Wolfe, MD
Heather Murray, MD, MPH
Alyssa Broker, DO
Robert Davies, MD

**Educational Objective**
1. Understand the importance and supporting evidence of wellness initiatives in addressing the issue of resident burnout
2. Locate specific areas which may be contributing to resident burnout in their home institutions
3. Identify possible wellness initiatives and barriers to implementing them within their home institutions

**Practice Gap**
Residency training has the potential to negatively impact trainee mental health which may result in burnout. Although it has been established that wellness behaviors can be helpful in preventing burnout, structural changes and changes in the training culture also need to be addressed. Too often during wellness conversations, the responsibility is placed on the individual. The concern is that "wellness" becomes yet another burden for residents and something they can feel badly about if they are not personally doing something about it. A more effective approach comes from the program itself. Unfortunately, many residency programs face multiple barriers to instituting and maintaining wellness initiatives within their programs. This workshop is intended to describe specific initiatives that have been developed in a large US psychiatric residency program to focus on resident wellness, and to explore solutions to barriers to such initiatives that exist in participants' own programs.

**Abstract**
In this workshop, we will discuss key components of our wellness initiatives, which have been incorporated throughout all four years of residency training, as well as discuss important lessons that have been learned from these initiatives regarding how to maintain interest and engagement by residents, especially during times of high stress or possible burnout. These include the implementation of a quarterly wellness half day policy, empowering residents in creating and leading wellness focused initiatives that address their specific needs and improving communication throughout the residency program. Finally, we will discuss ways for residency programs to make meaningful changes and address barriers to building and maintaining wellness initiatives within their programs. This workshop will be interactive and draw upon participants own experiences either as a resident or a faculty member. Participants will complete a wellness "needs assessment" for their own institution and then brainstorm solutions in larger groups.

**Agenda**
Welcome and introduction: 5 minutes

Didactic presentation of the current state of wellness and burnout in residencies, specific information on initiatives implemented in presenters' residency program, information on the supporting literature: 30 minutes

Small groups facilitated by the presenters to identify areas of focus for wellness initiatives at participants' home institutions through brief needs assessment: 20 minutes

Large group to identify common areas of need and brainstorm possible initiatives that can be brought back and implemented at participants' home institution: 30 minutes

Summary and conclusion: 5 minutes

**Scientific Citations**
Cedfeldt AS, Bower EA, English C, Grady-Weliky TA, Girard DE, Choi D. Personal time off and residents' career satisfaction, attitudes and emotions. Med Educ. 2010;44:977-984

Cedfeldt AS, Bower EA, Grady-Weliky TA, Flores C, Girard DE, Choi D. A comparison between physicians and demographically similar peers in accessing personal health care. Acad Med. 2012;87:327–331

Jennings M, Slavin S. Resident Wellness Matters: Optimizing Resident Education and Wellness Through the Learning Environment. Academic Medicine. September 2015; 90(9): 1246-1250.

Lefebvre D. Resident Physician Wellness: A New Hope. Academic Medicine. May 2012; 87(5): 598-602.

## Workforce Development through Psychiatry Residency Tracks and Expansion

**Presenters**
Deborah Cowley, MD
Rashi Aggarwal, MD
Lindsey Pershern, MD
Kirsten Aaland, MD
Melanie Drake, MD

**Educational Objective**
At the conclusion of this workshop, participants will be able to: 1. Discuss the results of the AADPRT workforce development survey, including their own and other residency directors' perspectives on the challenges and opportunities for expanding psychiatry residency programs and developing residency tracks; 2. Describe issues involved in developing residency tracks,

especially in underserved areas; 3. Discuss ways to advocate to increase awareness of psychiatrist workforce shortages and expand graduate medical education funding.

**Practice Gap**

The United States has a psychiatrist workforce problem. Only one in eight people with a psychiatric disorder see a psychiatrist. Over 75% of counties have a shortage of mental health professionals, especially psychiatrists. Psychiatrists are in particularly short supply in non-urban areas and public mental health settings. While the population of the United States is growing and the demand for mental health care increasing, the existing number of residency slots allows only replacement of the current workforce. Furthermore, the population of psychiatrists is "graying." A 2013 Substance Abuse and Mental Health Services Administration report found that the median age of psychiatrists was 55.7 years, with 46% over the age of 65, and so likely to retire soon. There is a need to train more psychiatrists in order to address these current and projected shortages of psychiatrists, through psychiatry residency expansion and the development of programs or tracks focused on preparing psychiatrists to work in non-urban areas and with underserved populations.

**Abstract**

Given the national shortage of psychiatrists and projected increasing psychiatrist workforce problem, AADPRT has convened a Workforce Development Task Force as a forum to study obstacles to increasing the psychiatrist workforce and the feasibility of potential strategies and solutions. The task force will survey AADPRT members in the fall of 2019 to explore opportunities, challenges, and obstacles to residency and fellowship expansion and the development of new programs and tracks. In this workshop, we will present and discuss the results of this survey regarding core psychiatry residency programs and two examples of ways to increase psychiatrist workforce through the creation of regional residency tracks and through statewide advocacy for GME expansion and the development of a rural and public mental health track.

Participants will learn the results of the survey and will have the opportunity to discuss workforce development challenges and opportunities in their own setting. In the first example of workforce development, the core program residency director involved in development of the track, the track director, and a resident in the track will discuss issues involved in establishing and growing a regional residency track in Idaho aimed at preparing psychiatrists to practice in a non-urban, underserved area, including financial, community engagement, educational, resident recruitment, and program development issues. The second example will discuss coordinated advocacy across programs in Texas to develop a position statement and white paper related to the goals of public mental health education and recruitment in the state and advocacy efforts with the legislature to increase awareness of workforce shortages. This advocacy resulted in expansion of GME funding and positions, including for a Rural and Public Mental Health track at UT-Southwestern, which is under development.

Finally, the workshop will include discussion of ways in which participants can increase psychiatrist workforce in their own programs and institutions.

**Agenda**

- Presentation of the AADPRT Workforce Development Survey compiled responses from psychiatry residency directors (15 minutes)
- Pair and share, followed by large group discussion, reflecting on participants' own responses to survey questions and/or experience with opportunities and challenges regarding program expansion, track development, or other ways to expand psychiatrist and mental health workforce (15 minutes)
- Example: development of a regional residency track (15 minutes)
- Q&A, discussion (5 minutes)
- Example: state-level advocacy for GME expansion (15 minutes)
- Q&A, discussion (5 minutes)
- Individual goal-setting (2 minutes)
- Pair and share regarding goals and next steps (3 minutes)
- Large group discussion of next steps and potential approaches (15 minutes)

**Scientific Citations**

Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve month use of mental health services in the United States: results from the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005; 62:629-640.

Thomas KC, Ellis AR, Konrad TR, Holzer CE, Morrissey JP. County-level estimates of mental health professional shortage in the United States. Psychiatr Serv 2009; 60:1323-1328.

Kupfer JM. The graying of US physicians. Implications for quality and the future supply of physicians. JAMA 2016; 315:341-342.

Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues; SAMSHA 2013; Aging Workforce;11

Cowley DS, Keeble T, Jones J, Layton M, Murray SB, Williams K, Bakker C, Verhulst J. Educating psychiatry residents to practice in smaller communities: a regional residency track model. Academic Psychiatry 2016; 40:846-849.

Reardon CL, Factor RM, Brenner CJ, Singh P, Spurgeon JA. Community psychiatry tracks for residents: a review of four programs. Community Mental Health Journal 2014; 50:10-16.

# Educational Workshops Session 5

## Maintaining a Sense of Wellness Following an Adverse Event: The Development of a Pilot Committee for Resident Safety

**Presenters**

Vanessa Padilla, MD
Cody Bryant, MD
Jessica Healey, MD
Julia Salinas, MD
Omar Munoz, MD

**Educational Objective**

After attending this workshop, the participant will be able to:

1. Identify the impacts of adverse events on resident well-being.
2. Describe challenges and barriers to resident safety when an adverse event occurs.
3. Discuss the creation and development of an institutional protocol to assist psychiatry residents when adverse events occur.
4. Identify the roles and responsibilities of faculty and training directors before, during, and after resident-impacting adverse events.
5. Promote the development of resources that fit the needs of the psychiatry residency program and institution.

**Practice Gap**

Psychiatrists care for patients with a variety of conditions that can affect their insight, judgment, and impulse control. This may lead to a multitude of potential risks that can put the well-being of the psychiatrist in jeopardy. Often encountered adverse events include, among others, risk of physical harm of the psychiatrist by a patient, medical errors, and completed patient suicide. As recent medical graduates, psychiatry residents face additional challenges when dealing with adverse events, such as limited training to predict or avert an adverse event, not being fully aware of the available resources at their new facility to help them recover following an adverse event, and potential self-perception of inadequacy (feeling "not good enough") when seeking help following an adverse event. Psychiatry residents must deal with the emotional and, if any, physical sequelae occurring after an adverse event while continuing to comply with duty hours, often in the midst of financial difficulties and health issues. Training programs are responsible for overseeing and ensuring resident safety, and for providing psychiatry residents adequate training in how to assess and maintain both patient and physician safety.

At our institution, no standardized protocol or committee existed to assist psychiatry residents during and after adverse events. We created a committee designed to educate residents about safety in the workplace, guide the residents to the appropriate available resources, and analyze the data obtained following adverse events.

**Abstract**

Patient suicide and assault by a patient have been described as the most stressful of the adverse events that a psychiatry resident can experience (Kozlowska et al, 1997). A 2014 literature review reported that psychiatry residents experience patient suicide at an alarming rate of 30–60%, while 25–64% are assaulted by a patient at some point during training (Deringer et al, 2014). Physicians often have difficulty coping after work-related traumatic events. A 2018 Dutch study showed that following adverse events, Ob-Gyn physicians find peer-support with colleagues as the best coping mechanism, while others may resort to unhealthy coping strategies such as substance use and medication misuse (Baas et al, 2018). It can often be difficult for physicians to seek support following adverse events for a variety of reasons. These can include, among others, feelings of guilt, shame, loss of confidence/preoccupation about future errors, anxiety, fatigue/sleeping difficulties, fears about confidentiality, and

concerns for impact on their career (Waterman et al, 2007; Lane et al, 2018). In an effort to help and support a physician who falls victim to a severe adverse event, institutional programs must be developed and implemented to promote recovery (Scott et al, 2009).

In 2019, our institution implemented The Severe Adverse Events Committee (SAVE) which is comprised of psychiatry faculty members from each of our three training sites, residents from each training year, and all chief residents. The purpose of the committee is to monitor, respond to, and analyze adverse events involving our psychiatry residents. The protocol provides specific steps on how to contact supervisors, file police/institutional reports, facilitate access to available resources, and receive immediate medical care if necessary. Impacted residents are offered time off from work, assistance with debriefing, and consolidation of necessary but often distressing meetings following the adverse event (i.e. risk management, court hearings, morbidity and mortality conference). The committee is also responsible for conducting bi-annual educational workshops for residents, focusing on topics related to physician/patient safety, crisis intervention, conflict de-escalation techniques, and physician well-being. Resident feedback is gathered to assess the impact of our committee.

This interactive workshop will provide an opportunity for academic leaders to explore the creation of a protocol designed to ensure resident safety and well-being after exposure to an adverse event. We will facilitate an interactive discussion with the audience by working through two scenarios of adverse events and providing an opportunity to create a standardized protocol tailored to their specific residency programs. Through this workshop, we will guide the audience through our process of protocol development, and will invite the audience to self-evaluate and initiate their own plans to actively address resident wellness following adverse events.

**Agenda**

- Welcome and Introduction (5 mins)
- Overview of adverse events and resident safety (10 mins)
- How are we doing it? From creating to implementing a severe adverse events committee (15 mins)
- Resident Perspective (15 mins)
- Small group discussion (30 min):
  (a) Discuss two specific scenarios of adverse events (i.e, patient completed suicide and resident assault by patient) and propose how to address resident safety, while facilitating report, debrief and supportive strategies.
  (b) Tailor and discuss ideas related to your specific residency program.
- Open discussion with audience: Developing an action plan (10 mins)
- Q&A (5 mins)

**Scientific Citations**

- Baas, M.A.M., Scheepstra, K.W.F., Stramrood, C.A.I., Evers, R., Dijksman, L.M., & van Pampus, M.G. (2018). Work-related adverse events leaving their mark: a cross-sectional study among Dutch gynecologists. BMC psychiatry, 18(1), 73.

- Deringer, E., & Caligor, E. (2014). Supervision and responses of psychiatry residents to adverse patient events. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 38(6), 761-7.
- Kozlowska, K., Nunn, K., & Cousens, P. (1997). Adverse experiences in psychiatric training. Part 2. The Australian and New Zealand journal of psychiatry, 31(5), 641-52; discussion 653-4.
- Lane, M.A., Newman, B.M., Taylor, M.Z., O?Neill, M., Ghetti, C., Woltman, R.M., & Waterman, A.D. (2018). Supporting Clinicians After Adverse Events: Development of a Clinician Peer Support Program. Journal of patient safety, 14(3), e56-e60.
- Scott, S.D., Hirschinger, L.E., Cox, K.R., McCoig, M., Brandt, J., & Hall, L.W. (2009). The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Quality & safety in health care, 18(5), 325-30.
- Waterman, A.D., Garbutt, J., Hazel, E., Dunagan, W.C., Levinson, W., Fraser, V.J., & Gallagher, T.H. (2007). The emotional impact of medical errors on practicing physicians in the United States and Canada. Joint Commission journal on quality and patient safety, 33(8), 467-76.

## Teaching Case Formulation, or, How to Make Meaning Central to Treatment

**Presenters**
David Mintz, MD,
Deborah Cabaniss, MD
David Ross, MD, PhD

**Educational Objective**
At the end of this presentation, participants should be able to:
1) Discuss ways that formulating the intersection of meaning and biology enhances all aspects of psychiatric practice
2) Use new techniques for teaching basic formulation skills
3) Utilize new techniques for promoting the integration of psychological formulation into daily practice

**Practice Gap**
At the national level, there is a recognized gap between what we know about the value of patient-centered approaches and their actual implementation, transmitted through the influential Institute of Medicine (IOM) report on the “quality chasm” in American medicine (2001) and instantiated in the Affordable Care Act. Psychiatry has not been immune from pressures which promote an illness-centered model of treatment. Many of the leaders of Academic psychiatry (Cabaniss, et al, 2015; Ross, et al, 2016; Brenner, 2016) recognize that the biopsychosocial and psychodynamic formulation are approaches for ameliorating this practice gap.

**Abstract**
Though our residents generally enter residency with an interest in integrative approaches to the patient, the pressures and efficiencies of modern medical practice may inadvertently

reward more illness-centered approaches. "Formulation," as a disciplined approach to incorporating a psychological (or psychosocial) understanding of the manifestation of the patients' illness, emerged, in part, as an antidote to reductionistic pressures in the medical environment. While changes in the environment of practice have made the integrative task of formulation even more important, they have also necessitated adaptations to how formulation is conceptualized and taught.

In past generations, residents were steeped in psychodynamic approaches that considered patients' complex and conflicting motivations in relation to illness and its care. In the contemporary academic environment, residents must master a number of psychotherapies and vastly more neuroscientific information. These residents often benefit from teaching approaches that do not presume a high degree of psychological-mindedness, but which help the resident to address the questions of the "why" of illness manifestations and of treatment-seeking. Further, in an era when relatively fewer psychiatrists can expect to practice psychodynamic psychotherapy, teaching approaches must also demonstrate the relevance of formulation to domains of practice beyond psychodynamic psychotherapy.

In this workshop, we will explore the value of an integrative formulation that emphasizes the contribution of the patient's subjectivity for multiple domains of psychiatric practice, including psychotherapeutic approaches, pharmacotherapy, and medical leadership. Using examples and simple exercises, we will demonstrate strategies for teaching formulation skills to residents who are not well-versed in more complicated psychological concepts, and for enhancing the skills and capacities of more advance residents. Formulation can be used not just to help guide effective treatment, but also to help patients in self-understanding and self-management. In this workshop, we will explore how to talk to patients in ways that promote patient agency. Further, we will demonstrate techniques to promote the integration of formulation into the everyday practice of our trainees, so that it is not just an academic exercise, but, rather, becomes a foundational approach to patient care.

**Agenda**

0-5 minutes: Welcome, presenters and participants frame their interest in the topic.
5-25 minutes: Dr. Mintz discusses the Overall Diagnosis and integration of formulation into daily practice
25-40 minutes: Dr. Cabaniss address the topic of "Finding the Why"
40-50 minutes: Interactive exercise led by Dr. Cabaniss - "Finding the Why"
50-70 minutes: Interactive exercise led by Dr. Ross: "What to say" - Integrating Meaning and Neuroscience
70-85 minutes: Group discussion
85-90 minutes: Workshop evaluation

**Scientific Citations**

Committee on Quality of Health Care in America, & Institute of Medicine Staff. (2001). Crossing the quality chasm: A new health system for the 21st century. National Academies Press.

Brenner, A. M. (2016). Revisiting the biopsychosocial formulation: neuroscience, social science, and the patient's subjective experience. Academic Psychiatry, 40(5), 740-746.

Cabaniss, D. L., Moga, D. E., & Oquendo, M. A. (2015). Rethinking the biopsychosocial formulation. The Lancet Psychiatry, 2(7), 579-581.

Ross, D. A., van Schalkwyk, G. I., & Rohrbaugh, R. M. (2016). Developing a Novel Approach for Teaching Biopsychosocial Formulation. Academic Psychiatry, 40(3), 540-542.

## Protecting your Trainees and your Program: How to deal with Trainee Unprofessionalism

**Presenters**
Ahmad Hameed, MD
Ken Certa, MD

**Educational Objective**
Educational objectives:
By the end of this seminar the attendees will be able to:

1. Describe steps for evaluating (and documenting) the conduct of trainee professionalism
2. Identify strategies for managing unprofessional trainees
3. List resources that might be available in dealing with issues of professionalism
4. Discuss the emotional, psychological, and administrative impact that unprofessional trainees have on their colleagues and the program

**Practice Gap**
Despite the best efforts of training directors and recruiting committees to select flawless trainees , some trainees will display unprofessional and troubling behavior during their training. These behaviors may initially fall short of gross unprofessional conduct but do raise concerns among staff members and trainees . Residency programs are often ill-prepared to define the line between acceptable, if unusual, behavior and frank misconduct which warrants administrative action or even termination. This 'grey zone' may include misuse of resources or time, sexualized comments and behavior, extreme displays of emotion etc. Training programs can be guided by therapeutic impulses to ignore the behavior or treat the trainees rather than to confront or punish the trainee . This can have an unintended, adverse impact on trainees or staff members who are witnessing the same behavior and having a different personal response. Trainees and staff can divide into pro-trainee and anti-trainee camps in a similar fashion as splitting occurs on inpatient psychiatric units. Few resources exist to help training directors consider and discuss these situations.

**Abstract**
This workshop will describe several cases of trainees who manifested, unexpected unprofessional and troubling behavior during their residency programs. Initially this behavior

might not be egregious enough to warrant immediate administrative action. Often the reports of troubling behavior were second or third hand, undocumented, and minimized or denied by the trainee . Among the cases to be discussed included trainees who:

- Taking extreme advantage of vacation and CME policies
- Taking extreme advantage of generous cafeteria policies
- Behavior detrimental to the profession, institution and the program outside working hours
- Sexual innuendos in the presence of other trainees and medical students
- Hearing and reading what they wanted to hear and read to justify their behavior and actions

We will discuss some of the aspects that make these cases so difficult. There are often delays in reporting concerns but once the first concern is voiced there is a "piling on" of complaints. Other trainees may be reluctant to "tattle" on a peer. Some faculty members may be prone to pathologize or explain away bad behavior and give the trainee third and fourth chances. Those same faculty members may exhibit a desire to be seen as "nice" and protective of the trainees . Decision makers like the Program Director may resist seeing the big picture and base their actions only on what they have personally experienced. Program Directors may also see identifying a failing trainee as a narcissistic injury to them which they resist.
Because of these factors, programs are often slow to react. Responding to these complaints requires the training director to either take on a potentially uncomfortable investigator role or to ignore unsubstantiated but concerning accusations from the staff and trainees. Programs often fail to appreciate the long-term impact that delaying action causes on trainees, their colleagues and the program. These behaviors can result in significant splits among trainees and faculty; between those who are ready to punish and those who deny that there is a problem or want to handle it therapeutically. The importance of thorough documentation will be stressed. Documentation should include signed statements from eyewitnesses as well as all documentation of the discussions and decisions concerning the trainee . We will review the options available to the training directors and review how they can select the most appropriate option.

Attendees will be invited to describe similar cases in their programs and how they resolved them.

**Agenda**

- Introduction of speakers – 5 minutes
- Description of case 1 – 5 minutes
- Large group discussion about appropriate behaviors – 10 minutes
- Description of case 2 – 5 minutes
- Small group discussion about appropriate behaviors – 10 minutes
- Description of case 3 – 5 minutes
- Large group discussion about appropriate behaviors – 10 minutes
- General principles for managing these troubling residents (Didactic) – 10 minutes
- Identification of resources for managing troubling residents (Didactic) – 5 minutes

- Cases from attendees – (Large Group Discussion) - 15 minutes
- Next Steps for residency programs - 10 minutes

**Scientific Citations**

References:
1. Chang, HJ, Lee, YM, Lee YH, Kwon HJ. Causes of resident lapses in professional conduct during the training: A qualitative study on the perspectives of residents. Medical Teacher, 2017; 39:278-284.
2. Fargen KM, Drolet BC, Philibert J. Unprofessional Behaviors Among Tomorrow's Physicians: Review of the Literature With a Focus on Risk Factors, Temporal Trends, and Future Directions. Academic Medicine, 2016; 91: 858-64.

## Community Based Psychiatry Program Development: A Practical Primer

**Presenters**

Tanya Keeble, MD
Elizabeth Ann Cunningham, DO
Kelly Blankenship, DO
Bill Sanders, DO, MS
Areef Kassam, MD

**Educational Objective**

1) Name 3 funding opportunities available for new program development, track development or expansion
2) Understand several effective approaches to developing faculty and resident scholarly culture in community based programs
3) Define one recruitment strategy likely achievable in your specific residency training setting
4) Have the contact details for at least one AADPRT peer that they can lean on for support or advice during the early years of program development

**Practice Gap**

Workforce development is a critical issue in the United States, with many parts of the country without any mental health provider, let alone psychiatrist. By 2030 the supply of psychiatrists is expected to decrease by approximately 27% given the number of psychiatrists entering, leaving, and changing work hours. Demand for psychiatrists is expected to increase by 6% over that timeframe, resulting in an estimated shortage of 21, 150 FTE psychiatrists by 2030. In 2019 AADPRT convened a specific taskforce to focus on this issue. In the 5 years leading up to academic year 18-19 we have seen a national burgeoning of new program development, most notably in the area of community based psychiatry residency training. In the 3 years prior to AY 18-19, we had a 31% increase in the number of newly accredited general psychiatry training programs (AY 2016-17 = 15 new programs, AY2016-17 = 19 new programs, AY 2017-18 = 22 new programs). In AY 18-19 only 9 new categorical programs were ACGME accredited, possibly due to a natural slowing after such a marked rise in new accreditation. Of newly accredited

programs, we have had a consistent increase in the percentage of new programs being community sponsored or based. In AY 2016-17, 10 out of 19 (52%) of the categorical programs were entirely community based programs, and this increased further in AY 2017-18, where 16/22 programs (72%) were community programs and AY 2018-19 6/9 (66%) were community based.

Thus, even with a marked decrease in the total # newly accredited programs in the past AY, the trend for non-university accredited program development continues.

It is clear from our 2017 and 2018 new program workshop polls of attendees, that AADPRT attendees include those who are in the planning stages of psychiatry residency development, are in the initial stages of accreditation or have not yet graduated their first class. There are currently few targeted resources available to guide new program development, with little collaboration around novel funding mechanisms, best practices for development of an educational community outside an academic institution, innovative rotation creation, faculty and resident recruitment and pathways to growth and fellowship development.

This workshop seeks to enable new or potential directors and faculty to learn from the work (and mistakes) of 3 newer community based psychiatry training programs and to develop contacts between programs who are struggling with similar challenges. The three programs presented include: Pine Rest/MSU Psychiatry residency in Grand Rapids Michigan, Providence Psychiatry Residency Program in Spokane, Washington, and Community Health Network Psychiatry Residency Program in Indianapolis, Indiana.

**Abstract**
New Psychiatry Programs are in development across the United States, with much of the growth occurring in community settings, either as track programs accredited by academic medical centers, or through consortium partnerships aimed at developing psychiatry workforce in underserved areas. Collaboration with new program partners is an effective way to develop best practices, understand the unique challenges of smaller, community based medical center programs, and walk through the accreditation process from the initial stages, through continued accreditation and beyond. We present work at three community centered psychiatry residency programs, each with unique attributes, who have worked together to share ideas, and support each other in creating high quality clinician based programs. Each program is in a different stage of development. Pine Rest/Michigan State University Psychiatry Residency in Grand Rapids, MI is the oldest program started and graduated its inaugural class in July 2018. It is an example of a larger community based program which moved quickly to offer fellowship options after starting its categorical program. The second program, Psychiatry Residency Spokane started as a track program of the University of Washington psychiatry residency program over 25 years ago, and developed into a stand-alone affiliated program, accepting its first class in 2015. This program recently began work on development of its first fellowship program, a State funded supported child and adolescent training program. The third program, Community Health Network Psychiatry Residency Program, is a community partnership which achieved ACGME accreditation in 2015 and has a novel funding mechanism.

New, community and small programs share many common strengths and challenges. This workshop will provide time for attendees to engage with peers and obtain concrete support as they develop their own programs. The speakers will share their experiences with the group from the earliest stage of program development, through initial and continued accreditation into fellowship development. The educational strategies will include: initial polling of the audience to gather information about the audience in order to shape the rest of the session to audience needs, didactic presentation, small group planning, and large group brainstorming work. The content will focus on funding structure strategies, development and maintenance of a scholarly culture, program expansion and creation of fellowship programs, and faculty and resident recruitment strategies (strong medical student clerkships and subI's, mentoring structures, fellowship opportunities and exposure to new models of care that address the underserved, including collaborative care and telepsychiatry.

**Agenda**

5 min
Overview of ACGME new psychiatry residency program accreditation in the past 5 years: community to academic program mix, program development (track versus stand alone, academic medical center accreditation versus affiliation.
Tanya Keeble
Didactic

10 min
Let's get to know a little about you, your programs, your main challenges what you hope to get out of attending this workshop
Areef Kassam
Tanya Keeble
Bill Sanders
Ann Cunningham
Poll
Small group discussion

20min
Sponsorship and funding
Bill Sanders
Didactic
Large group discussion

15min
How to right size your program including fellowship development
Kelly Blankenship
Didactic
Large group discussion

20min

Creating an scholarly culture
Tanya Keeble, Ann Cunningham
Didactic
Small group planning activity with large group report back

10min
Faculty and resident recruitment strategies
Tanya Keeble
Areef Kassam
Didactic
Large group brainstorming session

10 mins
Wrap up – did we address the objectives and do you have the contact details for an AADPRT peer
Areef Kassam
Large group discussion

**Scientific Citations**


1. Federal analysis of behavioral health workforce 2018. Accessed 10/23/19https://www.thenationalcouncil.org/capitol-connector/2018/12/new-federal-analysis-of-behavioral-health-care-workforce-released/
2. Behavioral Health Workforce Projections 2016-2030: Psychiatrists. HRSA National Center for Health Workforce Analysis.
3. Deborah S. Cowley, Tanya Keeble, Jeralyn Jones, Matthew Layton, Suzanne B. Murray, Kirsten Williams, Cornelis Bakker, Johan Verhulst. (April 2016). Educating Psychiatry Residents to Practice in Smaller Communities: A Regional Residency Track Model. Academic Psychiatry, Vol 40, number 2. DOI 10.1007/s40596-016-0558-3. PMID 27114242
4. List of Newly Accredited All programs Academic Year 2015-19: acgme.org. Accessed 10/23/19
5. https://www.aamc.org/news-insights/addressing-escalating-psychiatrist-shortage
6. AADPRT Workforce Task Force.


## Competency-Based Behavioral Interviewing: Using a structured interview method to enhance residency and fellowship interviews

**Presenters**
Ashley Walker, MD
Kristy Griffith, MD
Christine Langner, DO

**Educational Objective**

1. Identify the rationales and evidence-base supporting competency-based behavioral interviewing (CBBI) as an alternative or complementary approach to the traditional, less structured interviewing format.
2. Utilize a method to identify which competencies are most relevant to trainee success.
3. Utilize tools and workshop experiences to integrate CBBI into one's own training program.

**Practice Gap**

As the number of applications to psychiatry residencies and fellowships continues to rise, programs are faced with the challenge of how to effectively identify potentially successful applicants from among the large volume of applications received. One important evaluation method is the residency interview. However, faculty are often not trained in how to effectively interview program applicants, and interview methods may vary widely between and even within programs. Furthermore, traditional unstructured interviews may not consistently provide an adequate prediction of applicant success in the training program. The Association of American Medical Colleges (AAMC) has recently promulgated best practice recommendations for conducting residency and fellowship interviews, promoting structured interviews and standardized evaluation methods which aim to gather reliable and valid information (1). This workshop will detail a structured interviewing method called Competency-Based Behavioral Interviewing and will provide participants an interactive experience to train them in how to use this interviewing method for residency recruitment.

**Abstract**

Residency and fellowship recruitment is a complex process in which programs weigh many factors to determine how to rank applicants for the matching process. The formal interview typically weighs heavily in the determination of how to rank applicants, but interviewing methods vary widely among and even within programs. Furthermore, faculty are often not trained in how to effectively interview residency applicants. As the number of applicants to psychiatry residencies and fellowships continues to rise, programs are faced with the challenge of how to compare and rank applicants effectively for optimal fit. The AAMC acknowledges the challenges faced by programs, noting a dearth of resources to guide program faculty in how to conduct effective interviews and how to ensure standardized evaluations of applicants. The AAMC has promulgated best practice recommendations for conducting residency and fellowship interviews, promoting structured interviews and standardized evaluation methods, which aim to gather reliable and valid information. Competency-based behavioral interviewing (CBBI) is a structured interview method that uses job-related behavioral questions to predict applicants' performance in specific competency areas. Paired with standardized evaluation tools, this method may assist programs in better assessing applicant fit for their unique training experiences. This interactive workshop will introduce participants to one program's experience with using CBBI, and will engage participants in tasks including identifying program-specific competency areas, selecting competency-based questions that may predict success in a given training program, practicing using CBBI in small groups, and practicing using a standardized evaluation tool for measuring an applicant's performance in the interview. Participants will

leave the workshop prepared to implement CBBI in their own programs as a complementary or alternative interview method to assist with residency applicant selection for ranking.

**Agenda**

1. 5 min - Introductions and defining the practice gap
2. 10 min - Define CBBI and its evidence-base
3. 5 min - Introduction to identifying competencies
4. 10 min - Practice identifying relevant competencies using 3-3-3 method
5. 10 min - Interview questions, rating scales, and interviewer training
6. 5 min - Interview demonstration
7. 15 min - Practice the CBBI interview (small groups)
8. 5 min - Practice using rating scales
9. 10 min - Sharing what we've learned and how to tailor the process
10. 15 min – Questions, discussion, session evaluation

**Scientific Citations**

1. Best Practices for Conducting Residency Program Interviews. Association of American Medical Colleges. Washington, D.C. 12 September 2016. https://www.aamc.org/download/469536/data/best_practices_residency_program_interviews_09132016.pdf

## Adventures in Active Learning: Active Learning Resources to Fit Any Budget

**Presenters**

Lillian Houston, MD
Cesar Cardenas, Jr., MD

**Educational Objective**

At the end of the workshop, participants should be able to:

1. Describe adult learning theory
2. Describe several available online learning tools (Nearpod, Factile, and Educaplay) and their relative strengths and weaknesses, including associated costs.
3. Design their own classroom activities utilizing both available online resources and offline (board game-based) resources.

**Practice Gap**

The study of andragogy has led to the rise of active learning techniques at multiple levels of education, including medical student and resident education. Studies thus far indicate that active learning greatly enhances long-term retention of material and its integration into clinical practice. However, educators often lack the time and/or finances to locate new teaching resources, making it difficult to embrace new teaching methodology. Workshops presented at educational conferences often highlight the same resources repeatedly, which does not assist attendees already familiar with these resources. This workshop was created to highlight resources that have not been featured at prior conferences. The material was recently presented at the Association for Academic Psychiatry 2019 Annual Meeting and was both well-

attended and well-received, demonstrating the need that educators feel for new material and new concepts in teaching.

**Abstract**
Andragogy is a term popularized by Malcolm Knowles which refers to the methodology of teaching adult learners. Studies in this area have provided changes to teaching methodology across multiple settings, including medical school and residency. The use of active learning methodology has the potential to foster adaptive expertise and to create true lifelong learners. However, locating useful resources can be difficult when instructors have limited protected time and/or budgetary constraints. This workshop will draw from the presenters' experience in locating, appraising, and creating interactive classroom activities to demonstrate the use of online and offline resources that may be new to the audience with an emphasis on accessibility and budget. The group will participate in short demonstrations of 3 online resources (Nearpod, Factile, and Educaplay) and 2 offline resources (Pictionary and Taboo). The group will then reconvene to discuss how the resources and techniques demonstrated can be utilized at their home institutions to create memorable and engaging learning activities. Participants are highly encouraged to bring an electronic device with internet access and to download the Nearpod app prior to attending.

**Agenda**
Introduction of leaders and attendees – 5 minutes

Presentation on the background and practice of andragogy with integrated presentation of Nearpod capabilities/costs – 15 minutes

Presentation of offline activities with discussion of how to choose and develop offline activities – 20 minutes

Presentation of other online resources with discussion of capabilities and costs – 30 minutes

Group discussion/Q&A session – 20 minutes

**Scientific Citations**
Bishop, J. L., & Verleger, M. A. (2013, June). The flipped classroom: A survey of the research. In ASEE national conference proceedings, Atlanta, GA (Vol. 30, No. 9, pp. 1-18).
Bonwell, C. C., & Eison, J. A. (1991). Active Learning: Creating Excitement in the Classroom. ERIC Digest.
Knowles, M. S., Holton III, E. F., & Swanson, R. A. (2012). The adult learner. Routledge.
Mayer, R. E. (2010). Applying the science of learning to medical education. Medical education, 44(6), 543-549.
Merriam, S. B. (2001). Andragogy and self?directed learning: Pillars of adult learning theory. New directions for adult and continuing education, 2001(89), 3-14.
Miller, B. M., Moore Jr, D. E., Stead, W. W., & Balser, J. R. (2010). Beyond Flexner: a new model for continuous learning in the health professions. Academic Medicine, 85(2), 266-272.

Prince, M. (2004). Does active learning work? A review of the research. Journal of engineering education, 93(3), 223-231.

## *WITHDRAWN* -- To Retreat or Not to Retreat: Strategic Use of Resident Retreats as a Wellness Tool with Cues from the Corporate World

**Presenters**
Victoria Kelly, MD
Thomas Roach, DO
Nathan Massengill, MD
Zoellen Murphy, CTAGME
Krisi Williams, MD

**Educational Objective**

1. Identify the role resident retreats have in improving resident wellness, leadership, and cohesion.
2. Review executive coaching strategies from the business field and recognize components that can be incorporated into resident retreats
3. Use a “SWOT matrix” (Strengths, Weaknesses, Opportunities, and Threats) to analyze a mock residency program and develop a sample retreat agenda
4. Identify challenges & potential solutions to resident retreat planning

**Practice Gap**

"Coming together is a beginning. Keeping together is progress. Working together is success.” – Henry Ford

The Merriam-Webster dictionary defines a retreat as “a period of group withdrawal for prayer, meditation, study or instruction under a director” [1]. A retreat provides residents a time to bond with their colleagues, which fosters physician and program wellness. This bonding experience helps residents build better working relationships with their peers, which lowers burnout rates [2]. Resident retreats help trainees master the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Psychiatry & Neurology’s (ABPN) psychiatry core competency expectations of ‘Interpersonal and Communications Skills’, ‘Professionalism’, and ‘Systems-Based Practice’ [3].

Searching Pubmed for “resident retreat,” “wellness” and/or “burnout” yielded only 15 results. Of those, one result found radiology residents to have improved camaraderie after a retreat [4]. Another result found emergency medicine residents had increased team building, resident bonding, and faculty-resident bonding after an “Amazing Race” style retreat [5]. Several more results pertained to pharmacy students and family practice. Although one article discussed using a research retreat to improve career development opportunities for psychiatry residents, it focused on a regional conference rather than the traditional residency retreat [6]. Most notably, no literature was found providing guidance to programs on planning retreats or

psychiatry-specific data on residency retreats. This is especially meaningful, given that 43.9% of psychiatry residents in 2018 noted symptoms of burnout [7].

Chief residents are often sent to “Leadership” trainings, where the most valued skills learned are giving feedback, delegating duties, building teamwork, managing time, making presentations, being on rounds, coping with stress, teaching at the bedside, writing memos, and managing meetings [8]. However, there is a lack of formal training in leadership skills at the program level. A resident retreat is a useful tool for program leadership (director, coordinator, chief resident) to develop or reinforce leadership skills and address the specific and unique needs of the individual program. The ability to function as a physician leader and demonstrate interprofessional skills are addressed in the ACGME Adult Psychiatry milestones of MK6 (Practice of Psychiatry) and SBP1 (Patient Safety and the Health Care Team), PBLI1-2.1A & 2.2A (Development and execution of lifelong learning through constant self-evaluation), and PBLI3 (Teaching) [9].

Formal education and discussion of retreat planning as a wellness tool will empower program directors and chief residents to be more prepared in addressing challenges residents encounter. Having a strategic plan for resident retreats allows for demonstration of managerial skills, fosters interpersonal and professional growth, and addresses burnout all within a bonding experience. Resident retreats also assist in the cultivation of professional development as found within the ACGME milestones PROF2 (Accountability to self, patients, colleagues, and the profession), and ICS1 (Relationship development and conflict management with patients, families, colleagues).

**Abstract**

“In order to understand the world, one has to turn away from it on occasion." – Albert Camus, The Myth of Sisyphus and Other Essays

In the changing climate of healthcare, resident psychiatrists are expected to conquer challenging professional and interpersonal terrains while progressing academically, often without formal training in how to do so. [10]. Poor work-life balance, the changing role of the physician in the healthcare setting, and dealing with conflicts in professional and personal lives, have all been shown to contribute to burnout in physicians. Burnout is a well-known, but not well-defined, problem that has been shown to be particularly high in residents. Now more than ever, trainees need formal guidance on how to prevent burnout and develop professionally while navigating this ever-changing landscape.

Interventions designed to increase well-being and decrease burnout include individual level approaches directed toward enhancing individual well-being as well as systemic interventions aimed at changing workplace factors such as culture, leadership, autonomy, and workflow. These workflow factors include assistance with administrative burdens, increasing physician autonomy) [11]. For residents, factors that contribute to burnout require interventions. These include demands on time, lack of control, work planning, organization, inherently difficult job situations, and interpersonal relationships [12]. In 2015, a national panel of United States

multispecialty residents and fellows specifically recommended resident retreats as a way to increase resident wellness activities [13]. One of the best ways to improve the performance of a medical practice team is to hold a team retreat [14]. A major goal of a retreat is to encourage socialization in an informal setting, allowing barriers to be broken down, and improving teamwork [15]. In medicine, this may indirectly impact patient care due to teamwork factors affecting patient handoff and coverage issues.

Program directors, coordinators / administrators, and chief residents have a unique opportunity to use resident retreats strategically in several ways: as a wellness tool, to evaluate the program's strengths / weaknesses / opportunities / threats, to identify individual professional development needs, to promote bonding, and potentially enact larger departmental change. Incorporating cues from the corporate world provides resident retreats with the general framework that can be adapted to the unique needs of the individual psychiatry residency programs.

To address this need, our interactive workshop will discuss corporate & coaching approaches, potential benefits & impact on residency programs, and ways to enhance the experience. Participants in the workshop will have the opportunity to examine their own program, practice creating an optimal retreat agenda, and discuss challenges & potential solutions for an effective retreat. Upon completion of this workshop, the participant should have an increased knowledgebase and confidence in the ability to strategically plan a resident retreat that will benefit the residents and the program.

**Agenda**

1. 15 minutes – Introduction, Overview, and Why a retreat is important (wellness, milestones & competencies, professional development, and borrowing from the business world)
2. 10 minutes – Breakout – How a retreat could make your program better
3. 15 minutes – Strategic planning and building your retreat - components of agenda, structure, goals like leadership support, program evaluation, teambuilding, and consideration of lasting gains
4. 20 minutes – Breakout – given a standardized scenario, evaluate a mini-SWOT and create a retreat agenda
5. 10 minutes – Breakout – challenges that programs face to making retreats happen successfully
6. 10 minutes – Final discussion points and sample retreat agenda
7. 10 minutes – Wrap up and questions

**Scientific Citations**


1. Definition of Retreat, Merriam-Webster, www.merriam-webster.com/dictionary/retreat.
2. Lee, Huan-Fang, et al. "A Meta-Analysis of the Effects of Coping Strategies on Reducing Nurse Burnout." Applied Nursing Research, vol. 31, 2016, pp. 100–110., doi:10.1016/j.apnr.2016.01.001.?

3. ABPN Board of Directors. ABPN Psychiatry Core Competencies Outline, 22 July 2011, www.abpn.com/wp-content/uploads/2015/02/2011_core_P_MREE.pdf.?
4. Haber MA, Gaviola GC, Mann JR, et al. Reducing Burnout Among Radiology Trainees: A Novel Residency Retreat Curriculum to Improve Camaraderie and Personal Wellness - 3 Strategies for Success. Curr Probl Diagn Radiol. 2019;?
5. Cornelius A, Cornelius BG, Edens MA. Increasing Resident Wellness Through a Novel Retreat Curriculum. Cureus. 2017;9(7):e1524.?
6. Besterman AD, Williams JK, Reus VI, Pato MT, Voglmaier SM, Mathews CA. The Role of Regional Conferences in Research Resident Career Development: The California Psychiatry Research Resident Retreat. Acad Psychiatry. 2017;41(2):272-277.
7. Dyrbye LN, Burke SE, Hardeman RR, et al. Association of Clinical Specialty With Symptoms of Burnout and Career Choice Regret Among US Resident Physicians. JAMA. 2018;320(11):1114–1130. doi:10.1001/jama.2018.12615
8. Lim RF, Schwartz E, Servis M, Cox PD, Lai A, Hales RE. The chief resident in psychiatry: roles and responsibilities. Acad Psychiatry. 2009;33(1):56-9.
9. Thomas, Christopher R. Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurololgy, 6 Nov. 2015, www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf?ver=2015-11-06-120520-753.
10. Thakur A, O'leary B, Cowie W, Soklaridis S. The Development and Validation of a Workplace-Based Leadership Program for Senior Residents in Psychiatry. Acad Psychiatry. 2019;43(1):123-127.
11. “Well-Being and Burnout.” American Psychiatric Association, www.psychiatry.org/wellbeing.
12. Ishak, Waguih William, et al. “Burnout During Residency Training: A Literature Review.” Journal of Graduate Medical Education, vol. 1, no. 2, 2009, pp. 236–242., doi:10.4300/jgme-d-09-00054.1.
13. Daskivich, Timothy J., et al. “Promotion of Wellness and Mental Health Awareness Among Physicians in Training: Perspective of a National, Multispecialty Panel of Residents and Fellows.” Journal of Graduate Medical Education, vol. 7, no. 1, 2015, pp. 143–147., doi:10.4300/jgme-07-01-42.
14. Hills L. How to improve the performance of a good medical practice team: twelve techniques. J Med Pract Manage. 2013;28(6):378-81.
15. Goodale JG. Effective teamwork and productivity conferences. Clin Lab Manage Rev. 1994;8(3):241-5.

# No More Sitting and Staring at Powerpoint! Using Interactive Teaching Techniques to Enhance Meaning-Making in Trainee Didactics

**Presenters**
David Hankins, MD, MS
Julie Penzner, MD
Mark Sullivan, MD
Susan Samuels, MD

**Educational Objective**
By the end of this workshop, participants will be able to:

1. Explain how incorporating active learning techniques into formal didactic sessions is evidence-based and tied to improved learner outcomes
2. Describe at least five active learning techniques that can be incorporated into didactic sessions
3. Anticipate and address barriers to the implementation of active learning techniques
4. Create a new psychiatry didactic session incorporating active learning techniques

**Practice Gap**
When trainees at many medical schools and psychiatry residencies walk into a one-hour didactic session, they know exactly what to expect: sixty minutes of an instructor talking at them, often aided by a set of PowerPoint slides. Lecture-based instruction persists in many settings despite decades of research supporting active learning techniques as means to propel adult learners to higher, more enduring understanding.

Trainees have grown accustomed to passive teaching and learning, and may struggle to even imagine alternative methods. Instructors of didactics for psychiatry trainees have typically trained within the same lecture-driven approach without any formal instruction in pedagogical methods. Lectures are often prepared in advance, and delivered by rote, obviating opportunities for meaning-making for either teacher or learners. Many teachers and learners have identified that the current approach is sub-optimal, but tools to teach and learn differently are not readily available.

Passive presentation formats root learners firmly in the lower two levels of Benjamin Bloom's landmark Taxonomy of Educational Objectives ("knowledge" and to some extent "comprehension") (Bloom 1956), offering no opportunity for learners or teachers to create meaning from the new material by application, analysis, synthesis, or other creative uses. In the context of medical education, research in active learning has focused on problem-based learning and a flipped curriculum model. Both approaches are most readily implemented at the institutional level, in larger, extended courses. But what can one individual teacher, asked to teach a class, do to incorporate active learning techniques into a one-hour session? What can one teacher do if they have rarely or never participated in active learning settings themselves? Finally, how can teachers and learners maximize meaningful contact not just with course

material, but with one another, as we all strive to defend against burnout and promote well-being? Deliberate use of active learning techniques offers opportunity for higher-order learning, as well as for meaningful interpersonal contact between class participants.

**Abstract**
Medical students and psychiatry residents spend considerable time learning key concepts in one-hour didactics taught by teachers who are further along on the training continuum. Frequently, didactic sessions follow a time-worn format: an hour-long lecture with hundreds of factoids of varied importance. Typical didactics are short on learner participation and create little enduring opportunity for learners to use the information meaningfully. Furthermore, most teachers of residency didactics do not have formal educational training, nor have they experienced active learning during their own training. Thus we aim to offer active learning examples that can be readily implemented by novice faculty in psychiatry classes.

Our workshop will review basic educational theory (actively!) and consider evidence supporting the use of active learning to achieve higher-order comprehension. Active learning techniques have been shown to improve retention and ability to activate and apply new material, to increase teacher and learner enjoyment of class, and to improve collaboration. Over-reliance on passive learning misses opportunities for higher-order use of material. We introduce participants to a variety of active learning techniques available for immediate incorporation into didactics, with the goal of increasing learners' interest, enjoyment, and retention. A side benefit is that as learners are more active and engaged, teachers are likely to feel similarly, therefore infusing meaning into teaching, and encouraging real classroom interpersonal contact. The workshop co-leaders, two of whom have formal training as classroom teachers, have implemented active learning techniques in varied settings and in groups of between 3 and 50 medical students and psychiatry residents with success (and some complaining—which they will talk about too!).

Techniques to be modeled include audience response mechanisms for large-group settings, paired and small-group approaches for larger classes (think-pair-share, K-W-L charts, gallery walk, jigsaw method), and options for written responses to the new material. Techniques modeled in this workshop are particularly useful because they can be incorporated into any didactic presentation regardless of institutional policies regarding active learning (e.g. problem-based learning or flipped curriculum). Anecdotally cited barriers to the use of active learning techniques include minimal participant willingness to prepare before class, lack of teacher knowledge of techniques, fear that students will hate it, and lack of time to implement new methods. We will consider these barriers during the workshop.

Our workshop helps close the practice gap by providing participants with specific techniques that they may have never seen used before, but can readily apply to make learning sessions more active. Participants will learn the evidence supporting the use of active learning techniques and will engage with techniques in the workshop itself. Therefore participants will have a chance to see how these new techniques can actually work, to practice their use, to ask questions and address potential challenges, and to decide which of the techniques fit best with

their personal approach to teaching. As we all struggle to "reclaim meaning through teaching," we purport that deliberate use of the active learning strategies practiced in this workshop will confer both educational and psychological benefit to teachers and learners alike.

**Agenda**

0:00 – 0:25 Introductions, presentation of evidence on active learning techniques, and discussion of barriers to incorporating active learning, using interactive modeling of multiple active learning techniques

0:25 – 0:40 Gallery Walk – will reinforce new concepts and model an active learning technique

0:40 – 1:05 Small Group Activity: Reclaiming a Didactic Session – participants will work in small groups to re-create an early psychiatry trainee didactic on a common topic, changing it from one hour of PowerPoint presentation to a more interactive format using techniques discussed in the workshop.

1:05 – 1:20 Each group will share its work with the larger group

1:20 – 1:25 Review of key points and learning objectives

1:25 – 1:30 Participant review

**Scientific Citations**

Bloom, B. S. (1956). Taxonomy of educational objectives: The classification of educational goals. New York: Longmans, Green.

Freeman, S., Eddy, S. L., McDonough, M., Smith, M. K., Okoroafor, N., Jordt, H., & Wenderoth, M. P. (2014). Active learning increases student performance in science, engineering, and mathematics. Proceedings of the National Academy of Sciences, 111(23), 8410-8415.

Markant, D. B., Ruggeri, A., Gureckis, T. M., & Xu, F. (2016). Enhanced memory as a common effect of active learning. Mind, Brain, and Education, 10(3), 142-152.

Muzyk, A. J., White, C. D., Kinghorn, W. A., & Thrall, G. C. (2013). A psychopharmacology course for psychiatry residents utilizing active-learning and residents-as-teachers to develop life-long learning skills. Academic Psychiatry, 37(5), 332-335.

Roediger III, H. L., & Butler, A. C. (2011). The critical role of retrieval practice in long-term retention. Trends in cognitive sciences, 15(1), 20-27.

Taylor, D. C., & Hamdy, H. (2013). Adult learning theories: Implications for learning and teaching in medical education: AMEE Guide No. 83. Medical teacher, 35(11), e1561-e1572.

# Recruitment vs. Selection: Minimizing Systematic Bias During the Match Process

**Presenters**
Christin Drake, MD
Deepti Anbarasan, MD
D Bhatt, MD, PhD
Tyra Bailey, MA

**Educational Objective**
Participants will:

1. Understand the systematic biases inherent to the tools we use to evaluate applicants to our residency programs.
2. Experience their own susceptibility to these biases.
3. Learn about the presenters' experiences implementing a less-biased recruitment process at NYU
4. Consider and discuss strategies to minimize the bias in their own recruitment processes

**Practice Gap**
We are all making great efforts to meet the treatment needs of the diverse populations we serve and the educational needs of our residents. Many departments are rightly focused on recruiting applicants who are members of groups historically underrepresented in psychiatry as a part of their strategy to mitigate barriers to care and race-based structural problems with access and quality. However, many of the tools available to us to evaluate candidates for residency training have been developed in systems that are, themselves, biased against underrepresented groups. Additionally, there is more and more cause to question whether the tools we use to predict applicants' success as residents are reliable even without the concerns around bias. This results in a recruitment and selection process that may work in opposition to our ability to build the diverse residency programs and workforce that we know are needed.

**Abstract**
Out of concern for difficulty faced in recruiting a diverse class of residents one year ago and an ever growing literature showing the systematic biases embedded in the residency selection process, the New York University Psychiatry Residency training office developed and implemented a system for recruitment designed to minimize the impact of bias on our final rank list. We were first convinced through group discussions and independent reflection of our own biases and the risks related to these biases influencing our selection process. We then reviewed the literature and developed a plan to blind our interviewers to all but the personal statement and CV of the applicants they would meet. We oriented a large group of interviewers to the data supporting the new procedure and requested that each interviewer perform their own Implicit Assumption Testing to prepare themselves for the interview.

In this workshop, we will share what we have learned in this process and its impact on the representation of underrepresented students on our rank and match lists. There have been interesting dynamics to observe, technical issues to navigate, and some pitfalls that we hope

will be useful to others. We will also offer the opportunity for attendees to participate in a mock applicant rating exercise that will help them examine their own biases and their impact on how participants assess candidates. Finally, we will ask participants to consider how they might implement similar strategies in their home departments and help anticipate how to address challenges they may face.

**Agenda**
Introduction and Background - 10 minutes

Breakout Session #1 - Exercise in rating composite applicants - 15 minutes

Post-breakout Debrief #1- 10 minutes

Presentation of workshop leaders' recruitment approach - 10 minutes

Details of implementation, pitfalls and lessons learned - 10 minutes

Breakout Session #2 - Exercise rating applicants with bias-minimized materials - 15 minutes

Post-breakout Debrief #2 - 10 minutes

Sharing results of our rank/match and unblinding of ratings given by workshop participants in the session - 10 minutes

**Scientific Citations**
https://www.ncbi.nlm.nih.gov/pubmed/?term=Academic+Medicine.+94(4)%3A562–569%2C+APRIL+2019

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2607210

https://www.ncbi.nlm.nih.gov/pubmed/29923892

https://www.jgme.org/doi/10.4300/JGME-D-18-00979.3

## Reclaiming Meaning for Everyone: exploring power, privilege, and allyship with psychiatry residents

**Presenters**
Jackie Wang, MD
Isela Pardo, MD
Belinda Bandstra, MD, MA

**Educational Objective**

1. Define privilege and allyship, discuss how these concepts relate to power dynamics within the practice of psychiatry
2. Demonstrate interactive, self-reflective, experiential activities that can be used to explore these concepts with psychiatry trainees
3. Discuss opportunities and challenges to implementing curricula on power, privilege, and allyship at participants' home institutions

**Practice Gap**

Psychiatry residents and the patients they serve are becoming increasingly diverse, but residents are not necessarily receiving training on how to navigate differences between their own identities and those of their patients, which may or may not be familiar to trainees.

The ACGME's accreditation standards for psychiatry residency programs state that residents are required to "demonstrate knowledge of … social-behavioral sciences, as well as the application of this knowledge to patient care." The required knowledge base includes "aspects of American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power." Many trainees may recognize that differences in cultural identity, values and preferences, and perception of power may exist between them and their patients, but may not feel adequately trained in how to identify, process and address these differences in a clinical setting. The experiential learning they do receive may be ad-hoc based on specific clinical encounters, rather than deliberately planned sessions designed to (1) acknowledge the affective potency that these topics elicit and (2) provide intentional space for self-reflection and group discussion.

**Abstract**

"The cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power" are important for psychiatry residents to understand not only because of ACGME accreditation standards, but because these elements pervade all clinical encounters between psychiatrists and their patients, whether or not they are explicitly acknowledged and discussed. Privilege, defined as an unearned advantage given by society to all members of a dominant group and resulting from marginalization of another social group, is one important way in which personal identity intersects with power dynamics. Allyship is an active, consistent, and arduous practice of unlearning and reevaluating that those with privilege use to act in solidarity with a marginalized group. These concepts can provide a helpful lens for residents to explore "the dynamics of differences" in power and identity between themselves and their patients, and consider how they might navigate these differences. However, these topics are often affectively charged and can be challenging to confront. Educational sessions about power and identity must therefore be predicated on the tenets of cultural humility, including an emphasis on self-reflection, open discussion, and shared learning in order to engage all learners.

In this workshop, we will demonstrate key activities from a three-session didactic series given to PGY2 residents to introduce them to concepts of power, privilege, and allyship in clinical contexts. These activities are designed explicitly to: feel accessible to an audience with diverse perspectives and experiences regarding these topics; incorporate self-reflection about one's own relevant experiences, both personal and clinical; be experiential and interactive; ground the discussion in specific, real-life clinical scenarios. The presenters will provide reflections on their experience designing and facilitating the didactic series, including challenges encountered and reflections on Reclaiming Meaning Through Teaching. Throughout the workshop, participants will discuss strategies to implement similar sessions into their own training curricula and barriers to implementation.

**Agenda**

Introduction (10 min)

1. Power: individual self-reflection activity about power hierarchy in one's home clinical setting (7 min), followed by small or large group discussion, depending on size of workshop (8 min) and didactic contextualization (5 min)
2. Privilege: media introduction to privilege (3 min), followed by small or large group discussion (7 min)
3. Allyship: pair-share activity of clinical scenarios with complex power dynamics (15 min), didactic introduction to allyship (5 min), followed by large group discussion (10 min)
4. Small group brainstorm opportunities and barriers for implementing curriculum at home institution (7 min)
5. Large group share-out, debrief and questions (8 min)
6. Whova feedback (5 min)

**Scientific Citations**


1. ACGME Program Requirements for Graduate Medical Education in Psychiatry. Effective July 1, 2019: https://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pfcatid/21/Psychiatry.
2. Hansen H, Braslow J, Rohrbaugh R. From cultural to structural competency: training psychiatry residents to act on social determinants of health and institutional racism. JAMA Psychiatry. 2018; 75(2): 117-118.
3. McIntosh P. "White privilege and male privilege: a personal account of coming to see correspondences through work in women's studies." 1988.
4. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved. 1998 May; 9(2): 117-125.
5. Willen S, Bullon A, Good M-J. Opening up a huge can of worms: reflections on a "cultural sensitivity" course for psychiatry residents. Harvard Review of Psychiatry. 2010 July/August; 18(4): 247-253.
6. Wu D et al. The efficacy of an antioppression curriculum for health professionals. Family Medicine. 2019; 51(1): 22-30.

# Being a Peer Reviewer: Why and How?

**Presenters**
Rashi Aggarwal, MD
Adam Brenner, MD
Richard Balon, MD
Ann Tennier, BA, BS

**Educational Objective**
At the end of the workshop, participants will be able to:
1. Recognize the benefits of serving as a reviewer for an academic journal,
2. Appreciate the qualities of a good reviewer,
3. Identify the components of a review,
4. Understand how to effectively use reviewer feedback to improve their manuscripts,
5. Practice assessing the quality of reviews provided by others.

**Practice Gap**
While serving as a reviewer for academic journals is considered an essential part of being an academic faculty and educator, there is usually no formal training on how to be a reviewer. In general, there is no formal feedback system on the quality of reviews provided. There are no mechanisms available to faculty who are interested in learning how to do good reviews or how to improve the quality and effectiveness of their reviews.

**Abstract**
The peer review process is an essential and central aspect of scientific publication. Despite that, there is usually no formal process for training to become a reviewer. In addition, while the importance of peer reviewers is clear to anyone aspiring to publish as well as to the editors of academic journals, the benefits of serving as a peer reviewer can be less clear to potential reviewers. Serving as a reviewer can help academic faculty in several ways including enhancing their own learning, establishing their identity as an academician, and adding substantially to their CV.

While there are no formal qualifications to be a reviewer, good reviewers possess some essential skills which can be developed. Workshop attendees will learn the structure and the components of a review that is helpful to both authors and journal editors. Such a review examines the suitability of the manuscript for the journal by looking at its relevance and quality, including clarity of the study design and of the writing. This task can appear intimidating to many new faculty. In this workshop, we will clarify the steps of a review, assess the typical time commitment, and go over the process of writing the review. We will also discuss how to develop subject matter expertise and how to do effective reviews when at the beginning of your career.

This workshop will be interactive and practical and will be beneficial to both potential and experienced reviewers as well as to potential authors. Interested participants will be able to sign up to be a reviewer for Academic Psychiatry at the end of the session.

**Agenda**

1. Introductions (5min)
2. Benefits of being a peer reviewer: Why should you be a reviewer? (5 min)
3. How to become a reviewer and what does it entail? (10 min)
4. Qualities of a great reviewer (15 min)
5. Using the reviews: Tips for authors (optional) (10min)
6. Practicum-Rate the quality of reviews (10min)
7. Practicum- Try your hand at reviewing (15min)
8. Discussion (20 min)

**Scientific Citations**


1. Bordage G, Caelleigh AS: A tool for reviewers: "Review Criteria for Research Manuscripts." Acad Med 2001; 904–908
2. Jacobson R.M., Fairbrother G., Sheldrick R.C, et al. The role of the peer reviewer. Acad Pediatr., 17 (2017), pp. 105-106
3. Roberts L.W., Coverdale J., Edenharder K. et al. Acad Psychiatry (2004) 28: 81.
4. Roberts, L.W. Acad Psychiatry (2002) 26: 221.
5. Tandon R. How to review a scientific paper. Asian Journal of Psychiatry, 11 (2014), pp. 124-127


## How to become a Journal Club Superstar!

**Presenters**


Lindsey Pershern, MD
Adriane Dela Cruz, MD, PhD


**Educational Objective**

After participating in this workshop, participants will be able to:

1. Identify potential benefits associated with a structured journal club activity
2. Experience a structured journal club activity
3. Discuss new journal club format and compare/contrast to current journal club format/s at home institution
4. Consider application of this journal club format to address their own challenges at home institution

**Practice Gap**

Journal club, a gathering of colleagues to discuss a medical literature article, has been a part of medical education since the time of Osler, and the role of journal club in undergraduate and graduate medical education has been studied for more than 30 years. In theory, journal clubs in

graduate medical education typically serve dual roles of teaching skills in critical appraisal of the literature and keeping residents and faculty up-to-date on key findings. In practice, however, these sessions are often staid presentations in which the journal club leader presents a summary of the article with little discussion amongst journal club attendees. In our residency program, we identified a need to enrich the journal club experience, as few residents enter GME training with strong skills in literature appraisal and residents consistently reported feeling unable to fully engage in the journal club due to the lack of these skills. A small, early study suggested that journal club is not an effective way for psychiatry residents to learn critical appraisal skills [1], at least over a 12 week period in which the journal club format consists of resident-selected articles and a single resident leading the discussion of each article. More recent work has highlighted the importance of utilizing a format that encourages the active participation of multiple residents [2], meeting monthly [3], clearly stating the goals of the journal club [3, 4], and articulation of reasons for article selection for discussion [4], and emphasizing the connection of the article to clinical practice [3, 5]. We are guided also by the incorporation of these topics into resident training requirements in multiple milestone sub-competencies including PBLI1, PROF2, PC3, PC5, MK1, MK3[6]. These changes to journal club allow each resident to consider the importance of the selected articles to their practice.

**Abstract**

Gaining familiarity and comfort with reading the psychiatric literature is a critical skill for all trainees to gain during residency. Additionally, residents need knowledge of foundational findings in the literature to provide evidence-based care and for successful completion of in-training and board exams. Many residents do not gain skills in critical appraisal of the literature in medical school and need to actively learn skills for reading the literature in residency. To address this gap, we have developed a comprehensive journal club curriculum, Journal Club Super Star, recently published as an AADPRT model curriculum. The Journal Club Super Star curriculum provides three documents for each journal club session: the preguide, the article, and the postguide. The preguide contains a list of questions specific to the article to help residents engage with the article and to highlight aspects of the research design. The preguide emphasizes areas in which the authors made critical decisions in either the study design or the presentation of the outcomes. Each preguide contains a "technical point" that poses a specific question about statistics and design. The postguide provides a brief summary of the article, highlighting both the strengths and the weaknesses of the design and analysis, and addressing the "technical point." The discussion in the postguide ensures that consistency among information taught across all groups. Over the course of the PGY2-4 curriculum, residents read and critique the major effectiveness trials (e.g., STAR-D, STEP-BD), traditional randomized controlled trials, neuroimaging and human laboratory studies, large cohort analyses, and other pertinent literature. The PGY1 curriculum focuses on major effectiveness trials and pairs each article from the primary literature with a brief review article focused on research design and statistics. All articles are selected by the course directors to ensure that high quality articles on a variety of topics utilizing different techniques are included in the journal club. This curriculum has been well accepted by residents, with residents evaluating the journal club sessions in the good (3/5) to very good (4/5) range and rating the sessions as equally strong in development of psychiatric knowledge and development of skills in reading the literature. The curriculum also

received high ratings from the AADPRT model curriculum peer reviewers with all domains rated as “excellent” or “outstanding” and with a total score of 36 out of a possible 40 points. In this workshop, we will provide an overview of the Journal Club Super Star Curriculum, including a review of the primary literature articles covered by the curriculum. Workshop attendees will then break into small groups and hold an abbreviated journal club session, utilizing materials from the curriculum. We will then discuss the implementation of these materials in attendees’ home programs. Programs currently using the Journal Club Super Star curriculum are encouraged to attend to discuss their experiences with these materials.

**Agenda**

For a 90 minute workshop, the timeline would be as follows:

0:00-0:20

- Introduction of presenters and participants
- Overview of learning objectives and poll of audience of interest in topic and personal goals of participation
- Introduction to journal club materials and PGY2-4 vs PGY1 curriculum

0:20- 0:55

- Small group journal club session
- Participants will be asked to divide into groups of 10
- Each group will conduct a mock journal club using provided materials

0:55 - 0:75

- Small group reflections
- Participants will reflect on what did and did not work with utilizing the journal club materials
- Participants will be encouraged to compare/contrast presented materials to those used at home institution

0:75-0:90

- Large group discussion and question/answer with session leaders followed by conclusion

**Scientific Citations**


1. Fu et al. (1999) Is a Journal Club Effective for Teaching Critical Appraisal Skills. Academic Psychiatry 23(4): 205-209.
2. Rodriguez and Hawley-Molloy (2017). Revamping Journal Club for the Millenial Learner. Journal of Graduate Medical Education 9(3): 377-378.
3. Deenadayalan et al (2008). How To Run an Effective Journal Club: A Systematic Review. Journal of Evaluation in Clinical Practice 14: 898-911.
4. McLeod et al (2010). Twelve Tips for Conducting a Medical Education Journal Club. Medical Teacher 32(5): 368-370.
5. Hartzell et al (2009). Resident Run Journal Club: A Model Based on the Adult Learning Theory. Medical Teacher 31(4):e156-e161.
6. ACGME and ABPN. The Psychiatry Milestone Project. July 2015

# 2020 Poster Listing

## Implementing Individualized Feedback into a Psychiatry Resident Outpatient Clinic

**Presenters**
Samar McCutcheon, MD
Anne-Marie Duchemin, MD

**Educational Objective**
1. Review current approaches to resident feedback
2. Describe implementation of a new feedback method into an outpatient resident clinic
3. Summarize the resident perceptions and assessment of individualized feedback

**Practice Gap**
Feedback is an important element of graduate medical education as it helps residents assess their skills, make improvements as necessary and ultimately meet their competency milestones. There is some preliminary research into what psychiatry residents value in feedback, however, research specific to the optimal method of delivering feedback to psychiatry residents is spare. Faculty has various levels of comfort with delivering feedback and may use varying feedback techniques given the lack of a best practice consensus.
Residents begin their outpatient clinic third year with various levels of clinical and educational competency. They have experienced shorter rotations, typically no more than 1-2 months, that may not have allowed sufficient opportunity to receive consistent formal feedback. In addition, residents may not have the experience of receiving feedback, implementing recommendations, and receiving follow up feedback to assess success. Having 12 months of outpatient clinic offers the opportunity to develop a structured individualized feedback approach that can be targeted to the resident's needs and may have higher educational value than an informal approach. Resident self-determination of educational goals for their outpatient clinic may serve as a conduit to improving the feedback provided by the attending faculty and inducing a more collaborative and positive learning environment. In this study, we evaluated the implementation of a standard individualized formal feedback approach in the third year of residency training.

**Abstract**
Background:
Psychiatry residents spend their third year in the resident outpatient clinic where they see patients under the supervision of an attending psychiatrist. Feedback has been defined as "specific information about the comparison between a trainee's observed performance and a standard, given with the intent to improve the trainee's performance". In our program, feedback has historically been provided in real-time while staffing cases in clinic and semiannually via electronic evaluation forms mirroring milestone competencies. While real-

time feedback is consistent with the best practices, it can be limited by the time constraints of clinic and the presence of other residents during staffing. Electronic evaluations are also useful to track progress but can lack an individualized approach.

Method:

To optimize the benefits of feedback, a formal feedback process was implemented in our residency program. One month into third year, the residents had a one-on-one meeting with the director of outpatient resident education to create 2-3 educational or clinical goals for their third year. Measurable objectives for each goal were selected during the meeting so attendings could assess progress towards these goals. Quarterly 30 minute follow-up meetings with the director were scheduled so residents could receive individualized feedback that was driven by their goals, in a private setting. Feedback about resident performance was solicited from all clinic attendings prior to these meetings. There was flexibility to mark goals as "achieved" and add new goals at the quarterly meetings. At the end of the year, the residents had a final session to reflect on their overall progress and accomplishments.

Results:

To evaluate their experience with the program, an anonymous survey was distributed to residents at the beginning and end of the academic year. The study was approved by the IRB. Response rate to the survey was high, with 80% of the residents completing both the pre and post surveys. Most questions were rated on a Likert scale ranging from 1 to 5. At the end of the year, the residents all rated their success at reaching their goals as 5. The average rating of both the helpfulness and quality of quarterly feedback meetings was 4.85.

Conclusions:

Utilizing individualized feedback sessions based on goals selected by the residents may help define the role of faculty during the supervision and place emphasis on incorporating the resident's goals into progress indicators. We expect this implementation will improve the ability of residents to reach their competency milestones while at the same time providing a framework for faculty to provide constructive feedback that is well-received.

**Scientific Citations**

Beaulieu AM, Kim BS, Topor DR, Dickey CC. Seeing is believing: an exploration of what residents value when they receive feedback. Acad Psychiatry. 2019 Jun 3. doi: 10.1007/s40596-019-01071-5.

Galanter CA, Nikolov R, Green N, Naidoo S, Myers MF, Merlino JP. Direct Supervision in Outpatient Psychiatric Graduate Medical Education. Acad Psychiatry. 2016 Feb; 40(1):157-63.

The Psychiatry Milestone Project. J Grad Med Educ. 2014 Mar; 6(1 Suppl 1): 284–304

Reardon C, May M, Williams K. Psychiatry resident outpatient clinic supervision: how training directors are balancing patient care, education, and reimbursement. Acad Psychiatry. 2014 Aug; 38(4):476-80.

Kogan JR, Conforti LN, Bernabeo EC, Durnin SJ, Hauer KH, Holmboe ES. Faculty staff perceptions of feedback to residents after direct observation of clinical skills. Medical Education 2012: 46: 201–215

## Child PRITE Micro-Quizzes for Psychiatry Residents and Child Psychiatry Fellows: A Pilot Study

**Presenters**
Elise Fallucco, MD
Kitty Leung, MD
Colleen Kalynych, PhD

**Educational Objective**
(1) Understand how to develop an online, micro-quiz system to help general psychiatry residents and child and adolescent psychiatry fellows practice CHILD PRITE questions
(2) Harness the educational concepts of spaced learning and the testing effects to help trainees reinforce learning and long-term retention of material
(3) Evaluate resident and fellow satisfaction with this online, micro-quiz program

**Practice Gap**

Each year, nearly all child and adolescent psychiatry (CAP) fellows in the United States take the American College of Psychiatrists' Child Psychiatry Resident In-Training Examination (CHILD PRITE). Traditionally, trainees and their program director use these results to assess the trainee's medical knowledge regarding specific content areas. CHILD PRITE sub-section scores can also be used to identify individual trainee strengths and weaknesses and can assist with curriculum development. Further, performance on the CHILD PRITE can be used to alert trainees and program directors of the likelihood of subsequent performance on American Board of Psychiatry and Neurology subspecialty board certification exam.

In addition to providing valuable summative feedback, the CHILD PRITE could be used as a formative tool to help trainees reinforce knowledge, and promote learning and long-term retention. These positive effects of test-taking on learning are collectively referred to as the testing effect. The benefits of practicing questions can be further enhanced by taking brief quizzes spaced over a period of time rather than in one massed event. Such spaced learning is an effective way to help with long-term retention of material. Many educational studies demonstrate that those who utilize spaced learning techniques outperform on tests, and are also better able to transfer knowledge to new situations. While testing and spaced learning on their own are each effective, combining the two strategies strengthens the benefits. Based on these educational principles, practicing CHILD PRITE questions (i.e., quizzes) at spaced intervals throughout the year may assist trainees with material retention and consolidation of their medical knowledge. However, this is not typically done in a structued way at training programs.

While the techniques of spaced learning and testing have been shown to be effective in medicine across specialties and topics, this type of learning has not been formally studied in child and adolescent psychiatry. Given the availability of various online question banks that

allow learners to practice quiz questions in preparation for the CHILD PRITE and board certification examination, it would be important to understand the learners' perspectives and satisfaction with this type of learning tool as well as the feasibility of implementing spaced testing using online platforms.

**Abstract**
Objective: The goals of this project were to pilot an online Child Psychiatry Resident In-Training Examination (i.e., CHILD PRITE) micro-quiz program for general psychiatry residents and child and adolescent psychiatry fellows, and to assess trainee satisfaction with the program.
Methods: Senior psychiatry residents and child psychiatry fellows from three training programs were invited to participate in an 8 week pilot program involving online CHILD PRITE micro-quizzes. Participants were asked to complete weekly, three question micro-quizzes. At the end of the pilot period, participants completed an anonymous satisfaction survey. Data were evaluated using frequencies, means, and standard deviations.
Results: Six child psychiatry fellows and three general psychiatry residents from three training programs participated. On average, trainees spent 98 seconds completing each quiz. Eight trainees (n=89%) consistently completed at least six of the eight weekly quizzes. All trainees agreed that the quizzes helped to improve or reinforce their child psychiatry knowledge, and helped to identify topics they needed to improve. All trainees agreed that the quizzes were helpful for preparing them for exams, and that they enjoyed the challenge of the quizzes. Five trainees (56%) noted that the quizzes prompted them to read more on their own.
Conclusions: This project piloted a weekly, online CHILD PRITE micro-quiz program with general psychiatry residents and CAP fellows. Trainees reported high satisfaction with the program and maintained a high level of participation. Future studies should examine the effects of micro-quizzes on performance on the CHILD PRITE and board certification exam.

**Scientific Citations**
Karpicke, J. Retrieval-based learning: Active retrieval promotes meaningful learning. Psychological Science. 2012; 21(3): 157–163. DOI: 10.1177/0963721412443552
Roediger, HL, Butler, AC. The critical role of retrieval practice in long-term retention. Trends Cogn Sci. 2011;15(1):20-7. doi: 10.1016/j.tics.2010.09.003.
Kang SHK. Spaced Repetition Promotes Efficient and Effective Learning. Policy Insights from the Behavioral and Brain Sciences. 2016;3(1):12-19. doi:10.1177/2372732215624708.
Carpenter, S. K, Cepeda, N. J., Rohrer, D., Kang, S. H. K., Pashler, H. Using spacing to enhance diverse forms of learning: Review of recent research and implications for instruction. Educational Psychology Review. 2012; 24: 369-378.

## Forensic Psychiatric Evaluation As Part of Psychiatry Residency Training: A Novel Approach

**Presenters**
Andrei Nemoianu, MD
Victoria Tyrell, DO

Brandyn Powers, DO
Mary Harris, MD
N/A N/A, N/A

**Educational Objective**

1. Describe the current practices for training psychiatry residents in the United States in conducting forensic evaluations.
2. Describe a novel approach to preparing residents for competence to stand trial evaluations.

**Practice Gap**

There are guidelines issued by the AAPL for forensic psychiatry training, but little in the way of guidance as to how to prepare general psychiatrists for conducting a forensic evaluation. As such, results for forensic competency are variable. We present the curriculum used at our facility to prepare for forensic examinations, specifically by using a standardized patient to practice interviewing.

**Abstract**

Competence to stand trial is one of the most commonly requested forensic evaluations. Because of the lack of forensic psychiatrists in rural areas, general psychiatrists might be called on for evaluations of competence to stand trial, and so it is especially important for all psychiatry residents to have good working knowledge of how to present and address these forensic evaluations. Forensic psychiatry training is required for all U.S. Psychiatry residents as per the ACGME. These requirements state that residents must have training in "experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency". These requirements are broad, however, and there is limited guidance as to how residencies can accomplish these goals. Many programs use didactic seminars to train residents regarding criminal and civil forensic psychiatry, as well as observational exposure to a variety of forensic settings. The psychiatry residency at Geisinger uses a standardized patient program in combination with didactic seminars to prepare residents for conducting evaluations of competence to stand trial.

**Scientific Citations**

Accreditation Council for Graduate Medical Education: ACGME program requirements for graduate medical education in psychiatry: revised common program requirements effective July 1, 2019. Available at: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_Psychiatry_2019.pdf?ver=2019-08-26-134127-827. Accessed Oct 2nd, 2019

Cerny-Suelzer, C. A., Ferranti, J., Wasser, T., Janofsky, J. S., Michaelsen, K., Alonso-Katzowitz, J. S., . . . Spanggaard, M. (2019). Practice resource for forensic training in general psychiatry residency programs. The Journal of the American Academy of Psychiatry and the Law, 47(2), 266-19. doi:10.29158/JAAPL.003846-19 [doi]

# Buprenorphine Waiver Training for Psychiatry Residents: A Response to the Opioid Crisis

**Presenters**
Renee Bayer, MD

**Educational Objective**
1. Increase residents' knowledge on medications used to treat opioid use disorders
2. Increase residents' confidence in prescribing medications for patients with opioid use disorders
3. Improve residents' attitudes towards treating patient with opioid use disorders
4. Improve the quality of care provided by residents to patients with opioid use disorders

**Practice Gap**
Rates of prescribing for medications used to treat opioid use disorder remain low among psychiatrists, despite the growing opioid crisis. Lack of adequate physician training is implicated. ACGME Residency curricula requirements for psychiatry residency currently include one block of Addiction Medicine. We reviewed current successful resident interventions related to treating patients with opioid use disorders. We surveyed psychiatry residents regarding buprenorphine waiver training and found that none of our residents had completed the buprenorphine waiver training, and that none of our PGY 3 & 4 residents felt adequately trained to prescribe buprenorphine. Finally, only a small percentage of our PGY 3 & 4 residents currently plan to prescribe buprenorphine in the future.

**Abstract**
In an effort to bridge the gap between providing patients with opioid use disorders and physician prescribing habits, in 2019, we offered buprenorphine waiver training to thirteen PGY3 and PGY4 psychiatry residents. We coordinated with the APA to offer the eight, one hour waiver training videos as a group over two regularly scheduled didactic afternoons. Prior to and following the buprenorphine waiver training intervention, we surveyed residents. At the end of the waiver training, residents were provided with a link to register in order to complete the waiver training. Further, we provided residents with instructions on how to register to prescribe buprenorphine post-graduation.

| Buprenorphine Waiver Training & Survey | Pre | Post |
|---|---|---|
| Completed training | 0% | 53% |
| Agreed or strongly agree to feeling adequately trained | 0% | 100% |
| Plan to prescribe | 29% | 57% |

Our intervention was small and not statistically significant. It was, however, inexpensive, used regular didactic training time, and relatively effective in helping residents feel adequately trained to prescribe and modestly effective in increasing the number of residents planning to treat patients with opiate use disorder post residency. Based on feedback from those who

completed the training, we incorporated buprenorphine waiver training into the addiction medicine block which occurs in PGY1 rather than wait until PGY 3 & 4 to expose residents to this information earlier in residency. PGY1 residents now review the training videos on-line through the APA during that block, and residents are required to show their waiver training certificate to the addiction medicine specialists to complete the block. Other possible follow-up research may include tracking how many graduates attain the waiver post-graduation. Further research may include tracking the percent of graduates who are prescribe buprenorphine in their subsequent psychiatry practice

**Scientific Citations**

1. U.S. Center for Disease Control: Opioid Overdose: State Information. https://www.cdc.gov/drugoverdose/states/index.html Accessed December 2018
2. Deborah Dowell, MD; Tamara M. Haegerich, PhD; Roger Chou, MD. U.S. Center for Disease Control: CDC Guideline for Prescribing Opioids for Chronic Pain https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm. Accessed December 2018:
3. Jennifer J. Carroll, PhD, MPH; Traci C. Green, PhD, MSc; and Rita K. Noonan, PhD. U.S. Center for Disease Control: Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States An introduction for public heath, law enforcement, local organizations, and others striving to serve their community https://www.cdc.gov/drugoverdose/policy/index.html. Accessed December 2018.
4. Srinivas B. Muvvala, MD, MPH1; Ellen Lockard Edens, MD, MPE1; Ismene L. Petrakis, MD1. JAMA Psychiatry. Published online November 28, 2018. doi:10.1001/jamapsychiatry.2018.3123. "What Role Should Psychiatrists Have in Responding to the Opioid Epidemic?"
5. Taylor JL1, Rapoport AB2, Rowley CF2, Mukamal KJ3, Stead W2, 2018. Substance Abuse Journal 2018 Feb 12:1,6. "An opioid overdose curriculum for medical residents: Impact on naloxone prescribing, knowledge, and attitudes."

## The Role of Social Media in Psychiatry Recruitment: A Survey of Program Directors

**Presenters**

Evelyn Ashiofu, MD,MPH
Lia Thomas, MD

**Educational Objective**

To identify how psychiatry program directors (PDs) use social media (SM) in the residency recruitment process.
To assess attitudes about psychiatry and social media from Program Directors
To identify how else social media is use by PDs and/or their residency programs.

**Practice Gap**

In recent years, the use of social media has significantly increased and become a very apparent part of our mainstream culture. Inevitably, we as psychiatrists are no strangers to utilizing social media in one way or another. There has been literature that looked at the use of social media in regards to medical education specifically looking at its role in teaching and instruction as well as guidance on handling social media when it comes to patient care.

Something that has not been talked about as much in literature is the use of social media in the recruitment of psychiatry residency applicants. Reviewing the social media profiles of anyone can be as easy as a quick Google search and thus several questions remain unanswered regarding its use in the recruitment domain. Are psychiatry program directors looking at the social media profiles of applicants prior to their interviews? If so, are these practices significantly changing the desirability of an applicant? Are they utilizing social media in any other ways? Should there be more guidance from governing bodies about how to best deal with this dilemma? This preliminary study serves to hopefully answer these questions at hand.

**Abstract**

The use of social media in today's society is something that does not show any signs of slowing down anytime soon. The medical field, specifically medical and residency education is also a part of this rapidly growing phenomena. According to a study published in 2010, about 70% of medical students had some sort of social media page. It would not come as a shock if this number has increased in the last almost 10 years since that study was published. In a systematic review of social media use in graduate medical education, it was noted that some surgical residency programs were reviewing the profiles of prospective applicants and using the information discovered to help guide their decision on ranking. The question remains if this is something that is commonly done and how exactly are program directors utilizing this information. This preliminary study attempts to assess the use of social media by psychiatry program directors

A 26 item survey was sent to psychiatry program directors with programs participating in the 2019-2020 Match cycle. Questions about whether they reviewed the SM of applicants, when in the process and whether decisions about ranking were made based on the information found were asked of PDs. PDs were also asked about their general thoughts on social media, and if social media was being used in any other forms throughout their program.

(Please note, the study was sent out in 10/1/19 and will close on 12/30/2019 – we will have preliminary data to present at the conference.)

**Scientific Citations**

Wells BM "When Faced With Facebook: What Role Should Social Media Play in Selecting Residents?" J Grad Med Educ. 2015 Mar;7(1):14-5. doi: 10.4300/JGME-D-14-00363.1.

Sterling et al. "The Use of Social Media in Graduate Medical Education: A Systematic Review" Academic Medicine 2017, 2(7): 1043–1056

Go et al "Attitudes and Practices of Surgery Residency Program Directors Toward the Use of Social Networking Profiles to Select Residency Candidates: A Nationwide Survey Analysis J Surg Educ. 2012; 69:292–300).

Erik W. Black, Lindsay A. Thompson, W. Patrick Duff, Kara Dawson, Heidi Saliba, and Nicole M. Paradise Black (2010) Revisiting Social Network Utilization by Physicians-in-Training. Journal of Graduate Medical Education: June 2010, Vol. 2, No. 2, pp. 289-293.

## How Much Education and Training Do Residents Across Specialties Receive in Neuropsychology Throughout the United States?

**Presenters**
Matthew Macaluso, DO
Seher Chowhan, DO
Phillip Martin, PhD
Ryan Schroeder, PhD

**Educational Objective**
1. Assess the adequacy of training on neuropsychological services within psychiatry, neurology, family medicine, and internal medicine residency programs across the United States.
2. Assess resident understanding of the nature of services provided by a neuropsychologist.
3. Assess resident comfort level and willingness to consult/order neuropsychological tests in practice.

**Practice Gap**
Clinical neuropsychology is defined as the sub-specialty of clinical psychology dedicated to understanding brain-behavior relationships. Neuropsychologists play an important role on multidisciplinary teams with physicians from multiple specialties, including physicians who treat patients with neurocognitive disorders and other mental or neurologic conditions. According to Schoenberg and Scott, referrals for neuropsychological evaluations are typically requested for (1) diagnostic clarification, (2) describing neuropsychological status, (3) treatment planning/program placement (e.g. nursing home placement), (4) monitoring effects of treatment, (5) the identification of underlying processes for cognition and/or effects of treatments, and (6) forensic applications.

The literature supports the fact that physicians from multiple specialties refer patients to neuropsychologists. Neuropsychologists receive most of their patient referrals from neurologists, psychiatrists, and primary care physicians. In a survey of physicians, it was found the majority of respondents (89%) reported they had referred patients for neuropsychological evaluations.

When broken down by physician specialty type, anywhere from 99% (neurologists) to 70% (primary care physicians) of responding physicians indicated they had referred patients to

neuropsychologists.

Despite physicians working in multidisciplinary teams with neuropsychologists, the extent to which physicians across specialties are trained on the use of neuropsychological services during residency is unclear. Therefore, additional research is needed on the adequacy of residency training on neuropsychological services and whether clinical exposure to neuropsychological services during residency contributes to clinician attitudes and the appropriate use of neuropsychological services in practice.

**Abstract**

OBJECTIVE: The goal of this study was to survey medical residents across multiple specialties throughout the United States to assess resident education, training, and comfort level with neuropsychological services. A secondary objective was to identify gaps in training curricula.

METHODS: We emailed survey invitations to program directors of every psychiatry, neurology, family medicine, and internal medicine residency program within the United States. Program directors were asked to forward the survey link to their current residents. REDCap, a web-based database designed to house data in a secure environment, was used to administer the survey, which included an online consent to participate. Survey questions assessed resident exposure to neuropsychological services and perceived adequacy of education, training, attitudes, referral practices, and barriers surrounding neuropsychological services. Residents did not have to answer all questions to participate. The University of Kansas Human Subjects Committee (IRB) approved the study.

RESULTS: A total of 434 residents consented to the survey. By specialty, 22.4% were from psychiatry programs (n = 97), 32.8% were from family medicine programs (n = 142), 30.0% were from internal medicine programs (n = 130), and 11.5% were from neurology programs (n = 50). 3.2% (n = 14) did not indicate their specialty.

The proportion of residents exposed to neuropsychology during residency varied significantly according to resident specialty $\chi 2$ (3, N=419) = 51.4, $p < .001$. Psychiatry (96.9%) and neurology (90.0%) residents did not significantly differ regarding exposure to neuropsychology; however, more psychiatry and neurology residents reported exposure to neuropsychology during residency than residents in family medicine (71.8%) or internal medicine (58.8%) ($p < .01$). Common avenues for exposure, irrespective of specialty, included clinical experiences where neuropsychological services were utilized (32.5%), didactics (31.8%), writing orders for neuropsychological evaluations (30.9%), and reading of the medical literature (28.8%). Differences between specialties were also found regarding the proportion of residents who 'agree' or 'strongly agree' they understand the nature of services provided by a neuropsychologist $\chi 2$ (3, N=415) = 40.4, $p < .001$. Pairwise comparisons found psychiatry (76.3%) and neurology (71.4%) residents more commonly agree or strongly agree they understand the use of neuropsychological services than family medicine (48.6%) and internal medicine (38.0%) residents ($p < .01$). However, the majority of residents across specialties

(85.7%) reported they are likely to consult/order neuropsychological services when they practice
independently. Psychiatry residents indicated being more likely to consult neuropsychology than
internal medicine residents $\chi 2$ (1, N=226) = 14.1, $p < .001$, with other group differences being non-significant.

CONCLUSIONS: While the majority of residents in all specialties reported being exposed to neuropsychological services in some manner, specific types of exposure varied. Results indicate an increased need for specific types of education and training in neuropsychological services, especially within family medicine and internal medicine programs where residents less clearly understand the use neuropsychological services. Interestingly, despite not having a clear understanding of neuropsychological services, the majority of these residents still agreed they would utilize neuropsychology services in future practice.

**Scientific Citations**

1) Boake, C. (2008). Clinical Neuropsychology. Professional Psychology: Research and Practice, 39(2), 234-239. DOI:
10.1037/0735-7028.39.2.234

2) Schoenberg, M.R. and Scott, J.G. (2011). The Little Black Book of Neuropsychology: A Syndrome-Based Approach. New York:
Springer Science+Business Media, LLC.

3) Sweet, J. J., Benson, L. M., Nelson, N. W., & Moberg, P. J. (2015). The American Academy of Clinical Neuropsychology,
National Academy of Neuropsychology, and Society for Clinical Neuropsychology (APA Division 40) 2015 TCN professional
practice and 'salary survey': Professional practices, beliefs, and incomes of U.S. neuropsychologists. The Clinical
Neuropsychologist, 29, 1069-1162.

4) Temple, R. O., Carvalho, J., & Tremont, G. (2006). A national survey of physicians' use

## "Can you hear me?" Developing an ambulatory telepsychiatry rotation between an urban psychiatry residency program and a rural family medicine residency program

**Presenters**

Tanya Keeble, MD
Amy Burns, MD
Erk Loraas, MD

**Educational Objective**

1. Understand the specific and most significant healthcare disparities that exist in rural areas of the USA
2. Understand how telemedicine can address those healthcare disparities
3. Understand how to embed QI principles into program implementation
4. Understand how psychiatrists can leverage themselves to improve access to care
5. Understand how psychiatrists can leverage themselves as educators to remote primary care residents
6. Develop a commitment as psychiatrists to reach into emerging models for residency training

**Practice Gap**

Psychiatry Residency Spokane is a new community based training program, building core rotation rotations aimed at training residents in emerging patient care delivery structures. As such, the program has already developed collaborative care training, and was interested in developing face to face psychiatric consultation to a collaborative care implementation site in a rural city 70 miles north of Spokane. Traditional psychiatric consultation was not feasible for most of these patients, many of whom have significant healthcare disparities and limited insurance and financial resources.

Telepsychiatry represents an approach to healthcare delivery with significant potential to improve access to expert care, especially in rural areas where psychiatric care may otherwise be challenging to obtain. Patient and provider satisfaction and economic benefit of Telepsychiatry in rural communities has been previously demonstrated 1,2,3. Despite its benefits, Telepsychiatry remains underutilized and slow to implement 4,5. Reasons for this disparity include limited access to appropriate technology, unclear regulatory requirements, and shortage of trained providers 6,7,8.

The residency program saw an opportunity to train both psychiatry residents and family medicine residents who in the rural Colville Track of Family Medicine Residency Spokane, by developing a telepsychiatry pilot site between the 2 programs.

**Abstract**

Methods

We worked over the course of 6 months to develop a Telepsychiatry program from scratch, and embed within the program a quality improvement project. The main areas of focus were increased access to care; positive patient impact, specifically in the area of decreased burden of psychiatric illness; increased provider satisfaction with psychiatric consultation availability and quality; financial sustainability and positive educational impact to residents in both programs. We developed rotation goals and objectives, pre and post tests of medical knowledge, a curriculum learning checklist, and a milestone based attending of resident evaluation tool. Patient PHQ and GAD scores were monitored over treatment course. We developed and implemented patient and provider satisfaction surveys, and monitored revenue cycles to ensure long term financial viability of the residency rotation.

Results

Data from the first 6 months of the program is promising and shows improved access to care, high levels of patient and primary care provider satisfaction, and improvement in measures of individual symptom severity. Pilot data supports the cost effectiveness of Telepsychiatry, with money saved in terms of travel and lost productivity. Revenue cycle analysis show improving rates of reimbursement. Family medicine and psychiatry residents have developed medical knowledge and skills in this important patient care delivery system.

Discussion

Telepsychiatry rotation development can serve as a system in which to train both psychiatry and family medicine residents. It can also serve as an efficient use of specialist teaching resources - this psychiatry residency based telepsychiatry rotation was able to utilize one psychiatry attending at the distant site to provide patient care supervision and education to residents from 2 different specialties; psychiatry, and family medicine. The program was able to successfully develop a financially sustainable stepped model of primary care consultation, providing both collaborative care consultation and Telepsychiatry to an underserved patient group that had minimal mental health access prior to implementation.

Conclusions

Telepsychiatry rotation development can address rural health disparities by improving access to care in underserved areas. It can also provide a collaborative training environment for both psychiatry residents and primary care residents at rural residency sites.

**Scientific Citations**


1. Hilty DM, Marks S, Wegelin J, Callahan EJ, Nesbitt TS. A Randomized, Controlled Trial of Disease Management Modules, Including Telepsychiatric Care, for Depression in Rural Primary Care. Psychiatry. 2007;4(2):58-65.
2. Dham P, Gupta N, Alexander J, Black W, Rajji T, Skinner E. Community based telepsychiatry service for older adults residing in a rural and remote region- utilization pattern and satisfaction among stakeholders. BMC Psychiatry. 2018;18(1):316.
3. Yilmaz SK, Horn BP, Fore C, Bonham CA. An economic cost analysis of an expanding, multi-state behavioural telehealth intervention. Journal of Telemedicine and Telecare. 2018. doi: 10.1177/1357633X18774181.
4. Serhal E, Crawford A, Cheng J, Kurdyak P. Implementation and Utilisation of Telepsychiatry in Ontario: A Population-Based Study. The Canadian Journal of Psychiatry. 2017;62(10):716-725.
5. Cloutier P, Cappelli M, Glennie JE, Keresztes C. Mental health services for children and youth: a survey of physicians' knowledge, attitudes and use of telehealth services. Journal of Telemedicine and Telecare. 2008;14(2):98-101.
6. Glover JA, Williams E, Hazlett LJ, Campbell N. Connecting to the future: telepsychiatry in postgraduate medical education. Telemedicine and E Health. 2013;19(6):474-479.
7. Teshima J, Hodgins M, Boydell KM, Pignatiello A. Resident Evaluation of a Required Telepsychiatry Clinical Experience. Academic Psychiatry. 2016;40(2):348-352.

# Help me if you can, I'm feeling down: A GME-sponsored project to address burnout in three Mount Sinai outpatient resident clinics

**Presenters**
Paul Rosenfield, MD
Daniel Safin, MD
Arpan Parikh, MD
Trevor Griffen, MD

**Educational Objective**
1. Identify system-related drivers of burnout
2. Demonstrate how an institution's GME can stimulate creative system responses to excessive work demands and burnout
3. Share the results of a project to reduce non-clinical demands for psychiatry residents in the outpatient setting
4. Stimulate ideas for further system-based projects to reduce burnout

**Practice Gap**
The majority of research in burnout has looked at individual, rather than organizational, strategies to alleviate it in physicians, despite the evidence that workload and workplace demands make a strong contribution to burnout (1,6,7,8,9). For example, physicians identify increased clerical burden and “bureaucratic tasks” as strong causes of job dissatisfaction and burnout, respectively (3,4). However, efforts to address burnout through focusing on systemic issues have been limited. This project provides an example of a GME-sponsored effort to reduce resident burnout through a systems-related rather than an individual resident-focused approach.

Psychiatry residents report a significant level of burnout during residency training, which ultimately can have a detrimental impact on patient care (1,2). During their outpatient clinical experiences, there are many contributory factors including care of high-risk patients, limited access to resources, productivity expectations, and an abundance of clerical and non-clinical tasks. With limited clerical and case management support to address the challenges of appointment attendance, significant psychosocial stressors of their patients, regulatory expectations (such as treatment plans), and incomplete coordination of care, residents work extra hours to personally reach out to their patients to reschedule them, find community resources for their needs, request records from other medical providers, and assistance with medication prior authorizations. Some of these tasks could be delegated to support staff so the residents can devote themselves to the clinical care likely to result in improved patient outcomes.

**Abstract**
When the Mount Sinai GME office funded a Clinical Intensity Grant to generate creative ideas to reduce the burden of non-clinical work in residency, the three psychiatry residencies at the Mount Sinai Health System joined forces to submit a proposal to hire coordinators in the outpatient clinics to help make referrals to PCPs, obtain records from hospitals and other providers, follow-up on no-shows and cancellations, and to assist with prior authorizations and other time-consuming tasks.

A brief baseline survey was sent to PGY3 residents at the three Mount Sinai Health System residencies to assess the amount of time they spend on outreach and engagement: calling patients to reschedule after no-shows, calling high risk patients to remind them of their next appointments, calling patients' PCPs and specialty physicians to obtain records and coordinate care, and arranging referrals to community resources. Results demonstrated significant burden of all these aspects, and a desire for assistance with the nonclinical aspects of the work, as less than 50% of their time was dedicated to direct clinical work.

Coordinators were hired with GME funding, matched by departmental funding, to assist with these tasks. Outcomes were assessed by follow-up surveys of residents to understand how the hiring of these coordinators impacted the amount of time spent on non-clinical tasks and their level of burnout. While there were variable results by site, each demonstrated a positive impact on residents and their ability to focus more on direct clinical care which led to greater satisfaction.

**Scientific Citations**
1. Jovanovi N, Podlesek A, Volpe U et al. Burnout syndrome among psychiatric trainees in 22 countries: Risk increased by long working hours, lack of supervision, and psychiatry not being first career choice. European Psychiatry. 2016;32:34-41. doi:10.1016/j.eurpsy.2015.10.007.
2. Martini S. Burnout Comparison Among Residents in Different Medical Specialties. Academic Psychiatry. 2004;28(3):240-242. doi:10.1176/appi.ap.28.3.240.
3. Woolhandler S, Himmelstein D. Administrative Work Consumes One-Sixth of U.S. Physicians' Working Hours and Lowers their Career Satisfaction. International Journal of Health Services. 2014;44(4):635-642. doi:10.2190/hs.44.4.a.
4. Peckham C. Physician Burnout: It Just Keeps Getting Worse. Medscape. 2018. Available at: https://www.medscape.com/viewarticle/838437. Accessed March 2, 2018.
5. Schaufeli W, Leiter M, Maslach C. Burnout: 35 years of research and practice. Career Development International. 2009;14(3):204-220. doi:10.1108/13620430910966406.
6. Deb A. Practical Considerations in Addressing Physician Burnout. CONTINUUM: Lifelong Learning in Neurology. 2017;23:557-562. doi:10.1212/con.0000000000000461.
7. Maslach C, Leiter M. Understanding the burnout experience: recent research and its implications for psychiatry. World Psychiatry. 2016;15(2):103-111. doi:10.1002/wps.20311.
8. Maslach C, Leiter M. Early predictors of job burnout and engagement. Journal of Applied Psychology. 2008;93(3):498-512. doi:10.1037/0021-9010.93.3.498.
9. Montgomery A, Panagopoulou E, Esmail A, Richards T, Maslach C. Burnout in healthcare: the case for organisational change. BMJ 2019;366:l4774

# Evaluating a Medical Educator Track (MET) in Psychiatry at Southern Illinois University: One Year Post-Implementation

**Presenters**
Sohail Nibras, MD
Kari Wolf, MD

**Educational Objective**
1. Describe creation and implementation of a Medical Educator Track (MET) within SIU Psychiatry's Educational Programs.
2. Explore the early experience of enrolled residents and fellows
3. Analyze the ways the MET has promoted the development of residents as teachers.

**Practice Gap**
ACGME and ABPN jointly initiated psychiatric milestones to assess core competencies of successful psychiatry residents. One of these core competencies includes "development of residents as teachers." This category requires that residents should recognize their role as teachers in clinical settings, communicate goals and objectives for instruction, and evaluate and provide feedback to early learners. As residents progress through training, they should be able to participate in activities where they can demonstrate teaching skills, including organizing content and methods for delivering individual instruction. Residents are expected to give formal didactic presentations to groups and effectively use feedback on their teaching to improve teaching methods and approaches. They should be able to educate the broader professional community/public and organize and develop curriculum materials.1, 2 The Liaison Committee on Medical Education (LCME), has also presented its guidelines on how residents should be prepared to teach medical students.3 Furthermore, about a decade ago, the Institute of Medicine issued a warning highlighting a decline in psychiatric researchers which would harm the public. Despite these recommendations, the number of academicians in psychiatry continues to decline.4 Multiple factors impede a resident's development into an educator; these include high demand of clinical work, limited training on teaching skills, lack of protected time, limited access or availability of mentors and teaching/scholarly work opportunities. The SIU MET program is designed to seek out academically oriented residents and provide them with the opportunity to expand their teaching skills, learn about curricular assessment and design, and develop a scholarly project while being mentored by an experienced educator in the department.

**Abstract**
Background: The last two decades have seen more educational tracks implemented into psychiatry residencies. In 2010, Jibson, et al. outlined the efforts of the University of Michigan, Baylor University, and the University of California, Davis as they developed tracks. These programs require residents to apply; once accepted, they are assigned a mentor and required to complete a scholarly project. They also have supervised teaching experiences in a medical school and residency program and develop curriculum and participate in educational

administration.5 In 2018, Southern Illinois University's Psychiatry Department launched a Medical Educator Track to implement ACGME requirements, enhance psychiatry trainees' teaching skills, and further their interest in academic medicine. As a 2-year program, trainees from the Psychiatry Residency, the Med-Psych Residency, and the Child Fellowship apply and are selected. Our MET has two main components: on-going didactics open to all residents, fellows, and faculty in the department and a scholarship/mentorship component for those trainees officially accepted into the MET. This program offers a Certificate to those trainees not in the MET Track who attend at least 10 didactic sessions. MET residents are assigned a developmental mentor to help with their professional formation, learn about curriculum development, participate in scholarly projects, and attend didactics. Currently, there are 2 general psychiatry, 2 medicine-psychiatry, and one 1 CAP fellow enrolled.

Methods: An online survey was emailed to all post-PGY-1 trainees and recent graduates. Data were collected anonymously and analyzed. Several trainees also agreed to qualitative interviews. This poster will present comparison data from the quantitative surveys and qualitative interviews.

Results: 18 unique individuals completed the survey. Four were formally enrolled, four informally attended the didactic sessions, and ten were non-MET participants. Analysis of the survey will be provided in the poster which will highlight the educational gains of the program and the barriers to participation.

Discussion: The MET program at SIU is a significant step toward promoting academicians for the future. The enrolled learners have revealed promising early interest of nurturing a passion for teaching, educational leadership, and scholarship while focusing on their identity formation as future educators. The barriers to implementing such tracks include the availability of developmental mentors and protected time. The non-MET participants in the survey expressed a lack of protected time as a barrier; the MET didactic sessions and scholarly projects require time commitment in addition to residency training requirements. Similarly, Jibson et al. described that the three institutions, Michigan, Baylor, and UC Davis' educational tracks also struggled with providing protected time.5 Despite these limitations, MET provides an opportunity to develop skills in critically important areas including curriculum development, scholarly projects, and clinical teaching supervised by a developmental mentor for academically inclined trainees. To generate a future academician in psychiatry, we encourage other institutions to consider initiating medical educator tracks.

**Scientific Citations**


1. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. 2019 [Accessed 10/14/19]; Available from: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_Psychiatry_2019.pdf?ver=2019-08-26-134127-827
2. The Psychiatry Milestone Project. A Joint Initiatives of Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. July

2015 [Accessed 10/14/19]; Available from: https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf?ver=2015-11-06-120520-753
3. Functions and Structure of a Medical School. LCME. March 2019 [Accessed 10/14/2019]; Available from: https://lcme.org/wp-content/uploads/filebase/standards/2020-21_Functions-and-Structure_2019-10-04.docx.
4. Institute of Medicine 2003. Research Training in Psychiatry Residency: Strategies for Reform. Washington, DC: The National Academies Press. https://doi.org/10.17226/10823.
5. Jibson MD, Hilty DM, Arlinghaus K, Ball VL, McCarthy T, Seritan AL, et al. Clinician-educator tracks for residents: three pilot programs. Acad Psychiatry. 2010; 34:269–76.

## Error Disclosure Workshop: A Model for Teaching Error Disclosure Techniques to Psychiatry Residents via Standardized Patient Encounters

**Presenters**
Milicent Fugate, MD
Angela Oulay, MD
Sandra Batsel-Thomas, MD
James Norton, PhD
Sarah Oros, MD

**Educational Objective**
Illustrate the need for more comprehensive training for psychiatry residents regarding the disclosure of medical errors.

Present one model for teaching error disclosure through didactic lectures, discussion, and standardized patient encounters.

**Practice Gap**
Practice Gap: In the practice of medicine, human fallacy will inevitably lead to the occurrence of medical errors, despite robust attempts to minimize such occurrences.5 The majority of physicians feel that disclosure of medical errors to a patient is an ethical imperative; however, several factors impact if and how a physician may disclose such errors.4 Disclosure of medical errors has been increasingly mandated in the United States, and disclosure of adverse events is included as a core program requirement by the Accreditation Council for Graduate Medical Educate (ACGME).1 Research demonstrates several studies focusing on error disclosure training for medical students,6,10 as well as various medical specialties including internal medicine,2,9,10,11 pediatrics,10,11 surgery3,10,11 emergency medicine,8,10 obstetrics and gynecology,10 and neurology10. Little information is available regarding error disclosure training for psychiatry residents and other mental health practitioners. Given that medical errors will occur despite all efforts to the contrary, it is imperative that psychiatry residents

receive adequate training in error disclosure, specifically training tailored to errors that may commonly occur in the practice of psychiatry.

**Abstract**
Background: Despite efforts to the contrary, medical errors will inevitably occur during the practice of medicine5. ACGME lists experience in disclosure of adverse events as a core program requirement for residency training1; however, little is known regarding error disclosure training in psychiatry residency programs.
Objective: Provide a psychiatry residency training experience in error disclosure through the use of clinical vignettes and standardized patient encounters tailored to presentations that commonly occur in the practice of psychiatry.
Method: Psychiatry residents and fellows (n=12) were assigned mandatory participation in an error disclosure workshop to meet ACGME mandates for exposure to error disclosure training during residency training. Participating residents include PGY -1 categorical psychiatry residents, PGY-2 triple board (TB) residents, and PGY-4 or PGY-5 fellows in child and adolescent psychiatry (CAP) or addiction medicine. Workshop attendance was capped at four training participants, and included 1 hour of didactics and discussion, followed by 1 hour of standardized patient encounters. Residents were divided into groups of two, and presented a clinical vignette regarding a medical error that resulted in harm to a patient. The clinical vignette was a scenario pertinent to psychiatric training. Residents were given fifteen minutes to review the clinical vignette and discuss error disclosure strategies with their partner. Each group was then given an opportunity to disclosure the error to a standardized patient. Standardized patient encounters were conducted in an observational suite through a two-way mirror and was observed by the other residents, a chief resident and two faculty members. Following each patient encounter residents were given feedback from faculty and the standardized patient and allowed to process the encounter. This poster has been produced by trainees with a faculty mentor/AADPRT member.

Results: Residents who participated in the error disclosure workshop were asked to complete anonymous pre and post workshop ques

**Scientific Citations**
1. Accreditation Council for Graduate Medical Education: Common Program Requirements . (2017, February). Retrieved October 2019, from https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf.

2. Bonnema, R. A., Gonzaga, A. M. R., Bost, J. E., & Spagnoletti, C. L. (2012). Teaching error disclosure: Advanced communication skills training for residents.?Journal of Communication in Healthcare,?5(1), 51–55. doi: 10.1179/1753807611y.0000000018

3. Chan, D. K., Gallagher, T. H., Reznick, R., & Levinson, W. (2005). How surgeons disclose medical errors to patients: A study using standardized patients.?Surgery,?138(5), 851–858. doi: 10.1016/j.surg.2005.04.015

4. Gallagher, T. H. (2003). Patients and Physicians Attitudes Regarding the Disclosure of Medical Errors.?Jama,?289(8), 1001. doi: 10.1001/jama.289.8.1001

5. Gorovitz, S., & Macintyre, A. (2012, March 23). Toward a theory of medical fallibility. Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.2307/3560992.

6. Krumwiede, K. H., Wagner, J. M., Kirk, L. M., Duval, T. M., Dalton, T. O., Daniel, K. M., … Rubin, C. D. (2019). A Team Disclosure of Error Educational Activity: Objective Outcomes.?Journal of the American Geriatrics Society. doi: 10.1111/jgs.15883

7. Rathert, C., & Phillips, W. (2010). Medical Error Disclosure Training: Evidence for Values-Based Ethical Environments.?Journal of Business Ethics,?97(3), 491–503. doi: 10.1007/s10551-010-0520-3

8. Spalding, C., & Rudinsky, S. (2018). Preparing Emergency Medicine Residents to Disclose Medical Error Using Standardized Patients.?Western Journal of Emergency Medicine, 211–215. doi: 10.5811/westjem.2017.11.35309

9. Stroud, L., Mcilroy, J., & Levinson, W. (2009). Skills of Internal Medicine Residents in Disclosing Medical Errors: A Study Using Standardized Patients.?Academic Medicine,?84(12), 1803–1808. doi: 10.1097/acm.0b013e3181bf9fef

10. Stroud, L., Wong, B. M., Hollenberg, E., & Levinson, W. (2013). Teaching Medical Error Disclosure to Physicians-in-Training.?Academic Medicine,?88(6), 884–892. doi: 10.1097/acm.0b013e31828f898f

11. Wong, B. M., Coffey, M., Nousiainen, M. T., Brydges, R., Mcdonald-Blumer, H., Atkinson, A., … Stroud, L. (2017). Learning Through Experience: Influence of Formal and Informal Training on Medical Error Disclosure Skills in Residents.?Journal of Graduate Medical Education,?9(1), 66–72. doi: 10.4300/jgme-d-16-00263.1

## Implementation of the Advanced Psychiatry Pathways Longitudinal Experiences (APPLE) Taskforce: Curriculum redesign and track-based experiences

**Presenters**
Stephanie Wick, BA, DO, MBA
Eric Leppink, BA
Lora Wichser, MD

**Educational Objective**
The purpose of this poster is to:

1. Describe the goals and implementation of the APPLE Taskforce - a novel faculty and resident co-led committee.

2. Identify the key steps in revamping the didactic and clinical rotation curriculum of the University of Minnesota's Adult Psychiatry Resident program.
3. Describe the process of designing and implementing longitudinal subspecialized learning tracks based on trainees' interests.
4. Explore the future goals and plans for continued curriculum development.

**Practice Gap**

Changes to curriculum within residency training programs are both inevitable and necessary, but evidence to guide and support these changes remains limited in available literature. Curricular changes can, understandably, be a source of increased stress for residents, a population already subject to a myriad of stressors, from taking on a new physician role to high personal expectations for performance. It is critical for programs to be mindful of these issues when implementing new curriculum features and requirements. To reduce the stress caused by these changes, it is important to involve representatives of the major stakeholders for the program, most notably the faculty and residents. To this end, the use of co-led committees offer a unique opportunity to both achieve change goals, while also giving adequate opportunities for involvement.

Curricular changes were informed by key areas of graduate medical education, including not only the direct clinical experiences and education, but also areas such as mentorship and individually driven learning and development. As the landscape of healthcare and its demands have changed, it is critical to evaluate how programs can integrate best practices in clinical education to provide the highest quality training possible for residents. Areas of note when considering program-wide changes include longitudinal learning opportunities, near-peer and faculty mentoring, interest

**Abstract**

The University of Minnesota Department of Psychiatry initially formed the APPLE taskforce with the goals of re-evaluating didactic and rotation curriculum, designing and implementing longitudinal learning tracks, and addressing resident wellness as it related to curriculum. From the start, APPLE was designed as a collaborative committee co-led by faculty members and resident representatives from each class. This shared responsibility fostered a culture of collaboration and efficient relaying of taskforce ideas to all program trainees, thus qualitatively reducing change related stress to residents. Prior to addressing specific goals for change and planning, APPLE created a pyramidal hierarchy of needs for the program, which was then used to identify and guide the next steps in curriculum and program review. Each step in the process was added to a growing concept map depicting the taskforce's progress and implementation, allowing for increased transparency and clarity on an ongoing basis.

The first hierarchical tier includes the program's mission, vision, and values. The initial phase of the taskforce involved established and clarifying these areas as guiding philosophies for the program, which was accomplished through discussions with both residents and faculty. These guiding principles where then disseminated throughout the department as both text and graphic displays.

The second hierarchical tier focused on rotation and didactic curriculum redesign. This included transition from in-house overnight call to home call, initiation of a neuromodulation rotation, revamping the mental illness/chemical dependency (MICD) rotation, and identifying and addressing weaknesses within the didactic curriculum.

The third hierarchical tier focused on establishing three longitudinal tracks: Clinical Neuroscience, Development Across the Lifespan, and Global Community. The goal of the tracks is to use a near-peer learning model to establish routes of mentorship, education opportunities, and rotation experiences specific to residents' interests within the field of psychiatry.
Future goals of APPLE include continuing to tailor facets of psychiatry training to resident interests through implementation of track specific elective rotations, expansion of the Resident Social Committee to promote resident wellness, and implementation of multidirectional milestone feedback through Entrustable Professional Activities (EPAs). While the implementation of new curriculum features continues to be a gradual process, grounding these changes in collaborative decision making, openness to change, and a dedication to resident wellness has helped hold the APPLE taskforce accountable to the guiding principles for the program, its graduates, its faculty, and the community it serves.

**Scientific Citations**

ACGME Common Program Requirements. Accessed Oct 25 2019. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf

Burch, C; Guthrie, P; Kidd, M; Lewis, C and Smiler, P. Near-peer Learning in Clinical Education: A Systematic Review [online]. Focus on Health Professional Education: A Multi-disciplinary Journal, Vol. 11, No. 3, June 2010: 1-21.

Young, et al. Developing End-of-Training Entrustable Professional Activities for Psychiatry: Results and Methodological Lessons. Academic Medicine 2018 Jul; 93(7)

## A Resident-led Initiative to Promote Increased Use of Safety Event Reporting Systems by Psychiatry Trainees

**Presenters**

Christina Lee, MD, MPH
Clara Kim, MD
Amber Frank, MD

**Educational Objective**

After reviewing this poster, participants will be able to:
1. Describe the importance of promoting the reporting of adverse events and near misses by residents and fellows
2. List potential barriers to reporting safety events for psychiatry trainees and concrete steps that can be taken to mitigate these barriers

3. Describe how similar quality improvement efforts could be pursued at one's home institution

**Practice Gap**

Nearly two decades after the publication of the Institute of Medicine's landmark report "To Err is Human," medical errors remain a leading cause of death in the United States. As front-line providers at teaching hospitals, residents have a unique and valuable vantage point from which they observe adverse events and near misses. Moreover, ACGME program requirements note that residents must understand their responsibility to report patient safety events and near misses, know how to do so at their institutions, and receive a summary of their institution's patient safety reports. However, studies have shown that residents tend to underreport safety events, potentially compromising patient care as well as ACGME-established educational goals. Psychiatry trainees may also face additional barriers to reporting safety events relative to peers in other specialties, as adverse events may be less concrete and more difficult to define and measure. This poster will describe ways in which training programs can increase psychiatry trainee engagement in institutional safety event reporting, as illustrated by a quality-improvement initiative at Cambridge Health Alliance (CHA) that assessed and improved the rate of safety event-reporting among general psychiatry residents.

**Abstract**

Patient safety event reporting systems are required by both the Joint Commission and ACGME and offer a means to identify and mitigate health hazards in healthcare systems, as well as improve overall patient safety. This poster will describe a quality improvement initiative in the Cambridge Health Alliance (CHA) Adult Psychiatry Residency to increase the rate of safety event reporting by Adult Psychiatry Residents, which historically had been lower than reporting rates by residents in other specialties in our institution. In this resident-led and faculty-mentored initiative, an anonymous quantitative and qualitative survey (n= 26) was first used to identify common barriers preventing psychiatry residents from filing safety event reports. Subsequent focus groups further explored these barriers and identified potential interventions to increase reporting rates. Notably, over 70% of psychiatry residents considered reporting a safety event in the prior year but did not, primarily due to lack of time and lack of confidence that reporting would result in change. A prominent theme that emerged from focus groups included a desire for more closed-loop communication regarding what happens after reports are filed. Key findings from the survey and focus groups were shared with psychiatry residents, the residency training office, and the CHA Department of Risk Management to develop a collaborative improvement plan. A primary feature of this plan was the initiation of a reliable report-back structure, in which a PGY4 chief resident meets with institutional Risk Management on a quarterly basis and shares the outcomes of safety event reports filed by residents at an all-resident meeting.

Over the course of this improvement project, reporting rates among psychiatry residents increased to rates comparable to or even better than other training departments at our institution. In addition, feedback from residents on the PGY4-led report-back presentations has been positive, with residents expressing better understanding of what events qualify as reportable, as well as appreciation for greater transparency around institutional responses to

adverse events and near misses. As the medical field is held to ever-higher standards with respect to medical errors, interventions like this one can play an important role in increasing resident engagement in patient safety and understanding how patient safety initiatives specifically relate to the care of psychiatric patients.

**Scientific Citations**

1. Makary MA, Daniel M. Medical error-the third leading cause of death in the US. BMJ. 2016;353:i2139.
2. American Council on Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. July 1, 2019. Accessed 10/15/2019. <acgme.org/Portals/0/PFAssets/ProgramRequirements/400_Psychiatry_2019.pdf?ver=2019-08-26-134127-827>
3. Hatoun J, Suen W, Liu C, et al. Elucidating Reasons for Resident Underutilization of Electronic Adverse Event Reporting. Am J Med Qual. 2016;31(4):308-14.

## Resident Led Initiatives in Addressing Diversity and Inclusion in Residency Training

**Presenters**

Evelyn Ashiofu, MD, MPH
Lia Thomas, MD

**Educational Objective**

- To emphasize the importance of diversity initiatives in residency training
- To demonstrate a possible way to address the issues pertaining to diversity and inclusion in residency training
- To showcase the initiatives that are being created and implemented at a specific psychiatric residency program

**Practice Gap**

Issues pertaining to diversity in graduate medical education have been of ongoing discussion. It is well established that in order to address the concerns of healthcare disparities, assessments and evaluations of current practices have to be looked at on multiple levels, including the graduate medical level. ACGME has recently included in the core program requirements, the importance of focusing on diversity and inclusion throughout all residency programs. Though there are several recommendations that have been made on how to address this issue at the residency program level, there are very few examples showing what other residency programs have done and how it was implemented. The Diversity and Inclusion Committee at UTSW was created by residents to address this very issue and has become an important body of the residency program. If other residency programs have a similar group in place, it may help to make progress towards this requirement.

**Abstract**
Addressing the issue of disparities in health care has been of ongoing concern for several years. There have been several proposed mechanisms of dealing with this problem. According to the American College of Physicians, health disparities should be addressed by focusing on patient-centered communication, clinician sensitivity to cultural diversity, and efforts to create a diverse health care workforce. The ACGME has also worked to place special focus on the importance of diversity and inclusion. In 2018, the Common Program Requirements, governed by the ACGME, included a component of diversity and inclusion for the first time. This included core milestones pertaining to resident education. These milestones are expected to be mastered prior to graduation. Additionally, the ACGME has shed light on the importance of recruitment of residents, fellows, and faculty from diverse backgrounds. It states that residency programs are expected to "engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents…"(4). Although these goals are of utmost importance, there is currently no clear guidelines or best practices of how to best address this problem. Currently, the University of Texas at Southwestern psychiatry residency program has in place a Diversity and Inclusion Committee (D&I) as part of its greater Residency Education Committee. This resident-created and resident-led group is one made up of diverse residents whose goal is to improve the overall experience of residents in regards to diversity and inclusion. The committee has a focus on residency education in cultural aspects of psychiatry, recruitment of diverse psychiatry residents, patient care and community outreach, and ensuring residents are training in a safe environment. The D&I committee has developed innovative didactic lectures that tackle topics that bridge the gap between psychiatry and diversity. It has also developed creative initiatives that work to increase the numbers of diverse residents in the residency program. This poster serves to showcase some of the efforts the diversity and inclusion committee has made at UTSW and how this is a possible way to address the issue of the lack of diversity in residency training. Creating similar groups in other psychiatry residency programs, whose focus is on the issues of diversity and inclusion, may help to keep this problem as a top priority of the program.

**Scientific Citations**

1) Maldonado, M. E., Fried, E. D., Dubose, T. D., Nelson, C., & Breida, M. (2014). The Role That Graduate Medical Education Must Play in Ensuring Health Equity and Eliminating Health Care Disparities. Annals of the American Thoracic Society, 11(4), 603–607. doi: 10.1513/annalsats.201402-068ps

2) Peek, M. E., Kim, K. E., Johnson, J. K., & Vela, M. B. (2013). "URM candidates are encouraged to apply": a national study to identify effective strategies to enhance racial and ethnic faculty diversity in academic departments of medicine. Academic medicine : journal of the Association of American Medical Colleges, 88(3), 405–412. doi:10.1097/ACM.0b013e318280d9f9

3) Aagaard, E. M., Julian, K., Dedier, J., Soloman, I., Tillisch, J., & Pérez-Stable, E. J. (2005). Factors affecting medical students' selection of an internal medicine residency program. Journal of the National Medical Association, 97(9), 1264–1270.

4) ACGME Common Program Requirements, effective July 1, 2019: https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements. Note that the same CPR accreditation standard on diversity and inclusion exists in both the "Residency" and "Fellowship" documents.

## Assessment of Burnout and Associated Factors in a Group of Psychiatry Residents at a Major Academic Medical Center

**Presenters**
Radu Iliescu, MD
Timothy Scarella, MD

**Educational Objective**

1. Provide an overview of the current psychiatry burnout literature and the need for additional research in the field
2. Assess burnout rates in a cohort of psychiatry residents
3. Determine which residency-specific factors showed a strong association with higher burnout rates in the study participants

**Practice Gap**

In the past three decades, burnout has increasingly been recognized as a major occupational hazard of the medical profession, and is thought to be related to the high emotional and interpersonal demands of the job. (1) During this time period, there have been numerous attempts to quantify and better understand the impact of burnout on physicians. However, these attempts have been complicated by the fact that burnout rates seem to vary significantly based on physician specialty, the country and setting of their practice, their career stage, and their gender. (2) Moreover, the field has been slow to reach a consensus definition of burnout, and there is significant heterogeneity of available measurement tools. (3) All of these factors have led to substantial variation in the literature, with estimated physician burnout prevalence ranging between 0% and 80.5%. (3) Nonetheless, there seems to be agreement around the fact that physician burnout is increasing at an alarming rate and that increased burnout is associated with lower patient satisfaction, poorer quality of care, and decreased patient safety. (4, 5)

Similar findings have been noted for psychiatry, and the psychiatry-specific literature suffers from similar shortcomings related to heterogeneity of definitions and measurements. (1, 4, 5, 6) There are also reasons to believe that psychiatrists are at an even higher risk of burnout than other medical specialties, likely due to the very high emotional and interpersonal demands of caring for psychiatric patients. (1) For these reasons, there is a significant need to continue to assess burnout rates among psychiatrists and to gain a deeper understanding of the associated factors.

**Abstract**

Background

The goal of this study was to evaluate the prevalence of burnout in a cohort of psychiatry residents from a major academic medical center, by using the Maslach Burnout Inventory (MBI), considered the standard tool in the field. (1) In addition, this study aimed to determine which residency-related factors were associated with increased scores in the various burnout domains: emotional exhaustion (EE), depersonalization (DP), and decreased personal accomplishment (PA).

Methods

The psychiatry residents (N=48) training at a medical center in Boston were invited to complete an internet-based survey at two different times in the academic year (April 2019 and June 2019). The survey included the questions from the MBI for Medical Personnel, along with an additional 7 questions asking participants to rate residency-related factors – average number of calls, average number of patients evaluated during a call shift, perceived stress during call shifts, perceived support by supervisors during call shifts, perceived work stress outside of call, perceived life stress outside of work, and satisfaction with work-life balance – based on their experience over the 2 months prior to the survey. Residents were determined to be at risk of burnout based on achieving a high score in at least one of the three MBI domains (EE>26, DP>12, or PA>30). Multiple regression analysis was used to determine which of the seven factors showed a statistically-significant association with increased scores in each of the MBI domains. An additional analysis was performed to determine which of the factors was associated with increased call stress.

Results

The overall survey response rate was 63.5%. Among the PGY1-PGY3 residents, over 60% from each residency class were at risk of burnout based on their MBI scores from April 2019. By June 2019, over 80% were at risk of burnout. For the PGY4 group (lowest call burden in the program), 42.9% and 40.0% were at risk in April and June, respectively. The factors that had a statistically-significant ($p<0.05$) association with increased scores on the MBI among the PGY1-PGY4 residents were perceived call stress (correlated with emotional exhaustion), and satisfaction with work-life balance (correlated with increases in all three domains). Subgroup analyses revealed various statistically-significant associations between other factors and MBI scores – most notable were the June 2019 survey responses (end of academic year) from the PGY2 resident group (highest call burden), which showed that as many as 5 of 7 factors were associated with both emotional exhaustion and depersonalization. Call stress had an independent, statistically-significant association with the average number of patients evaluated during a call shift.

Discussion

A very high percentage of psychiatry residents were at increased risk of burnout and this number increased with progression of the academic year. The factorsmassociated with increased burnout were the residents' satisfaction with work-life balance and their perceived

call stress. In addition, call stress had an independent, statistically-significant association with the average number of patients evaluated during a call shift. Additional research is necessary to determine other factors contributing to increased psychiatry resident burnout in order to develop targeted solutions.

**Scientific Citations**


1. Maslach C, Leiter MP. Understanding the burnout experience: recent research and its implications for psychiatry. World Psychiatry. 2016;15(2):103-111.
2. Lemaire JB, Wallace JE. Burnout among doctors. BMJ. 2017;358:j3360.
3. Rotenstein LS, Torre M, Ramos MA, et al. Prevalence of burnout among physicians: A systematic review. JAMA. 2019;320(11):1131-1150.
4. Panagioti M, Geraghty K, Johnson J, et al. Association between physician burnout and patient safety, professionalism, and patient satisfaction: A systematic review and meta-analysis. JAMA Intern Med. 2018;178(10):1317-1331.
5. Parks T. Report reveals severity of burnout by specialty. American Medical Association. https://www.ama-assn.org/practice-management/physician-health/report-reveals-severity-burnout-specialty Published January 31, 2017. Accessed October 20, 2019.
6. Chan MK, Chew QH, Sim K. Burnout and associated factors in psychiatry residents: A systematic review. Int J Med Educ. 2019;10:149-160.


## Mental Health Trainee Facilitation of Sibling Support Groups: Understanding its Influence on Views and Skills of Family-Centered Care

**Presenters**


Swathi Damodaran, MD, MPH
Eileen Huttlin Kirtane, MD
Emily Lauer, MPH
Emily Rubin, MA
Amber Frank, MD


**Educational Objective**

After viewing this poster, participants will be able to
1. List the benefits of learning family-centered practice skills in residency training.
2. Describe a program in which mental health trainees facilitate a sibling support group, including evidence for its effectiveness in promoting family-centered values and skills.
3. Identify opportunities to implement similar programs at one's own institution.

**Practice Gap**

Family involvement and interactions are listed as core competencies for trainees by the Accreditation Council for Graduate Medical Education (1,2). Research suggests that clinicians share this view and identify skills gained by working with families as important and useful, yet they also report that family-centered skills have historically been among the least taught during training (3-5). This poster describes a novel approach to including family experience during

psychiatry training through trainee facilitation of a sibling support group for siblings of child and adolescent patients with mental illness.

**Abstract**
This poster provides an overview of an elective learning opportunity for trainees in Psychiatry, Psychology, and Social Work to facilitate a support group for siblings of patients admitted to a child and adolescent psychiatric unit, with goals of improving family-centered care and promoting family-centered values and skills among trainees. The program also offers a unique opportunity for exposure to normal childhood development for mental health trainees through working with siblings. In this program, trainee facilitators co-lead a support group in which siblings discuss their experiences growing up with a sibling with mental health needs. They also develop ways to cope with their sibling's mental illness. To evaluate the trainee experience of participation in this program, two adult psychiatry residents with faculty mentorship surveyed facilitator trainees and a control group of non-facilitator trainees about their experience and views of family-centered care. Facilitator trainees also received a second survey to assess their views of their experience leading a sibling support group. The results of these surveys indicated that trainees who participated in this elective had more experience with family-centered care during their training ($p<0.05$), reported greater comfort in using family-centered skills ($p<0.05$), and had greater desire to practice in a family-centered way in the future ($p<0.05$). General psychiatry residency and fellowship training programs that want to improve exposure to family-centered care for their trainees may consider creating similar opportunities for trainees to facilitate sibling support groups.

**Scientific Citations**
1. Berman, Ellen, and Alison M. Heru. 2005. Family systems training in psychiatric residencies. Family Process. doi:10.1111/j.1545-5300.2005.00062.x.
2. Berman, Ellen M, Alison M Heru, Henry Grunebaum, John Rolland, Beatrice Wood, and Heidi Bruty. 2006. Family Skills for General Psychiatry Residents: Meeting ACGME Core Competency Requirements. Academic Psychiatry 30: 69–78. doi:10.1176/appi.ap.30.1.69.
3. Rickerby, Michelle L, and Thomas A Roesler. 2015. Training Child Psychiatrists in Family-Based Integrated Care. Child and Adolescent Psychiatric Clinics of North America 24: 501–515. doi:https://doi.org/10.1016/j.chc.2015.03.001.
4. Slovik, Lois S, James L Griffith, Linda Forsythe, and Alexis Polles. 1997. Redefining the Role of Family Therapy in Psychiatric Residency Education. Academic Psychiatry 21: 35–41. doi:10.1007/BF03341895.
5. Celano, Marianne, Shannon Croft, and Erin Morrissey-Kane. 2002. Family Evaluation Clinic. Academic Psychiatry 26: 17–25. doi:10.1176/appi.ap.26.1.17.

## Don't Sweat It! Check Your Call Guide! Implementation of an on-call guide at a state psychiatric hospital

**Presenters**
Shelby Register, MD

Mary Weinel, MD
Winston Li, MD

**Educational Objective**

1. Identify perceptions and concerns of first-year psychiatry residents regarding overnight call at a state psychiatric hospital.
2. Develop a written guide that may assist residents in developing proficiency in taking overnight call.
3. Assess the impact of the guide towards improving residents' perceptions and concerns regarding overnight call.

**Practice Gap**

First-year psychiatry residents taking overnight call face challenges and concerns that are novel to their level of training. We see potential avenues for improvement in the process of orienting and guiding residents to call shifts. We developed a written guide covering common on-call issues at our institution, and sought to measure the impact this guide had on attitudes and experiences on call shifts.

**Abstract**

Background/Aim

As a first year psychiatry resident, overnight call in a psychiatry hospital can foster an environment of relative autonomy and clinical demand (1). At UNC, when interns take call in the state psychiatric hospital there are a total of 3-4 providers present on site to care for over 400 patients, but only one provider is receiving psychiatric floor calls. There are a variety of patient populations at our state psychiatric hospital: general adults, geriatrics, children, adolescents, and forensics. Although interns will rotate with the adolescent and adult populations during their intern year, in-house call may be the first time that interns provide care for certain populations. Trainees gain experience with a broad range of tasks including assessing and admitting patients, evaluating risk, and devising management plans. In general, on-call periods can be seen as valuable learning experiences and differ from normal daytime work (2). In order to ease the transition for new residents to their on-call experience, we devised an on-call guide book for our state psychiatric hospital. Previously, primers for call for more specialized psychiatric populations have had success with residents finding them helpful (1). The topics of the on-call guide book were proposed by residents that had previously taken call at our state psychiatric hospital. Edits and suggestions were also obtained from both medical and psychiatric attending physicians at the state psychiatric hospital. We hypothesized that a written on-call guide with information about overnight calls would be helpful to first-year residents.

Methods

An on-call guide was distributed to 16 psychiatry interns at UNC Hospitals, who were the target research participants for this study. Participation in this research endeavor was completed on a voluntary basis and was approved by the UNC Institutional Review Board. Surveys were distributed using an anonymous Qualtrics web link. The first survey was distributed before each

intern's first call at our state psychiatric facility to assess their comfort level of responding to overnight pages. Follow-up surveys will be completed on two other occasions: 1) at the end of their first rotation with overnight call and 2) at the completion of their first rotation with overnight call at a state psychiatric facility. Surveys also assessed use of the on-call guide and how the on-call guide affected their comfort with overnight calls.

Outcome
According to provisional data, among the first survey responders, 100% of participants said that they felt an on-call guide would be helpful in knowing how to respond to overnight calls and pages. When asked to rate how comfortable they felt in handling overnight calls, only one participant rated themselves as moderately comfortable, and the majority (60%) felt either slightly or moderately uncomfortable. On pre-rotation surveys, calls about self-harm and aggression were rated as most worrisome by interns. However, after their first rotation, interns rated self-harm and acute mental status changes as most anxiety-provoking. On follow-up survey, every participant (100%) rated that on-call guide at least somewhat improved efficiency during overnight calls. We will continue to collect data.

**Scientific Citations**
1. Thomas, N. A., Van Enkevort, E., Garrett, R. K., & Camp, M. M. E. (2019). Geriatric Psychiatry Inpatient Primer for Residents. Academic Psychiatry, 1-5.
2. Callaghan, R., Hanna, G., Brown, N., & Vassilas, C. (2005). On call: a valuable training experience for senior house officers?. Psychiatric Bulletin, 29(2), 59-61.

## Department-Funded "ClassPass" Membership as a Strategy to Improve Resident Connectedness and Well-being

**Presenters**
Heather Kawalick, MD
Abigail Benudis, MD, MPH
Julie Penzner, MD

**Educational Objective**
1. Consider the top challenges facing residents during training. Explore barriers to well-being.
2. Introduce a model for wellness programming that confers physiologic, financial and psychological benefits.
3. Evaluate resident response to the introduction of a program-funded wellness initiative to see if this intervention improves connectedness to work and to colleagues.
4. Using surveys, quantitatively and qualitatively assess the effectiveness of a program-funded wellness initiative to residents as a means to address the challenges associated with physician well-being in training.

**Practice Gap**

Because of the high risk of physician burnout, the Accreditation Council for Graduate Medical Education (ACGME) recently amended the Common Program Requirements to address wellness. However, specific programmatic initiatives are not specified. Although it is known that exercise, nurturing relationships with others, and lower perceived stress are associated with higher well-being and may be overall protective against both depression and burnout (1, 2), there is little research that has examined the most effective means of promoting these tenets of wellness for residents.

Residents cite overwhelming educational debt, long work hours, sleep disturbances, poor self-care, social isolation, and burnout as top challenges faced during their training. Too often the demands of medical training and the burdens of residency can interfere with young physicians' abilities to practice wellness, and can lead to emotional and physical exhaustion, poor job satisfaction and engagement, and ultimately depression and burnout. In fact, the prevalence of depression or depressive symptoms in residents is estimated to be approximately 29%, ranging from 21% to 43% depending on the instrument used (3). Additionally, residents are more than 1.5 times more likely to exhibit symptoms of depression or burnout than their aged-matched college graduate peers (4). Given the high impact of the problem, varied and creative approaches are needed.

**Abstract**

To lower barriers to resident well-being, specifically financial strain, work hours sub-optimal for exercise, social isolation, and stigma associated with utilizing "wellness" services, the Department of Psychiatry at Weill Cornell introduced a novel Department-funded resident wellness initiative aimed to reduce these barriers and to promote social connectedness among residents. In January 2019, the residency program fully funded 44 resident memberships to ClassPass, a monthly service giving users access to community-based fitness classes and wellness services. ClassPass uses a "credit system." Each resident was given 45 credits per month which they could use alone or with co-residents. 45 credits amounts to approximately 5 workout classes over the course of one month.

Approximately 3 months after the initiation of the wellness initiative, an anonymous survey about resident experience with ClassPass was sent to residents. The survey included 8 questions about exercise habits before and after ClassPass. Perceived ClassPass benefits were also queried, with specific attention to whether perceived benefits increased when exercising with colleagues versus alone, and whether Department-funded exercising enhanced feelings of connectedness to work.

Results

All 44 residents activated their ClassPass memberships and 60% used the membership for exercise or wellness services. 29 out of 44 residents completed the anonymous survey with an overall positive response. 55% of residents responding to the survey used ClassPass to exercise with resident colleagues and 14% exercised with resident colleagues more than two times per week. 69% of respondents strongly agreed that exercise was beneficial to their well-being and

100% of respondents felt that exercising with other residents improved their connectedness toward these same colleagues. 75% of respondents felt more connected to their work and 87.5% felt more connected to the residency program. 100% of respondents felt that the department should continue to offer residents ClassPass in the future.

Discussion

The main finding of our pilot study is that residents responded positively to a Department-funded wellness initiative offering them individual or group fitness, as well as other wellness services. They exercised more, and spent less money on gym membership; we believe that increased exercise and decreased debt are drivers of well-being. However, we also hypothesized that the Department's facilitating residents spending productive time together would increase connectedness feelings among trainees, which might confer psychological benefit at work. Given that a purported etiology for burnout is lack of meaning at work and reduced social connectedness, we aimed to infuse work with more meaning, albeit through a program outside of the work day.

Resident response data supported suggests that ClassPass appears to be an effective intervention in increasing residents' feelings of connectedness to work, to co-workers, and to their residency program. Resident feedback was encouraging, with comments referencing the financial benefits, community building, and wellness promotion. Interestingly, the cost to the Department is relatively small compared to an overall operating budget (approximately $7500 per year). The benefits are as yet unquantifiable.

**Scientific Citations**


1. Laskowski ER, Lexell J. Exercise and sports for health promotion, disease, and disability. PM R. 2012;4(11):795-796.Lebensohn P, Dodds S, Benn R, Brooks A, Birch M, et al. Resident Wellness Behaviors: Relationship to Stress, Depression, and Burnout. Fam Med 2013;45(8):541-549
2. Mata DA, Ramos MA, Bansal N, et al. Prevalence of Depression and Depressive Symptoms Among Resident Physicians: A Systematic Review and Meta-analysis. JAMA. 2015;314(22):2373–2383.
3. Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med 2014:89:443-51.
4. Shanafelt TD, et al. "Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014." Mayo Clinic Proceedings. 2015; 90(12): 1600 – 1613.
5. Dyrbye LN, Thomas MR, Massie FS, et al. Burnout and suicidal ideation among US medical students. Ann Intern Med 2008;149:334
6. Shanafelt TD, Boone S, Tan L, Dyrbye LN, Sotile W, Satele D, West CP, Sloan J, Oreskovich MR. Burnout and Satisfaction With Work-Life Balance Among US Physicians Relative to the General US Population; Arch Intern Med. 2012;172(18):1377-1385.

7. Goldman ML, Bernstein CA, Konopasek L, Arbuckle M, Mayer LES. An intervention Framework for Institutions to meet New ACGME Common Program Requirements for Physician Well Being, Academic Psychiatry 2018 42:542-547.
8. Rogers E, Polonijo AN, Carpiano RM. Getting by with a little help from friends and colleagues. Canadian Family Physician Nov 2016, 62 (11) e677-e683.
9. MacKinnon M, Murray S. Reframing Physician Burnout as an Organizational Problem: A Novel Pragmatic Approach to Physician Burnout. Acad Psychiatry (2018) 42:123–128

## Interprofessional Simulation Training of a Psychiatric Behavioral Emergency

**Presenters**
Jessica Bentzley, MD
Diana Willard, MD
Lisa Ledonne, BS
Kristin Raj, MD
Sallie DeGolia, MD, MPH

**Educational Objective**
1. To identify if an interprofessional combined simulation and didactic educational curriculum can lead to more confidence using a systematic approach to manage a psychiatric emergency.
2. To assess if an interprofessional combined simulation and didactic educational curriculum can lead to more confidence in understanding the roles and responsibilities of each team member when taking care of an agitated patient.
3. To measure if an interprofessional combined simulation and didactic educational curriculum can lead to more understanding the purpose of a post-crisis interprofessional debriefing.

**Practice Gap**
Acute behavioral agitation on inpatient psychiatric units is a high-risk medical emergency that impacts the safety of patients and staff. As such, effective training of physicians, nurses, and security personnel is essential; yet, current training programs are often exclusively didactic and interprofessionally siloed. We hypothesized that a formal, interprofessional training program, focused on experiential simulation-based teaching would improve participant confidence in management of acute behavioral agitation.

**Abstract**
Introduction: Acute behavioral agitation on inpatient psychiatric units is a high-risk medical emergency that impacts the safety of patients and staff. As such, effective training of physicians, nurses, and security personnel is essential; yet, current training programs are often exclusively didactic and interprofessionally siloed. We hypothesized that a formal, interprofessional training program, focused on experiential simulation-based teaching would improve participant confidence in management of acute behavioral agitation.

Methods: A simulation program was developed at an academic medical center. Each simulation included one standardized patient actor who interacted with a team of 1-2 nurses, 1 resident physician, and 1 security officer. The simulation narrative was a patient with psychosis involuntarily hospitalized on an inpatient unit, experiencing an escalating level of agitation that required emergent medications and/or physical restraints. Each simulation lasted 10 minutes, was followed by a 45-min debriefing by faculty, and was accompanied by a 1-hr didactic. Surveys were administered a week before and a week after the simulation to assess confidence, knowledge, etc. Data were collected from 2018-2019. Data for resident physicians are presented herein.

Results: Twenty-six PGY1-2 psychiatry resident physicians completed the simulation program. The pre- and post-simulation response rates were 21/26 (81%) and 15/26 (58%) respectively, with post-simulation surveys still in collection. Self-reported confidence in ability to manage agitation improved (pre: 23.8% of residents were completely or moderately confident; post: 86.7%), as well as confidence in knowledge the physician's specific role (pre: 42.9%; post: 73.3%), confidence in verbal de-escalation (pre: 19%; post: 66.7%); confidence in knowledge of a systematic approach to agitation management (pre: 14.3%; post: 73.4%), and confidence in participating in a post-crisis debriefing (pre: 23.8%; post: 73.4%).

Conclusion: An interdisciplinary simulation experience combined with targeted didactics may be an effective approach to improve confidence in ability to manage acute behavioral agitation. Future directions include re-analysis upon completion of data collection, analysis of nursing and security officer data, and examining effects on patient care.

**Scientific Citations**

Vestal, H. S., Sowden, G., Nejad, S., Stoklosa, J., Valcourt, S. C., Keary, C., et al. (2017). Simulation-Based Training for Residents in the Management of Acute Agitation: A Cluster Randomized Controlled Trial. Academic Psychiatry, 1–6. http://doi.org/10.1007/s40596-016-0559-2

Vieta, E., Garriga, M., Cardete, L., Bernardo, M., Lombraña, M., Blanch, J., et al. (2017). Protocol for the management of psychiatric patients with psychomotor agitation, 1–11. http://doi.org/10.1186/s12888-017-1490-0

## Incorporating residents individual cultural-religious backgrounds into the mentorship model: A mentor-mentee perspective from two psychiatry residency programs

**Presenters**

Zain Memon, MD
Saba Afzal, MD
Ramon Solhkhah, MD
Stacy Doumas, MD

**Educational Objective**

1. To assess differences in perspectives in-between residents and faculty on the importance of incorporating cultural-religious background into the mentorship model

2. To utilize the survey method and results to better recognize and interpret trainee needs and develop tools to assist resident supervisors in their mentoring relationships with trainees

3. To better understand the value of cultural-religious backgrounds in the mentorship model

**Practice Gap**

Residency although classified by many as a daunting experience, is condemned by several as one of the most difficult period of their professional lives. Cultivating academic environment supportive for trainee growth is of prime importance for many prestigious academic centers where the leadership is focused and committed in developing innovative approaches to promote trainee growth and development. Nevertheless, it continues to remain an exhausting task.

United states widely recognized as a country of many nations is a unique place to go through residency because of the sheer diversity of residents and faculty in work place environments from different cultural and religious backgrounds. Good mentoring relationships during residency is one well-established approach utilized to facilitate and encourage trainees professional growth. The literature review suggests various mentor-mentee traits deemed characteristic for a successful mentoring relationship but ver

**Abstract**

It is only human to maintain the status quo; deliberate and proactive behaviors are required to counteract factors that contribute to the observed disparities in academic and career outcomes. One of those factors documented in the scientific literature is access to evidence-based mentorship, particularly mentorship that embraces and celebrates the cultural diversity within mentoring relationships. At its best, mentoring can be a life altering relationship that inspires mutual growth, learning, and development. Its effects can be remarkable, profound and enduring with the capacity to transform individuals' groups, organizations and communities.

The published literature identifies various important traits that contribute to a successful mentoring relationship but very few studies if any comment on the impact of incorporating mentees' cultural-religious background into the mentorship model during residency.We conducted a self-administered electronic survey which was emailed to residents and faculty of two psychiatry residency programs to gauge the percentage of faculty that factor in the individual residents' diverse cultural-religious background into their mentorship model, their reasons for following such a model and their experiences on its impact on resident outcomes.

The resident survey was utilized to assess residents' perspective about the faculty sufficiently applying the sensitized cultural-religious mentorship model approach for their personal and professional growth and to share their impression if such an approach is or would be beneficial.

Results showed that 85% (17/20 total) of residents and 73% (11/15 total) of the faculty completed the survey. Only 47% of residents reported their mentors taking into account their cultural-religious practices Versus 82% of faculty who reported taking into account residents cultural-religious background in their mentorship model to further resident professional growth. 91% of faculty reported, the cultural-religious sensitized mentoring approach being beneficial for residents personal as well as professional growth. 71% of the residents and 90% of the surveyed faculty gave supporting feedback on incorporating a mentorship model that accounts for mentee's individual cultural-religious nuances to help groom their abilities for productive outcomes in training as well for their successful transition into practice.

A successful mentorship model requires the ability to come to a clear understanding of each mentee's unique needs and desires as well as mentee's ability to capitalize on an opportunity towards their chosen goal. The results of this small survey although has many limitations but it provides a unique insight into the perspectives of psychiatry residents and program faculty at the two psychiatry residency programs. It highlights the importance of utilizing participant voices to tailor interventions for maximum impact in individual programs. Future research needs to focus on how such tailored interventions can be utilized to develop meaningful tools for better generalizability.

**Scientific Citations**


- House, S., Spencer, K. and Pfund, C. (2018), "Understanding how diversity training impacts faculty mentors' awareness and behavior", International Journal of Mentoring and Coaching in Education, Vol. 7 No. 1, pp. 72-86. https://doi.org/10.1108/IJMCE-03-2017-0020

- Pfund, C., Byars-Winston, A., Branchaw, J. et al. Defining Attributes and Metrics of Effective Research Mentoring Relationships. AIDS Behav (2016) 20(Suppl 2): 238. https://doi.org/10.1007/s10461-016-1384-z

- Stephen A. Geraci MD and S. Calvin Thigpen MD. A Review of Mentoring in Academic Medicine American Journal of the Medical Sciences, The, 2017-02-01, Volume 353, Issue 2

- Ragins, Belle & Kram, Kathy. (2007). The Handbook of Mentoring at Work

- Warner, C.H., Rachal, J., Breitbach, J. et al. Acad Psychiatry (2007) 31: 270. Current Perspectives on Chief Residents in Psychiatry. https://doi.org/10.1176/appi.ap.31.4.270

# Keeping up with the Joneses: Impact of benefits for Canadian vs. US residents as a means of enhancing well-being.

**Presenters**
Gurjot Malhi, MD
Vishal Madaan, DFAACAP, FAPA, MD

**Educational Objective**

1. Review the differences between benefits available to Canadian and American residents and physicians.
2. Identify key differences that can be adopted from the Canadian system to promote resident and faculty well-being in US.

**Practice Gap**

Research on the burnout and wellness has consistently revealed that the prevalence of burnout is significantly higher in physicians compared to other professionals as well as the general population. It has also been demonstrated that several factors involving well-being are local or personal. As the focus shifts to finding ways to improve well-being in residency training, outside the box measures in multiple domains are necessary. This poster explores the benefits provided to physicians during residency in Canada and discusses the feasibility of adopting some of the strategies to US residency programs, such as enhanced parental leave policies. Additionally with increasing interest in single payer reform , this poster also explores the benefits to physicians of a single payer system as established and demonstrated in Canada.

**Abstract**

As training directors and Graduate Medical Education (GME) officers grapple with making substantial changes in strategies to address trainee burnout and enhance well-being, a variety of potential options at individual, programmatic and institutional measures are being considered. While it is clear that 'one size fits all' approaches don't work, it is often local measures that have considerable 'buy-in' from the trainees. For example, a local change brought in with 6 weeks of paid parental leave policy has been initiated at one of the authors' workplace, which may have significant impact on residents pursuing parenthood during their training. The ACGME has also brought physician burnout and wellness into limelight by emphasizing the importance of this topic and by calling out to experts nationally to find solutions to tackle this challenge. This poster session will aim to explore wellness strategies employed in Canada by reviewing the benefits provided to residents in Canada and compare them to benefits in US. We will compare the national reports published by Canadian Resident Matching Services (CaRMS) and Association of American Medical Colleges (AAMC). Thereafter, we will aim to identify the key differences among these benefits and provide future directions to implement and study some of the strategies already employed by Canadian residencies. With a growing interest on single payer system, we will also explore differences between

benefits and work responsibilities of physicians during and after residency both in Canada and US.

**Scientific Citations**


1. Forese, L. (2018, October 9). Making the case for parental leave during residency. Retrieved from https://www.aamc.org/news-insights/insights/making-case-parental-leave-during-residency
2. Morra D, Nicholson S, Levinson W, Gans DN, Hammons T, Casalino LP. US physician practices versus Canadians. Health Aff (Millwood). 2011;30(8):1443-1450.
3. Salaries and benefits for postgraduate training by province. (2019). Retrieved from https://www.carms.ca/match/r-1-main-residency-match/salary/#1511459027032-06ec5e41-5301
4. Survey of Resident/Fellow Stipends and Benefits Report. (2019). Retrieved from https://www.aamc.org/system/files/reports/1/2018stipendsurveyreportfinal.pdf
5. Tawfik, D. S. et al. Physician Burnout, Well-being, and Work Unit Safety Grades in Relationship to Reported Medical Errors. Mayo Clin. Proc. 2018;93:1571–1580
6. Vidovic, D. Physician burnout: Current perspectives. Dalhousie Medical Journal, 2019;45(2).
7. Woolhandler S, Himmelstein DU. Single-Payer Reform - "Medicare for All". JAMA. Published online May 31, 2019321(24):2399–2400. doi:10.1001/jama.2019.7031


## Challenges of implementing "M-PSYCH-PASS": A two year follow up study following adaptation of a psychiatric hand-off system

**Presenters**


Ana Ozdoba, MD
Arslaan Arshed, MD
Samantha Labib, MD


**Educational Objective**

- Discuss the two year follow up data of "M-PSYCH-PASS", a hand-off process developed and implemented at Montefiore Medical Center's Department of Psychiatry Residency Training program.
- Describe the challenges and barriers to the implementation of an inpatient hand-off embedded in the electronic medical record.
- Describe the methods utilized to improve training, ongoing monitoring and supervision of an inpatient psychiatric hand-off process.

**Practice Gap**

Residency training programs are tasked with ensuring that patients are safely transitioned between providers and continuity of care in ensured during the hand-off process. There is limited literature on the hand-off process in Psychiatry, with one exception being M-PSYCH-PASS, a hand-off process implemented in our Psychiatry residency training program back in

2017, adapted from "I-PASS" hand-off used in Pediatrics. After two years of utilizing this hand-off system, we aim to discuss the barriers and limitations involved in implementing “M-PSYCH-PASS” as well as share methods utilized to improve training, education and ongoing monitoring and supervision of this hand-off process in the inpatient psychiatric unit.

**Abstract**
In 2003, resident duty hours were reduced to promote an era of safer medicine with decreased patient morbidity and mortality. Despite this, studies have revealed that restrictions on duty hours had little impact on patient care.[1] It became apparent that decreased duty hours resulted in more resident hand-offs, which ultimately led to increased medical errors from inadequate communications during transition of care.[2,3] In response, the Joint Commission on Patient Safety set a goal in 2006 to improve communication related to transitions of care. Various formalized methods of hand-off were created for specialties, with studies suggesting reduction of medical errors and preventable adverse events.4 Despite this growing evidence that favored the use of formal hand-offs incorporated into hospital electronic medical records (EMR) systems, no EMR-based hand-off was created for Psychiatry until the development of PSYCH-PASS in 2017. [4,5]

The Department of Psychiatry at Montefiore Medical Center created a hand-off system called  M-PSYCH-PASS , which was adapted from the well-studied  IPASS .4 This hand-off system was incorporated into the EMR EPIC. The components of "M-PSYCH-PASS" are: Montefiore, Patient summary, Situational awareness,  whY  is the patient here, Comorbidities, Hemodynamics, Pharmacology/PRNs, Action list, Specifics, and Synthesis.  This hand-off system was implemented within the psychiatry inpatient services. Residents, fellows and attendings were trained on the hand-off mnemonic, participated in two educational workshops, and were instructed to utilize M-PSYCH-PASS as their hand-off system.

Two years after the implementation, a survey was distributed to psychiatry residents to evaluate the new hand-off s functionality and identify

**Scientific Citations**
1. Bolster, L., & Rourke, L. (2015). The Effect of Restricting Residents' Duty Hours on Patient Safety, Resident Well-Being, and Resident Education: An Updated Systematic Review.?Journal of graduate medical education,?7(3), 349–363. doi:10.4300/JGME-D-14-00612.1
2. Riebschleger M, Philibert, I. (2011) The ACGME 2011 Duty Standard. Chicago, IL: ACGME.
3. Ulmer C, Wolman D, Johns M, eds; Committee on Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedules to Improve Patient Safety, Institute of Medicine. Resident Duty Hours: Enhancing Sleep, Supervision, and Safety. Washington, DC: National Academies Press; 2008.
4. Amy J. Starmer, Nancy D. Spector, Rajendu Srivastava, April D. Allen, Christopher P. Landrigan, Theodore C. Sectish. I-PASS, a Mnemonic to Standardize Verbal Handoffs. Pediatrics. Feb 2012;129(2): 201-204.
5. Patel, D.A., Arshed, A., Woulfe, J. et al. Acad Psychiatry (2019) 43: 503.

# Addressing the Nationwide Shortage of Child and Adolescent Psychiatrists: Determining Factors Influencing the Decision to Pursue Child and Adolescent Psychiatry Training

**Presenters**
Sarah Mohiuddin, MD
Nancy Cheng, MD

**Educational Objective**
1. Attendees will review current information around the growing need for child and adolescent psychiatrists in the nation.

2. Attendees will review which factors influence whether medical trainees choose to pursue training in general psychiatry.

3. Attendees will review which factors determine whether residents pursue additional training in child and adolescent psychiatry.

4. Attendees will discuss methods in which residency training may bolster exposure to child and adolescent psychiatry based on preliminary data

**Practice Gap**
There has been a widely recognized shortage of child psychiatrists within the nation, which was formally identified and addressed in the Report of the Surgeon General in 1999. This problem has continued to grow over the past two decades. Despite increasing numbers of medical students applying and matching in general psychiatry training programs, child psychiatry fellowship programs continue to have unmatched and unfilled positions, with disproportionate openings for fellowship positions in the midwestern region of the United States. Several proposals have been put forth to address this gap, including shortening the length of training. However, little is known about why residents do or do not choose to pursue further training in child psychiatry.

**Abstract**
Background: The American Academy of Child and Adolescent Psychiatry's task force on workforce needs projected that the demand for child psychiatrist will increase by 100% between 1995 and 2020, which translates into 12,624 psychiatrists needed to meet demand at present. This is far greater than the current supply of 8,312 child psychiatrists in practice. While the number of child and adolescent psychiatry fellows has steadily increased from 709 fellows in 2004 to 858 in 2017, there remain significant barriers in recruiting the volume of child and adolescent psychiatrist necessary to meet the national shortage.

Purpose: To identify factors that influence whether psychiatry residents pursue child and adolescent psychiatry fellowship

Method: In this study, standard surveys were administered to all the current University of Michigan general psychiatry residents in their PGY-1 through PGY-4 year of training. IRB approval was obtained to administer the survey. The survey comprises of 5 multiple-choice demographic questions followed by a 24 item Likert scale assessment inquiring about the importance placed on various factors in determining future career choice and statements pertaining specifically to the field of child psychiatry.

Results: 32/45 residents completed the survey. Of those residents, 91% rated personal interest in the specialty as being extremely/very important in determining their field of training. Other top factors influencing specialty choice which were rated as extremely/very important include work-life balance (81%), ability to work directly with patients (75%), future job prospects/job security (71%), and working with mentors within the field of interest (59%). Of the items surveyed, the items that were rated as not at all/slightly important in specialty career choice by residents were the specialty's reputation within the field of medicine (56%), followed by confidence in matching (31%), length of training (28%), and scientific advancements within the field (28%).

Within the context of child psychiatry, there was greatest consensus amongst residents that child psychiatry offered ample job opportunities with 100% of residents answering strongly agree/agree to that statement. This was followed by 97% of residents identifying the child psychiatry program at the University of Michigan being a reputable program, 87% stating that child psychiatry would allow them to live in a desirable geographic area, 80% agreeing that child psychiatry would confer a good work-life balance, and 80% of residents finding the field of child psychiatry to be intellectually stimulating.

Discussion: The nationwide shortage of child psychiatrists is well recognized by psychiatry residents. Personal interest in a subspecialty was identified as the most important factor in determining career choices by residents. While a majority of residents voiced interest in child psychiatry, a minority of graduating residents ultimately opted to pursue fellowships in child psychiatry.

Conclusions: Given the high levels of interest in child psychiatry amongst general psychiatry residents, it would be important to further identify avenues by which psychiatry training programs can hone residents' existing interest in child psychiatry with the ultimate goal of training more child psychiatrists to meet the growing need.

**Scientific Citations**

1) AACAP Work Force Fact Sheet (April 2019) {https://www.aacap.org/App_Themes/AACAP/docs/resources_for_primary_care/workforce_issues/workforce_factsheet_updated_2018.pdf]. Retrieved from American Academy of Child and Adolescent Psychiatry (2019, June 20).

2) Dept. of Health and Human Services, U.S. Public Health Service. (1999). Mental health: A Report of the Surgeon General: Executive Summary. Rockville, MD.

3) Kim, W.J. & The American Academy of Child and Adolescent Psychiatry Task Force on Workforce Needs Acad Psychiatry (2003) 27: 277. https://doi-org.proxy.lib.umich.edu/10.1176/appi.ap.27.4.277

## Psychiatry Milestones-Based Learning Trajectories: A Multisite Collaborative Study

**Presenters**
Yoon Soo Park, PhD
Robert Marvin, MD
Robert Lloyd, MD, PhD
Senada Bajmakovic-Kacila, MD
Ara Tekian, PhD

**Educational Objective**

1. Understand trends in developmental progress of psychiatry residents in meeting expected milestones toward unsupervised practice.
2. Identify multiple learning trajectories that reflect different patterns of learning.
3. Implement best-practice guidelines that link learning trajectories to educational curriculum to support learners that need remediation.

**Practice Gap**

The Next Accreditation System (NAS) by the Accreditation Council for Graduate Medical Education (ACGME) has prompted residency programs to transform the training and assessment of learners in graduate medical education.1,2 To meet this challenge, psychiatry assessment tools, including rotation evaluation forms, cognitive tests, and clinical skills assessments have been developed to align with the Psychiatry Milestones (22 subcompetencies). Milestones are reported to the ACGME every six months, reflecting developmental progress of learners. However, validity evidence supporting these assessments has not been sufficiently investigated, including their contribution to progress on the milestones.3

Trended milestone levels reported to ACGME every six months could serve as learner outcome data that can be used to measure learning trajectories.4,5 To date, only hypothesized learning trajectories exist, without empirical evidence supporting different patterns. Using the multisite collaboration, retrospective data from the three institutions will allow identifying different patterns of learning trajectories in psychiatry (i.e., number and types of learning trajectories), which can serve to target and remediate learners who may show signs of difficulty in their training. Identifying learning trajectories will also allow study of factors that may mediate their learning progress.

**Abstract**

Purpose: Examining learning trajectories will form a contribution to psychiatry education that meets the educational goals of the NAS and prepares better psychiatrists for unsupervised practice. This study investigates how psychiatry residents progress in their training with respect to their milestone levels, targeting different types of developmental learning trajectories. We aim to identify patterns of learning trajectories that can yield meaningful intervention and remediation for psychiatry residents.

Methods: Data from The Chicago Consortium were collected, from July 2015 to June 2019. Multisite data from cohorts of psychiatry residents (n = 26 residents; 3 psychiatry residency programs) were used to evaluate learning trajectories, focusing on subcompetencies in patient care and medical knowledge. Descriptive statistics were used to examine trends in data. Mixed-effects longitudinal regression methods were used to examine longitudinal learning trajectories of residents.

Results: Data from residents showed significant improvement in milestones levels across training years and reporting periods, $p < .001$. Patterns of developmental progress varied by competency; medical knowledge and patient care had consistent improvement across training years, whereas professionalism had higher milestone rating at baseline (PGY-1), but slower rate of improvement during the final years of training. Results also yield multiple patterns of developmental learning trajectories that vary by subcompetencies; some trajectories showed rapid increase, whereas other trajectories had more gradual and delayed growth.

Conclusions: Learning trajectories in psychiatry can be used to understand residents' developmental progress which can be tailored to create more individualized learning plans.

**Scientific Citations**

1. Nasca TJ, Philibert I, Brigham T, Flynn TC. The next GME accreditation system. New England Journal of Medicine 2012; 366:1051-6.
2. Swing SR, Cowley DS, Bentman A. Assessing resident performance on the psychiatric milestones. Academic Psychiatry 2014; 38:294-302.
3. ten Cate O, Snell L, Carraccio C. Medical competence: the interplay between individual ability and the health care environment. Medical Teacher 2010;32:669–75.
4. Park YS, Riddle J, Tekian A. Validity evidence of resident competency ratings and the identification of problem residents. Medical Education 2014;48:614-22.
5. Park YS, Zar FA, Norcini JJ, Tekian A. Competency evaluations in the next accreditation system: Contributing to guidelines and implications. Teaching and Learning in Medicine 2016; 28:135-45.

# Advocacy Curriculum can Mitigate Burnout

**Presenters**
Lisa Durette, MD
Sandra Fritsch, MD
Syed Quadri, MD

**Educational Objective**
This poster will include an innovative advocacy curriculum outline as well as our trainee's anectodal experience in advocacy:
1) Demonstrate the importance of training in advocacy components of advocacy curriculum and the connection to ACGME milestones
2) Describe a fellow's experience within an advocacy curriculum
3) Future direction: quantify the connection between advocacy training and professional satisfaction, trainee retention and reduced perceived burnout as well as future plans to quantify burnout pre and post curricular experience (1) Thomas and colleagues, as well as other studies, examine the psychometric validity of the Maslach Burnout Inventory for Healthcare Professionals.

**Practice Gap**
Studies demonstrate 25-60% physicians experience burnout, and specifically Low's metaanalysis reveals a 42% aggregate burnout rate amongst psychiatry trainees.(2) Many trainees leave residency and fellowship with little exposure to the intersection between local, state and federal governance and clinical practice. Too frequently this leads to factors contributing to burnout including a lack of autonomy and professional uncertainty.(3) To have agency over your destiny increases a sense of internal control and reduces perceived helplessness. 2002, Williams ES et al in Health Services Review describe a positive correlation between increased control over one's workplace and higher career satisfaction/lower reported stress. The skills and knowledge base gained from an experiential advocacy curriculum provides such agency and engenders lifelong career competencies, improves overall professional satisfaction, and can improve local retention of trainees by engagement in the local community.

Mental health issues are continuously discussed in the public arena on TV, computer or radio. Debates are common surrounding gun violence, suicide, federal and state funding for mental health, all topics that intersect with psychiatry. The common program requirements of the ACGME do not include specific guidance on the inclusion of advocacy in training, whereas some of the core child psychiatry competency milestones do include advocacy in their description: MK3, level 5; MK6, level 5; PROF2, level 4. (4) A literature search using keywords of Advocacy+Psychiatry+/-Training+/-GME only reveals scant articles from the 1970s-80s, yet there is a robust discussion of advocacy in the general medical literature. Psychiatrists are trained to apply a systems-based framework to the care of their patients, incorporating elements such as socioeconomic status, local resources, education/employment, and food/housing security into our clinical formulations and treatment planning Public systems,

which impact patients, are under the umbrella of social determinants of health (World Health Organization), and have become a focus of the American Academy of Pediatrics who now formally includes a robust advocacy expectation for both didactics and experiences.
These elements collectively present myriad opportunities for the psychiatrist to advocate for the needs of their patient. At this time, few training programs formally incorporate social determinants of health and advocacy into their training curriculum.

Advocacy is a skill we believe is crucial to the welfare of our patients, their families and is a core competency of our profession. Without the voice of psychiatrists, legislative decisions are made in the mental health arena which are not aligned with the best interest of the individual, and may create barriers to the successful execution of our profession. Thus, we are presenting this curriculum to illustrate inclusion of advocacy into psychiatry training from both the perspective of the faculty and the trainee.

**Abstract**
Psychiatry training currently does not include ADVOCACY as a core component. Yet, our clinical milestones incorporate prompts which encompass the skills and practice of an advocate. For example, MK-6 (Practice of Psychiatry), PBLI-3 (Teaching), SBP and PROF all describe the roles of an advocate: teacher, communicator, ethical psychiatrist.

Anecdotally, through regional training director discussion at AADPRT, the authors receive feedback from recent graduates that they are frustrated with low insurance reimbursement, laws that appear counter to best practice recommendations in psychiatry, and stigma against mental health. These early career psychiatrists often report they don't know where to turn. The skills and practice of advocacy during training can be transferred to early career practice and lead to professional satisfaction.

The UNLV Department of Psychiatry created a formal advocacy curriculum that focuses on engaging lawmakers, learning the existing mental health policies on the local and federal level, as well as providing education to various stakeholders. After training, a psychiatrist in this role is able to translate scientific knowledge and various clinical experiences to policy makers that impact the lives of children and adolescents. Going beyond the scope of direct clinical care and individual patient interactions develops well-rounded psychiatrists that have a professional duty to do no harm to those that don't have a voice in the legislative process.

Our four-part curriculum includes the following elements:
- Didactic session defining advocacy and lobbying. Lecture includes descriptions of local coalitions and consortia, and local, state and federal governance. Instruction also includes a basic overview of the pathway for a bill draft to become a law, and the areas in which an advocate can intervene in the creation of the law.
- Trainees independently select a topic about which they wish to advocate. Examples include educating local leaders on the role of a psychiatrist, testimony supporting or refuting a bill draft, and visits to local legislators' offices to discuss specific mental health issues. The

trainee receives supervision pertaining to their desired advocacy work which helps refine their planned advocacy task.

- Experiential phase: trainees engage with local leaders or legislators and deploy their advocacy activity
- Reflection: trainees write a reflection paper and discuss their experience during didactic session. The reflection phase describes what the trainee has learned, identifies gaps in the local system of care the trainee has identified, and the skills practiced that the trainee learned in the curricula.

To date 8 child and adolescent psychiatry fellows have participated in our advocacy curriculum. Feedback from past trainees has been overwhelmingly positive about the inclusion of this curricular element. Trainees have met with our state governor, have traveled to Washington, DC and have become members of local consortia advocating for children's mental health. Furthermore, 100% of our graduates have remained in the local area following training and all continue to deploy the skill of advocating for their patients and their profession.

**Scientific Citations**

References:

1 - Thomas J. Kalliath, Michael P. O'Driscoll, David F. Gillespie & Allen C. Bluedorn (2000) A test of the Maslach Burnout Inventory in three samples of healthcare professionals, Work & Stress, 14:1, 35-50

2 – Low et al: Prevalence of Burnout in Medical and Surgical Residents: A Meta-Analysis Int. J. Environ. Res. Public Health 2019, 16, 1479

3 – Patel, et al: Factors related to physician burnout and its consequences: a review, Behav. Sci. 2018, 8, 98; doi:10.3390

4 -- https://www.acgme.org/Portals/0/PDFs/Milestones/ChildandAdolescentPsychiatryMilestones.pdf

## Revisiting Trainee Wellbeing Through Group Process: Comparison of Weekly Wellness Groups in a CAP Fellowship

**Presenters**

Michelle Parker, MD
Amy Egolf Parker, MD
Douglas Bernon, PhD
Elizabeth Lowenhaupt, MD
Jeffrey Hunt, MD

**Educational Objective**

1. Describe ways in which a weekly process group benefits trainee wellness

2. Become familiar with the way in which an outcomes logic model can aid the development of similar wellness interventions
3. List components of wellness valued by trainees
4. Compare effectiveness of two different wellness groups within the same residency program

**Practice Gap**

Physician wellness both in medical training and practice has been highlighted more frequently in the literature in recent years. Physician burnout is a psychological syndrome emerging as a prolonged response to chronic stressors on the job leading to overwhelming exhaustion, feelings of cynicism and a sense of ineffectiveness (Maslach 2016). The phenomenon of burnout affects about 50% of physicians in practice and in training, including students and residents, and is prevalent in all fields of medicine (Dyrbye 2008; Dyrbye 2013; Shanafelt 2015). It is well documented that physician burnout can result in negative effects on patient care, professionalism, and physicians own health including being diagnosed with depressive and substance use disorders (West 2016). The alarming rates of physician and resident suicide further highlight the need for promoting wellness in training (Yaghmour 2017). Despite several personal characteristics in a physicians' themselves such as adaptability, optimism and flexibility that contribute to physician resilience, leaders in medical school and post-graduate medical education have an opportunity to foster workplace characteristics shown to promote resilience in challenging workplace environments including creating a secure base with strong management support and time for reflection (Matheson 2016). Such interventions have the potential to promote wellness practices throughout the professional career, thus decreasing burnout and improving patient care. Despite the abundant need, there are few studies looking at specific interventions to promote wellbeing during post-graduate medical education training (Ripp 2017).

**Abstract**

Introduction and Hypothesis: The Brown University Child and Adolescent Psychiatry Fellowship and Triple Board Program instituted a weekly, 45-minute group for both first and second year fellows and 4th and 5th year Triple Board residents beginning in 2013. The group, entitled "Reconsidering Certainties," is run by a doctorate level psychologist and meets separately for both junior and senior level trainees for the duration of each academic year. The group, a total of eight members per class per year, meets during the required didactic day for all fellows and residents. Since its inception, the overarching goal of the group has been to improve trainee wellness. The group aims to accomplish this via several means, including but not limited to easing the transition into fellowship, improving thoughtful clinical care of patients, and providing a community of peers with whom the trainees feel comfortable discussing difficulties of daily practice and life in medicine. In 2019, a new group, "Perspectives in Wellness & Practice" was introduced to incoming first year fellows and 4th year Triple Board Residents with a new doctorate level psychologist leader due to the leader of "Reconsidering Certainties" planned retirement in the summer of 2020. The initial group, "Reconsidering Certainties" was studied using an outcomes logic model in 2017 to investigate the effectiveness of the group to reach desired learner outcomes and found to have a significant or profound effect on wellness.

Methods: An outcomes logic model was used to design the study. This model provides a structure for the program to examine the degree to which the desired learner outcomes, program delivery methods, and measurement approaches are aligned. The goals and objectives that were defined as part of the group's formation were used to identify several areas that could be assessed using a survey. An anonymous survey was then created consisting of 10 questions related to planned outcomes, as well as general questions related to wellness. This survey will be sent via e-mail to current group participants of both "Reconsidering Certainties" (N=8), as well as "Perspectives in Wellness and Practice" (N=8), to study potential differences in group outcomes, as well as all graduates who previously attended "Reconsidering Certainties" (N=24).

Results: We have previously demonstrated that a weekly, 45-minute group held during regular duty hours was an effective means of promoting trainee wellness through a prior study. We hypothesize that despite changes in seminar leadership and structure with "Perspectives in Wellness and Practice", fellows will continue to find this a meaningful forum to promote physician resilience. This poster will provide qualitative and quantitative analyses of the two current groups, as well as demonstrate the long-lasting benefits to trainees who have graduated from Brown's child and adolescent fellowship program.

Conclusions: Given the relatively limited resources and time needed to run such a group, the implementation of similar groups across various levels of training in medical school, residency, and fellowship is a feasible and cost-effective method of promoting wellness that has the potential for significant and long-lasting benefits to trainees.

**Scientific Citations**

Dyrbye, L.N. et al., (2008). Burnout and suicidal ideation amount US medical students. Annals of Internal Medicine,149(5):334-41.

Dyrbye, L.N. et al., (December 2013). Physician satisfaction and burnout at different career stages. Mayo Clinic Proceedings, 88(12):1358-67.

Maslach, C. & Leiter, M.P., (2016). Understanding the burnout experience: recent research and its implications for psychiatry. World Psychiatry,15:103-111.

Matheson, C. et al., (July, 2016). Resilience of primary healthcare professionals working in challenging environments: A focus group study. British Journal of General Practice, 66(648):e507-15.

Ripp, J.A. et al., (July, 2017). Well-being in graduate medical education: A call for action. Academic Medicine, 92(7):914-17.

Shanafelt, T.D. et al., (December, 2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clinic Proceedings, 90(12):1600-13.

West, C.P. et al., (2016). Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. The Lancet, 388(10057):2272-2281.

Yaghmour, N.A. et al., (July, 2017). Causes of death of residents in ACGME-accredited programs 2000 through 2014: Implications for the learning environment. Academic Medicine, 92(7):976-83.

## Vitality Signs: A monthly lecture series for residents that addresses multiple dimensions of wellness

**Presenters**
Cortney Taylor, MD
Elizabeth Lowenhaupt, MD
Jeffrey Hunt, MD

**Educational Objective**
List multiple domains of individual wellness that are targeted in this intervention
Explain the aim of the Vitality Signs lecture series
Describe how the lecture series will be evaluated and predicted outcomes

**Practice Gap**
Residency program directors are faced with a challenge: the rates of reported burnout are high and the consequences can be significant, influencing patient care and resident mental health (IsHak 2009). However, information about how to solve this serious issue is still limited and the proposed interventions can vary significantly in their focus with limited information to support what is effective (Busireddy 2017). Program leadership often faces difficult decisions about how to incorporate effective interventions while balancing service demands and educational needs. In addition, the trainees that the intervention is aimed at reaching will also vary in the strengths and vulnerabilities that they bring with them into training. This lecture series takes a multidimensional approach and makes use of clinician role models who are invited to speak to the group based on their expertise in a selected topic. Residents are given a voice to select topics that they are most interested in learning about. By holding the lecture at lunch and providing a meal, it incentives residents to attend the lecture series and does not take away from other demands. Many trainees end up utilizing the same means of coping with the demands of being a resident and this curriculum looks to offer those tools to everyone in a more formal way and hopefully acts to address burnout before it sets in. It also sends a clear message that attempts to attend to one's own wellness in residency are valued and accepted as a part of our culture.

**Abstract**

Introduction: Evidence continues to accumulate that supports high rates of burnout in medical trainees with associated effects on patient care and resident mental health. However, less data has been published supporting specific interventions to reduce burnout and increase resilience. There are multiple domains of wellness that can contribute to individual wellbeing that include social, emotional, financial, physical, occupational and intellectual that can be targeted to support resident wellbeing.

Methods: Monthly hour-long lectures are given to a group of fifteen combined pediatric/psychiatry/child psychiatry residents on rotating topics presented by a guest speaker with lunch provided funded by the Rhode Island Hospital Graduate Medical Education Wellness Grant. Lecture topics were selected based on a need assessment performed at the initial meeting, in addition to providing a list of resources including local healthcare providers. Topics will include social wellness, justice-doing, sleep, nutrition, mindfulness and yoga, financial planning, mentorship, therapy, acupuncture, narrative medicine and gratitude. Anonymous surveys are being collected to assess resident behavior prior to the presentation and will be collected at the end of the year to assess whether a change in behavior occurred, in addition to qualitative and quantitative feedback about the individual lectures.

Results: Pre and post-lecture survey data will be compared to assess the number of residents engaging in the behavior targeted in each lecture. For example, the number of residents that are currently engaged in individual therapy will be assessed prior to the lecture and again at the end of the year. Other examples would include changing their sleep schedule and nutrition habits, having primary care providers in the area, practicing mindfulness, engaging in social justice work and attending resident social events. The expected result is that the number of residents engaging in these healthy behaviors will increase after the lecture. Feedback about the individual lectures will be used to modify the curriculum for future years and demonstrate that the lecture series did influence resident behavior.

**Scientific Citations**

IsHak, W. W. et al., (2009). Burnout during Medical Training: A Literature Review. Journal of Graduate Medical Education, 1(2): 236–242.

Bussireddy, K. R. et al. (2017). Efficacy of Interventions to Reduce Resident Physician Burnout: A Systematic Review. Journal of Graduate Medical Education, 9(3): 294–301.

# Successes and Challenges in Implementation of a Wellness Curriculum in a CAP Fellowship Training Program

**Presenters**
Michelle Parker, MD
Kristyn Storey, MD
Elizabeth Lowenhaupt, MD
Jeffrey Hunt, MD

**Educational Objective**
1. Describe ways in which the formal implementation of a wellness curriculum in the 2018-2019 academic year, with a focus on burnout and vicarious trauma, benefits trainee wellness
2. Present data on trainee burnout before and after implementation of 2018-2019 wellness curriculum
3. Describe changes implemented thus far to 2019-2020 wellness curriculum including shifting focus from trainee burnout to wellness

**Practice Gap**
Physician wellness both in medical training and practice has been highlighted more frequently in the literature in recent years. Physician burnout is a psychological syndrome emerging as a prolonged response to chronic stressors on the job leading to overwhelming exhaustion, feelings of cynicism and a sense of ineffectiveness (Maslach 2016). The phenomenon of burnout affects about 50% of physicians in practice and in training, including students and residents, and is prevalent in all fields of medicine (Dyrbye 2008; Dyrbye 2013; Shanafelt 2015). It is well documented that physician burnout can result in negative effects on patient care, professionalism, and physicians own health including being diagnosed with depressive and substance use disorders (West 2016). The alarming rates of physician and resident suicide further highlight the need for promoting wellness in training (Yaghmour 2017). Despite several personal characteristics in a physicians themselves such as adaptability, optimism and flexibility that contribute to physician resilience, leaders in medical

**Abstract**
Introduction: The Brown University Child and Adolescent Psychiatry Fellowship Program has weekly process groups have been a part of the formal curriculum since 2013 in an effort to target trainee wellness, yet fellows continued to experience symptoms of burnout. In the 2018-2019 academic year, the chief residents of the child and adolescent fellowship presented a one-time module on vicarious trauma to provide psychoeducation on this subject, as well as the more general topics of burnout and physician wellness. In response to a needs assessment, they also created dedicated protected time one afternoon a week for trainees to have psychotherapy clinic rather than seeing patients late in the evening after their regularly scheduled rotations. Additionally, the chiefs hosted quarterly wellness events to promote adhesiveness within the 1st and 2nd year fellows and 4th and 5th year Triple Board residents in the program.

Methods

An anonymous survey was conducted assessing rates of trainee burnout as well as questions related to planned outcomes was administered before and after the intervention. Additionally, the 2019-2020 chief residents conducted a needs assessment among graduating, senior and incoming junior fellows and triple board residents regarding physician wellness in response to the results of the 2019 Graduate Medical Education (GME) Wellness and Burnout Survey which demonstrated that 71% of child and adolescent psychiatry fellows had at least one symptom of burnout. Several changes were implemented to the wellness curriculum of the 2019-2020 academic year including (1) specific restructuring of the first-year academic schedule targeting rotations with higher rates of burnout, (2) increased opportunities for activities outside of work to promote interclass cohesiveness, and (3) implementation of more frequent formal didactic opportunities, including Grand Rounds, targeting the topic of physician wellness.

Results

This poster will provide a qualitative analysis of a wellness curriculum to demonstrate the possible impact of targeting workplace characteristics as a vehicle to promote physician resilience within a child and adolescent psychiatry program. Specific results will be presented regarding

1) Pre-and-post intervention survey measures of physician burnout before and after implementation of the 2018-2019 wellness curriculum which consisted of a one-time module on vicarious trauma as well as quarterly wellness events
2) 2019 GME Wellness and Burnout survey as it relates to the child and adolescent psychiatry fellowship
3) Pre-survey measures of physician burnout rates prior to curriculum changes for the 2019-2020 academic year

Discussion

Child and adolescent psychiatry fellows and 4th and 5th year triple board resident feedback indicates a desire for increased education on ways to improve physician burnout and wellness rates. While resident feedback is critical when creating a wellness curriculum it is not clear to what degree it impacts well-being. Limitations of this analysis include a post-hoc study design that does not necessarily control for the multiplicity of factors that influence physician in training burnout and wellness, including individual resilience factors.

**Scientific Citations**

Dyrbye, L.N. et al., (2008). Burnout and suicidal ideation amount US medical students. Annals of Internal Medicine,149(5):334-41.

Dyrbye, L.N. et al., (December 2013). Physician satisfaction and burnout at different career stages. Mayo Clinic Proceedings, 88(12):1358-67.

Maslach, C. & Leiter, M.P., (2016). Understanding the burnout experience: recent research and its implications for psychiatry. World Psychiatry,15:103-111.

Matheson, C. et al., (July, 2016). Resilience of primary healthcare professionals working in challenging environments: A focus group study. British Journal of General Practice, 66(648):e507-15.

Ripp, J.A. et al., (July, 2017). Well-being in graduate medical education: A call for action. Academic Medicine, 92(7):914-17.

Shanafelt, T.D. et al., (December, 2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clinic Proceedings, 90(12):1600-13.

West, C.P. et al., (2016). Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. The Lancet, 388(10057):2272-2281.

Yaghmour, N.A. et al., (July, 2017). Causes of death of residents in ACGME-accredited programs 2000 through 2014: Implications for the learning environment. Academic Medicine, 92(7):976-83.

## A Diversity Advisory Committee (DAC) to address the ACGME requirement of engaging in practice that focus on systematic recruitment and retention of a diverse and inclusive workforce

**Presenters**
Alan Koike, MD,MS
Bethel Essaw, MD
Christine Kho, MD
Poh Choo How, MD,PhD
Ruth Shim, MD

**Educational Objective**
After reviewing this poster, readers will be able to:
1. Learn how incorporating a Diversity Committee in one's program can enhance recruitment efforts of attaining a diverse and inclusive workforce
2. Highlight various ways a Diversity Committee can be an important platform in collaborating with, mentoring and educating the next generation of psychiatrists

**Practice Gap**
The Accreditation Council of Graduate Medical Education (ACGME) has placed a new requirement effective July 2019 that programs must engage in practices that focus on systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows and faculty members. This is part of a large-scale effort to address the gap in representation of underrepresented minorities in residency program and beyond. This poster will describe one

method for psychiatry residency programs to address this issue. Creating a psychiatry department diversity advisory committee comprised of faculty, residents and students can help recruit and retain a diverse and inclusive work force through mentoring, implementing specific recruitment efforts in residency application process and promoting social events.

**Abstract**

As several studies have shown that underrepresented minority physicians play a critical role in addressing racial/ethnic disparities in healthcare, there are national initiatives to encourage institutions to become more engaged in diversity efforts (1). However, recent data has shown that underrepresented minority (URM) residents experience additional burdens during graduate medical education that is secondary to race/ethnicity. Addressing these unique challenges related to race/ethnicity is crucial to creating a diverse and inclusive work environment (2). As ACGME has now placed a new requirement for programs to engage in practices that focus on systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows and faculty members, this poster will discuss how a diversity advisory committee within a psychiatry department can serve as a supportive medium for retention in addition to recruitment. At the UC Davis Department of Psychiatry and Behavioral Sciences, the diversity advisory committee (comprised of faculty and residents) has been essential in promoting systematic ways of recruiting diverse pool of residency applicants by hosting revisit days and supporting holistic review process. The committee also promotes social events and provides mentors for residents and junior faculty which is instrumental in retention. Monthly meetings provide a consistent and supportive environment to discuss race and intersectional identities as main subjects of conversation which have been postulated to improve well-being of URM trainees (2). Lastly, the committee provides a medium in which diversity and inclusion issues are raised as an organization rather than as an individual, further reinforcing that individual concerns may be reflective of structural issues important to address.

Sources:

1. Reede JY. A recurring theme: the need for minority physicians. Health Aff (Millwood). 2003;22(4):91-3.

2. Osseo-asare A, Balasuriya L, Huot SJ, et al. Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace. JAMA Netw Open. 2018;1(5):e182723.

**Scientific Citations**

Pierre, J., Mahr, M., Carter, F., & Madaan, A. (2017). Underrepresented in Medicine Recruitment: Rationale, Challenges, and Strategies for Increasing Diversity in Psychiatry Residency Programs. Academic Psychiatry, 41(2), 226-232

Position Statement on Diversity. American Psychiatric Association website. https://www.psychiatry.org/File%20Library/About.../Position-2017-on-Diversity.pdf

Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. 2019

## Experience and Preparedness of Resident Transfers into Psychiatry Programs

**Presenters**
Riley Machal, MD
Erin Fulchiero, MD
Julie Niedermier, MD

**Educational Objective**
1. Demonstrate an understanding of the current literature regarding resident transfers;
2. Identify opportunities for improvement in the transition to allow for improved patient care and resident wellbeing;
3. Appreciate various factors influencing residents' decisions to enter or exit residency programs.

**Practice Gap**
Each year more than a thousand residents transfer between residency programs. Despite this, there is little research examining the experience of these residents or systematic processes at receiving programs to ease this transition. Previous studies have examined the reasons behind residents leaving their initial residency program, but there is limited data on the resident's perspective of the experience of the transfer itself or the adjustment to a new residency program. This project aims to gather the experiences of residents in one Midwestern state who have transferred into psychiatry residencies to better understand their perspectives on the experience of transferring residencies and identify opportunities for improvement in the process.

**Abstract**
According to the Accreditation Council for Graduate Medical Education (ACGME) Data Resource book, 1044 residents transferred residency programs in the 2017-2018 academic year. Most research regarding residency transfers is analyzing the attrition rates in a specific specialty and the reasons behind leaving a residency program. There are limited data analyzing residents after they have transferred residency programs. This project aims to gather experiential data from residents who transferred into psychiatry residencies in Ohio to determine which tools or resources are subjectively helpful for patient care and resident wellbeing.

In spring 2019, all Ohio psychiatric residency program directors were sent a request to speak with any residents who transferred into their program. A total of 6 residents at two separate institutions in Ohio were able to be contacted, and 4 residents completed a telephone survey analyzing their unique experiences in transferring residency programs. Data collected include: experiential accounts and a description of resources provided to resident transfers and resident

perceptions of resources that would have been beneficial although not in place. This poster will examine these accounts and determine possible areas for improvement to assist in planning for the transfer of residents between programs.

**Scientific Citations**

Accreditation Council for Graduate Medical Education. (2018). Data Resource Book, Academic Year 2017-2018. Chicago, IL: Accreditation Council for Graduate Medical Education.
Gilpin, M. M. (2005). Residency attrition rate in obstetrics and gynecology: are we losing more postgraduates today? American Journal of Obstetrics and Gynecology, 193(5), 1804-1806.
Aufses Jr, A. H., Slater, G. I., & Hollier, L. H. (1998). The nature and fate of categorical surgical residents who "drop out". American Journal of Surgery, 175(3), 236-239.
Laufenburg, H. F., Turkal, N. W., & Baumgardner, D. J. (1994). Resident attrition from family practice residencies: United States versus international medical graduates. Family Medicine, 26(10), 614-617.
Weisman, C. S., Levine, D. M., Steinwachs, D. M., & Chase, G. A. (1980). Male and female physician career patterns: specialty choices and graduate training. Journal of Medical Education, 55(10), 813-825.

## Faculty Scholarly Activity and Grand Rounds; The Need for a Meeting of the Minds

**Presenters**

Marla Hartzen, MD

**Educational Objective**

1. Demonstrate faculty interest in providing Psychiatry Grand Rounds at outside institutions
2. Demonstrate institutional need for identifying Psychiatry Grand Rounds speakers
3. Demonstrate the value of a resource which could connect faculty with institutions for Psychiatry Grand Rounds opportunities

**Practice Gap**

Providing Psychiatry Grand Rounds at outside institutions is one way that faculty achieve scholarly activity, and such activity may serve an essential role in academic advancement. Faculty may also bear responsibility for organizing the Grand Rounds at their home institutions, with few resources available to assist them in identifying speakers. This project applied a novel approach for connecting faculty with Grand Rounds opportunity, and demonstrated the need for a more formal national Grand Rounds database.

**Abstract**

Introduction:
Grand Rounds are a longstanding tradition in graduate medical education. In a world of increasingly digital learning, they provide both educational opportunity and an important sense of community for members of hospital departments.

Faculty are likewise in need of scholarly opportunities to share their work. Academic advancement is frequently linked to such activities, however opportunities to prepare and present may be challenging for faculty to find.

Missing is a resource for educators in these two categories to connect.

This study attempted to determine the acceptability and feasibility of using a Program Director's Listserv to identify and recruit Psychiatry Grand Rounds speakers for a community-based academic hospital in Illinois, while also providing scholarly opportunity for AADPRT listserv members.

Methods:
On April 3, 2018 a single email was submitted to the professional listserv of the American Association of Directors of Psychiatry Residency Training (AADPRT) seeking faculty members interested in providing Psychiatry Grand Rounds at Advocate Lutheran General Hospital (ALGH).

Results:
- Of the 731 members of the AADPRT listserv community, 48 responded (6.5%) within the first week
- Responders represented psychiatry faculty from 20 different states
- 14 Grand Rounds speakers were successfully scheduled in just 8 days

Discussion:
This study demonstrated strong interest among AADPRT members for the scholarly activity of providing Grand Rounds, and the willingness to travel in order to do so. However, on a larger scale a listserv is not the optimal resource for matching faculty with Grand Rounds opportunities. There may be significant value in creating a database to connect educators with institutions seeking Grand Rounds speakers.

**Scientific Citations**
https://journals.lww.com/academicmedicine/Fulltext/2000/06000/Scholarly_Activities_Recorded_in_the_Portfolios_of.18.aspx

## No Fear of Near-Peer: Improving the Quality of Psychiatry Resident Education through Near-Peer Teaching Initiatives

**Presenters**
Jennifer Sotsky, MD
Meredith Senter, MD
Emma Golkin, MD
Deborah Cabaniss, MD

**Educational Objective**

After reviewing this poster, participants will:

1. Be able to describe near-peer teaching and the literature supporting its use
2. Gain familiarity with two examples of near-peer teaching in psychiatry
3. Consider new methods of incorporating near-peer teaching into psychiatry residency programs

**Practice Gap**

Near-peer teaching, in which senior learners teach junior learners in their same program or field, is increasingly recognized as a method that provides benefits for teachers, learners, and educational systems.1,2,3 Compared to other health professions training programs, there is a paucity of literature addressing near-peer teaching in psychiatry training. Psychiatry residency has a unique structure in which first-year residents spend the majority of their year rotating on outside services, second-year residents work mainly in acute care settings, and third-year residents primarily practice individually in outpatient settings. Thus, inherent opportunities for near-peer teaching may be somewhat limited in psychiatry residencies.

**Abstract**

Though near-peer teaching has been widely studied in the health professions literature for groups including medical students, nursing students, and paramedics, as well as in life sciences university education, there has been a lack of research on this topic for psychiatry residents. We developed two initiatives to create opportunities for near-peer teaching in our residency program. The first is an intervention in which four fourth-year residents developed and used interactive case-based sessions to teach introductory psychopharmacology to small groups of first-year residents. The second is an activity in which residents videotaped mock psychotherapy interventions and received feedback from a senior peer. We hypothesize that these near-peer initiatives will benefit both resident teachers and learners. For resident teachers, we hypothesize that these interventions will offer opportunities for consolidating knowledge and developing instructional skills. For the resident learners, we hypothesize that the interventions will provide uniquely practical, immediately-relevant knowledge and "survival skills", that are different from what faculty instructors provide. We also hypothesize that these near-peer teaching sessions will communicate the so-called "hidden curriculum," defined as unintended lessons about norms and values in our field,4 in a supportive, non-intimidating learning environment. We are currently using surveys and interviews to collect quantitative and qualitative data to evaluate the impact of our initiatives, which we will report in this poster. Based on our findings, we will also include ideas for future research on how to utilize near-peer teaching to improve the quality of psychiatry resident education.

**Scientific Citations**

1. Knight, J. K., & Brame, C. J. (2018). Peer instruction. CBE Life Sciences Education. https://doi.org/10.1187/cbe.18-02-0025

2. Secomb, J. (2008). A systematic review of peer teaching and learning in clinical education. Journal of Clinical Nursing. https://doi.org/10.1111/j.1365-2702.2007.01954.x

3. Ten Cate, O., & Durning, S. (2007). Peer teaching in medical education: Twelve reasons to move from theory to practice. Medical Teacher. https://doi.org/10.1080/01421590701606799
4. Hafferty, F. W. (1998). Beyond curriculum reform: Confronting medicine's hidden curriculum. Academic Medicine, Vol. 73, pp. 403–407. Lippincott Williams and Wilkins.

## Residency Training on Methylenetetrahydrofolate Reductase: A National Survey

**Presenters**
Matthew Macaluso, DO
Thien Vu, BA
Rosey Zackula, MA

**Educational Objective**
1. Assess the adequacy of training on MTHFR polymorphisms across psychiatry, internal medicine, and family medicine residency programs in the United States with the goal of identifying potential gaps in curriculum.
2. Understand resident perceptions across specialties of the quality and effectiveness of education on MTHFR polymorphisms and FDA approved supplementation.
3. Evaluate resident knowledge, attitudes, and comfort levels regarding identifying and treating mental disorders and other medical conditions related to MTHFR polymorhpisms.

**Practice Gap**
Methylenetetrahydrofolate reductase (MTHFR) is an enzyme important in folate metabolism. Genetic polymorphisms of MTHFR have broad clinical implications. There is established evidence that MTHFR genetic polymorphisms including C677T and A1298C are associated with psychiatric disorders and their treatment, including response to selective serotonin reuptake inhibitors (SSRI's). In fact, a biologically active form of metafolin is FDA approved for patients with schizophrenia or major depressive disorder who have certain MTHFR gene mutations.

Because of the broad clinical implications of MTHFR genetic polymorphisms, residents in a variety of specialties must understand how to identify MTHFR gene variants, interpret their clinical implications and be aware of treatment options. However, there is currently no literature outlining best practices for teaching about MTHFR genetic polymorphisms to medical residents. Anecdotal reports from medical residents at our institution suggests little is taught on this topic. A first step in assessing resident knowledge in this area is to conduct a national survey study across specialties where MTHFR gene variants are relevant in clinical practice.

**Abstract**
OBJECTIVE: The goal of this study is to survey medical residents across multiple specialties throughout the United States in order to understand resident knowledge of MTHFR

polymorphisms, resident understanding of treatment implications for MTHFR deficient patients, and resident perceptions of their training in this area.

METHODS: We emailed survey invitations to program directors of every psychaitry, internal medicine and family medicine residency program in the United States. This initial email instructed program directors to forward their residents the invitation to participate in the survey. REDCap, a web-based database designed to house patient data in a secure environment, was used to administer the survey, which included an online consent to participate. Survey questions assessed resident training, knowledge, attitudes, and barriers regarding MTHFR polymorphisms, their clinical implications, and treatment. Residents did not have to answer all questions to participate. The University of Kansas Medical Center Human Subjects Committee (IRB) approved the study.

RESULTS: A total of 525 participants consented to the survey. The survey results showed the majority of participants were unaware of the MTHFR gene (family medicine: 153/166, 92%, internal medicine: 135/151, 89%, psychiatry: 70/90, 78%) and the clinical associations of MTHFR genetic polymorphisms with cardiovascular diseases and psychiatric disorders. While 247 participants responded they knew about the gene, there were significantly more participants who did not know of the clinical effects of MTHFR polymorphisms ($p<0.001$), especially when it came to links between MTHFR mutations and depression ($p<0.001$) or cardiovascular disease ($p<0.001$). In addition, there were significantly more participants who felt they would not receive adequate training on the treatment ($p<0.001$), identification ($p=0.001$), and/or management of patients with MTHFR polymorphisms ($p<0.001$).

DISCUSSION/CONCLUSION: This study concluded that while many residents may be aware of the MTHFR gene, most of the knowledge was minimal, especially when it came to the many effects of genetic mutations. Though knowledge about MTHFR appeared to increase with training, most residents stated that MTHFR was not covered in their curriculum and many would be uncomfortable with the identification and management of patients with MTHFR genetic polymorphisms. Therefore, we recommend residency training programs assess their level of training on MTHFR, its genetic polymorphisms, and treatment of patients with clinical syndromes resulting from MTHFR gene polymorphisms.

**Scientific Citations**


1. Wan, L., Li, Y., Zhang, Z., Sun, Z., He, Y., & Li, R. (2018). Methylenetetrahydrofolate reductase and psychiatric diseases. Translational Psychiatry, 8(1). doi:10.1038/s41398-018-0276-6
2. Kang, S. S., Wong, P.W., Susmano, A., Sora, J., Norusis, M., & Ruggie, N. (1991). Thermolabile methylenetetrahydrofolate reductase: An inherited risk factor for coronary artery disease. American Journal of Human Genetics, 48(3), 536–545.
3. Levin, B. L., & Varga, E. (2016). MTHFR: Addressing Genetic Counseling Dilemmas Using Evidence-Based Literature. Journal of Genetic Counseling, 25(5), 901-911. doi:10.1007/s10897-016-9956-7

4. Liew, S., & Gupta, E. D. (2015). Methylenetetrahydrofolate reductase (MTHFR) C677T polymorphism: Epidemiology, metabolism and the associated diseases. European Journal of Medical Genetics, 58(1), 1-10. doi:10.1016/j.ejmg.2014.10.004
5. D'Angelo, V., Ramaglia, M., Iannotta, Adriana., & Addeo, R. (2014). Pharmacogenetics of methotrexate in pediatric hematological neoplasm treatment: does it need a personalized regimen based on MTHFR polymorphisms?, Expert Review of Hematology, 7:5, 517-519, doi:10.1586/17474086.2014.960386
6. Jamerson, B. D., Payne, M. E., Garrett, M. E., Ashley-Koch, A. E., Speer, M. C., & Steffens, D. C. (2012). Folate metabolism genes, dietary folate and response to antidepressant medications in late-life depression. International journal of geriatric psychiatry, 28(9), 925-32.
7. Jha, S., Kumar, P., Kumar, R., & Das, A. (2016). Effectiveness of add-on l-methylfolate therapy in a complex psychiatric illness with MTHFR C677 T genetic polymorphism. Asian Journal of Psychiatry, 22, 74-75. doi:10.1016/j.ajp.2016.05.007
8. Froese, D. S., Huemer, M. , Suormala, T. , Burda, P. , Coelho, D. , Guéant, J. , Landolt, M. A., Kožich, V. , Fowler, B. & Baumgartner, M. R. (2016), Mutation Update and Review of Severe Methylenetetrahydrofolate Reductase Deficiency. Human Mutation, 37: 427-438. doi:10.1002/humu.22970
9. Eysenbach G. (2004). Improving the quality of Web surveys: the Checklist for Reporting Results of Internet E-Surveys (CHERRIES). Journal of medical Internet research, 6(3), e34. doi:10.2196/jmir.6.3.e34. Retrieved from http://www.equator-network.org/reporting-guidelines/improving-the-quality-of-web-surveys-the-checklist-for-reporting-results-of-internet-e-surveys-cherries/
10. Burns, K. E., Duffett, M., Kho, M. E., Meade, M. O., Adhikari, N. K., Sinuff, T., & Cook, D. J. (2008). A guide for the design and conduct of self-administered surveys of clinicians. Canadian Medical Association Journal, 179(3), 245-252. doi:10.1503/cmaj.080372
11. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap)--a metadata-driven methodology and workflow process for providing translational research informatics support. Journal of biomedical informatics. 2009;42(2):377-381.

## Choose your own adventure: Schizophrenia

**Presenters**
Justin Faden, MD
Ruby Barghini, MD,MS
Rebecca Anthony, MD
Meera Chatterjee, MD
Miyuki Fukui, MD

**Educational Objective**

1) Identify an alternative to traditional PowerPoint lectures for teaching psychopathology and psychopharmacology

2) Assemble a basic story board idea that can be integrated with brief smartphone video clips to create an interactive presentation for use within the didactic curriculum at the participant's institution
3) Increase awareness of this novel and fun teaching methodology to residents in order to motivate and engage them as teachers and learners

**Practice Gap**

PowerPoint lectures are ubiquitous with the resident and medical student didactic experience. However, often times PowerPoint talks can fail to engage the audience, leading to inattentiveness and a suboptimal learning environment. Novel strategies to engage learners have been championed by initiatives such as the National Neuroscience Initiative Curriculum (NNCI), and steer the focus away from traditional PowerPoint lectures. However, another strategy to maintain participant engagement is by creating interactive multimedia content, and integrating the content into PowerPoint. Videos, taken from any smart phone, can be integrated into PowerPoint to create an interactive  Choose your own adventure style didactic experience, which can be utilized to create a reimagined curriculum, or augment an existing curriculum. Residents are often hesitant to volunt

**Abstract**

Netflix has captivated the worldwide television market, leading to a paradigm shift in how TV shows and movies are watched. An innovative approach to television programming is their "Choose your own adventure" style interactive content, including popular programs such as: Black Mirror, Minecraft, and You vs Wild. Traditional PowerPoint lectures can fail to engage the audience, leading to the popular colloquial expression "Death by PowerPoint". In this workshop, participants will learn how to create short videos on their smart phones and integrate them into an interactive PowerPoint experience after creating a basic "Choose your own adventure" style educational idea. This concept has increased resident participation as both teachers and learners. Residents were involved in creating and filming scenarios that were included in the interactive lecture, demonstrating an exciting way to incorporate resident physicians into developing educational content. Strategies to incorporate an engaging and educational experience into an existing didactic curriculum will be discussed, highlighting how interactive multimedia content can be utilized to foster participant engagement without sacrificing educational content. Participants will break-up into small groups, formulate a basic idea for an interactive didactic experience, and create short one minute or less videos that can be integrated into an interactive presentation.

**Scientific Citations**

1. Pedersen, K., Moeller, M.H., Paltved, C. et al. Students' learning experiences from didactic teaching sessions including patient case examples as either text or video: A qualitative study. Acad Psychiatry. 2018;42: 622
2. McNaughton N, Ravitz P, Wadell A, Hodges BD. Psychiatric education and simulation: a review of the literature. Can J Psychiatr. 2008;53:85–93
3. Hobson WL, Hoffmann-Longtin K, Loue S, et al. Active Learning on Center Stage: Theater as a Tool for Medical Education. MedEdPORTAL. 2019 Jan 30;15:10801.

4. Stacy GS, Thiel SG. Use of hyperlinks in powerpoint presentations as an educational tool. Acad Radiol. 2017 Oct;24(10):1318-1324.

## "Close all the cracks!" Ensuring outpatient follow up during the final transition.

**Presenters**
Brian Sweatt, MD
Amy Burns, MD
Christine Prato, MD

**Educational Objective**
1. Understand factors that make an outpatient at risk for being lost to follow up in transition.
2. Understand how a transitions workflow can reduce those risks.
3. Further demonstration of the effectiveness of QI principles to residents while developing an outpatient transitions of care program

**Practice Gap**
Transition of care systems on inpatient services are frequently reviewed, but lapses in outpatient transitions of care in psychiatry residencies are frequent and represent a space for improvement. Our psychiatry residency is a new program. We were interested in developing an effective transition system for our outpatients to remain engaged in treatment as they transition from graduating residents to underclassman. This project represents data from our first outpatient transition of care. We are planning to continue to iterate on our process to improve in future years. A literature review was unable to reveal data of transition of care effectiveness from other psychiatry residencies. Because of this, we used published data from the Internal Medicine literature to compare our effectiveness.

**Abstract**
Aims Statement:
Develop a workflow to transition psychiatry outpatients from graduating residents to junior residents with minimal (less than 30 percent) patients lost to follow up at 3 months after transition.

Methods:
Residents identified high risk patients, maintenance patients, and patients to transfer back to their primary care provider by 03/19/2019. 1/2 day was set aside for graduating residents to submit a clinical course that included medication trials, outstanding labs, and what labs were due for each patient, and when these labs were due. This was due by 06/01/2019. A list of maintenance and high risk patients was provided to the MA and Scheduler. A form letter was sent to patients identifying their new resident psychiatric provider on 06/11/2019. Junior residents were educated on the transfer process, including how to monitor outpatient inbaskets, length of transfer appointments, and where to find transition information. On

09/09/2019 all graduating / transitioning resident s outpatients were reviewed to see if follow up had occurred, 20 patients did not have follow up at that time. The scheduler was asked to call these patients and attempt to schedule them. On 10/01/2019 the 20 previously unscheduled patients were chart reviewed, and 19 remained withou

**Scientific Citations**

1.)Mutanga, J. N., Mutembo, S., Ezeamama, A. E., Song, X., Fubisha, R. C., Mutesu-Kapembwa, K., … Whalen, C. C. (2019). Predictors of loss to follow-up among children on long-term antiretroviral therapy in Zambia (2003-2015). BMC public health, 19(1), 1120. doi:10.1186/s12889-019-7374-0
2.)Kuchukhidze, G., Kumar, A. M., de Colombani, P., Khogali, M., Nanava, U., Blumberg, H. M., & Kempker, R. R. (2014). Risk factors associated with loss to follow-up among multidrug-resistant tuberculosis patients in Georgia. Public health action, 4(Suppl 2), S41–S46. doi:10.5588/pha.14.0048
3.)Kruse GR, Rohland BM, Wu X. Factors associated with missed first appointments at a psychiatric clinic. Psychiatr Serv 2002; 53:1173-1176. doi: 10.1176/appi.ps.53.9.1173
4.)Bump G. M. (2015). Residents' final transition: the graduation clinic hand-off. Journal of general internal medicine, 30(2), 145–146. doi:10.1007/s11606-014-3038-z
5.)Phillips, E., Harris, C., Lee, W. W., Pincavage, A. T., Ouchida, K., Miller, R. K., … Arora, V. M. (2017). Year-End Clinic Handoffs: A National Survey of Academic Internal Medicine Programs. Journal of general internal medicine, 32(6), 667–672. doi:10.1007/s11606-017-4005-2
6.)Brenner, A.M., Balon, R., Coverdale, J.H. et al. Acad Psychiatry (2017) 41: 202. https://doi.org/10.1007/s40596-017-0679-3
7.)Singla Mamta, Goyal Sandeep Kumar, Sood Arun, Philips Arjin, Philips Sharad. (2015) Profile and pattern of follow-ups of psychiatry outpatients at Christian Medical College, Ludhiana. Journal of Mental Health and Human Behavior. V 20 (2) pp: 76-79

## Utilizing a Strategic Planning Approach to Redesigning Our CL Fellowship

**Presenters**

Samuel Greenstein, MD
Madeleine Fersh, MD
Christopher Burke, MD
John Q Young, MD, MPH, PhD

**Educational Objective**

1) Learn how to perform and utilize strategic planning methods.
2) Describe the future state of CL psychiatry.
3) Identify the implications for CL fellowship training.

**Practice Gap**

The US health care system faces severe challenges, including reducing the cost of care while improving the access that patients receive (OECD 2019, Park-Lee 2016). This has led to a

growing appreciation for developing more effective ways to manage behavioral health within medical settings (Hussain 2014). In this context, consultation-liaison (CL) psychiatry has moved beyond its historical focus as consultant to individual medically hospitalized patients ("traditional" CL) to integrated models across the continuum of care. These developments have led to new opportunities for CL fellowships.

**Abstract**

Background:

The US health care system faces severe challenges, including reducing the cost of care while improving the access that patients receive (OECD 2019, Park-Lee 2016). This has led to a growing appreciation for developing more effective ways to manage behavioral health within medical settings (Hussain 2014). In this context, consultation-liaison (CL) psychiatry has moved beyond its historical focus as consultant to individual medically hospitalized patients ("traditional" CL) to integrated models across the continuum of care. These developments have led to new opportunities for CL fellowships.

Methods:

We are currently in the process of redesigning our Zucker Hillside Hospital Consultation-Liaison fellowship at the Zucker School of Medicine at Hofstra/ Northwell. We used a standard strategic planning methodology with the following steps:

1) Describe the future state of CL psychiatry.
2) Identify the implications for CL fellowship training.
3) Locate national best practices in fellowship training.
4) Assess our own current fellowship
5) Perform a gap analysis and, propose a redesign.

Results:

Our review suggests a future state in which CL is more engaged in ambulatory settings, team embedded care delivery, and larger population health strategies. These roles require the acquisition of distinct competencies. National best practices include curricula that emphasize these types of experiences. Our gap analysis revealed that 85% of our focus is on inpatient traditional CL.

These analytic steps led to a new proposed mission ("To graduate CL psychiatrists that are able to lead and heal at the intersection of psychiatry and medicine") and a proposed new clinical curriculum that dedicates more of the fellows training to: delivery of individual care in the ambulatory setting, team embedded care, and elective time. We believe that by increasing elective time, we encourage our fellows to develop a "pathway to expertise" in an area that they are passionate about.

Discussion:

The application of strategic planning tools can help structure redesign processes and yield compelling new programmatic visions and plans.

Implication:
This approach can be utilized by other programs which will further enhance the trainee's experience.

**Scientific Citations**


1. OECD (2019), "Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database), https://doi.org/10.1787/data-00349-en (accessed on 28 March 2019).
2. Park-Lee, E., Lipari, R. N., Hedden, S. L., Copello, E. A. P., & Kroutil, L. A. (2016, September). Receipt of services for substance use and mental health issues among adults: Results from the 2015 National Survey on Drug Use and Health. NSDUH Data Review. Retrieved from http://www.samhsa. gov/data/
3. Hussain M, Steitz, D. Integrated Models of Care for Medical Inpatients With Psychiatric Disorders: A Systematic Review. Psychosomatics 2014; 55 (4): 315-325


## Psychiatric Screening Tools and Rating Scales…who cares? We all should.

**Presenters**


Matthew Macaluso, DO
Rachel-Anne Magsalin, MD
Syeda Quadri, MD
Mike Parmley, BA


**Educational Objective**

1. To assess resident familiarity and utilization of standardized mental health screening tools and ratings scales across medical specialties which include psychiatry, internal medicine, family medicine and obstetrics and gynecology.
2. To encourage residents across medical specialties to incorporate mental health screening tools and rating scales in everyday practice as a means to identify mental disorders.
3. To ensure residency training curricula across medical specialties contain adequate education on standardized screening tools and rating scales for identifying mental disorders.

**Practice Gap**

The incidence of mental disorders is growing in the United States and world-wide. Given their prevalence, physicians across medical specialties must be equipped to identify, diagnose and treat individuals with mental disorders. There are several tools used for screening and assessing common mental health disorders including, but not limited to, major depressive disorder (MDD), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD) and bipolar disorder. Most screening tools and rating scales are simple and easy to use, requiring minimal training and time. Based on a literature review, there are no articles on best practices for

teaching residents about rating scales in practice. While screening tools and rating scales are not a replacement for a complete psychiatric assessment, these tools may aid physicians in identifying and treating mental disorders. Early identification of mental disorders can lead to improved outcomes. Therefore, physicians across specialties should have a baseline familiarity with screening tools and rating scales for common mental disorders.

**Abstract**

OBJECTIVE: The goal of this study is to survey residents across multiple medical specialties throughout the United States to better understand the utilization and effectiveness of standardized mental health screening and assessment tools in everyday clinical practice.

METHODS: An email survey containing 7 questions with 9 sub-questions was distributed to program directors of every psychiatry, internal medicine, family medicine and obstetrics and gynecology residency program in the United States. The email instructed program directors to forward their residents the invitation to participate in the survey. The survey was anonymous with no personally identifiable information and residents were able to choose not to participate. REDCap, a web-based database designed to house patient data in a secure environment, was used to administer the survey, which included an online consent form. Survey questions assessed the years of training (PGY1 to PGY5), amount of exposure to patients with mental disorders and their familiarity with standardized screening and assessment tools. Standardized screening and assessment tools included those most commonly used for identifying the following mental disorders: major depressive disorder (MDD), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), bipolar disorder, suicide risk, alcohol use disorder and cognitive impairment. Residents were asked if the screening and assessment tools were helpful in clinical practice and if they would aid in making referrals to a psychiatrist for further care and treatment. Survey questions assessed resident training and utilization regarding mental health screening and assessment tools. We assessed if the residents used the screening tools and rating scales routinely in their residency training in order to identify mental disorders. We also assessed their understanding and interpretation of the scales. This included an assessment of the amount of training residents received on screening tools and rating scales, the usefulness of the screening tools and rating scales, and their attitudes and behaviors for incorporating screening tools and rating scales in everyday clinical practice.

RESULTS/DISCUSSION/CONCLUSION: Data is currently being collected and will be ready in time for the AADPRT annual meeting.

**Scientific Citations**

Gupta,S., Wood, J.M.(2017 February). Using rating scales in a clinical setting: A guide for psychiatrists. Current Psychiatry. 16(2):21-25

Mulvaney-Day, N.,Marshall, T., Pisocopo, K.D., Korsen, N., Lynch, S., Karnell, L.H., Moran,G.E., Daniels, A.S., Ghose, S.S., Screening for Behavioral Health Conditions in Primary Care Settings:A Systematic Review of the Literature, Journal of Internal Medicine, 33(3):335–46

Harrington, J., Barclay,L., Bertenthal-Smith, J., Brady, S., Giunta, S.A., Field, T., Hall, S., Langer, K., Miller, J.E., Mobley, K., Otis, G,. (2017). The Need for Early Mental Health Screening and Intervention Across the Lifespan. Retrieved from https://www.amhca.org/AMHCA Clinical Practice Briefs

Duerr,H.A., (2012,November 29). Brief Screening Tools Can Improve Patient Care. Psychiatric Times,

Sanderson, R.,(2016 January). Tools to Detect Common Mental Health and Substance Use Disorders: A Compendium and Review Richard Sanderson PASRR Technical Assistance Center

Mann, C., (2013, March 27). Center for Medicaid and CHIP Services Prevention and Early Identification of Mental Health and Substance Use Conditions. Retrieved from https://www.medicaid.gov/federal-Policy-Guidance

Baer, Lee, Blais, Mark A. (Eds.) (2010). Handbook of Clinical Rating Scales and Assessment in Psychiatry and Mental Health. New York, NY. Current Clinical Psychiatry

## Use of educational technology in meeting the needs of adult learners: A method of remediation using an online weekly curriculum to improve below average PRITE performance.

**Presenters**
Angela Oulay, MD
Milicent Fugate, MD
Amy Meadows, FAAP, FAPA, MD, MS
Sandra Batsel-Thomas, MD

**Educational Objective**
1) To discuss an educational tool used to improve performance on PRITE and overall medical knowledge.
2) Evaluate effectiveness of using an online curriculum for PRITE remediation.

**Practice Gap**
Performance on in-training exams is an important means of feedback on educational progress for residents & residency programs. In addition, psychiatry in-training exam (PRITE) scores have been shown to be a moderate to strong predictor of performance on the American Board of Psychiatry and Neurology (ABPN) examination [1,2]. In fact, specific PRITE scores have been defined for program directors to identify residents at risk for failure of the board exam [2]. Therefore, adequate preparation for PRITE has been of interest for residency programs [2]. However, only a few studies have examined effective methods of improving PRITE performance, such as: implementation of an accountability program with consequences and

privileges based on performance, peer-assisted learning, or audience response system technology in review sessions [3,4,5].

Considering resident feedback regarding the desire for a structured approach for reading/learning outside of didactics while accounting for time restraints, we were interested in implementing an online weekly curriculum. Additionally, though it is well known that use of educational technology can facilitate learning, information regarding the outcomes of utilization of educational technology is limited [6].

**Abstract**

Background: Residents have evolving educational needs with increasing reliance on online resources [6]. We will aim to evaluate if use of an online curriculum to meet educational needs of residents can improve PRITE performance.

Method: 19 categorical psychiatry (PGY 1-3) residents were included. Based on 2018 PRITE performance, residents were either 1) exempt from; or 2) assigned a tiered remediation plan based on norm rank score with lower performance resulting in a greater number of weekly curriculum modules to be completed.

| Norm Rank Score As Compared to Peer Group | Required number of modules to be completed |
|---|---|
| >50 | None |
| 50-40 | 10 |
| 40-30 | 20 |
| 30-20 | 30 |
| <20 | 40 |

Decker Scientific American Psychiatry Weekly Curriculum [8] was used. The weekly curriculum available for psychiatry, as well as multiple other specialties, provided reading and multiple-choice questions on essential topics. The curriculum, released on a weekly basis, was focused on the core areas of neurobiology, psychopathology, and treatment in order to maximize applicability to PRITE questions. Residents could select modules based on areas of weaknesses or topics of interest. Those exempt from mandatory completion of modules were allowed to prepare for PRITE as usual and had the option of completing modules if desired. Following the 2019 PRITE, the proportion of assigned modules completed and PRITE performance will be evaluated. We predict that increased participation and completion of online weekly curriculum will lead to the largest improvement in scores.

Statistical analysis: Data will be de-identified and analyzed for pre/post changes (by paired t-test) in the overall and norm rank PRITE scores for 14 residents who were required to complete Decker modules.

The University of Kentucky Medical IRB reviewed and approved data collection as part of a larger Educational Enhancement Initiative. This project was produced by trainees with faculty supervision.

Results: 18/19 (95%) of residents completed at least one module in academic year 18/19, including 4/5 (80%) who had no required modules (due to performing >50% norm rank on their PRITE.) PRITE scores from 2018 and 2019 will be evaluated to determine if completion of online weekly curriculum was effective at improving scores. Results will be presented as part of the poster.

Conclusion: Decker modules were frequently accessed and acceptable to residents as evidenced by the majority of residents logging into Decker and completing at least one module.

The beneficial aspects of Decker Scientific American Psychiatry Weekly Curriculum were that 1) content was easily accessible and specific to psychiatry; 2) consisted of high quality information focused on pertinent topics; and 3) provided an interactive learning component of pre/post-tests and customizable question banks. Topics were assigned weekly, but residents also had the opportunity to complete topics of inte

**Scientific Citations**

1. Webb, L., Juul, D., Reynolds, R., Ruiz, B., Ruiz, P., Scheiber, C. and Scully, J. (1996). How well does the psychiatry residency in-training examination predict performance on the American Board of Psychiatry and Neurology. Part I. Exam. - PubMed - NCBI. [online] Ncbi.nlm.nih.gov. Available at: https://www.ncbi.nlm.nih.gov/pubmed/8633702
2. Juul, D., Schneidman, B., Sexson, S., Fernandez, F., Beresin, E., Ebert, M., Winstead, D. and Faulkner, L. (2014). Relationship Between Resident-In-Training Examination in Psychiatry and Subsequent Certification Examination Performances. [online] SpringerLink. Available at: https://link.springer.com/article/10.1176/appi.ap.33.5.404
3. Hettinger, A., Spurgeon, J., El-Mallakh, R. and Fitzgerald, B. (2014). Using Audience Response System Technology and PRITE Questions to Improve Psychiatric Residents Medical Knowledge. [online] SpringerLink. Available at: https://link.springer.com/journal/40596/38/2
4. Mariano, M., Mathew, N., Del, P. and Pristach, C. (2013). Improving Residents' Performance on the PRITE: Is There a Role for Peer-assisted Learning?. [online] PubMed - NCBI. Academic Psychiatry. Available at: https://www.ncbi.nlm.nih.gov/pubmed/24026377
5. Ferrell, B., Tankersley, W. and Morris, C. (2015). Using an Accountability Program to Improve Psychiatry Resident Scores on In-Service Examinations. [online] PMC. Journal of Graduate Medical Education. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4675411/
6. Eysenbach, G., Ruiz, J., Zhang, M., Torous, J., O'Connor, R., Franzen, J., Boland, R. and Kitts, R. (2015). Creating a Pilot Educational Psychiatry Website: Opportunities, Barriers, and Next Steps. [online] PMC. JMIR Medical Education. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5041344/
7. Cooper, A., Richards, J. (2017). Lectures for Adult Learners: Breaking Old Habits in Graduate Medical Education. [online] Wiley Online. The American Journal of Medicine. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/1742-6723.12191
8. Decker Scientific American Psychiatry Weekly Curriculum. https://www.deckerip.com/

# 2020 Poster Listing

## Designing and implementing a novel PGY1 National Neuroscience Curriculum Initiative (NNCI) resource based neuroscience didactic curriculum at the University of Minnesota

**Presenters**
Stephanie Wick, DO, MBA, MS
Lora Wichser, MD

**Educational Objective**
Describe the process of design, implementation, and resident feedback of PGY1 NNCI based neuroscience didactic curriculum at the University of Minnesota Psychiatry Residency Program.

**Practice Gap**
With recent advances in the filed of neuroscience, psychiatry residents have a desire for increased neuroscience education and training. The neurobiological formulation of mental illness is a relatively new phenomenon with the National Institute of Mental Health (NIMH) launching Research Domain Criteria (RDoC) for classification of mental illness in 2009. There is need for development of curriculum to help psychiatry trainees implement neuroscience principles into their clinical practice.

**Abstract**
Here we present a PGY1 resident neuroscience didactic curriculum focused on helping trainees incorporate neurobiological principals into their clinical psychiatry practice. This course consisted of six two-hour sessions taking place during blocked PGY1 didactic time on Thursday afternoons. Sessions were split into two one-hour blocks. The first hour consisted of residents in pairs working through NNCI resource based activities including online modules, worksheets, and discussion of pre-read pillar articles in the field of neuroscience. The second hour consisted of continued discussion with faculty guest experts in the field of neuroscience. Topics covered during the six didactic sessions included the basic brain, magnetic resonance imaging in psychiatry, cognition in schizophrenia, precision psychiatry in mood disorders, fear brain-circuitry related to trauma, autism spectrum disorder, and the neurobiology of chronic pain. Upon completion of the sixth didactic session residents completed a survey providing feedback regarding the neuroscience didactic course. Five of eight residents completed post surveys. All five residents surveyed indicated they either agreed or strongly agreed they would recommend the course to other residents. All five residents stated their confidence in incorporating neuroscience into clinical practice increased – three stated significantly, with two residents stating it increased somewhat. This data will be used to enhance further development of this clinical neuroscience didactic course for future PGY1 resident classes.

**Scientific Citations**

Fung, L. K., Akil, M., Widge, A., Roberts, L. W., & Etkin, A. (2014). Attitudes toward neuroscience education among psychiatry residents and fellows. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 38(2), 127–134. doi:10.1007/s40596-014-0034-x

Kupfer, David J., and Darrel A. Regier. "Neuroscience, Clinical Evidence, and the Future of Psychiatric Classification in DSM-5." American Journal of Psychiatry, vol. 168, no. 7, 2011, pp. 672–674., doi:10.1176/appi.ajp.2011.11020219.

ACGME Common Program Requirements. Accessed Oct 25 2019. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf

## Does Inter-rater Reliability Improve through the completion of a Self-Directed Online Training Curriculum for Evaluators Conducting American Board of Psychiatry and Neurology Clinical Skills Evaluations?

**Presenters**

Kaz Nelson, MD
Daniel Volovets, MD
Michael Jibson, MD,PhD

**Educational Objective**

Educational Objectives:
1) Increase access to high-quality CSE training materials to improve the integrity and standardization of the CSE process and to reduce barriers to CSE evaluator training.
2) Reduce or eliminate the need for faculty resources associated with in-person training.
3) Improve inter-rater reliability among ABPN Certified Psychiatrists assessing psychiatry residents as part of the CSE process.

**Practice Gap**

AADPRT assembled a task force shortly after the ABPN CSE requirement was instated with the goal of creating CSE rater training curricula.[1] Each session provided three video vignettes featuring real physician-patient interviews in which the evaluators were trained to apply standardized criteria to each vignette. In 2009, psychiatric educators gathered at the annual meeting of the American Association of Directors of Psychiatry Residency Training (AADPRT) and established consensus ratings for each of the video vignettes utilizing an ABPN approved CSE rubric 2. This established an opportunity to create training curriculum that is available online and would not necessitate in-person training. It is necessary to demonstrate the achievement of inter-rater reliability for the online curriculum to assess the effectiveness of the training.

**Abstract**
We have designed a self-directed, online module intended for psychiatry residency program directors and/or evaluators of psychiatry graduate medical trainees poised to conduct American Board of Psychiatry and Neurology (ABPN) Psychiatry Clinical Skills Evaluations (CSEs). The goal of this curriculum is to teach the standardized criteria for assessment of Clinical Skills Evaluation (CSE) candidates and improve inter-rater reliability. This curriculum was designed to be interactive, easily disseminated, with the objective to align the application of evaluation criteria with consensus ratings. We have piloted this online training curricula and are ready to share the first set of analyses hypothesized to demonstrate improved inter-rater reliability, with each subsequent vignette. The ABPN may use this data to highlight the integrity and standardization of the CSE process.

**Scientific Citations**
1) ABPN Clinical Skills Evaluation Task Force. (2009). Clinical Skills Assessment. Retrieved from Association for Academic Psychiatry: http://www.academicpsychiatry.org/htdocs/Fidlerdocs/Education/Clinical_Skills_Assessment/index.html

2) GDalack, MJibson. (2012, March 1). Clinical Skills Verification, Formative Feedback, and Psychiatry Residency Trainees. Acad Psychiatry, 36(2), 122-125.

3) KNelson, DVolovets, MJibson. (March 2019) The Development of a Self-Directed Online Learning Module as a Training Curriculum for Evaluators Conducting American Board of Psychiatry and Neurology Clinical Skills Examinations. Poster abstract presented at the annual AADPRT meeting, San Diego, CA.

## The FIT (Factors Influencing Transition) of Residents From General Psychiatry to Child and Adolescent Psychiatry

**Presenters**
Salma Malik, DFAACAP, DFAPA, MD, MS
Veeraraghavan Iyer, MD
Stephanie Kuntz, DO
Michael DiBianco, MD

**Educational Objective**
1. Understand factors governing the transition of residents from general psychiatry residency to child and adolescent psychiatry (CAP) fellowship.
2. Develop a process for data collection (Transition, competency and burn out related questions).
3. Understand and suggest strategies to ease transition into CAP fellowship.
4. Utilize a follow up system to track progress as the year progresses

**Practice Gap**

There appears interplay between a number of factors in relation to trainee transitioning from adult psychiatry residency to Child and Adolescence Psychiatry (CAP) fellowship. To name some - Fellow factors such as individual factors, personality traits, distress tolerance; Program factors such as organizational differences between prior and current training, structure of rotations, means of providing validation/support (process groups, etc.); and Clinical factors such as clinical load, interaction with parents and patients, inter-departmental interactions (Mehta, & Forde, 2013).

Although means of easing transitions are left largely to a program's discretion, there are no general guidelines to help ease transitioning into fellowship. This survey helps broaden the understanding of factors that influence trainee transitioning from adult to CAP programs. Understanding the experiences not only helps validate, but also helps to formulate a focused approach to ease transition. There is also value in considering the enduring benefits of implementing such a problem focused approach. A success transition means benefits in at least three domains - the program, the trainee and the community. The program by virtue of earning recognition for efficient and compassionate training; the trainee by means of optimal engagement and learning; and the community benefiting by virtue of well-trained child psychiatrists. This Quality Improvement project would broadly inspect factors in three domains - Transition, competency and burnout/wellness related.

**Abstract**

Introduction:

There appears interplay between a number of factors in relation to trainee transitioning from adult psychiatry residency to Child and Adolescence Psychiatry (CAP) fellowship. To name some - Fellow factors such as individual factors, personality traits, distress tolerance; Program factors such as organizational differences between pre and current training, structure of rotations, means of providing validation/support (process groups, etc.); and Clinical factors such as clinical load, interaction with parents/patients, inter departmental interactions (Mehta, & Forde, 2013).

Other significant factors discussed are differences between the stated national programs and the "lived" experience of trainees. The study suggested substantial variations at local level (Russet, Humbertclaude, Dieleman et al., 2019). This 2019 study by Russet and colleagues is the only review known to have assimilated case descriptions and narrative accounts of numerous European CAP programs. This study comments upon the disparities in supervision and the modules of education at CAP programs in different European countries, but does not address factors influencing trainee transitioning into child programs.

Aims:

From extant literature, no formal surveys have been conducted. Ours is an attempt to understand such factors as described above with a hope of improving resident transition into CAP fellowship programs.

Method:
A survey was disseminated to CAP fellows at Institute of Living/Hartford Hospital, Boston Children's Hospital, University of Tennessee and University of Connecticut. The survey was sent to all the first and second year CAP fellows at the above mentioned programs.
The survey is composed of 21 questions. 17 of the responses to these questions are captured based on a 5-point Likert scale. 3 responses in the form of 'yes' or 'no' and 1 is a descriptive response subjective to each fellow's experience. Some of the questions in the survey were modified from the Job Satisfaction Scale (Spector, 2014). The fellows at the Institute of Living/Hartford Healthcare helped with preparing the survey as well as gathering data.

Discussion:
About 53% felt neutral about their experience of transition into fellowship. Most likely reasons being newness to program. About a third of participants felt sub optimally prepared in general psych residency. Likely reasons were limited clinical experience related to CAP in general residency, none or limited CAP focused didactics.

Only 15% felt extremely confident of clinical decision making and conducting risk assessment. About 30-38% were fairly confident in the above skills including using developmentally appropriate language with patients. About 38.5% struggled with systems of care knowledge with only 15% feeling somewhat confident. 30.8% were prone to negative thinking about work and feeling deficient at work. This was unanimously attributed to perceived lack of knowledge, experience and confidence. Other areas of unanimous agreements seemed having retreats in the beginning months of fellowship and twice a year in addition to having process groups.

General suggestions for improvement included a robust "boot camp" educating about the basics of CAP, state specific laws, introduction to formulations and note writing and offering frequent supervision sessions.

**Scientific Citations**
Webster, M. (n.d.). Transition. Retrieved from merriam-webster.com/dictionary/transition
Russet, F., Humbertclaude, V., Dieleman, G., Dodig-?urkovi?, K., Hendrickx, G., Kova?, V., … Purper-Ouakil, D. (2019). Training of adult psychiatrists and child and adolescent psychiatrists in europe: a systematic review of training characteristics and transition from child/adolescent to adult mental health services. BMC Medical Education, 19(1), 204. https://doi.org/10.1186/s12909-019-1576-0
Mehta, S. J., & Forde, K. A. (2013). How to Make a Successful Transition From Fellowship to Faculty in an Academic Medical Center. Gastroenterology, 145, 703–707. https://doi.org/10.1053/j.gastro.2013.08.040
Spector, P. (2014). The Assessment of Job Satisfaction. In Job Satisfaction: Application, Assessment, Causes, and Consequences (pp. 5–22). https://doi.org/10.4135/9781452231549.n2

# Effects of an Educational Enhancement Initiative on Graduated Resident Satisfaction

**Presenters**
Jessica Dotson, DO
Amy Meadows, FAAP, FAPA, MD, MS
Milicent Fugate, MD
Sandra Batsel-Thomas, MD

**Educational Objective**

1. Describe the Educational Enhancement Initiative at University of Kentucky Psychiatry, which seeks to utilize adult learning principles, incorporate expanding medical knowledge, and balance the clinical and educational pressures of the current health system.
2. Examine resident engagement and satisfaction before and after implementation a comprehensive Educational Enhancement Initiative

**Practice Gap**

Education is the core mission of a psychiatry residency training program (Accreditation Council for Graduate Medical Education, 2017).Residents must learn and incorporate medical knowledge, professionalism principles, systems-based thinking, and communication skills within a finite time period. Given changes in our understanding of adult learning principles (Spencer & Jordan, 1999), increases in medical knowledge (Densen, 2011), and the increasing pressures of clinical settings (Markit, 2017), residency programs must actively adapt to meet the education needs of residents.

**Abstract**

Background: Residency education involves meeting the distinct needs of adult, professional learners while balancing clinical care in an increasingly complex medical environment (Spencer & Jordan, 1999). Given the challenges in the clinical learning environment, University of Kentucky has embarked on a multi-year Educational Enhancement Initiative focused on determining the needs of learners, shaping curriculum to fit those needs, and helping faculty to effectively teach the curriculum (Curriculum development for medical education: a six-step approach, 2016; Genn, 2001)

Objective: Assess graduated resident satisfaction amongst varying training domains by graduating residents and fellows before and after the implementation of a comprehensive Educational Enhancement Initiative.

Methods: Surveys on educational experiences during residency and/or fellowship training were electronically sent to residents and fellows for completion after graduation. Surveys were completed by residents and fellows in the 2017 – 2018 graduating cohort (n=3/8; 33% response

rate) and in the 2018 – 2019 graduating cohort (n=7/9; 78% response rate ). Survey responses were compared between cohorts .

University of Kentucky Medical IRB approved the study.

Results: Overall satisfaction scores demonstrated an upward trend in the 2018 – 2019 graduating cohort as compared to the 2017 – 2018 graduating cohort. Overall satisfaction increased from a mean of 3.7 to 5.7 on a 7-point Likert scale where 7 was "very satisfied." On the 2018-2019 survey, 100% of respondents (7/7) reported they had achieved what they expected during residency compared only 33% of respondents (1/3) during 2017-2018. Additional marked improvements were noted in the domains of preparation to achieve board certification, self-directed and independent study, confidence in ability to practice psychiatry independently, clinical/bedside teaching, and likelihood of recommending the training programs to medical students. Descriptive statistical analysis will be presented as part of the poster presentation.

Conclusion: Residency training program review of post-graduate educational experience surveys demonstrate overall improvement in reports of satisfaction in post-graduate physicians. Numerous changes were enacted in the 2018 – 2019 academic year that may have contributed to the improvement in reported satisfaction. Specifically, we adopted a comprehensive Educational Enhancement Initiative, which included a faculty and resident needs assessment, didactic curriculum changes, and enhanced faculty development opportunities. Curriculum changes included initiation of a formalized attending-led board review didactic curriculum, investment in a self-directed online learning module system (Decker Scientific America), explicit efforts to enhance communication throughout residency/fellowship hierarchy, as well as dedicated group supervisory meetings and obligatory attending check-out schedule in the outpatient setting. While small sample size precludes statistical significance between survey responses, generalized results demonstrate that residents and fellows reported feeling increasingly prepared to achieve board certification, endorsed enhanced confidence in their ability to practice independently, and were more likely to recommend their training program to future physicians.

**Scientific Citations**

Accreditation Council for Graduate Medical Education. (2017). ACGME Program Requirements for Graduate Medical Education in Psychiatry. Retrieved from https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf

Curriculum development for medical education: a six-step approach. (2016). (P. A. Thomas, D. E. Kern, M. T. Hughes, & B. Y. Chen Eds. 3e ed.). Baltimore: JHU Press.

Densen, P. (2011). Challenges and opportunities facing medical education. Transactions of the American Clinical and Climatological Association, 122, 48.

Genn, J. (2001). AMEE Medical Education Guide No. 23 (Part 1): Curriculum, environment, climate, quality and change in medical education–a unifying perspective. Medical Teacher, 23(4), 337-344.

Markit, I. (2017). The complexities of physician supply and demand: projections from 2015 to 2030.

Spencer, J. A., & Jordan, R. K. (1999). Learner centred approaches in medical education. BMJ : British Medical Journal, 318(7193), 1280-1283. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1115656/.

## Puzzled about How to Teach Neuroscience without a Specialized Neuroscience Faculty? A Multi-faceted Approach

**Presenters**
Kiran Khalid, MBBS
Cynthia Pristach, MD
Paula DelRegno, MD

**Educational Objective**

- Describe the process of designing and implementing a neuroscience curriculum that:
- Spans across the 4 years of training
- Can be implemented in a psychiatry residency training program that has no specialized neuroscience faculty
- Utilizes multiple teaching methods and learning tools.

**Practice Gap**

Incorporating neuroscience into the psychiatry residency curriculum has long been considered essential, since the assessment, treatment and prevention of brain disorders are grounded in studies based on clinical neuroscience (1). Results from a 2012 national survey found that there is agreement among stakeholders for increased neuroscience education (2). With ongoing advances in the field, psychiatry residents must have a firm understanding of the human brain, neural pathways and genomics in order to apply this knowledge clinically to improve the health and understanding of their patients. In addition, neuroscience is included under Medical Knowledge as part of the ACGME Milestones. In 2016 the Psychiatry Resident-In-Training Exam (PRITE) introduced a specific category to measure residents' neuroscience knowledge, further emphasizing its importance in the residency curriculum. Despite this, programs have struggled to develop or enhance their existing neuroscience curricula. Obstacles include the explosion of information in the field, the limited number of faculty who have training in neuroscience and who feel comfortable teaching the material, resistance of residents to engage in the learning process because of their own discomfort with the material, and availability of a curriculum which is manageable and clinically applicable (3). The National Neuroscience Curriculum Initiative (NNCI) (4) was developed to serve as a portable neuroscience curriculum that could be

applied to a wide variety of programs, even those whose faculty have limited training in neuroscience. It includes a broad variety of neuroscience topics which can be applied in a multitude of settings, including faculty led sessions, on-line learning modules and scientific articles for discussion. The NNCI offers consultation to individual programs to identify existing strengths and weaknesses, explore available resources, and propose a plan for neuroscience curriculum development.

**Abstract**

The University at Buffalo Department of Psychiatry obtained an NNCI consultation in October 2018. Prior to this, the curriculum included 9 sessions, led by two faculty members. The curriculum was revised to include additional faculty members and increase resident engagement in their own learning The plan was introduced at separate orientation & training sessions for recruited faculty and all residents.

The faculty were surveyed to measure their comfort level with teaching neuroscience. They were introduced to the NNCI, and given a One Minute Preceptor (5) script designed to complement each NNCI session in order to solidify knowledge and make the topic clinically relevant. A post-training session survey was completed by the faculty.

Residents completed a survey using a 4 point Likert Scale (1-poor, 4-excellent) rating their knowledge of neuroscience and comfort applying it in the clinical setting. They were introduced to the new curriculum and their role in the learning process.

The curriculum was initiated in January 2019 and included:
PGY 1: 2 didactic and 2 on-line NNCI sessions, 4 neuroscience journal clubs
PGY 2: 12 (6 NNCI) didactic and 2 on-line NNCI sessions, 4 neuroscience journal clubs
PGY _: 2 on-line NNCI sessions 4 didactic and, 4 resident-led Pecha Kucha (6) style sessions focusing on basic science and clinical topics, 4 neuroscience journal clubs

Results: Faculty: Informal feedback from participating faculty indicated excitement, increased confidence, and more buy-in following the demonstration and review of online materials on the NNCI website and the One Minute Preceptor scripts. Six out of seven faculty participants filled out the survey completely. All (7/7,100%) indicated they were very likely to apply the knowledge from the training session when teaching learners. All respondents indicated improvement in level of comfort with teaching neuroscience using web-based modules in a classroom setting. Within the next month, the faculty will complete a follow-up surve

**Scientific Citations**

1.Reynolds CF, Lewis DA, Detre T, Schatzberg AF, Kupfer DJ. The future of psychiatry as clinical neuroscience. Acad Med. 2009;84(4):446-50.
2. Fung LK, Akil M, Widge A, Roberts LW, Etkin A. Attitudes toward neuroscience education among psychiatry residents and fellows. Acad Psychiatry. 2014;38(2):127-34.
3. Coverdave J, Balon R, Beresin EV, et al. Teaching Clinical Neuroscience to Psychiatry Residents: Model Curricula. Acad Psychiatry 2014; 38:111-115.

4. www.nncionline.org
5. Neher JO, Gordon KC, Meyer B, Stevens N. A five-step "microskills" model of clinical teaching. Clin Teach. 1992;5:419–24.
6. Carroll AJ, Tchangalova N, Harrington EG. Flipping one-shot library instruction: Using Canvas and Pecha Kucha for peer teaching. J Med Libr Assoc. 2016; 104(2): 125-130

## Just In Time Teaching Tips – A Targeted Email Campaign to Improve Resident Teaching

**Presenters**
Sarah Marks, BA, MD, MS
Alice Fornari, BA, PhD
John Q Young, MD, MPH, PhD
Timothy Kreider, BA, MD, PhD

**Educational Objective**
After engaging with this poster, participants will be able to:
1) Recognize the need to provide support and training to improve residents as teachers
2) Appreciate how mobile technology can be leveraged to support resident teaching and build a culture that values resident teaching
3) Explain how the Just in Time Teaching Tips program can help residents develop their identities and skills as educators

**Practice Gap**
Residents spend almost 25% of their time teaching medical students (1) and up to 85% of medical students' clinical teaching comes from residents (2, 3). This emphasizes the significant and important role placed on residents as teachers and the fact that graduate medical education programs heavily rely on peer-assisted learning as a form of educational instruction. Accordingly, the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME) have established teaching as an essential competency. Structured programs to develop and enhance residents' teaching skills are now required as part of maintaining accreditation. In order to train residents to be effective educators, programs have been adopting Resident as Teacher (RaT) curricula to provide this formal training. However, RaT Programs are often difficult to implement and time consuming, sometimes limited in scope, and lack frequent reinforcement (4, 5). RaT programs that offer isolated workshops or didactics found that teaching skills decline over time, especially if residents are not provided with opportunities for reinforcement (6).

To address this need, the Just In Time Teaching Tips Email Campaign ("JiTT Campaign") was implemented. The JiTT Campaign served as an adjunct to an existing RaT curriculum, and the campaign involved weekly emailed teaching tips that were available "just in time" to residents on their clinical services. The campaign's goals were to:

1. Reinforce specific pedagogical skills right where and when the residents could practice those skills
2. Provide teaching scripts for residents to use when teaching certain common, complex topics in psychiatry
3. Activate residents' intrinsic motivation to teach and enhance their self-identification as educators

**Abstract**

Methods

The content of the teaching tips emails had two domains: evidence-based pedagogical skills shown to be effective for teaching during the clinical workflow, and targeted psychiatry-specific content. Four tips on general pedagogy were included (setting expectations, feedback, directed observation, five microskills) and two tips were developed on how to teach psychiatry content (biopsychosocial formulation, types of psychotherapies).

The specific tips were distilled into easy-to-read steps and emails were designed using Canva, an online graphic design program, then uploaded into OpenMoves, an email system that would allow automated sending and tracking of the weekly teaching tips emails. The emails were delivered in a 6-week campaign coordinated with the psychiatry clerkship, with tips matching the relevant point of the clerkship cycle (e.g., "setting expectations" on week 1).

Evaluation of the intervention had several components. Pre- and post-campaign surveys were administered to all resident participants to assess the impact on their teaching knowledge, skills, and attitudes, using both multiple-choice and free-text responses. Utilization data from the OpenMoves platform was analyzed in conjunction with the survey data. Finally, survey items were added to the end-of-clerkship program evaluation completed by students, asking whether residents used particular teaching strategies promoted by the JiTT Campaign.

Results

On the post-campaign survey, 78% of residents reported reading "some" or "most" of the teaching tip emails. This data will be compared with the utilization data provided from the OpenMoves platform once available.

Residents reported changes in their teaching practice as a result of the campaign. In particular, 31% of residents reported giving feedback differently, incorporating and using techniques from the emails. Conversely, only 13% of residents reported that they taught more frequently as a result of receiving the weekly email reminders.

Two specific teaching practices highlighted in the email campaign were used by almost all residents: 79% used the evidence-based teaching strategy of directed observation during the campaign period, and 93% provided an orientation to their learners (setting expectations and goals). This resident self-report was corroborated by student evaluation of residents, which reflected near-universal "strong agreement" that residents oriented them to the clinical service during the campaign.

Following the 6-week email campaign, 44% of R1s and R2s described themselves as frequently confident about their teaching ability, compared to only 22% of residents 6 weeks prior. Overall, the residents provided positive feedback regarding the frequency and character of the teaching tip email delivery method. Survey respondents felt the JiTT Campaign content was helpful and applicable, and they requested additional teaching tip emails for the future.

**Scientific Citations**

1. Busari OJ, Vervoort M, Hermans SM, Blom JR. Medical education in the new millennium--a Caribbean perspective. Medical education. 2001;35(7):703-6. Epub 2001/07/05. PubMed PMID: 11437976.
2. Dotters-Katz S, Hargett CW, Zaas AK, Criscione-Schreiber LG. What motivates residents to teach? The Attitudes in Clinical Teaching study. Medical education. 2016;50(7):768-77. Epub 2016/06/15. doi: 10.1111/medu.13075. PubMed PMID: 27295481.
3. Busari JO, Arnold A. Educating doctors in the clinical workplace: unraveling the process of teaching and learning in the medical resident as teacher. Journal of postgraduate medicine. 2009;55(4):278-83. Epub 2010/01/20. doi: 4103/0022-3859.58935. PubMed PMID: 20083878.
4. Al Achkar M, Hanauer M, Morrison EH, Davies MK, Oh RC. Changing trends in residents-as-teachers across graduate medical education. Adv Med Educ Pract. 2017;8:299-306. Epub 2017/05/13. doi:
5. Watkins AA, Gondek SP, Lagisetty KH, Castillo-Angeles M, Gangadharan SP, Cahalane MJ, Kent TS. Weekly e-mailed teaching tips and reading material influence teaching among general surgery residents. Am J Surg. 2017 Jan;213(1):195-201.e3. doi: 10.1016/j.amjsurg.2016.05.004. Epub 2016 Jul 9. PubMed PMID: 27640910.
6. Wamsley MA, Julian KA, Wipf JE. A literature review of "resident-as-teacher" curricula: do teaching courses make a difference? Journal of general internal medicine. 2004;19(5 Pt 2):574-81. Epub 2004/04/28. doi: 10.1111/j.1525-1497.2004.30116.x. PubMed PMID: 15109328; PubMed Central PMCID: PMCPmc1492323.

## Creating an X+Y scheduling system at a Psychiatry Residency Program

**Presenters**

Evan Vitiello, MD
Mark Goodman, MD
James Mayo, MD, MPH
Winston Li, MD

**Educational Objective**

1. Detail the administrative and logistical challenges in resident training schedules after a large structural change in our academic institution, where our outpatient services were moved from the hospital medical center to satellite sites.
2. Propose and describe a scheduling system that ameliorates the impact of the location change and promotes residents' clinical training and learning.

**Practice Gap**

Our institution recently underwent a significant structural change where outpatient clinics were moved from the hospital medical center to satellite sites. This location change significantly affected the existing PGY3 scheduling system, which incorporated concurrent inpatient and outpatient duties, and relied on co-located inpatient and outpatient services. We propose a new scheduling system to address this logistical challenge.

**Abstract**

Background:

Psychiatry training, like other specialties, encompasses a mix of supervised inpatient and outpatient clinical experiences designed to prepare trainees for a variety of careers (1). While historically many Psychiatry residency programs have organized their curriculum to stress early inpatient experience in the first two years, several programs have moved to provide earlier ambulatory exposure. At UNC residents begin caring for outpatients in PGY2, which allows not only early ambulatory exposure but also greater continuity with medication management and therapy patients. During PGY3, residents maintain a panel of continuity outpatients which are balanced with inpatient and consult service responsibilities.

When our outpatient clinics were moved to satellite locations, logistical challenges emerged for third-year residents simultaneously managing inpatient and outpatient duties. In response, we explored restructuring our Psychiatry training program to utilize an X+Y scheduling model consisting of continuous inpatient responsibilities for 3 weeks (X) followed by a protected ambulatory block for 1 week (Y). This shift mirrors emerging paradigms in internal medicine and pediatrics, in which residents also have to balance inpatient and outpatient duties (2, 3, 4, 5).

Methods:

When ambulatory clinics were moved to satellite locations (20 minutes from hospital campus), the department initially implemented a "half-day" system in which residents each had a dedicated afternoon to see continuity outpatients. While this served as a workable intermediary solution, we also used this time to explore X+Y.

Preparation for the transition to 3+1 scheduling began with piloting a version of the "+Y" ambulatory week for PGY4 residents who have the most flexible schedules. This trial period allowed data collection and continued discussion with focus groups comprising trainees, faculty, and leadership. Additional preparation included drafting a mock PGY3 schedule, identifying new outpatient experiences and supervising faculty, designing a backup coverage system, and exploring creative new ways to satisfy all ACGME requirements. We plan to begin scheduling PGY3 into "X+Y" scheduling July 2020.

Discussion:

We present a proof of concept for creative scheduling within Psychiatry residency to allow for early ambulatory experience (PGY2) and subsequent balancing of inpatient and outpatient responsibilities (PGY3). While many internal medicine and pediatric training programs have

adopted “X+Y” scheduling paradigms, to our knowledge there are no Psychiatry programs with this method of scheduling.

**Scientific Citations**
References:

1) ACGME Program Requirements for Graduate Medical Education in Psychiatry. 2019 Accreditation Council for Graduate Medical Education (ACGME).

2) Shalaby et al. “X+Y Scheduling Models for Internal Medicine Residency Programs- A Look Back and a Look Forward.” Journal of Graduate Medical Education, Dec 2014: 639-642.

3) Noronha et al. “X+Y Scheduling Models in Internal Medicine Residency Programs: A National Survey of Program Directors’ Perspectives.” The American Journal of Medicine (Vol 131, No1), January 2018: 107-114.

4) Ray et al. “Improving Ambulatory Training in Internal Medicine: X+Y (or Why Not?)” Journal of General Internal Medicine 31 (12): 1519-22.

5) Osborn et al. “X+Y Scheduling in Pediatric Residency: Continuity, Handoffs, and Trainee Experience.” Academic Pediatric (Vol 19, No5), July 2019: 489-494.

## Teaching Cognitive Bias: Development and implementation of dual process theory curriculum in a child and adolescent psychiatry (CAP) fellowship.

**Presenters**
Kimberly Kelsay, MD
Anne Penner, MD

**Educational Objective**
After viewing this poster attendees will
1) Understand potential gaps in knowledge of psychiatry trainees regarding cognitive bias.
2) Identify key components of a curriculum for CAP fellows designed to improve knowledge, skills of cognitive bias and application of de-biasing strategies in clinical care provided by psychiatry trainees.
3) Discuss outcomes of this curriculum and implications for other training programs.

**Practice Gap**
Decision making in psychiatry is complicated by diagnostic complexity. Cognitive bias can impact both diagnosis and medical decision making, resulting in errors with consequent increases in morbidity and more rarely mortality (1). The Institute of Medicine report in 2003 drew attention to the frequency and cost of medical errors. Subsequent studies have increased the estimate of frequency of death due to medical errors to the third leading cause of death (2),

with _ being attributable to misdiagnosis and another _ of these attributable to thought errors (3). The science of cognitive bias, specifically the Nobel winning dual process theory described by Tversky and Kahneman, has been applied to medical decision making to decrease errors from cognitive bias (1). Yet, these more recent developments are not routinely taught in medical training. Furthermore, literature review of cognitive bias in psychiatry generates few studies related to dual process theory and de-biasing strategies (4), although there are studies to suggest that cognitive bias does impact diagnoses and treatment in psychiatry (5). Cognitive bias is not covered in ACGME milestones or competencies, other than by extension through competencies of patient care, systems based practice and practice based learning and improvement.

**Abstract**

We performed a needs assessment of child and adolescent psychiatry faculty and fellows at a child and adolescent psychiatry fellowship and utilized this assessment to inform curriculum development. The 16-question survey (4-point Likert scale) was completed by 11/12 (92%) of fellows and 18 /28 (64%) of faculty. The majority of fellows and faculty respondents report they engage in cognitive bias (91%, 72%), yet don't feel confident they can avoid cognitive bias (54%, 72%). The majority haven't had training in the dual process model of cognitive bias (91%, 90%). No respondents feel confident in their understanding of this model and less than half correctly named 3 cognitive biases (36%, 44%). The needs assessment results informed curriculum design. Objectives of the curriculum included that attendees would:

1) Develop knowledge of Kahneman and Tversky's dual process model of cognitive bias to recognize and apply this to their work in psychiatry.
2) Identify how implicit bias is encompassed within this model.
3) Commit to applying this knowledge to improve experiences and outcomes of patients in their care and/or improve systems of care.
4) Develop an interest to continue lifelong learning as this science continues to develop.

The curriculum was delivered using active learning strategies and think-pair-share experiences over 6, 1-hour weekly sessions to twelve fellows. The poster will present the curriculum in greater detail. Nine fellows attended all sessions. Following the curriculum, 8/9 attendees completed the 23 question post survey. Attendees demonstrated a statistically significant improvement in knowledge ($p<0.05$), and more individuals ($p<0.05$) self-reported improved overall competence and confidence in their ability to avoid cognitive bias after attending the sessions. Specifically, more attendees reported understanding dual process cognitive bias model, comfort in teaching cognitive bias to medical learners, and ability to correctly name 3 cognitive biases. The majority committed to applying this to their work. All attendees reported an increase in their interest, a belief that this should be taught during graduate medical education, and they were engaged in the course and felt it was the right length. Feedback suggestions included using more real-life cases in a Morbidity and Mortality style discussion. This curriculum was well received, achieved objectives, and has potential to improve patient care.

**Scientific Citations**


1. Croskerry P. Bias: a normal operating characteristic of the diagnosing brain. Diagnosis (Berl). 2014;1(1):23-27.
2. Makary MA, Daniel M. Medical error-the third leading cause of death in the US. BMJ. 2016;353:i2139.
3. Graber ML, Franklin N, Gordon R. Diagnostic error in internal medicine. Arch Intern Med. 2005;165(13):1493-1499.
4. Mendel R, Traut-Mattausch E, Jonas E, et al. Confirmation bias: why psychiatrists stick to wrong preliminary diagnoses. Psychol Med. 2011;41(12):2651-2659.
5. Garb HN. Cognitive and social factors influencing clinical judgment in psychiatric practice. World Psychiatry. 2013;12(2):108-110.


## Does Program Director Effectiveness Correlate with Resident Burnout?


**Presenters**

Jason Schillerstrom, MD
Aline Cenoz-Donati, MD


**Educational Objective**

1. Assess the perceived quality of residency program directors across multiple specialties using the Resident Edition of the Program Director Evaluation tool.
2. Assess resident wellness across multiple specialties using the Professional Quality of Life scale.
3. Determine the correlation between resident burnout and perceived program director effectiveness.

**Practice Gap**

Burnout rates are high among physicians-in-training. Factors contributing to burnout include long duty hours, administrative burden, and the stresses of the work environment. The impact of graduate medical education (GME) leadership on trainee wellness is less studied. A recent article published by the Mayo Clinic showed that the leadership qualities of physician supervisors also appear to impact wellness and burnout. However, there are currently no publications specifically examining the relationship between program director quality and resident wellness. This study examines this relationship using the Professional Quality of Life (ProQOL) and the Program Director Evaluation (published in Academic Psychiatry 2018) as metrics for burnout and program director quality respectively.


**Abstract**

The term “burnout” is defined by the World Health Organization International Classification of Diseases as a “state of vital exhaustion”, and has been associated with depression and decreased job satisfaction. The Accreditation Council for Graduate Medical Education (ACGME) has made resident wellness a priority, placing program directors in a unique position to address factors leading to burnout. While program directors can certainly reduce burnout by improving the work environment, they themselves may be contributing to adverse resident wellness

through ineffective leadership qualities. In 2018 we published the first Program Director Evaluation in the journal Academic Psychiatry. This study aims to determine if program director effectiveness is associated with resident wellness across multiple specialties. Residents across multiple specialties were surveyed using the ProQOL and Program Director Evaluation. The ProQOL is a public domain, 30-item rating scale that measures the negative and positive effects of helping others. It includes sub-scales for compassion satisfaction, burnout, and compassion fatigue. The Program Director Evaluation is a 10-item assessment residents complete to highlight the successes and opportunities for improvement of program directors in professional and career development, leadership, and role modeling. We hypothesized that resident perceived program director quality would correlate with resident wellness. We used multivariable modeling to search for between specialty differences. It is our hope that this data can be used to better target interventions aimed to improve resident wellness.

**Scientific Citations**

1. ACGME Common Program Requirements. Accreditation Council for Graduate Medical Education. 2017. www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements.
2. Specialty-specific References for DIOs: Program director scholarly activity ACGME. ACGME; 2017
3. Shanafelt, Tairt D., Gorringe, Grace, et al. Impact of Organizational Leadership on Physician Burnout and Satisfaction. Mayo Clin Proc. April 2015;90(4):432-440
4. Cenoz-Donati AB, Schillerstrom JE, Pokorny JJ. Development of Evaluations to Assess the Quality of Residency Program Directors. Acad Psychiatry. 2019 Feb;43(1):28-36

## Creating an Evidence-based Algorithm for Neuroleptic Initiation for PGY-1 Residents to Increase Resident Confidence in Making Treatment Recommendations.

**Presenters**

Rana Jawish, MD
Lora Wichser, MD

**Educational Objective**

- Describe how a psychotropic treatment algorithm was used to address the gap in psychopharmacology training at the University of Minnesota.

- Explore the change in confidence in residents exposed to a treatment algorithm for psychosis

- Consider applications in participant's home institution for a similar teaching tool

**Practice Gap**

Psychiatry Residents at the University of Minnesota residency program repeatedly requested an improved psychopharmacology curriculum, over the historical didactic-based approach. While Powerpoint-based didactics were the expectation for many years, new emphasis on adult-learning theory informed curriculum has forced a critical revision of many educational experiences. The use of psychotropic medications is one of the highest priorities for psychiatry training, representing 2 of 5 of the Patient Care ACGME psychiatry milestones, and 2 of 5 Medical Knowledge Milestones. ABPN Psychiatry board certification examination is up to 20% focused on psychiatric treatments. Residents are thus evaluated throughout their training on, and look forward to board certification that focuses heavily on, psychopharmacology. A substantial gap thus exists between expectations for performance, and the established educational content of the University of Minnesota residency didactic curriculum. This gap has been identified for several years by the residents, at their end of year feedback retreat. An adult-learning theory approach, which focuses on problem-based learning and self-motivated learning is the answer.

**Abstract**

We here present the creation and dissemination of an evidence-based treatment algorithm for patient with acute psychosis, without a mood component, on the inpatient psychiatry units for PGY-1 residents. This algorithm utilizes existing guidelines in the field regarding neuroleptic medication initiation and recommended doses. The tool was developed through an active dialogues between the current PGY-2 residents and three faculty members who are directly involved in resident teaching and clinical supervision on the inpatient units. It was designed as an educational tool to address a common concern raised by the residents regarding their psychopharmacology knowledge, and it's application in daily clinical practice. This tool is designed to encourage residents to make treatment recommendations by tailoring first and second line management based on each clinical case.

Before use, a survey was sent to all residents in the program to assess the level of stress and confidence that residents have when they think about initiating psychotropic medications in this setting, and if possible, to identify the main barrier that contributed to the stress and lack of confidence. Noteably, only 20% of the residents from the PGy1 and PGY-2 classes felt that they were very prepared to initiate psychotropic medication for this patient population, 20% felt that they are not prepared at all and 60% felt somewhat prepared. 40% of the residents did not feel at all prepared to recommend a starting dose of the medication of their choice, and only 40% felt somewhat prepared to make a recommendation dose. Remarkably 100% of the residents that took the survey identified the lack of knowledge is the main reason for their discomfort with making treatment decisions. A follow-up survey after a 3-month period will be completed soon to assess the efficacy of this tool in alleviating the stress and discomfort among residents, and educational value of adding this new innovative model to the established curriculum for PGY-1 and PGY-2 residents.

**Scientific Citations**

ACGME Psychiatry Milestones. Accessed 10-28-19.
https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf

ABPN Psychiatry Certification Specifics. Accessed 10-28-19. https://www.abpn.com/wp-content/uploads/2018/11/2019_Psychiatry_CERT_Content_Specifications.pdf

## Assessing the Educational Value of a Formal 3-Year CSV Practicum in Residency Training

**Presenters**

Eileen Kavanagh, MD
Yael Holoshitz, MD
Christopher Cselenyi, MD, PhD
Julia McMillan, BA
Melissa Arbuckle, MD, PhD

**Educational Objective**

One objective of the survey is to evaluate the perceived value and educational effectiveness of the 3-year practicum begun in 2014.

The objectives of the 3-year practicum we've surveyed former residents about are:

- Hone a critical skillset and consolidate clinical learning to prepare them for independent clinical work
- Comprehensive & accurate interview, conveying compassion & clinical acumen, with thorough clinical presentation and defense of diagnostic differential & treatment plan

**Practice Gap**

In 2007, the Clinical Skills Verification (CSV) exam was instituted by the ABPN to replace the live oral boards. In addition to clinical assessment, the CSV was proposed as serving an educational purpose, with an opportunity for feedback. While the ABPN set certain standards for assessment, execution of the CSV is up to the discretion of residency administration. Directors of the residents' outpatient clinic noticed that:

(1) Strong residents, even as PGY3s, were not demonstrating the skillset that would have been required for passing the oral boards and were under no pressure without the oral boards to continue to work on the interviewing & presentation skills.

(2) With elimination of national psychiatry oral boards for certification, Directors of Clinic saw an opportunity for curriculum overhaul and instituted:

- 3 year practicum in clinical interviewing
- boards-style, observed exam each year starting in PGY2 year
- didactics using videos of residents interviewing real patients
- key feature: 3 trained examiners in every exam to improve quality of assessment and consistency of feedback and ideally the same examiners over the three-year period

**Abstract**
Background: In 2007, the Clinical Skills Verification (CSV) exam was instituted by the ABPN to replace the live oral boards. In addition to clinical assessment, the CSV was proposed as serving an educational purpose, with an opportunity for formative and summative feedback. While the ABPN set certain standards for assessment, execution of the CSV is up to the discretion of residency administration.

Purpose: The goal of this study is to evaluate the perceived educational value of different models for implementing CSVs in residency training.

Methods: An anonymous survey was sent to all residents from graduation years 2015-2019, assessing the degree to which they have used skills and knowledge from the CSV curriculum in their post-residency practice. Graduates were also asked about the effectiveness of having the observed CSV separate from their general clinical practice.

Results: Surveys were sent to 57 residents who graduated between the years of 2015-2019, with 46 people completing the survey (81% response rate). Graduated residents work in a variety of settings, including inpatient unit, outpatient clinic, emergency room, and private practice (several responders listed more than one setting). Overall, results of the survey showed that residents responded favorably to their 3-year CSV practicum. Most highly rated was the feature of the CSV interviews being observed by the same team of experienced examiners, over the course of 3-years. While overall well-received, a handful of residents reported low scores (strongly disagree), in particular as to whether they use skills/feedback from CSV in current patient interactions or in their own teaching.

**Scientific Citations**
Dalack GW, Jibson MD. Clinical Skills Verification, Formative Feedback, and Psychiatry Residency Trainees. Academic Psychiatry 2012; 36: 122-125.

Jibson et al. Clinical Skills Verification in General Psychiatry: Recommendations of the ABPN Task Force on Rater Training. Academic Psychiatry 2012; 36: 363-368.

Rao NR et al. Psychiatric Residents' Attitudes Toward and Experiences With the Clinical-Skills Verification Process: A Pilot Study on U.S. and International Medical Medical Graduates. Academic Psychiatry 2012; 36: 316-322.

## Group Training for Psychiatric Residents: Support Group Facilitation and Supervision with Didactics

**Presenters**
Meena Denduluri, MD
Jessica Gold, MD,MS
Wilmarie Cidre Serrano, MD

Jessica Bentzley, MD
Sallie DeGolia, MD,MPH

**Educational Objective**

1. To identify if a support group facilitation and supervision program can lead to greater perceived ability and knowledge in group facilitation.
2. To assess whether a support group facilitation and supervision program would be an educational program in which residents would be interested in participating.
3. To measure if a brief intensive training curriculum can lead to greater perceived ability and knowledge in group facilitation.

**Practice Gap**

Group therapy training, distinct from individual psychotherapy training, offers psychiatry residents improved understanding of an important modality to treat psychiatric illness, increases knowledge of group dynamics, and promotes self-awareness. Exposure to group therapy is required residency training curriculums by the Accreditation Council of Graduate Medical Education (ACGME). However, there have been challenges in implementing this training requirement in residency programs, including determining how and when groups should be taught during a resident's four years of training, given differing level of experience and knowledge with psychotherapeutic techniques. To address this issue, we implemented a group therapy intensive training program consisting of ongoing didactic and in-vivo learning through facilitation of medical student support groups.

**Abstract**

Introduction: In psychiatric residency, group psychotherapy merits separate training from individual psychotherapy. However, determining how and when to teach about groups is challenging. To address this issue, we implemented a group therapy intensive training program consisting of ongoing didactic and in-vivo learning through facilitation of medical student support groups.

Methods: Psychiatry residents from all years of training (PGY I-IV) voluntarily participated in a three-session training on group facilitation. Some residents were then selected to facilitate groups and participate in supervision. Residents completed brief self-report surveys assessing confidence and skill level in facilitation prior to and after initial training sessions. These data were analyzed with descriptive statistics. Respondents were also asked to provide open-ended comments on what motivated them to become a facilitator as well as feedback on training sessions and ongoing supervision.

Results: Twenty-three residents participated in training b

**Scientific Citations**

Roman, M., & Porter, K. (1978). Combining experiential and didactic aspects in a new group therapy training approach. International journal of group psychotherapy, 28(3), 371-387.

# Creating a Rural Mental Health Track and Curriculum

**Presenters**
Adam Brenner, MD
Rachel Zettl, MD
Karen Duong, DO
Shea Jorgensen, MD
Alexander Thompson, MBA,MD,MPH

**Educational Objective**

1. Describe training locations and rural-specific content currently available in psychiatry residencies.
2. Develop a framework model track and curriculum for starting a rural and public psychiatry track.
3. Explore ways to measure the effectiveness of a rural track to recruit and retain psychiatrists in rural areas.
4. Offer recommendations to training programs to prepare future psychiatrists for working in rural settings.

**Practice Gap**

Psychiatrists in the United States are concentrated in metropolitan areas, leaving more than three quarters of counties in the U.S. without a psychiatrist (1, 2). Psychiatry residency training programs are primarily located in major cities and most graduates practice in the area in which they completed their training (3), likely contributing to the psychiatric workforce shortage in rural America. This experience suggests a need for increased exposure to rural psychiatric practice in residency training. Currently, only 11 psychiatry training programs offer rural tracks or identify on their program websites that they are preparing their residents for rural practice, which are intended to increase residents exposure and interest in working in rural areas. The University of New Mexico Rural Psychiatry Residency Program, with a 20 year history of providing a rural track, has demonstrated that 37% of its rural track graduates practice in rural communities compared to 10% of the graduates from its traditional residency track (4). Additionally, family residency practice programs have demonstrated that providing exposure can increase the number of trainees who choose rural practice (5, 6).

The process of creating a new track requires developing a didactic curriculum highlighting the contextual issues involved in rural psychiatry and creating rural clinical experiences under appropriate preceptors. While each residency program would need to adapt curriculum and schedules to its unique site, basic tenets of the rural psychiatry track could be broadly applied across residency programs. Development of a rural psychiatry curriculum and model track may allow other residency programs to more easily create rural psychiatry tracks

**Abstract**
The University of Texas Southwestern Medical Center (UTSW) and University of Iowa Hospitals and Clinics (UIHC) are both in the process of developing rural and public psychiatry tracks in their psychiatry training programs. The aim is to develop purposeful and well-coordinated educational opportunities in rural settings that can address some of the barriers for recruiting and retaining psychiatrists. Both medical centers have received State funding to help accomplish this goal.

This poster will describe the creation of both program tracks, including the incorporation of components from the Columbia University Public Psychiatry Fellowship, the Rural Training Track Collaborative, and other established models of rural psychiatry education (7,8,9). UTSW matriculated their first two psychiatry residents in 2019 specifically to the Rural and Public Mental Health Track (RPMH). RPMH track residents will be based in Dallas during their first 2 years of training, completing core general program rotations within the UTSW affiliated institutions, including the public mental health experiences through Parkland Hospital and Metrocare. Track residents will complete 1-2 inpatient psychiatry rotations and 1-2 outpatient mental health rotations in a rural setting within reasonable driving distance from Dallas.

In regard to PGY3 and 4 years track residents will be practicing in a rural outpatient setting, providing telepsychiatry and integrated care services to remote clinics. Residents will be housed in rural locations, further integrating them into these communities. RPMH residents will also have the opportunity to work with state public mental health leadership in research and QI projects (9).

The presenters will discuss the obstacles to creating tracks at their respective programs, recruitment strategies used to attract applicants, and plans for data collection to measure the effectiveness of the tracks in retaining psychiatrists in rural areas following graduation. Additionally, this presentation aims to characterize the use of technologies such as video conferencing for didactics, psychotherapy supervision, and insuring residents remain connected to their home program despite geographic location. AADPRT provides an opportune atmosphere for collaboration among presenters and attendees allowing for open dialogue on ways to continue improving our current training models and to encourage other programs to follow suit.

**Scientific Citations**

1. Thomas KC, Ellis AR, Konrad TR, Holzer CE, Morrissey JP. County-level estimates of mental health professional shortage in the United States. Psychiatr Serv. 2009;60:1323–8.
2. Gamm LG, Stone S, Pittman S: Mental health and mental disorders, a rural challenge: a literature review, in Rural Healthy People 2010: A companion Document to Healthy People 2010, vol 2. Edited by Gamm LD, Hutchison LL, Dabey BJ, et al. College Station, TX, The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003, pp 97-113.

3. AAMC. Physician specialty data book. American association of medical colleges, November 2014 (updated 6/3/2015). 2014;21-22.
4. Bonham C, Salvador M, Altschul D, Silverblatt H. Training psychiatrists for rural practice: a 20 year follow-up. Acad Psychiatry. 2014; 38(5):623-6.
5. Rabinowitz HK, Diamond JJ, Markham FW, et al: A program to increase the number of family physicians in rural and underserved areas: impact after 22 years. JAMA. 1999; 281:255-260.
6. Nelson WA, Pomerantz A, Schwartz J. Putting "rural" into psychiatry residency training programs. Acad Psychiatry. 2007; 31(6):423-9.
7. Ranz J, Deakins S, LeMelle S, Rosenheck S, Kellermann S. Core elements of a public psychiatry fellowship. Psych Services. 2008; 59(7):718-720.
8. The RTT Collaborative. https://rttcollaborative.net/. Accessed 10/29/2019.
9. Rural and Public Mental Health Track. University of Texas Southwestern. 2019 https://www.utsouthwestern.edu/education/medical-school/departments/psychiatry/education-and-training/residency-program/rpmh-track.html. Accessed 10/29/2019.

## Introducing Brief CBT interventions on inpatient psychiatric unit in residency training.

**Presenters**
Rosemary Szparagowski, MD
Alisha Lee, PhD
Brian Evans, DO
Justin McCutcheon, MD

**Educational Objective**
1. To improve resident comfort in working within a cognitive behavioral paradigm for therapy.

2. To provide residents with early exposure to cognitive behavioral therapy prior to transitioning to the PGY 3 year.

3. To improve patient experience on an inpatient psychiatric unit by providing individualized brief CBT.

4. To introduce residents to the idea of psychotherapy on the inpatient psychiatric unit.

**Practice Gap**
The practice and delivery of psychotherapies is a critical milestone of psychiatry residency and an ACGME program requirement [1][2]. However, psychotherapy education is highly variable among training programs in the united states. [3] Residents often spend the first two years of their residency working on inpatient psychiatry units. The historical trend of inpatient psychiatric hospitalizations becoming shorter and reserved for patients with severely

decompensated mental illness has shifted resident exposure to psychotherapy into the outpatient experience. Typically, the outpatient experience begins in the PGY3 year. A survey of PGY 3 & 4 residents indicate that residents want higher exposure to therapies of all types during their residency [4]. Furthermore, residents prefer supervision and performing psychotherapy over didactics as a teaching modality [4]. By introducing residents to CBT early in residency, residents will gain confidence in their skills as a Cognitive Behavioral therapist and will be more likely to incorporate elements of CBT in their treatments for the remaining duration of their training.

Not only would introduction of a brief inpatient CBT module fill a gap in psychiatry resident education; it would also be beneficial for patients on the unit. CBT has been shown to be beneficial across multiple diagnoses including in patients with psychotic disorders. Brief interventions can be an effective tool for enhancing the inpatient experience and improving outcomes.

**Abstract**
The CBT module for PGY2s is a brief introduction to the key concepts of CBT giving residents the opportunity to practice CBT skills in an acute inpatient psychiatry setting. The inpatient CBT toolkit was designed by Alisha Lee, PhD, in collaboration with Brian Evans, DO, and the project was implemented by Rose Szparagowski, MD, a senior resident.

Methods: The CBT module is a manualized series of three to four individual therapy sessions which residents can implement with patients on the inpatient psychiatric units. To prepare residents to deliver brief CBT, residents are first introduced to the inpatient CBT toolkit via three lectures. During these lectures, residents are introduced to fundamental principles of CBT including: the CBT model, contraindications to CBT, and selecting appropriate patients for CBT. Residents are then trained on the brief CBT module to be implemented.

After receiving the training, at the beginning of their inpatient rotation the residents meet with the chief resident who will answer questions and help select appropriate patients for the intervention. Therapy sessions are to be performed in the afternoon after resident's finish rounding. In the first session, "Catch it!," residents introduce the basic model of CBT to their patients. During this session they will help patients identify automatic thoughts and assist them in filling out a three-column work sheet identifying situation, emotion and automatic thoughts. During the second session, "Check it!," the resident will introduce the concept of thought distortions and help the patient recognize inaccurate or harmful thoughts. At the end of this session, they will ask patients to complete a three-column worksheet identifying situation, thought, and thought distortion. During the third session, "Change it!," residents will guide the patient in the process of changing their automatic thoughts to be more realistic or helpful thoughts. At the end of this session, they will assign the patient a four-column worksheet that includes situation, thought, thought distortion, and changed thought. If the patient is still in the hospital, residents are encouraged to have a fourth session to review the completed worksheet.

Results: Residents will be given surveys before and after they complete their inpatient rotation to assess their comfort level with delivering CBT. The questionnaire will specifically address resident's confidence in their ability to perform clinical competencies in patient care as listed in ACGME's Psychiatry Milestone Project. We will compare pre- and post-survey responses as a way of monitoring effectiveness of this educational intervention. A cost-benefit analysis outlining the resources required to initiate this intervention, hours of supervision required, and resident time spent on unit will be included in the results.

Conclusion and future directions: It is the hope that early introduction of CBT in residency through a manualized intervention will allow residents to more confidently approach cognitive behavioral therapy throughout residency. Possible future directions for this project include piloting intervention with PGY1 residents, assessing patient experience of intervention, and transitioning selected patients to outpatient residency psychotherapy clinic for ongoing care.

**Scientific Citations**

[1] ACGME Program Requirements for Graduate Medical Education in Psychiatry. Effective July 1, 2014. http://www.acgme.org/Portals/0/PDFs/400_psychiatry_RC.pdf

[2] The Psychiatry Milestone Project. A Joint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. Nov2013. https://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf Accessed Oct 26 2019.

[3] Sudak DM, Goldberg DA. Trends in psychotherapy training: a national survey of psychiatry residency training. Acad Psychiatry. 2012 Sep 1;36(5):369-73. doi:10.1176/appi.ap.11030057. PubMed PMID: 22983467.

[4] Kovach JG, Dubin WR, Combs CJ. Psychotherapy Training: Residents' Perceptions and Experiences. Acad Psychiatry. 2015 Oct;39(5):567-74. doi: 10.1007/s40596-014-0187-7. Epub 2014 Jul 10. PubMed PMID: 25008313.

## Helping Underserved Communities: The Upstate Rural-Academic Partnership Program (URAPP)

**Presenters**

Viral Goradia, MD
Zsuzsa Szombathyne Meszaros, MD, PhD
Scott Ulberg, MD
John Manring, MD
Mantosh Dewan, MD

**Educational Objective**

1. To describe the Upstate Rural-Academic Partnership Program (URAPP), a novel model for securing private funding for residency training and alleviating physician shortage in rural areas.
2. To review the benefits, challenges and opportunities associated with the creation of Rural Tracks.
3. To share feed-back from stakeholders; rural track residents, supervising attendings, administrative leadership and community members about the URAPP.

**Practice Gap**

In 1999 the AAMC projected a shortage of up to 122,000 physicians by 2032, affecting mainly rural communities (1). Factors contributing to this shortage include the rate of population growth, the aging of the population, medical utilization trends, and the limited number of federally funded residency positions (2).

Although the medical school admissions have increased by 30 percent since 2002, there has been no commensurate increase in the number of federally funded residency positions (3). This mismatch between the supply of available doctors and the number of available residency positions has created an ever growing number of unmatched medical-school trained physicians. This ever-growing supply of physicians without graduate medical education training and the growing national need for physicians has caused an increasing number of residency programs to look outside of the federal government for funding (4)

**Abstract**

The Upstate Rural-Academic Partnership Program (URAPP) is a novel model for securing private funding for residency training and alleviating physician shortage in rural areas.

Our departmenal leadership created a partnership between several rural Centers of Excellence (rCOEs) wherein the rCOE funds the complete training of a resident psychiatrist in exchange for 5 years of that psychiatrist's service following graduation. During residency the Rural Track Residents (RTRs) spend between two and four months per year at their site's inpatient psychiatric units, while they spend one day per week at their site's outpatient adult psychiatry clinics during their third and fourth years of residency. After becoming an Attending Psychiatrist, the newly trained physician remains affiliated with the academic medical center as voluntary faculty member of the Department of Psychiatry, thereby creating a regional Network of Excellence (rNOE).

To date, 13 RTRs are either actively completing their residency education through URAPP, or have already completed their residency, and are completing their post-residency service obligation at six participating rCOEs in Watertown, Binghamton, Oswego, Ogdensburg and Utica NY.

Financial benefits of the program include extra overhead costs to cover teaching related expenses, e.g. supervisor salaries, telepsychiatry equipment and office space. Educational benefits include exposure to a rural underserved population, increased cultural sensitivity and improved systems-based practice. The rural sites benefit from the presence of well-trained

residents and attendings, rural attendings gain exposure to Grand Rounds through televideo-conference. The residents benefit from the increased class sizes and the decreased call burden. The number of residents in our program increased from 26 (2016) to 39 (2019) in 3 years; this unprecedented growth shows the success of this approach.

The main challenges and opportunities in establishing a rural track included the need to obtain ACGME approval in order to increase the size of our residency program; limited availability of board certified supervisors at the rural site; having to establish suitable learning environments at the rCOEs; and training and support of supervisors.

The feed-back and evaluations from stakeholders; rural track residents, supervising attendings, administrative leadership and community members about the URAPP is overwhelmingly positive. We have received an unexpectedly high number of requests for residents from rural hospitals every year. We started out with one resident in 2015, expecting 1-2 rural track residents each year, and we had 5 contracts signed in 2019. Our URAPP received the Outstanding Rural Health Program of the Year Award from the New York State Association for Rural Health (NYSARH) in 2018.

**Scientific Citations**

1. AAMC: Physician Supply and Demand A 15 Year Outlook: Key Findings", 2019
2. AAMC: New Findings Confirm Predictions on Physician Shortage, April 23, 2019
3. NRMP: Results and Data: 2019 Main Residency Match
4. Dewan M., Mészáros Z.S., Manring J.: Addressing the Shortage of Psychiatrists in Rural Areas. Psychiatric Services, 2014, 65(12):1508.

## Gun! A simulated encounter with an armed and agitated patient

**Presenters**

Adam Schein, MD
Mohammad Farooqi, MBBS
Alexander Lerman, MD

**Educational Objective**

At the conclusion of this session, the participant will be able to:

- Identify firearms as objects charged with both physical and psychological risk and a source of anxiety that can disrupt the evaluation process;
- Discuss the impact of a mental health clinician's attitudes and preconceptions about firearms on the assessment of a firearm-possessing patient.;
- Demonstrate how to integrate a "firearms history and review of systems" into a comprehensive biopsychosocial formulation.;
- Identify data relevant to the estimation of acute firearm risk.
- Apply high-value interviewing competencies (e.g. formulation-guided interviewing, confrontation, warmth) to firearms-related threat assessment.

**Practice Gap**

The assessment of firearms possession, including the prospect of an encounter with a patient who is armed, represents an expanding, troubling frontier in the practice of psychiatry. In this workshop, we will examine the unique challenges associated with such assessment, including a potentially lethal potential to safety; unfamiliarity and discomfort with firearms among many clinicians, and the lack of clear guidelines regarding firearm-related incidents. In doing so, we seek to supplement limited existing training resources, which tend to focus on response to "active shooter" threats.

This study represents one component of a multi-year program aimed at identifying and defining discrete, measurable competencies, as demonstrated in the course of complex standardized simulated patient encounters. In this instance, we focus on a standardized simulated patient encounter with an agitated law enforcement professional whom the interviewer discovers to be currently in possession of a firearm. Interviewer performance prior to the firearm "reveal" will be assessed using a previously-established methodology (see "Teaching interviewing competencies" submitted with this abstract) and compared with management of the emergency precipitated by the discovery that the patient is in possession of the firearm.

**Abstract**

Simulated patient encounter

A cohort of 31 psychiatry residents engaged in a complex simulated patient encounter involving a depressed and angry corrections officer who was discovered drinking beer with a number of loaded weapons in his car. The patient's history is notable for a range of risk factors including adverse childhood events, academic underachievement, military trauma, work-related stress, a range of anxiety problems, and family problems.

The actor instructions call for the patient to be irritable, suspicious, and insulting, but compliant with all of the interviewer's questions or instructions. Approximately 15 minutes into the interview, the script calls for the actor to suffer a panic attack, mop his face with his shirt, revealing a pistol in his waistband.

The patient was portrayed by four professional actors provided with detailed scripting information indicating how to behave during the 25-minute interview. Interviews were conducted and videotaped in the NYMC Simulation Center. Interviewers were scored on a 32-item rating scale by two trained raters and a supervising project leader. Actors additionally supplied subjective assessment of the interview experience.

Survey:

A survey assessment attitudes and knowledge of firearms was conducted among attending psychiatrists and psychiatry residents n=52.

Results:

Simulation:

As in previous exercises, (see "Teaching interviewing competencies") interviewers exhibited a robust ability to gather basic factual information; coupled with more variable performance with regard to higher-level competencies (e.g. "engagement of affect", "confrontation", "therapeutic persistence").

On encountering the "firearm reveal" 23% of interviewers fled the room with little or no explanation, and 25 % asked the patient to surrender or secure the weapon. 52% continued the interview without making an effort to secure the firearm. 56% made an effort to elicit information regarding the patient's motivation for possessing a firearm.

Demonstration of "advanced interviewing competencies" (see companion poster) did not demonstrate a significant correlation with efforts to secure a firearm or decision to seek involuntary hospitalization, but did exhibit a significant association with evidence of a collaborative alliance between interviewer and patient by the end of the interview.

Survey:
Survey results exhibited high levels of anxiety and widespread lack of knowledge regarding types of firearms and procedures for their use.

Conclusion:
These results indicate high levels of unfamiliarity with FA in our clinical cohort, and serious deficiency in firearms-specific training in those participating in the simulated patient encounter, as well as the absence of a clear policy in our department. For many otherwise-capable individuals.

Once again, our results indicate that interviewing skill varied independently of training year, in-service testing, and clinical skill verification exams. Future initiatives include development of firearms-specific teaching and assessment modules.

**Scientific Citations**

Tanya Abramsky, Charlotte H Watts, Claudia Garcia-Moreno, Karen Devries, Ligia Kiss, Mary Ellsberg, Henrica AFM Jansen, Lori Heise. (2011) What factors are associated with recent intimate partner violence? findings from the WHO multi-country study on women's health and domestic violence. BMC Public Health11:109.
Beresin E, G. C. (2016). The Psychiatric Interview. In S. T, The Massachusetts General Comprensive Clinical Psychiatry, 2nd Edition.
Brenner, A. (2009). Uses and Limitations of Simulated Patients in Psychiatric Education. Academic Psychiatry, 33, 112–119.
Dave, S. (2012). Simulation in psychiatric teaching. Advances in Psychiatric Treatment, 18(4), 292-298.
Jacqueline M. Golding (1999). Intimate Partner Violence as a Risk Factor for Mental Disorders: A Meta-Analysis. Journal of Family Violence, Vol. 14, No. 2.
Eric Goralnick, Ron Walls (2015) An active shooter in our hospital. The Lancet 385:1728

McNaughton, N., Ravitz, P. C., Wadell, A., & Hodges, B. (2008). Psychiatric Education and Simulation: A Review of the Literature. Canadian Journal of Psychiatry, 53(2), 85-93.
Barry Mieir A, Martin A (2012) Real and virtual firearms nurture a marketing link. New York Times Dec. 24, 2012
Shea, C. (2017). Psychiatric interviewing: The art of understanding. New York: Elsevier.
Tobias Wasser (2014) Relevant Review of Violence APA Res Journal - January_2014
Tobias Wasser (2014) Attending to Safety in the Psychiatric Interview APA Res Journal - Oct 2014

## Teaching & Assessing Interviewing Competencies Through A Simulated Patient Encounter

**Presenters**
Mohammad Farooqi , MBBS
Adam Schein, MD
Dania Lerman, BA
Alexander Lerman, MD

**Educational Objective**

- Define specific behavioral, cognitive, and relational competencies intrinsic to the effective conduct of a psychiatric interview, including the capacity to develop a clinical formulation of a complex case as the interview proceeds, and to establish a trusting relationship in the process.
- Establish a reliable means to measure these competencies.
- Apply these assessment tools to previously-recorded standardized simulated patient interviews.
- Assess correlations between competencies and
- Negotiation of specific challenges or “gates” in the conduct of the simulated encounter
- Other measures of performance in the residency training program (e.g. year of training, in-service testing, clinical skills verification interviews).
- Development of training curriculum designed to develop skill in specific competencies so determined.

**Practice Gap**

Many leading psychiatric educators (Shea, 2017) (Beresin E, 2016) cite the ability to conduct a diagnostic interview as an essential clinical skill; on the other hand, it is hard to escape the conclusion that clinical interviewing occupies a position of diminished emphasis in modern psychiatric training. One problem is that the “art” of higher-order interviewing is hard to define, teach, or quantitatively assess, leading to diminished inclusion in overall assessment of residency performance. For example, the conduct of the psychiatric interview is reduced to a sub-competency of “Psychiatric Evaluation” in the “Patient Care” domain of the ACGME Milestones (Association Council for Graduate Medical Education, 2013); while the AADPRT Clinical Skills Verification (American Association of Directors of Psychiatry Residency Training ,

2019) worksheet preserves empathy and response to non-verbal cues as checklist subcomponents. Simulated patient interviews represent a dynamic and increasingly-utilized method for training in interviewing technique, but some have raised concerns about inappropriate use of the method in high-stakes assessment measures (McNaughton, Ravitz, Wadell, & Hodges, 2008).

**Abstract**
This study represents one component of a multi-year program aimed at identifying and defining discrete, measurable competencies, as demonstrated in the course of complex standardized simulated patient encounters.

Method:
A cohort of 17 psychiatry residents engaged in a simulated patient encounter involving a depressed and deceptive patient who displays a range of verbal or non-verbal behavior, including evasion at different points during the interview; each of which represents a specific checkpoint or "gate" at which the progress of the interviewer can be observed.

Results:
Interviewers exhibited a robust ability to gather factual information; coupled with significant deficiencies in case formulation and advanced interviewing skills, resulting in deficiencies in diagnostic assessment, treatment planning, and treatment alliance. A small subset of the interviewer cohort exhibited a superior ability across a range of competencies. Higher function appeared to be independent of level of training, in-service testing performance, and country of origin.

Interviewers who confronted discrepancies in the simulated patient's history showed higher levels of empathy and warmth, suggesting that higher performance was indicative of a level of engagement rather than a specific domain of competence.

The interview cohort achieved a mean score of 3.9 (SD=0.5) out of a maximum of 5.0 (clinical competence associated with a score of 3.5 or higher). Mean scores in other domains were lower (1.9 -2.8), with a wider variation in level of individual performance (SD =1.2 – 1.7). The wide standard deviation of this second set of values reflects the wide variation in "higher level" interview performance.

Unexpectedly, the authors found that interviewers who were rated as more effective in identifying and confronting discrepancies were also more likely to elicit affect and develop a trusting relationship with the patient during the encounter. A bivariate correlational analysis found a strong, highly significant positive correlation between Empathy/Relatedness scores and Confronting Non-Disclosure scores ($r(16) = .640$, $p<.01$).

Conclusion:
The "gated" design of the otherwise non-structured interview affords an opportunity to assess higher-order skills in a quantitative fashion, and to track the effectiveness of training. We see

this assessment technique as a training tool which help identify and support the strengths of some residents, and supplement deficient skills or traits in other residents.

Our results indicate that interviewing skill varied independently of training year, in-service testing, and clinical skill verification exams. The lack of correlation of proficiency with training year suggests weaknesses in the training program, i.e. measuring talent vs. training effect. Lack of correlation with inservice testing and other measures raise questions of whether this domain of skills is not assessed by Milestones and other rating methods. Future initiatives include development of additional advanced simulated patient encounters, along with assessment and teaching modules focused on specific domains of clinical performance.

**Scientific Citations**

Shea C Psychiatric Interviewing: The Art of Understanding 3rd Ed. New York: Elsevier; 2017.
Beresin E, G. C. The Psychiatric Interview. In S. T. eds., The Massachusetts General Comprehensive Clinical Psychiatry, 2nd Ed. pp. 54-72. Boston: Elsevier; 2016 .
The Accreditation Council of Graduate Medical Education/The American Board of Psychiatry and Neurology. The Psychiatry Milestone Project. 2013.
AADPRT Clinical Skills Verification worksheet. Published online. 2019.
Noordgard J, S. L. The psychiatric interview: validity, structure, and subjectivity. Eur Arch Psychiatry Clin Neurosci. 2013. 263, 353-364.
Dave, S. Simulation in Psychiatric Teaching. Advances in Psychiatric Treatment. 2012. 18 4 , 292-298. doi:10.1192/apt.bp.110.008482.
Pheister M, Stagno S, Cotes R, Prabhakar D, Mahr F, Crowell A, Schwartz A. Simulated Patients and Scenarios to Assess and Teach Psychiatry Residents. Academic Psychiatry. 2014. 41:114-117. DOI 10.1007/s 40596-015-0477-8.
Attoe C, Kowalski C, Fernando A, Cross S. Integrating mental health simulation into routine health-care education. The Lancet Psychiatry. 2016. vol 3: 702-703.
Rimondini M, Piccolo L, Goss C, Mazzi M, Paccaloni M, Zimmermann C. The evaluation of training and patient-centered interview skills for psychiatric residents. Psychological medicine. 2010. 40, 467-476.
Wuendrich M, Nissen C, Feige B, Philipsen A, Voderholzer U. 2012 Portrayal of psychiatric disorders: Are simulated patients authentic (letter). Academic Psychiatry. 2012. 36:6 page 501-502.
McNaughton, Nancy, MEd; Ravitz, Paula, MD, FRCPC; Wadell, Andrea, MD, FRCPC; Hodges, Brian D, MD, PhD, FRCPC. Psychiatric Education and Simulation: A Review of the Literature. Canadian Journal of Psychiatry. 2008. Vol. 53, Iss. 2, 85-93.
Brenner, A. Uses and Limitations of Si

# Design and evaluation of a cloud-based, information technology system to improve resident access to the didactic curriculum

**Presenters**
Alan Chen, MD
Isabel Lagomasino, MD, MSc
Christopher Snowdy, MD
Darin Signorelli, MD

**Educational Objective**

- To learn how to design a cloud-based, information technology system to create a central repository for didactic lecture materials and a resident feedback system
- To learn how to evaluate the usefulness of a central online repository for lecture materials
- To understand barriers and facilitators to resident use of online didactic materials

**Practice Gap**

The Accreditation Council of Graduate Medical Education (ACGME) requires that residents receive didactic instruction including lectures, seminars, and assigned readings. Combined with patient care responsibilities and clinical teaching, didactics help ensure that residents meet programmatic learning objectives during training. However, resident participation in scheduled didactics may be limited by call schedules, illness, vacation, or by lack of access to lecture content and materials. In this presentation, we describe how we designed a cloud-based, information technology system to improve access to educational materials and facilitate resident communication regarding the didactic curriculum. We anticipate that by improving access to materials and facilitating communication, residents will report greater understanding and use of didactic materials.

**Abstract**

Background: The existing didactic curriculum for the University of Southern California Psychiatry Residency Program lacked a central repository for didactic lecture materials, including objectives, slides, handouts, and references. Residents were often unable to review didactic content before or after lectures, or to access didactic materials for missed lectures. We describe our design and evaluation of a cloud-based, central repository for didactic content, which also facilitates resident communication and feedback.

Methods: Different groups or teams were created on the software platform Microsoft Teams. Each team consisted of cloud-based, shared storage drives that were linked to chat rooms and were accessible through personal computers and mobile phones. Residents and faculty were invited to join the teams and were trained in using the software. Lecture materials were regularly collected and uploaded to the cloud-based storage drives. Communication was encouraged through the chat and messaging functions of the online team. A pre-and post-evaluation by 32 second- to fourth-year residents is being used to assess resident access to

didactic content; use of online materials; perceptions regarding the curriculum (i.e., organization, comprehensiveness, usefulness, quality); and ease of providing feedback. The post-assessment will also assess barriers and facilitators for using the online materials and feedback mechanisms.

Initial Results: We created primary and secondary online teams. All 32 residents were invited to participate in the primary team, which had access to all uploaded didactic materials and to chat rooms for facilitating communication. The secondary team included a chief resident and two residents from each class year, who were responsible for soliciting and organizing curriculum feedback. Approximately 275 megabytes of curriculum material was uploaded onto the teams during the first three months of the academic year, consisting mostly of slide presentations, primary reference materials, and resident-created reviews. Materials were organized by year of training and course series, as guided by an overarching program curriculum. Chat rooms in the primary team were monitored for questions or feedback but were not frequently used. Chat rooms in the secondary team were utilized to collect lecture feedback. 30 of 32 eligible residents completed the pre-evaluation. Prior to initiation of the online system, less than 50% of residents reported having access to or using lecture materials, and 40-75% had positive reviews of the curriculum, depending on attribute. Although most residents felt comfortable providing feedback, they did so only 33% of the time. A post-evaluation will determine the impact of the new online system on these variables, and will assess barriers and facilitators to using the online system.

Discussion: Residents often lack adequate access to didactic curriculum materials. Modern technology systems offer innovative and flexible solutions for improving access to didactic materials and facilitating feedback. This presentation describes our design and evaluation of a cloud-based, information technology system that may improve residents' access to educational content; use of lecture materials; perceptions regarding the curriculum; and ease of communicating feedback.

**Scientific Citations**

Markova, T., & Roth, L. M. (2002). E-conferencing for Delivery of Residency Didactics. Academic Medicine, 77(7), 748–749.

Toohey, S. L., Wray, A., Wiechmann, W., Lin, M., & Boysen-Osborn, M. (2016). Ten Tips for Engaging the Millennial Learner and Moving an Emergency Medicine Residency Curriculum into the 21st Century. The Western Journal of Emergency Medicine, 17(3), 337–343.

Misra, A., & Lawson, C. (2019). Use of Technology to Identify and Cover Underweighted Topics in Resident Conference Curriculum. Cureus, 11(1), e3967.

# Survey of Cross-professional Bias Among Psychiatry and Psychology Interns in a Joint Education Program

**Presenters**
Mark Townsend, MD, MS
Michelle Moore, PhD
Lindsey Poe, PhD

**Educational Objective**
1. Be able to describe how psychiatry and psychology interns can share a clinical curriculum
2. Be able to discuss the challenges involved inter-professional education with psychology and psychiatry interns
3. Be able to describe the knowledge gaps and biases psychology and psychiatry interns have regarding each other's professional scope of practice and training

**Practice Gap**
Many clinical psychology internship programs co-locate their inpatient training with psychiatry residency programs. However, little is known about the potential benefits to psychiatric residents of this joint training. Pre-doctoral psychology interns start the year with firm grasp of psychotherapeutic principles, while post-doctoral psychiatry interns have a broad, albeit shallow, knowledge of medicine. In this report, we present the results of a survey used to determine how psychiatry and psychology interns conceptualized each other's education and professional scope of practice at the start of the academic year.

**Abstract**
US medical schools have little data to guide them in planning educational programs to address ACGME and LCME mandates for teaching collaborative care. For 12 months, our psychiatry interns and predoctoral psychology interns rotate through the same inpatient services, consisting of three distinct units focusing on mood, psychotic, and addictive disorders. Each psychiatry intern experiences six two-month blocks, taken in no set order: neurology; night float and emergency psychiatry; and two, two-month blocks each of internal medicine and inpatient psychiatry. The psychology interns, on the other hand, spend the entire year on these behavioral health units, also receiving training in outpatient practice at other sites.
Methods: We used two complimentary and anonymous surveys to determine group awareness of each other's professional training and scope of practice. Each instrument had ten seven-point Likert questions in three domains, knowledge of clinical abilities, clinical education, and professional practice.

Results: All 4 psychology and 6 psychiatry interns responded. Among the findings, both groups reported psychology interns are better able to effectively use psychotherapy and less able to recommend effective medications. Neither group reported they could describe the other's clinical training or abilities. Among significant differences, psychiatry interns reported a lower opinion of psychology interns' training than psychology of psychiatry's ($p<0.01$), and were less

likely to agree that their knowledge of human biology was equivalent to psychology's ($p<0.05$). They were also somewhat less likely to consider themselves "a peer" of the psychology interns ($p=0.08$).

Conclusions: The results indicate that while interns are confident about their own profession-specific abilities, they are much less certain of the other group's. Although jointly diagnosing and treating patients can provide a vehicle for sharing profession-specific information, learners may nevertheless arrive with biases that inhibit inter-professional learning.

**Scientific Citations**

1. World Health Organization (2010). Framework for action on interprofessional education & collaborative practice. Retrieved from http://www.who.int/hrh/resources/framework_action/en/

2. Robiner, W.N., Dixon, K.E., Miner, J.L., & Hong, B.A. (2014). Psychologists in medical school and academic medical centers: Over 100 years of growth, influence, and partnership. American Psychologist, 69(3), 230-248. doi:10.1037/a0035472

**2020 Annual Meeting Disclosure Declarations**

Financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent Conflict of Interest in the context of the subject of his/her presentation is listed below.

| Name | Stock | Consultant | Employee | Speakers Bureau | Grant/Research | Other financial or material support |
|---|---|---|---|---|---|---|
| Sallie DeGolia, MD, MPH | | | | | | Royalties from APA for published book for which I'm an editor: Supervision in Psychiatric Practice 2019 |
| Deepti Anbarasan, MD | | | NYC Neuropsychiatry | | | |
| Senada Bajmakovic-Kacila, MD | | | | | | I have recently attended a Janssen advisory board meeting where we discussed the use of Spravato. |
| Sheldon Benjamin, MD | | | | | | Author for, and partner in, Brain Educators, LLC, publisher of neuropsychiatric educational materials including The Brain Card. I serve as a psychiatry director on the American Board of Psychiatry and Neurology. |
| Adrienne Bentman, MD | | | | | | ACGME – Psychiatry RC – member, Psychiatry Milestone Working Group - member |
| Ellen Berkowitz, MD | Ellen Berkowitz, MD | | | | | |
| Deborah Cabaniss, MD | | | | | | I receive royalties for text books from Wiley and Norton. |
| Consuelo Cagande, MD | | | Children's Hospital of Philadelphia Department of Child and Adolescent Psychiatry and | New Jersey Psychiatric Association Speakers Bureau, but not paid. | | Co-editor, Positive Psychiatry, Psychotherapy, and Psychology – book with Springer Publishing due to be released Spring, 2020. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Behavioral Sciences | | | |
| Kenneth Certa, MD, DFAPA | | Independence Blue Cross, monthly advisory committee meeting < $4k per year | | | | Board of American Psychiatric Association, Board of Foundation of the Pennsylvania Medical Society, Board of Consumer Satisfaction Team, Inc. |
| Robert Cotes, MD | | | | | Roche, Alkermes, Lundbeck, Otsuka | |
| Sandra DeJong, MD, MSc | | | Cambridge Health Alliance | | Educational Innovation Award, American Board of Psychiatry and Neurology for Curriculum on Pediatric Telepsychiatry | Royalties, Elsevier, for a book on the topic of professionalism and the internet Advance from the American Psychiatric Publishing, Inc., for a book on ethics in child mental health Honoraria for grand rounds and presentations at professional schools and societies. In kind payment (travel, meals) from the American Academy of Child and Adolescent Psychiatry for participation in its Ethics Committee; my work as Secretary of the American Psychiatric Association; my work for ACGME; my work as Chair of the PRITE Commission for the American College of Psychiatrists. |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

# 2020 Resident and Program Administrator Award Winners

## George Ginsberg, MD Fellowship Award

***Committee Chair: Richard Lee, MD***

*George Ginsberg, MD, was a member of AADPRT for nearly two decades. During those years he served in a number of capacities: member and chair of numerous committees and task forces, one of our representatives to the Council of Academic Societies of the AAMC and as our President from 1987 to 1988. This list of positions in our association is noted to highlight his energy and commitment to AADPRT. Prior to his death, George served as chair of a committee charged with raising new funds for the development of educational rograms to be sponsored by our association. It was in that role that the AADPRT Fellowship was developed. Because of his essential role in its formation it was only appropriate that his work for our association be memorialized by the addition of his name to the fellowship. George served in varied roles as a psychiatrist for all seasons. With his death, the members of AADPRT lost a dedicated leader and friend, our students a dedicated teacher, his patients a dedicated physician, and all of psychiatry a model of the best that psychiatry can produce.*

### Brandi Karnes, MD

Dr. Brandi Karnes is a third-year resident in the Clinician Educator Track at The University of Texas Health Science Center at Houston Psychiatry Residency Program. She is the only person in her family in the medical field and is a first-generation college student. She studied human biology at The University of Texas at Austin prior to attending McGovern Medical School at The University of Texas Health Science Center at Houston. Her primary interests are wellness and education, and her project, which earned her the George Ginsberg Fellowship Award, involved both of these important topics as she developed a novel twelve-part wellness curriculum for her psychiatry residency training program. Dr. Karnes has also been extensively involved with medical student education delivering clerkship lectures for third-year medical students, small group lectures on ethics and professionalism, and a presentation on coping with stress in medical school to first-year medical students. As a result, she was selected by the psychiatry department for the “Kenneth Krajewski Award for Excellence in Medical Student Education” as a second-year resident. Following residency, Dr. Karnes plans to work in academic psychiatry where she will continue to develop organizational

interventions and innovative curriculum to improve the wellness and education of students, residents, and faculty. She also hopes to inspire the next generation of clinician educators thanks to the support she has received from her own educators and mentors.
***Training Director: Iram Kazimi, MD***

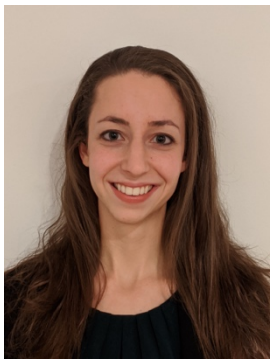
## Selena Magalotti, MD

Dr. Selena Magalotti is a PGY-6 forensic psychiatry fellow at University Hospitals Cleveland Medical Center/Case Western Reserve University. She earned her medical degree through an accelerated 6-year B.S./M.D. program at Northeast Ohio Medical University. She then completed her general psychiatry residency at the University of Toledo, afterward serving as chief fellow during her child and adolescent psychiatry fellowship at University Hospitals Cleveland Medical Center/Case Western Reserve University. She has a passion for educating trainees about the importance of public policy advocacy, the value of getting involved in organized psychiatry, and about medicolegal issues. She has published and presented locally and nationally on the topics of child psychiatry, forensic psychiatry, and residency education. Attending AADPRT annual meetings over the years has been formative in developing her interest in teaching and she has co-presented four AADPRT workshops as of the 2020 meeting. She has held several leadership positions in the local and state Ohio district branch of the American Psychiatric Association (APA), is active in the American Academy of the Psychiatry and the Law (AAPL), and has served on hospital committees during residency and fellowship. Dr. Magalotti has also been a recipient of the AAPL Rappeport Fellowship and the Midwest chapter of AAPL's Resnick Scholar Award. She is excited to pursue a career in academic child and forensic psychiatry when she finishes her training.
***Training Director: Cathleen Cerny-Suelzer, MD***

## Tara Thompson-Felix, MD

Dr. Tara Thompson-Felix is a fourth-year and chief resident at Temple University School of Medicine. She earned her bachelor's degree at Rutgers University and then subsequently completed her medical school training at Rutgers, Robert Wood Johnson Medical School. Her academic interests include child and adolescent psychiatry, perinatal psychiatry, neuroscience education and leadership. During residency, Dr. Thompson-Felix collaborated with the department of neuroscience and OBGYN to focus on the impact of prenatal exposures on child development. She presented her research at the 2018 APA colloquium on the epigenetic landscape of fetal neural exosomes associated with maternal exposure to opioids. She is actively involved in the National Neuroscience Curriculum Initiative (NNCI) and was selected as an NNCI scholar for 2019-2020. She is also involved in developing, implementing, and evaluating the educational activities of the Temple psychiatry residency program. After residency, she plans to pursue a fellowship in child and adolescent psychiatry and continue a career in academic medicine.
***Training Director: Jessica Kovach, MD***

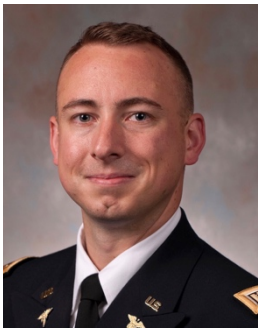
## Naomi Weiss-Goldman, MD



Dr. Naomi Weiss-Goldman was born in Israel and grew up in Connecticut, where she particularly enjoyed playing the piano and pole vaulting. She received her bachelor's degree at Yale University in music, primarily focusing on piano performance. After college, Dr. Weiss-Goldman attended the Icahn School of Medicine at Mount Sinai and remained at Mount Sinai for psychiatry residency where she is currently finishing her fourth year as chief resident. During residency, she has enjoyed teaching and mentoring medical students and junior residents in clinical settings earning the "Medical Student Teaching Award" in 2017 and 2018. Dr. Weiss-Goldman also has interests in both inpatient psychiatry and psychodynamic psychotherapy and plans to pursue these interests after residency as an inpatient attending psychiatrist.

***Training Director: Antonia New, MD***

## Sean Wilkes, MD



Dr. Sean Wilkes is a United States Army officer and PGY4 child and adolescent psychiatry fellow at Tripler Army Medical Center in Honolulu, Hawaii. He began his career in the U.S. Army as a medical science officer and later served as a clinical investigator in the Congo and as an inspector general at the Pentagon. As a medical student at the Uniformed Services University, he developed an interest in neuropsychiatry and pursued research on traumatic brain injury. Throughout both residency and fellowship he has been heavily involved in teaching medical students and residents. He is the author of several publications as well as curricula in neuroscience and teaching. Dr. Wilkes's current academic interests include neuroscience education and curriculum development, the psychiatric sequelae of traumatic brain injury, and the neurobiology of psychosis.

***Training Director: Paul Lee, MD, MPH***

## Peter Henderson MD Memorial Award

***Chair: Oliver Stroeh, MD***

*The late Peter Henderson, MD served as an active member on numerous AADPRT committees and was the first child and adolescent psychiatrist to serve as President of AADPRT (1983-1984). Dr. Henderson was specifically interested in nurturing and developing an effective link between child psychiatry and general psychiatry. Thanks to initiatives developed by Dr. Henderson, the vast majority of child and adolescent psychiatry programs are now represented in AADPRT, enhancing and expanding the areas of interest within graduate psychiatric education.*

### Allen Dsouza, MD

**Paper Title: Legalization of Marijuana and its Impact on Attitude Among Youth Towards Use**

Dr. Allen Dsouza is a PGY-5 Child and Adolescent Psychiatry fellow at the Zucker School of Medicine at Hofstra/Northwell, NY. He completed his general psychiatry training at Rutgers New Jersey Medical School, NJ. Allen graduated from medical school in India. His areas of specific interest are substance use in adolescents, ADHD, LGBTQ, psychiatry, autism, advocacy and resident wellness. He has served as the member-in-training committee representative at the New York Council on Child and Adolescent Psychiatry and as resident representative at the New Jersey Psychiatric Association. He has published and presented various peer reviewed papers at many national conferences. Outside of work he enjoys learning new languages, watching soccer and ballroom dancing.

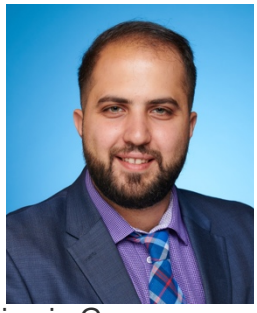
***Training Director: Richard Pleak, MD***

## Nyapati Rao and Francis Lu International Medical Graduate (IMG) Fellowship Awardees

***Chair: Ellen Berkowitz, MD***

*This mentorship program is designed to promote the professional growth of promising International Medical Graduates. In the context of a trusting, non-evaluative and emphatic relationship with an experienced mentor, IMGs can learn to recognize and to seek solutions to their professional and acculturation needs. As psychiatrists who have made valuable contributions to the field as educators, researchers, clinicians and administrators, the mentors will have met many of the challenges, which their younger colleagues will encounter. The goal of this program is to facilitate successful development of IMG residents as leaders in American Psychiatry, especially those interested in psychiatric education. This goal is reached by providing an opportunity for outstanding IMG residents to be mentored by senior role models in the field of psychiatry.*

## Ali Haidar, MD



Dr. Ali Haidar is a PGY4 Child and Adolescent Psychiatry fellow at Icahn School of Medicine at Mount Sinai. He graduated from the faculty of medicine at the American University of Beirut in 2015. Since completing his medical training, his journey has incorporated his drive to provide compassionate patient care while also being a vocal advocate for at-risk populations. After graduation from medical school, he joined the National Mental Health Program in the Lebanese Ministry of Public Health as an intern working on national policies and guidelines serving refugees and underserved populations. He subsequently interned at the World Health Organization in Geneva, Switzerland where he contributed to the Mental Health Gap Action Plan. He completed his adult Psychiatry residency at SUNY Downstate Medical Center. Dr. Haidar is also a first-year fellow for the American Psychiatric Association Leadership Fellowship. During residency, his research focused on the elements necessary for the provision of well-staffed psychotherapy for psychosis in a public clinic setting. His primary areas of interest include public psychiatry, psychodynamic psychotherapy, LGBTQ mental health, Cultural Psychiatry and Global Mental Health, particularly teenage refugee populations. He has presented talks, courses, and posters covering his various areas of interest at several national conferences.

***Training Director: Dorothy Grice, MD***

## Kiran Khalid, MD

Dr. Kiran Khalid is currently a second-year Child and Adolescent Psychiatry Fellow at the University at Buffalo where she is also serving as a Chief Fellow. She was born in Lahore, Pakistan and completed medical school at Aga Khan University, Karachi, Pakistan. After graduation from medical school, she worked for over a year in medical education in Pakistan, where she was involved in faculty development, curriculum development and improving the quality and effectiveness of teaching. In 2015, she joined the General Psychiatry residency program at University at Buffalo. During residency, Dr. Khalid developed various neuroscience education sessions and was involved in teaching medical students and residents as a member of the Medical Educator Track. She was also the outpatient chief, implemented various quality improvement measures, won numerous service-based and educational awards, and spoke at a monthly meeting for NAMI. She was inducted in the Gold Humanism Honor Society in 2017. After residency, she continued to train in Child and Adolescent Psychiatry. She remains involved in medical education for residents and medical students. With her residency training director, she has worked on improving and revamping the residency neuroscience curriculum, which has now been implemented. She is also working on furthering her exposure and experience in neuroimaging research. Her clinical interests include pediatric consultation/liaison psychiatry and her academic interests are mainly neuroscience education and neuroimaging research. Dr. Khalid intends to pursue a career in academic psychiatry, engaging in teaching and working in the Pediatric, CL, and ER settings clinically.

***Training Director: Sourav Sengupta, MD, MPH***

**Manal Khan, MD**

Dr. Manal Khan is a fourth-year psychiatry resident at University of Washington, Seattle. Manal was born and raised in Pakistan where she received her medical education. Before joining UW as a PGY2, Manal completed her intern year in Psychiatry at Duke University. Manal has held several leadership roles during her residency. In her third year of residency, she collaborated with faculty to establish the global mental health and cultural psychiatry pathway at her program. She developed the curriculum for the pathway and curated topics for monthly meetings. She was the resident-lead for the pathway and also served as the business meeting leader. Currently, Manal is the chief of recruitment and wellness and participates in admissions, wellness, and resident education steering committees. Manal's vision for her chief role includes diversity-conscious recruitment and community building. Manal implemented a strategy called "caring messages" through which chief residents provide support and guidance to night float residents. Manal also regularly performs a holistic review of the applications submitted by international medical graduates. Outside her program, Manal is a second-year American Psychiatric Association (APA) diversity leadership fellow and sits on the council of international psychiatry. She is also an executive committee member of Washington State Psychiatric Association. Manal has participated in several scholarly projects and is presenting at four conferences this year, including AADPRT. She plans on pursuing a career in Child and Adolescent Psychiatry with a focus on childhood adversity and trauma. Manal is a published poet and story writer. She is also a mother to a two-year-old boy, an Orange Theory Fitness enthusiast, and a Bollywood buff.
***Training Director: Anna Ratzliff, MD, PhD***

**France Leandre, MD**

Dr. France Leandre is a third-year resident at the UCF College of Medicine /HCA GME Consortium (Gainesville, FL). She was born in the US and raised in Haiti where she assisted in launching an educational program for low-income Haitians. She moved to the US at 15, then earned her Bachelor of Science degree in psychology at the University of Florida. There, she researched the dietary need in the HIV pediatric population and developed new tools to improve teaching and learning at the university. She attended medical school at Ross University where she started a didactic series on the use of psychotropic medications during the peripartum period which continued in residency. She also created other lecture series on the management of agitated patients and on the esketamine spray. At the 2017 APA conference, Dr. Leandre was a co-presenter on a workshop set to educate residents on the evaluation and treatment of patients belonging to the LGBTQ+ community. For her passion in teaching colleagues and medical students, she received the resident teacher of the year and resident of the year awarded by her residency program. Dr. Leandre was selected as one of Area Five Resident Fellow Member Poster Award Winner at the 2018 APA conference for her research poster on the demographic factors, BMI, and diagnosis that affected the

administration of emergency treatment orders in patients in psychiatric units. She also won the second place John E. Adams award at the Florida Psychiatric Society for that same project. Moreover, she is currently working on a research study looking at the demographic and referral patterns in the new psychiatric clinic. She was awarded the Tom and Donna Buchanan grant from the Florida Psychiatric Society for her involvement in research and case reports. After residency, Dr. Leandre is interested in working with her underfunded population and completing more research projects. In her spare time, she likes to spend time with her husband and two kids.
***Training Director: Almari Ginory, DO***

## Sanya Virani, MD, MPH

Dr. Sanya Virani is currently a PGY-4 and Chief Resident of Education and Research at Maimonides Medical Center in New York and the Resident-Fellow Member (RFM) Representative to the APA for New York state (Area 2). She attended K.J. Somaiya Medical College and Research Center in Mumbai, India, and upon completion, she was awarded the Aga Khan Foundation International Scholarship, the University of Minnesota Division Of Health Policy and Management Award, and the Veninga Donor Award among others, to pursue graduate education in the US. She completed her Master's in Public Health Administration and Policy at the University of Minnesota, while also working in Health Services Research at the National Marrow Donor Program/Be the Match in Minnesota. After graduating, she worked as a Data Manager for clinical trials on HIV vaccines at the Fred Hutchison Cancer Research Center in Seattle, Washington. She then moved to New York to start her residency in Psychiatry and is set to attend Yale School of Medicine for a fellowship in Addiction Psychiatry next year, which will be followed by a fellowship in Forensic Psychiatry.

Through the length of her residency training, she grew her research portfolio considerably and now has over 25 articles and book chapters to press, with a special interest in burnout (capstone project at grad school) and public policy, in addition to Addiction and Forensic Psychiatry. She has participated as a panelist at APA workshops and now AADPRT this year.

Most recently, Sanya was selected by the Deputy Medical Director and Director of Education for the APA to work on a national trainee census in spanning across a time period of 5 years. This seminal document is informative in regard to the large shifts in trends of applicants matching into Psychiatry and highlights the areas for improvement – need for a diversified workforce more representative of the patient population it serves. Her work has received national acclaim: the Census is on the APA's website and her article on the history and process of legalization of marijuana made its way to the national podcast of Psychiatric Services. She has brought a range of projects to fruition, most notable among which are a Simulation training module for all residents to manage agitated patients and "Code White", a hospital-wide protocol to manage patients presenting to the Emergency Room with different levels and etiologies of agitation.

Over the past two years, she acquired research experience in Digital Psychiatry (through apps developed at Harvard University) and also remained involved in the hospital-wide Clinical Informatics Committee. She has taken up several leadership roles: Resident

Safety and Quality Council Representative and CIR Delegate for the hospital and has been awarded by the ASCP, AAAP and Telluride Safety Initiative to attend and participate in workshops and conferences. Currently, she is the nominee for the APA's RFM Trustee Elect position and wishes to pursue a career in academic Psychiatry with a focus on Addiction and Forensic Psychiatry.
***Training Director: Anetta Raysin, DO***

## Lucille Fusaro Meinsler Program Administrator Award

***Committee Chair: Nancy Lenz, BBA, C-TAGME***

*The Lucille Fusaro Meinsler Psychiatric Residency Coordinator Recognition Award recognizes a psychiatry residency coordinator's outstanding communication and interpersonal skills, commitment to the education and development of residents, originality in improving an aspect of the residency program, and participation in national or regional coordinator meetings.*

**Dulce Madrid-Gonzalez**

Dulce Madrid-Gonzalez is the Administrative Director for the UCLA Psychiatry Residency and Fellowship Training Programs and the 2020 AADPRT Lucille Fusaro Meinsler Program Administrator Award recipient. In her role as Administrative Director, she oversees a team of coordinators and the administrative operations, educational activities, personnel, and financial management for the Adult Psychiatry Residency and clinical fellowships in Child and Adolescent Psychiatry, Geriatric Psychiatry, Forensic Psychiatry, Consultation-Liaison Psychiatry, and Addiction Psychiatry. Dulce is a native Angeleno who graduated from UCLA with a bachelor's degree in psychology. After graduation she joined the training programs as the program assistant and was then promoted to the program coordinator. Her role evolved along with the growth of the training programs. Dulce was instrumental in the application and accreditation of the Forensic and CL psychiatry fellowships. She collaborates with Program Directors, Chief Residents, and Departmental leadership in ensuring adherence to ACGME and internal/external training and regulatory requirements. She is devoted to supporting the residents and fellows and finding ways to make their time spent in training a little bit easier and as educationally enriching as possible. Always open to new ideas, Dulce loves being able to help a trainee or coordinator when they come to her with a suggestion or proposal. A dedicated and conscientious administrator, she constantly strives to find ways to improve the training programs and enjoys problem solving and being able to provide counsel. She looks forward to furthering her education and professional development as well as making future contributions to the field of graduate medical education and healthcare management.

# 2020 Victor J. Teichner and Lifetime Service Award Winners

## Victor J. Teichner Award

Co-chairs: Gene Beresin, MD (AADPRT) and Sherry Katz-Bernot, MD (AAPDP)

This program award jointly sponsored by AADPRT and the American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) honors the work and life of Victor Teichner, M.D., an innovative psychoanalyst and educator. The purpose of this award is to support a Visiting Scholar to a residency training program that wants to supplement and enrich its training in psychodynamic psychotherapy. The expenses and stipend for the Visiting Scholar are covered by the award for a one to three day visit, supported by an endowment provided by a grateful patient of Dr. Teichner.

**Tripler Army Medical Center Psychiatry Residency**
**COL Judy Kovell, MD**

**Cooper Medical School of Rowan University**
**Karim Ghobrial-Sedky, MD, MSc**

## Lifetime Service Award

The purpose of the award is to acknowledge a psychiatrist member who has either provided significant service to AADPRT, had an impact on psychiatric residency education nationally, demonstrated excellence in psychiatric residency education, or provided generativity and mentoring in residency, or some combination of these. The awardee will be honored at the Annual Meeting.

**Adrienne Bentman, MD**