46th AADPRT
ANNUAL MEETING
March 9-11, 2017
and
BRAIN CONFERENCE
March 8, 2017
Hilton San Francisco Union Square

Define "Psychiatrist": Merging Passions, Pressures, and Values

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American Association of
Directors of Psychiatric
Residency Training

AADPRT

46th Annual Meeting
March 9-11, 2017
BRAIN Conference: March 8

Define "Psychiatrist": Merging Passions, Pressures, and Values

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* This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Connecticut State Medical Society. The Institute of Living is accredited by the Connecticut State Medical Society to provide continuing medical education for physicians. The Institute of Living designates this educational activity for a maximum of 24.0 AMA PRA Category 1 Credits. (tm) Physicians should claim only credits commensurate with the extent of their participation in the activity.

COLOR KEY

Escalators and Stairs to Ballrooom Levels

Lobby Level Meeting Space
Golden Gate, Urban Tavern, FedEx, Plaza A/B and Executive Conference Center (Seacliff, Presidio, Sunset, Marina)

Ballroom Level Meeting Space
Continental, Imperial, Yosemite, Franciscan, Executive Boardroom

Grand Ballroom Level
Grand Ballroom and Green Room

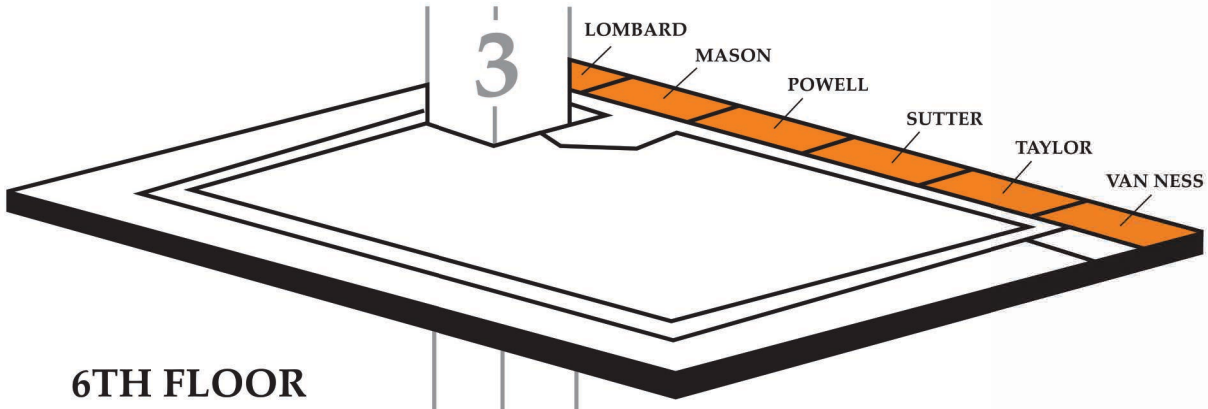
Union Square Rooms (4th Floor)
Rooms 1-25

Sixth Floor Meeting Rooms
Lombard, Mason, Powell, Sutter, Taylor, Van Ness

Accessible Facilities
Accessible restrooms are located on the following levels: ***L (Lobby), B (Ballroom), M (Grand Ballroom, Mezzanine)***

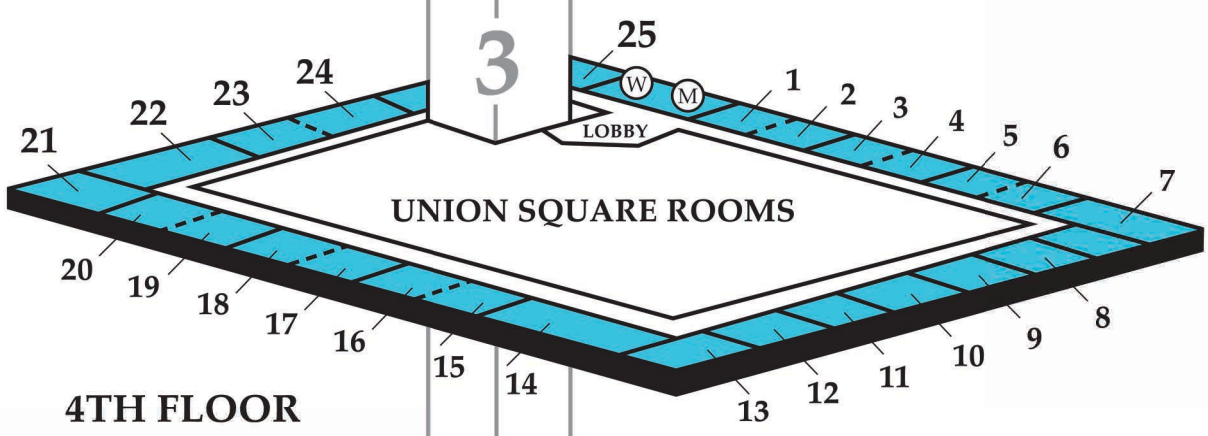
** Package Express located in Tower 3, Garage Level*
** Pool located in Tower 3, 16th Floor*
** Health Club located in Tower 1, Lower Level*

Herb N' Kitchen

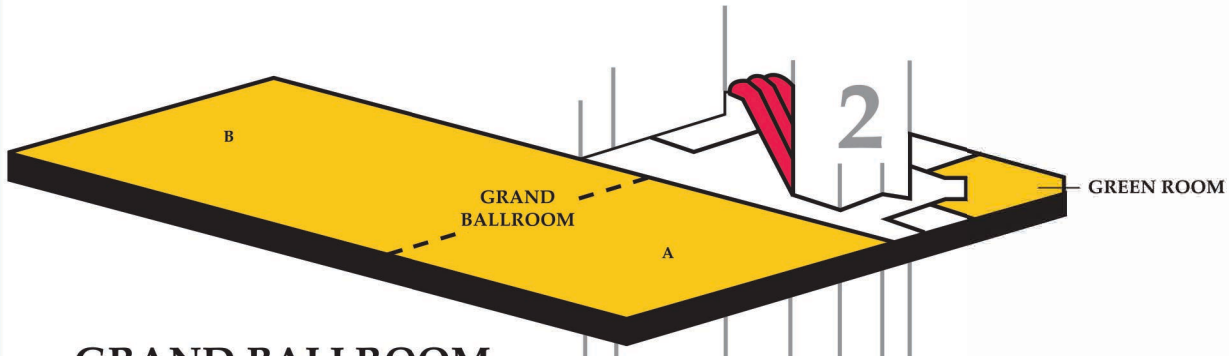


6TH FLOOR
TOWER 3

* BRAIN Conf. Workshops
* Meetings & Educational Workshops
* NTD Breakouts



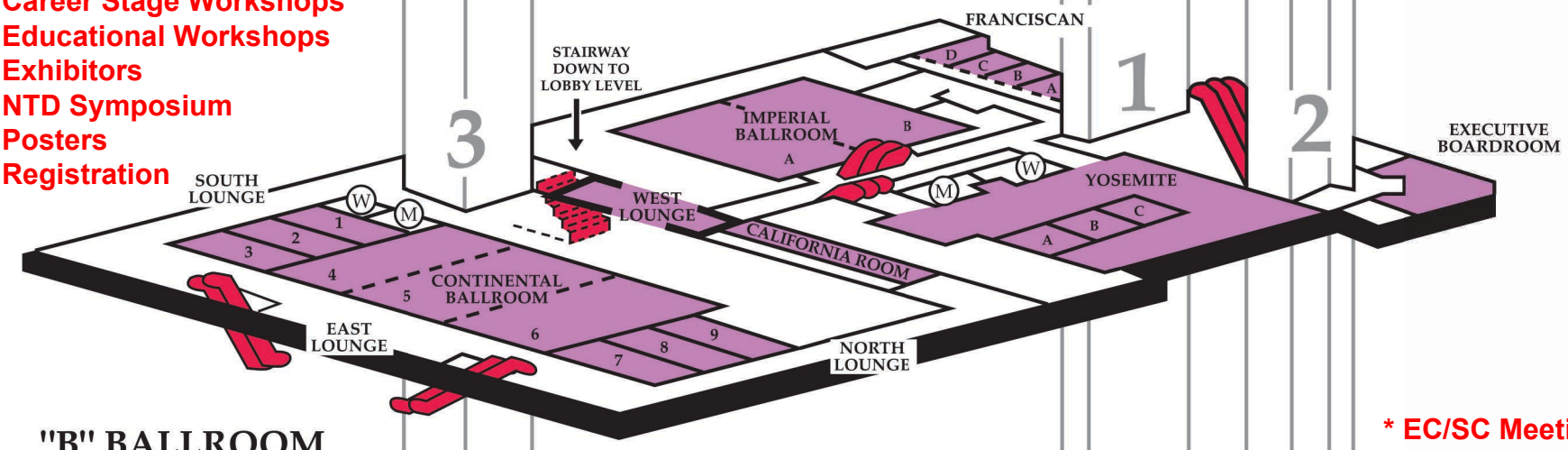
4TH FLOOR
TOWER 3



GRAND BALLROOM
"GB" LEVEL

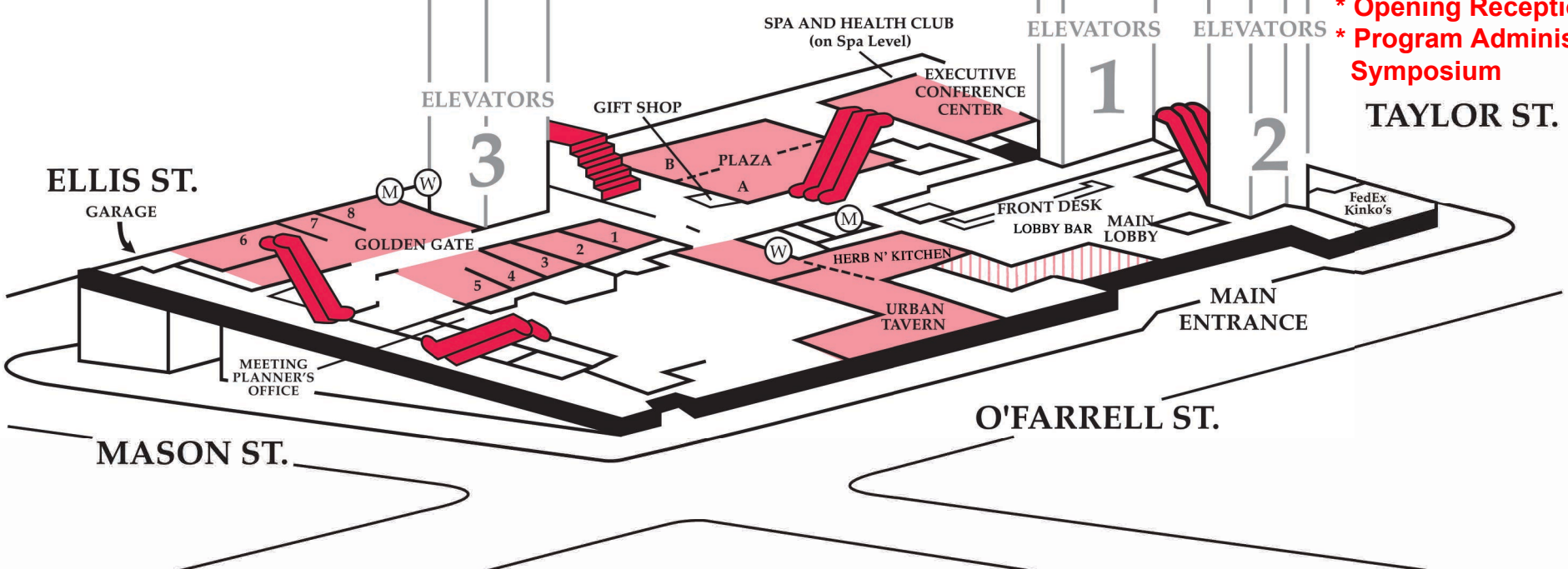
Hilton
San Francisco

* General Sessions
* Career Stage Workshops
* Educational Workshops
* Exhibitors
* NTD Symposium
* Posters
* Registration



"B" BALLROOM
LEVEL

* EC/SC Meetings
* Consultations
* Meals
* Opening Reception
* Program Administrator Symposium



AADPRT ANNUAL MEETING & BRAIN CONFERENCE
March 8 – 11, 2017

MEETING AT A GLANCE

**all times Pacific*

Program Administrator-specific activites noted in red

7 - Tuesday	Event	Leader/Presenter	Room
1:30 – 2:30 pm	Steering Committee Meeting	Art Walaszek, MD	Plaza A
2:45 – 7:00 pm	Executive Council Meeting & Dinner	Art Walaszek, MD	Plaza A
4:00 – 6:00 pm	BRAIN Conference & Annual Meeting Check In and Registration		Golden Gate 1
7:00 - 8:00 pm	BRAIN Conference Committee Meeting	Melissa Arbuckle, MD, PhD David Ross, MD, PhD Michael Travis, MD	Union Square 1/2
8 - Wednesday	**Event**	**Leader/Presenter**	**Room**
7:00 – 10:00 am, 3:00 – 6:00 pm	BRAIN Conference & Annual Meeting Check In and Registration		East Lounge
7:00 – 8:00 am	Breakfast (BRAIN Registrants Only)		Continental 4/5
8:00 – 8:30 am	BRAIN Conference Opening Session and NNCI Scholars Award Presentation	Melissa Arbuckle, MD, PhD David Ross, MD, PhD Michael Travis, MD	Continental 4/5
8:30 – 8:45 am	BRAIN Conference Transition to Breakouts		
8:45 – 10:15 am	BRAIN Conference: Workshop #1		Union Square: 5/6, 13, 14, 15/16, 17/18, 19/20, 21, 22, 23/24, 25
10:15 – 10:30 am	BRAIN Conference Break		Union Square Hallway
10:30 am – 12:00 pm	BRAIN Conference: Workshop #2		Same rooms
12:00 – 1:00 pm	Lunch (BRAIN Registrants Only)		Golden Gate 2-5 & Foyer
1:00 – 2:30 pm	BRAIN Conference Workshop #3		Same rooms
2:30 – 2:45 pm	BRAIN Conference Break		Union Square Hallway
2:45 – 4:15 pm	BRAIN Conference Workshop #4		Same rooms
4:00 – 5:00 pm	Program Administrators Committee Chairs Meeting	Kim Kirchner	Union Square 12
4:15 – 4:30 pm	BRAIN Conference Transition to Closing Session		
4:30 – 5:00 pm	BRAIN Conference Closing Session		Continental 4/5
5:00 - 6:00 pm	Program Administrators Meet & Greet	Angelia Powell Barbara Burns, BA, C-TAGME Elaine Danyew, C-TAGME	Golden Gate 1
5:00 - 7:00 pm	Executive Council Dinner Meeting	Art Walaszek, MD	Plaza A
7:30 – 8:30 pm	Membership Committee Meeting	Sallie DeGolia, MD, MPH Dorothy Stubbe, MD	Plaza B
9 - Thursday	**Event**	**Leader/Presenter**	**Room**
7:30 – 8:30 am	Steering Committee Meeting	Art Walaszek, MD	Plaza A

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8:00 am - 4:00 pm	Annual Meeting Check In and Registration		East Lounge
8:30 - 11:30 am	Program Administrators Symposium (coffee & bagels provided)	Barbara Burns, BA, C-TAGME Elaine Danyew, C-TAGME	Plaza B
8:30 – 9:00 am	Resident Meeting Orientation	Sandra DeJong, MD	Golden Gate 1
8:30 - 9:30 am	Peter Henderson Award Committee Meeting	Arden Dingle, MD	Union Square 23
8:30 - 9:30 am	IMG Fellowship Committee Meeting	Vishal Madaan, MD	Union Square 24
9:00 am – 6:30 pm	Exhibitors		East lounge
9:00 – 11:15 am	New Training Directors Symposium: "Nuts & Bolts", "Day in the Life", "Working with your Administrator" – *must pre-register* (coffee provided)	Sallie DeGolia, MD, MPH Dorothy Stubbe, MD	Continental 4
9:15 am – 12:45 pm	Executive Council Meeting & Lunch	Art Walaszek, MD	Plaza A
9:15 – 9:45 am	Ginsberg Fellow Orientation Session	Timothy Sullivan, MD	Union Square 22
9:30 – 9:45 am	Peter Henderson Awardee Orientation Session	Arden Dingle, MD	Union Square 23
9:30 – 9:45 am	Anne Alonso Awardee Orientation Session	Eugene Beresin, MD, MA	Union Square 21
9:30 – 10:30 am	IMG Fellow Orientation Session	Vishal Madaan, MD	Union Square 24
10:00 – 11:15 am	Early Career Workshop	Lisa Catapano, MD, PhD Erick Hung, MD Asher Simon, MD	Continental 5
10:00 - 11:15 am	Mid-Career Workshop	Mary Ahn, MD Joan Anzia, MD Peter Daniolos, MD	Continental 6
10:00 - 11:15 am	Lifers Workshop	Eugene Beresin, MA, MD David Kaye, MD Tony Rostain, MD, MA Geri Fox, MD John Sargent, MD	Continental 1/2/3
11:30 am – 12:45 pm	Lunch for those not participating in meetings		Golden Gate 2-5 & Foyer
11:30 am – 12:45 pm	New Training Directors Breakout Sessions & Lunch – *must pre-register, lunch to be picked up in Continental 4, beverages on 4th floor*	Sallie DeGolia, MD, MPH Dorothy Stubbe, MD	
		Joan Anzia, MD	Union Square 1
		Shashank Joshi, MD	Union Square 2
		Eugene Beresin, MA, MD	Union Square 3
		Kim-Lan Czelusta, MD	Union Square 4
		Arden Dingle, MD	Union Square 5
		Marshall Forstein, MD	Union Square 6
		Erick Hung, MD	Union Square 8

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		Michael Jibson, MD, PhD	Union Square 9
		Anita Kablinger, MD	Union Square 10
		David Roane, MD	Union Square 11
		Ann Schwartz, MD	Union Square 12
		Erica Shoemaker, MD, MPH	Union Square 13
		Asher Simon, MD	Union Square 14
		Tim Wolff, MD	Union Square 15
		Kristen Dunaway, MD	Union Square 16
11:30 am – 12:45 pm	Regional Representatives Committee Lunch Meeting *(By invitation only).* *Get lunch in Golden Gate before heading to meeting.*	Chandlee Dickey, MD	Union Square 17/18
11:30 am – 12:45 pm	Triple Board Program Directors/AACAP Lunch Meeting *Get lunch in Golden Gate before heading to meeting.*	Kristi Kleinschmit, MD	Union Square 19/20
11:30 am – 12:45 pm	Program Administrators Working Lunch	Barbara Burns, BA, C-TAGME Elaine Danyew, C-TAGME	Plaza B
1:00 - 2:40 pm	Opening Session: welcome, input, awards, Mind Games	Art Walaszek, MD Adam Brenner, MD Saul Levin, MD, MPA – APA Amin Azzam, MD, MA - AAP Eugene Beresin, MD, MA – *Academic Psychiatry* Ondria Gleason, MD – AACDP Gregory Briscoe, MD – ADMSEP Sandra DeJong, MD Timothy Sullivan, MD – Ginsberg Arden Dingle, MD – Henderson Vishal Madaan, MD – IMG Laura Roberts, MD, MA - Alonso Eugene Beresin, MD, MA – Teichner Nancy Lenz, C-TAGME – LFM Program Administrator Jacqueline Hobbs, MD & Kaz Nelson, MD – Curriculum Tim Blumer, DO - Poster Tristan Gorrindo, MD – Mind Games	Continental 4/5/6
2:40 – 2:50 pm	Coffee Break		East Lounge
2:45 - 4:30 pm	New Program Administrators University	Mary Barraclough, BS Zoellen Murphy, BA, C-TAGME	Plaza A
2:45 – 4:30 pm	Lifer Program Administrators University	Linda Gacioch, C-TAGME	Plaza B
2:50 – 4:30 pm	ABPN/ACGME Workshops & AADPRT Business Meeting	Larry Faulkner, MD George Keepers, MD Art Walaszek, MD	Continental 4/5/6

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		Mike Travis, MD Sallie DeGolia, MD Dorothy Stubbe, MD Bob Boland, MD Sandra DeJong, MD Brian Palmer, MD	
4:45 – 6:00 pm	**CAUCUS MEETINGS**		
	Region I: New England – Canada (Quebec, Toronto, Ontario), Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Judith Lewis, MD Steve Fischel, MD, PhD	Continental 1
	Region II: New York	Timothy Sullivan, MD Carrie Ernst, MD	Continental 2
	Region III: Mid-Atlantic – Delaware, Maryland, New Jersey, Pennsylvania, Washington DC	Gary Swanson, MD Terri Randall, MD	Continental 3
	Region IV: Midwest – Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin	Angela Mayorga, MD Sandra Rackley, MD	Continental 7
	Region V: Southeast – Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, West Virginia	Joy Houston, MD Laurel Williams, DO	Continental 8
	Region VI: California	Don Hilty, MD Robert McCarron, DO	Continental 9
	Region VII: Far West – Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming, Canada (Vancouver, Winnipeg, Manitoba)	Roxanne Bartel, MD Tim Blumer, DO	Plaza B
	Resident Caucus I	Stella Cai, MD	Plaza A
6:00 – 6:30 pm	Coffee Break with Exhibitors		East Lounge
6:30 - 7:30 pm	Shein Lecture	Elyn Saks, JD, PhD	Continental 4/5/6
7:30 - 9:00 pm	Opening Reception		Golden Gate 2-8
9:00 pm - 12:00 am	Pink Freud		Continental 7
10 - Friday	**Event**	**Leader/Presenter**	**Room**
7:00 am - 12:00 pm	Annual Meeting Check In and Registration		East Lounge
7:00 – 7:45 am	*Academic Psychiatry* Editorial Board Meeting (by invitation only)	Laura Roberts, MD, MA	Union Square 7
7:00 – 7:45 am	Workshop evaluators meeting	Don Hilty, MD Shashank Joshi, MD	Plaza A
7:00 - 8:00 am	Continental Breakfast (except Program Administrators) – Executive Council available for discussion		Golden Gate 2-5 & Foyer
7:00 - 8:00 am	ACGME Curbside Consultations-by appointment	Bob Boland, MD Josepha Cheong, MD George Keepers, MD Jed Magen, DO	Golden Gate 1
7:30 – 8:00 am	Program Administrators Breakfast and Programming	Barbara Burns, BA, C-TAGME Elaine Danyew, C-TAGME	Plaza B
7:30 am – 3:45 pm	Exhibitors		East Lounge

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7:30 – 9:15 am	Session 1 poster presenter check in and set up		Continental 4 & East Lounge
8:00 – 9:30 am	**Educational Workshops Session #1**		
	Competency-based Behavioral Interviewing: Using a Structured Interview Method to Enhance Residency and Fellowship Interviews	Ashley Walker, MD Bryan Touchet, MD John Laurent, MD	Continental 1
	Developing or Enhancing a Mentorship Program at Home	Sallie DeGolia, MPH, MD Deborah Cowley, MD Jesse Markman, MBA, MD	Continental 2
	Enhancing Your Substance Use Disorder Training Through the Development of Personalized Action Plans	John Renner, MD Andrew Saxson, MD Hector Colon-River, MD Tristan Gorrindo, MD	Continental 3
	Graduate Medical Education Funding Made Less Complex	Jed Magen, DO Alyse Ley, DO Katherine Krive, DO	Continental 7
	Helping Our Residents Heal after Patient Suicide: Using the "Collateral Damage" DVD in Residency Education	Joan Anzia, MD James Lomax, MD Priti Ojha, MD Deepak Prabhakar, MPH, MD Sidney Zisook, MD	Continental 8
	How to Rescue a Drowning Hip(p)o (or How to Coach the Underperforming High Potential Resident and Faculty)	Josepha Cheong, MD Mark D. Cannon, PhD	Continental 9
	Improving Psychotherapy Supervision Using the A-MAP – An Opportunity for Faculty Development	Randy Welton, MD Amber Frank, MD Erin Crocker, MD	Union Square 1/2
	SESSION CHANGE: Teaching with Technology	John Luo, MD Robert Boland, MD Patrick Ying, MD Carlyle Chan, MD	Union Square 3/4
	Remediating Professionalism Lapses: One Size Does Not Fit All	Susan Stagno, MD Kathleen Crapanzano, MD Anne Schwartz, MD Jacob Sperber, MD Lee Tynes, PhD, MD	Union Square 5/6
	SESSION CHANGE: Entrustable Professional Activities (EPAs) in Action: Wrestling with Implementation	John Q Young, MPH, PhD, MD Erick Hung, MD Caitlin Hasser, BA Colin Stewart, MD Jeff Kohlwes, MPH, MD	Union Square 15/16
	Sub-specialty Psychiatry Recruitment Barriers and Opportunities: Finding the Missing Link	Anna Kerlek, MD Sejal Shah, MD Rebecca Lewis, MD Jessica Kovach, MD	Union Square 17/18
	"That Resident is Terrific, Give Her a 3!" and Other Forms of Bias in Clinical Competency Committee Meetings	Chandlee Dickey, MD Barbara Cannon, MD David Topor, BA Christopher Thomas, MD	Union Square 19/20
	The Forgotten Stage: Developing Model Curricula in General Psychiatry and CAP Training Programs to	Zhanna Elberg, MD Daniel Kirsch, MD Shreya Nagula, MD	Union Square 21

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	Improve the Mental Health of Transitional Age Youth (TAY)	Michael Scharf, MD Timothy VanDeusen, MD	
	SESSION CHANGE: Strategies for Success for Early Career Academic Physicians: Writing for Publication	Laura Roberts, MA, MD	Golden Gate 6
	"This is the Coolest Thing Ever!" – What You and Your Learners Will Say After Taking Your Didactic Curriculum Online	Ross Yaple, MD Ravinderpal Singh, MD Kenneth Warren, EdD	Golden Gate 7
	When 5 is More Than 3+2: Creating an effective Child Track for Psychiatry Residencies	Edwin Williamson, MD Dorothy Stubbe, MD Sourav Sengupta, MPH, MD	Golden Gate 8
9:30 – 10:15 am	Poster Session 1 & Coffee Break		Continental 4 & East Lounge
10:00 – 10:50 am	Program Administrators Workshop Session 1		
	Workshop 1: ACGME Site Visits: Fact vs Fiction and Strategies for Survival	Jennifer R. Koser, Asc	Plaza B
	Workshop 2: Are You Well? Program Administrator Wellness, Well-Being, and Welfare in Residency Training Programs	Kimberly Kirchner	Plaza A
10:15 – 11:30 am	Plenary Session: TED Talks: Define 'Psychiatrist'	John Burruss, MD Deborah Cabaniss, MD Michael Travis, MD	Continental 4/5/6
11:00 – 11:50 am	Program Administrators Workshop Session 2		
	Workshop 1: Too Close to Home – When Pain and Psychiatry Unexpectedly Collide	Adrienne Van Winkle	Plaza B
	Workshop 2: TAGME Certificate: It's New, So Let's Review…(Again)	Angelina Berkley, BS, C-TAGME Zoellen Murphy, BA, C-TAGME Beverly Pernitzke, C-TAGME Dorothy Winkler, BA, C-TAGME	Plaza A
11:30 – 11:45 am	Poster Session 1 Tear Down		Continental 4
11:30 am – 1:00 pm	Lunch for all (except those attending meetings)		Golden Gate 2-5 & Foyer
11:30 am - 1:00 pm	ACGME Curbside Consultations-by appointment	Bob Boland, MD Josepha Cheong, MD George Keepers, MD Jed Magen, DO	Golden Gate 1
11:30 am – 1:00 pm	ABPN Consultations – ABPN will have staff persons available to meet with program directors and/or administrators with questions about preCERT or MOC. No appointment or sign up required.	Pat Janda Tina Espina	Golden Gate 2-5 & Foyer
11:30 am – 1:00 pm	Members of the PRITE editorial board available to discuss the exam	Arden Dingle, MD Kathryn Delk	Golden Gate 2-5 & Foyer
11:30 am – 1:00 pm	GME Financing Consultations	Jed Magen, DO, MS Kari Wolf, MD	Golden Gate 2-5 & Foyer
11:30 am – 1:00 pm	**COMMITTEE & TASK FORCE LUNCH MEETINGS –** *lunch available in south/east lounge for all meeting attendees except CAP Caucus*		
	Child & Adolescent Psychiatry Caucus Lunch Meeting, Session I - *lunch available in room*	Lisa Cullins, MD	Continental 4/5

MEETING AT A GLANCE

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	Curriculum Committee Lunch Meeting	Jacqueline Hobbs, MD, PhD Kaz Nelson, MD	Union Square 25
	Development Committee Lunch Meeting	Brian Palmer, MD	Union Square 9
	Integrated Care Taskforce Lunch Meeting	Robert McCarron, DO	Union Square 14
	International Medical Graduates Caucus Lunch Meeting	Jacob Sperber, MD	Union Square 13
	Neuroscience Education Committee Lunch Meeting	Melissa Arbuckle, MD, PhD	Union Square 22
	Psychotherapy Committee Lunch Meeting	Deborah Cabaniss, MD Randon Welton, MD	Union Square 23/24
	Recruitment and Workforce Committee Lunch Meeting	Glenda Wrenn, MD	Union Square 10
	Academic Psychiatry Governance Board Lunch Meeting *(By invitation only)*	Laura Roberts, MD	Union Square 11
	ADDED: Wellness Task Force Lunch Meeting	Heather Vestal, MD	Union Square 12
	ADDED: Community Programs Caucus Lunch Meeting	Scott Oakman, MD	Union Square 8
1:15 – 2:45 pm	**Educational Workshops Session #2**		
	3-Step Supportive Psychotherapy: A Brief Supervisory Manual for Busy Services	Deborah Cabannis, MD	Continental 1
	Back to the Basics of Faculty Development-Encouraging Faculty to Teach on the Fly and Love It!	Cosima Swintak, MD Joan Anzia, MD	Continental 2
	Da Vinci Code, Take 2: Understanding, Interpreting and Decoding the PRITE Examination and Reports	Vishal Madaan, MD Arden Dingle, MD Robert Boland, MD Marcy Verduin, MD Lauren Osborne, MD	Continental 3
	From Babies to Boards: Navigating Parental Leaves During Psychiatry Training	Sandra DeJong, MSc, MD Sol Adelsky, MD Tamar Katz, MPH, MD Felicia Smith, MD	Continental 7
	Lessons Learned from the IMG Training Experience: What Lies Ahead?	Nyapati Rao, MS, MD Jacob Sperber, MD Richard Balon, MD	Continental 8
	Preparing Psychiatrists for Value-Based Care: Applying Principles of Collaborative Care in Your Training Program	Anna Raztliff, PhD, MD Hsiang Huang, MPH, MD Tristan Gorrindo, MD	Continental 9
	Problem Residents and Resident Problems: Across the Generational Divide	Kim Lan Czelusta, MD Carol Bernstein, MD James Lomax, MD	Union Square 1/2
	Recruitment Tips, Tricks and Turbulence: From Application Avalanche to A+ Intern Class	Jessica Kovach, MD Anna Kerlek, MD Mark Servis, MD John Spollen, MD Glenda Wrenn, MD	Union Square 3/4
	Teaching Cultural Awareness: An Experiential Method	Zsuzsa Meszaros, MD Nanette Dowling, DO Ayame Takahashi, MD Mario Fahed, MD	Union Square 5/6

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		Mirabelle Mattar, MD	
	SESSION CHANGE: Not all Evidence is an RCT: An EBM Refresher to Invigorate Your Teaching	Jane Gagliardi, MSc, MD	Union Square 15/16
	The Family CSE. Demonstrating Competency in Family Interview and Assessment as a Requirement for Graduation in Child and Adolescent Psychiatry Training (and an Option for General Psychiatry, too!)	Kathleen Baynes, MD Alma Guerra, MD John Sargent, MD Michael Scharf, MD	Union Square 17/18
	The Zero Suicide Model: Bringing Evidence-Based Suicide Prevention Practices to Psychiatry Clinical Training	Beth Brodsky, PhD Sidney Zisook, MD Joel Bernanke, MD Yael Holoshitz, MD	Union Square 19/20
	Unconscious Bias and Stereotype Threat in the Clinical Setting – Causes, Effects, and Remedies Through Teaching	Erick Hung, MD Demian Rose, MD, PhD Laura Kaplan, MD Andrea Rosati, PhD, MD Amanda Wallace, MD	Union Square 21
	"We have to talk": How to Have Difficult Conversations with Residents about Adversity in the Workplace	Lisette A. Rodriguez-Cabezas, MD Roberto E. Montenegro, PhD, MD Auralyd Padilla, MD Andres Jovel, MD Kristen Wilkins, MD	Golden Gate 6
	Using Clinical Vignettes to Teach Residents about Autism Spectrum Disorder and Intellectual Disability	Kathleen Koth, DO Roma Vasa, MD	Golden Gate 7
	Using How We Learn to Learn How We Learn	Kari Wolf, MD Jane Ripperger-Suhler, MA, MD Santosh Shrestha, MD	Golden Gate 8
2:00 – 2:30 pm	Session 2 presenter check in and set up		Continental 4 & East Lounge
2:45 - 3:30 pm	Poster Session 2 & Coffee Break		Continental 4 & East Lounge
3:30 – 3:45 pm	Poster Session 2 tear down		Continental 4
3:45 – 5:15 pm	**Educational Workshops Session #3**		
	A Scholarly Activity Initiative: Breaking Barriers and Getting Published!	Rashi Aggarwal, MD Nicole Guanci, MD Tanya Keeble, MBBS Justin Faden, DO	Continental 1
	Are You as Good of a Supervisor as You Think you Are? Self-assessment for Supervisors	Susan Stagno, MD David Topor, BA Eva Mathews, MPH, MD Andrew Hunt, MPH, MD	Continental 2
	Assessment in the Age of Milestones: Improving and Refining your Resident Assessment Program	Kathleen Crapanzano, MD J. Luke Engeriser, MA, MD Sandra Batsel-Thomas, MD	Continental 3
	Avoiding Death by PowerPoint: Strategies to Improve your Presentation Skills	Carlyle Chan, MD Monique Yohana, MD	Continental 7
	Efficient and Effective EMR Use - A Model Curriculum	John Luo, MD John Torous, MD Steven Chan, MBA, MD	Continental 8

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	Enhancing Resident and Faculty Development through a Reverse Clinical Competency Committee	Kim Kelsay, MD Austin Butterfield, MD Sean LeNoue, MD Sumru Bilge-Johnson, MD Liberty Fritzler, MSBA, MD	Continental 9
	SESSION CHANGE: So You Developed a Great Course, Now What? How (and Why) to Create a Model Curriculum	Katherine Nelson, MD Jacqueline Hobbs, PhD, MD	Union Square 1/2
	Exploring the 4th Dimension: Developing a Biopsychosociospiritual Model in Psychiatric Residency	Timothy Lee, MD	Union Square 3/4
	Flipped Classroom Pedagogy: Experiential Learning of Liberating Structures	Kari Wolf, MD Jane Ripperger-Suhler, MA, MD Santosh Shrestha, MD	Union Square 5/6
	Residents as Teachers: Implementing a Curriculum to Facilitate Clinical Teaching	Jane Gagliardi, MSc, MD Shelley Holmer, MD	Union Square 15/16
	SESSION CHANGE: Why in the World Would Someone Become a Chair?	Laura Roberts, MA,MD	Union Square 17/18
	Teaching Research Literacy through Debates In Psychiatry (DIP into the Literature!)	Michelle Pato, MD Erika Nurmi, PhD, MD	Union Square 19/20
	Teaching Therapy: A Co-Therapy Model	Anita Kishore, MD Shani Isaac, MD Dorothy Stubbe, MD Nina Vasan, MD Isheetz Zalpuri, MD	Union Square 21
	Training 21st Century Psychiatrists in Reproductive Psychiatry: Implementing the National Curriculum Project	Sarah Nagle-Yang, MD Caitlin Hasser, BA Lauren Osborne, MD Neha Hudepohl, MD	Golden Gate 6
	The Disciplinary Process: Navigating Passions, Pressures, and Values	Ann Schwartz, MD Sallie DeGolia, MPH, MD Adrienne Bentman, MD Deborah Spitz, MD	Golden Gate 7
	To Dodge or Disclose: Minority Trainees' Perspectives on their own Cultural Identities in Clinical and Supervision Settings	Ekta Taneja, MD Priya Sehgal, MA, MD Alecia Greenlee, MPH, MD Amber Frank, MD	Golden Gate 8
5:30 – 6:30 pm	**CAUCUSES & MEETINGS**		
	Assistant & Associate Training Directors	Asher Simon, MD	Union Square 15/16
	Child & Adolescent Psychiatry Caucus, Session II	Lisa Cullins, MD	Continental 5/6
	Combined Training Programs	Mark Servis, MD	Continental 1
	Directors of Small Programs	Brian Touchet, MD	Continental 2
	Global Psychiatry	Mary Kay Smith, MD	Continental 3

AADPRT ANNUAL MEETING & BRAIN CONFERENCE
March 8 – 11, 2017

MEETING AT A GLANCE

**all times Pacific*

Program Administrator-specific activites noted in red

	Subspecialty Training Directors (Addictions, Forensics, Geriatric and Psychosomatic TDs)	Christine Finn, MD	Continental 7
	VA Training Directors	Sanjai Rao, MD	Continental 8
	Residents' Caucus, Session II	Stella Cai, MD	Continental 9
	Anne Alonso Award Committee & Victor Teichner Award Committee Joint Meeting	Eugene Beresin, MD, MA Sherry Katz-Bearnot, MD	Union Square 9
5:30 - 7:00 pm	Nominating Committee *(By invitation only)*	Bob Boland, MD	Union Square 7
6:45 - 7:15 pm	Regional Representatives Review Meeting *(By invitation only)*	Chandlee Dickey, MD	Plaza A
7:00 – 8:30 pm	Presidential Reception *(By invitation only)*	Art Walaszek, MD	Vista
9:00 pm - 12:00 am	Pink Freud		Continental 7
11 - Saturday	**Event**	**Leader/Presenter**	**Room**
7:00 - 8:30 am	ACGME Curbside Consultations-by appointment	Bob Boland, MD Josepha Cheong, MD George Keepers, MD Jed Magen, DO	Golden Gate 1
7:15 - 8:45 am	Executive Council Meeting and Breakfast with Current and Incoming Regional Representatives *(By invitation only)*	Art Walaszek, MD	Plaza A
7:30 – 9:30 am	Program Administrators Breakfast and Symposium	Barbara Burns, BA, C-TAGME Elaine Danyew, C-TAGME	Imperial AB
7:45 - 8:45 am	Continental Breakfast (except Program Administrators)		Golden Gate 2-5 & Foyer
9:00 – 9:45 am	**AADPRT Forum on Supporting IMGs in Residency Training**	Shalini Bhutani, PhD Eleanor Fitzpatrick, MA Tristan Gorrindo, MD Jed Magen, DO, MS	Continental 4/5/6
9:45 – 9:50 am	Coffee Break		Continental 4/5/6
9:50 - 10:50 am	**Presidential Symposium on Wellness**	Joan Anzia, MD Eugene Beresin, MA, MD Mark Servis, MD Heather Vestal, MD, MSc	Continental 4/5/6
10:50 – 11:00 am	**Closing Session**	Art Walaszek, MD Sandra DeJong, MD Melissa Arbuckle, MD, PhD Bob Boland, MD	Continental 4/5/6
11:10 am – 12:30 pm	**Skills Fair**		
	Drown-proofing for the Application Flood		Imperial A
11:10 - 11:30 am	How to Screen Hundreds (Thousands?) of Applications in ERAS	Michael Jibson, MD, PhD	
11:40 am – 12:00 pm	How to Assess the International Application	Donna Sudak, MD	
12:10 - 12:30 pm	How to Avoid NRMP Trouble	Sandra DeJong, MD, MSc	
	Put on Your Oxygen Mask First: Program Director Wellness		Imperial B
11:10 - 11:30 am	Essentials of Time Management	Chandlee Dickey, MD	
11:40 am – 12:00 pm	Peer Mentoring for Mutual Care	Suzanne Murray, MD	

AADPRT ANNUAL MEETING & BRAIN CONFERENCE
March 8 – 11, 2017

MEETING AT A GLANCE

**all times Pacific*

Program Administrator-specific activites noted in red

12:10 - 12:30 pm	Mindfulness	Erica Shoemaker, MD, MPH	
	Program Alchemy: Turning Residents into Scholars		Plaza A
11:10 - 11:30 am	Writing Effective Nomination Letters	Marcy Verduin, MD	
11:40 am – 12:00 pm	Teaching Residents to Search the Literature	Melissa Arbuckle, MD, PhD	
12:10 - 12:30 pm	Teaching Residents to Publish Case Reports	Julie Penzner, MD	
12:30 pm	Meeting Adjourns		
12:45 – 1:45 pm	Steering Committee Lunch Meeting	Sandra DeJong, MD	

1/26/2017

2017 AADPRT Program Administrator Symposium
San Francisco, CA
March 8-11, 2017

Wednesday, March 8, 2017

4 PM – 5 PM	**Program Administrator Caucus - Committee Chairs' Meeting**
5 PM - 6 PM	**Annual Program Administrator Caucus "Meet and Greet"**
	Once again, all Program Administrators Symposium attendees are invited to join us to unwind after travel, catch-up with returning friends and welcome new colleagues. Networking opportunities will be provided!

Thursday, March 9, 2017

8:30 AM – 11:30AM MORNING SESSION

8:30 – 8:40 AM	Introduction/Bagels and Coffee
	Elaine Danyew, C-TAGME, Co-Chair Program Administrators Symposium Program Planning Committee Fellowship Coordinator, Addiction Psychiatry, Sleep Medicine Department of Psychiatry, Dartmouth Hitchcock Medical Center
	Barbara Burns, BA, C-TAGME, Co-Chair Program Administrators Symposium Program Planning Committee Division Manager, Education Office Department of Psychiatry, University of Maryland
8:40–8:45 AM	Welcome
	Art Walasek, MD AADPRT President
	Adam Brenner, MD AADPRT Program Chair
	Sara Stramel-Brewer, MA AADPRT Administrative Director

8:45-9:45 AM **Welcoming Presentation: "The Program Administrator as a Leader"**
Deborah S. Cowley, M.D.
Professor and Vice Chair for Education and Faculty Development
Department of Psychiatry and Behavioral Sciences
University of Washington Medical Center

10-10:20 AM **ACGME Updates for 2017**

George Keepers, M.D.
Chair, ACGME Psychiatry Review Committee

10:20-10:40 AM **ABPN Updates and Changes for Program Administrators**

Pat Janda, Director, ABPN Credentials and Meetings
Tina K. Espina, Manager, Credentials

10:40-11:30 AM **Tips, Time-Savers, and Thoughtful Ideas for the Training Office**

1. "A Day in the Life of a Coordinator" INTERRUPTED!
   Cindy L. Harrison
   Psychiatry Program and Education Manager
   UT Health Science Center

2. "Building and Maintaining your resume - The Ultimate Guide on How to Prepare an Interview-Ready Resume".
   Kimberly Kirchner
   AADPRT Program Administrator Caucus Chair
   Academic Manager
   Western Psychiatric Institute and Clinic
   University of Pittsburgh Medical Center

3. "I Don't Have Time Right Now!"
   Beverly Pernitzke, C-TAGME
   Medical Education Coordinator
   Medical College of Wisconsin Psychiatry Fellowship Programs

4. "Make the Transition to Electronic Interview Packets"
   Amber Pearson C-TAGME
   Mayo School of Graduate Medical Education

5. "Streamlining CCC Meetings"
   Sharon Ezzo, MA
   Program Manager
   Cleveland Clinic

6. "Administrative Triage: Training a New Staff Member When You Just Don't Have the Time"
   Regina Hannah Herrera, B.S.
   Academic Program Coordinator
   Department of Psychiatry

UT Health San Antonio

Marisela Cardona, B.S.
Academic Program Coordinator
Department of Psychiatry
UT Health San Antonio

11:30am-12:45pm **LUNCH/CAUCUS** (Working lunch for first 30 minutes)

Update on Caucus Activities
Kimberly Kirchner, Chair, Program Administrator Caucus
Academic Manager, Western Psychiatric Institute and Clinic

Lucille Fusaro Meinsler Program Administrator Recognition Award Announcement
Nancy Lenz, BBA, C-TAGME
Program Coordinator, Western Michigan University

1:00 – 2:40 PM General Meeting – Opening Ceremony & Awards (All conference registrants, including Program Administrators, are invited and encouraged to attend this session.)

2:45 PM-4:30 PM AFTERNOON SESSIONS:

A. **New Program Administrators University**

This session offers a comprehensive review of administrative tasks for all new program administrators in order to master their program's management and accreditation requirements. A summary of the academic year and deadlines is also provided.

Mary Barraclough, B.S.
Program Manager, Hennepin-Regions Psychiatry Training Program

Zoellen Murphy, B.A., C-TAGME
Psychiatry Residency & Curriculum Coordinator
The University of Toledo College of Medicine & Life Sciences

B. **"Further Reflections on Life as a Career Program Administrator"**

Summary: This workshop provides an opportunity for experienced program administrators to share their thoughts and feelings regarding the nature and value of their work - to themselves, to their programs, to their colleagues and, perhaps, to their families and communities. Based on a "Lifer's Workshop" offered for training directors at the annual AADPRT conference, we hope to give participants valuable space and time to reflect upon each other's experiences in psychiatry and graduate medical education. In a spirit of collegial support, we'll discuss participants' views on a variety of topics relating

to their choice to persevere and thrive in their careers in graduate medical education

Linda Gacioch, C-TAGME
Training Administrator
Psychiatry Residency Education
University of Michigan

Friday, March 10, 2017

7:30 - 11:50 AM MORNING SESSION:

7:30-8:00 AM Continental Breakfast/Caucus Meeting

8:00-9:30 AM **PD Workshops (choose one of sixteen)**
Workshop information to be provided.

9:30-10:00 AM **Break**

10:00-10:50 AM **Program Administrators' Workshops - Session #1**

1. ACGME Site Visits: Fact vs Fiction and Strategies for Survival
Jennifer R. Koser, ASc, C-TAGME
Adult Residency Program Coordinator
Department of Psychiatry
Penn State Medicine, Milton S. Hershey Medical Center

Summary: There are many misconceptions regarding ACGME site visits. Some mistakenly believe the visits went away with the new NAS Self-Study while some others who understand they still exist, fear them. This workshop will review the types of site visits that can occur, common red flags that might lead to an unplanned site visit, preparation for a site visit every day, and practical tips for the program administrator's "survival" of the site visit.

2. "Are *You* Well?" - Program Administrator Wellness, Well-Being and Welfare in Residency Training Programs
Kimberly Kirchner
AADPRT Program Administrator Caucus Chair
Academic Manager
Western Psychiatric Institute and Clinic
University of Pittsburgh Medical Center

Summary: In the ever-changing world of ACGME, programs are doing more with less. There has been a great emphasis on resident well-being and burnout, but what about Administrator well-being and burnout? This workshop with provide Program Administrators with the necessary tools to identify fatigue, stress and burnout as well as how to cope with these day-to-day stressors at work and at home. It will also provide the resources that are available with a self-assessment to improve your own well-being.

10:50-11 AM **Break**

11:00 - 11:50 AM **Program Administrators' Workshops - Session #2**

1. Too Close to Home – When Pain and Psychiatry Unexpectedly Collide

Adrienne Van Winkle
Residency Coordinator
Creighton Psychiatry Residency Program

Summary: This workshop will take you through the events of a tragic day in March, 2016, when a residency program learned of the sudden death by suicide of a faculty member. The workshop will describe the events of that day and the steps taken by the Program leadership team to inform our residents and faculty that the unthinkable had happened.

2. TAGME Certification: It's New, So Let's Review . . . (Again)

Angelia Berkley, BS, C-TAGME
Program Coordinator
Palmetto Health/University of South Carolina SOM

Zoellen Murphy, BA, C-TAGME
Residency and Curriculum Coordinator
The University of Toledo COM & Life Sciences

Beverly Pernitzke, C-TAGME
Fellowship Program Coordinator
Medical College of Wisconsin

Dorothy Winkler, BA, C-TAGME
Medical Education Supervisor
Program Administrator
Texas A&M COM/Scott & White Program

Summary: TAGME certification can be an important part of a program administrator's professional development. This workshop will help participants understand how TAGME certification can be helpful to them. The workshop will discuss the TAGME leadership structure, the eligibility requirements for TAGME certification, and

the timeline and process for the TAGME certification assessment cycle.

Saturday, March 11, 2017

7:30 - 9 AM MORNING SESSION:

7:30 – 8:15 AM Continental Breakfast

7:30 - 7:40 AM **Updates from APA**
Chelsea Homer
Deputy Director, Membership, Product Development and Engagement
American Psychiatric Association

7:40 - 7:50 AM **Updates from the American College of Psychiatrists (PRITE)**
Craig Samuels, Executive Director
Kathryn Delk, Program Manager

8:00 – 9:00 AM **A Training Director / Program Administrator Panel:**

"You've Got Problems, We've Got Answers! – 2017 Edition" - Experienced Leaders Discuss Unexpected Problems for Training Programs

Summary: This is the third year for this very popular session. Program administrators deal with problem residents, communication issues, technology frustrations, etc. This panel will offer attendees a chance to submit problem scenarios in advance, and have our panelists, in real time at the conference, discuss their proposed solutions or what they would do in the situation.

Moderator: Linzi Conners
Sr. Program Coordinator
Child & Adolescent Psychiatry
Tulane University School of Medicine

Panel:
Tiffany Burns
Program Manager
and
Deidre Evans-Cosby, M.D.
Program Director
Morehouse School of Medicine

Michele Cepparulo, C-TAGME
Education Administrator
and
Anthony L. Rostain, MD

Vice Chair of Education
University of Pennsylvania

Alison Wellman, Coordinator
and
Robert Sahl, M.D., Program Director, Child and Adolescent Psychiatry
Institute of Living/Hartford Hospital

9 AM **Final Thoughts: Appreciations and Closing Remarks**

Welcome!

Important Information for Registrants

Meeting Evaluation and CME Credit/Certificates
You will receive an email immediately following the close of the meeting on Saturday, March 11 that will include a link to the evaluation that must be completed to receive CME credit. **The evaluation must be completed no later than March 31 (no exceptions).** You will then receive an email the week of April 10 with your customized CME certificate.

Internet Access
Complimentary wireless Internet is available in the hotel lobby, restaurants, and conference areas. The login below is for the conference rooms only.
Complimentary guest room internet access information will be provided at check-in to Hilton Honors Members.
SSID: Hilton Events
Access code: AADPRT2017

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

Poster Sessions
Attendees may view the first set of posters Friday, 9:30am-10:15am and the second set of posters (different than first set) Friday, 2:45pm-3:30pm. Both sessions will take place inside Continental Ballroom 4 located on the Ballroom Level. Presenters will be available to discuss their posters during these times.

Poster and Workshop Presenters
We're collecting your materials via Dropbox for sharing with AAPRT members. **Deadline for uploading materials is 3/31/17.** To upload, paste the appropriate url into your browser:
Posters: **https://www.dropbox.com/request/Oz6eTzTNYhWSWpPsbN2u**
Workshops: **https://www.dropbox.com/request/yYlOYNjWlcEOgAd7XK5h**

Messages for Attendees
Messages for attendees can be left at the front desk of the Hilton San Francisco Union Square Hotel.

Registration and Check-in

Attendees who have pre-registered should pick up name badges and materials at the Meeting Registration Desk during the times listed below. 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	**Golden Gate Lobby Main Floor**	4:00 pm - 6:00 pm
Wednesday	**East Lounge Ballroom Level**	7:00 am – 10:00 am 3:00 pm – 6:00 pm
Thursday	**East Lounge Ballroom Level**	8:00 am – 4:00 pm
Friday	**East Lounge Ballroom Level**	7:00 am – 12:00 pm

Exhibitors and Exhibit Schedule

Exhibitors

Ballroom Level in the East Lounge

Academic Psychiatry
American Academy of Child & Adolescent Psychiatry (AACAP)
American Professional Agency (APA, Inc.)
American Psychiatric Association (APA)
American Psychiatric Association Publishing (APAP)
for [MD]
Professional Risk Management Services (PRMS)
Staff Care
The American College of Psychiatrists
True Learn
VA

Exhibit Schedule

Thursday	9:00 am - 6:30 pm
Friday	7:30 am - 3:45 pm

Executive Council
March 2016 – 2017

Position	Name
President	Art Walaszek, MD
President-elect	Sandra DeJong, MD
Secretary	Donna Sudak, MD
Treasurer	Michael Travis, MD
Program Chair	Adam Brenner, MD
CHAIRS	
ACGME Liaison Committee	Art Walaszek, MD
Child & Adolescent Caucus	Lisa Cullins, MD
Development	Brian Palmer, MD, MPH
Information Management	John Luo, MD Sanjai Rao, MD
Membership	Sallie DeGolia, MD, MPH Dorothy Stubbe, MD
Curriculum	Jacqueline Hobbs, MD, PhD Kaz Nelson, MD
Neuroscience Education (BRAIN Conference)	Melissa Arbuckle, MD, PhD
Psychotherapy	Deborah Cabaniss, MD Randy Welton, MD
Recruitment	Glenda Wrenn, MD
Regional Representatives	Chandlee Dickey, MD
IMG Caucus	Consuelo Cagande, MD
Subspecialty Caucus	Christine Finn, MD
APPOINTED MEMBERS	
	John Q. Young, MD Heather Vestal, MD
LIAISON	
Governance Board, *Academic Psychiatry*	Sheldon Benjamin, MD
APA Council on Medical Education	Richard Summers, MD
PAST PRESIDENTS	Bob Boland, MD Adrienne Bentman, MD

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

The Endowment for the Advancement of Psychotherapy
for their grant support for this year's Anne Alonso, PhD Memorial Award

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 2017 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
Sheldon Benjamin, MD
Bob Boland, MD
Consuelo Cagande, MD
Sallie DeGolia, MD, MPH
Sandra DeJong, MD
Chandlee Dickey, MD
Christine Finn, MD
Kaz Nelson, MD
Brian Palmer, MD, MPH
Dorothy Stubbe, MD
Donna Sudak, MD
Richard Summers, MD
Heather Vestal, MD, MSc
Art Walaszek, MD
Glenda Wrenn, MD
John Q. Young, MD, MPH, PhD

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. For more information, click on the "Give to build the future of AADPRT" button at the bottom of the AADPRT website homepage, or click here.

2017 BRAIN CONFERENCE

21st Century: Learners, Technology, Neuroscience

When: Wednesday, March 8, 2017

Overview: Over the past two decades, advances in neuroscience have dramatically enhanced our understanding of the brain and of the neurobiological basis of psychiatric illness. 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 neurotransmitters and corresponding second messenger systems, the importance of neuroplasticity, and the functional dynamics of neural circuits.

At the same time, advances in technology have reshaped the way learners engage with content: lecture halls are vacant, books are passé, libraries are online. Traditional content becomes e-content. TED talks go viral. Google has become the go to resource.

Learners are adapting to these changes. We have come to expect information to be high yield, immediately available, and stimulating. Overwhelmed by the amount of information, we have learned to rapidly skim the surface for the most pertinent details. Gone are the days of rote memorization: remembering reams of content is less important than knowing how to rapidly access it. Emerging data confirm what we instinctively understand: the fundamental way in which our brains process information is changing as well. For better or worse, we have entered an age of "edutainment".

The goal of this year's meeting is to bring together 21st century neuroscience with 21st century technology in order to engage 21st century learners

Intended Audience: Medical educators with little or no neuroscience background, neuroscientists engaged in medical education, students and residents

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 is poised to assume in psychiatry, we continue to under-represent and fail to integrate this essential perspective in our work.

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 all day conference will include a series of morning and afternoon workshops designed to:

1) Empower faculty with or without a neuroscience background to feel confident that they can teach neuroscience effectively;
2) Engage conference attendees to participate as both student and instructor using new and innovative teaching methods; and
3) Provide programs with resources for how they might address, teach, and assess neuroscience-specific milestones.

Through large and small group activities, attendees will receive training in various new and creative approaches to teaching neuroscience.

The registration fee for the BRAIN Conference will cover all sessions, hand-outs, and breakfast and lunch. Sign up online when registering for the AADPRT meeting. We hope you will join us for an exciting and fun day!

Co-Chairs:

David A. Ross, MD, PhD
Yale School of Medicine

Melissa R. Arbuckle, MD, PhD
Columbia University Medical Center
New York State Psychiatric Institute

Michael J. Travis, MD
Western Psychiatric Institute and Clinic
University of Pittsburgh School of Medicine

BRAIN Conference

WEDNESDAY, MARCH 8, 2017

7:15am - 8:00am	30 minutes	Continental breakfast
8:00am - 8:30am	30 minutes	Opening Session & fellows award Presentation
8:30am - 8:45am	15 minutes	Break
8:45am - 10:15am	90 minutes	Workshop #1
10:15am - 10:30am	15 minutes	Break
10:30am - 12:00pm	90 minutes	Workshop #2
12:00pm - 1:00pm	1 hour	Lunch
1:00pm - 2:30pm	90 minutes	Workshop #3
2:30pm - 2:45pm	15 minutes	Break
2:45pm - 4:15pm	90 minutes	Workshop #4
4:15pm - 4:30pm	15 minutes	Break
4:30pm - 5:00pm	30 minutes	Closing Session

*Participants will receive their group and room assignments when they arrive at the meeting.

Confirmed Moderators/Facilitators (includes *NNCI Scholars and Co-Chairs)

Mayada Akil, MD
Georgetown University Hospital
Washington, DC

Joan Anzia, MD
McGaw Medical Center,
Northwestern University
Chicago, IL

Melissa Arbuckle, MD, PhD
Columbia University Medical Center and
the New York State Psychiatric Institute
New York, NY

*Erica Baller, MD, MS
Perelman School of Medicine at the University of Pennsylvania
Philadelphia, PA

Adrienne Bentman, MD
Institute of Living / Hartford Hospital
Hartford, CT

Robert Boland, MD
Brigham and Women's Hospital
Boston, MA

*Elizabeth Burch, DO
The Institute of Living - Hartford Hospital
Hartford, CT

Lisa Catapano, MD, PhD
George Washington University Medical Center
Washington, DC

Joyce Y. Chung, MD
National Institute of Mental Health
Bethesda, MD

Joseph Cooper, MD
University of Chicago
Chicago, IL

*Susan Conroy, MD, PhD

Indiana University School of Medicine
Indianapolis, IN

Deborah Cowley, MD
University of Washington Medical
Center Seattle, WA

Sallie G. DeGolia, MD, MPH
Stanford University School of Medicine
Stanford, CA

Sandra DeJong, MD, MSC
Cambridge Health Alliance
Cambridge, MA

Chandlee Dickey, MD
Harvard South Shore / VAMC
Brockton, MA

Jane Eisen, MD
St. Lukes / Mt. Sianai West
New York, NY

Marshall Forstein, MD
Cambridge Health Alliance / Harvard Medical School
Cambridge, MA

*Matthew Hirschtritt, MD, MPH
University of California, San Francisco
San Francisco, CA

Erick Hung, MD
University of California
San Francisco, CA

Michael Jibson, MD, PhD
University of Michigan Health System
Ann Arbor, MI

Shashank V. Joshi, FAAP , MD
Stanford University School of Medicine
Stanford, CA

David A. Ross, MD, PhD
Yale School of Medicine
New Haven, CT

Anthony Rostain, MD, MS
Perelman School of Medicine

University of Pennsylvania
Philadelphia, PA

Asher Simon, MD
Icahn School of Medicine at Mount Sinai
New York, NY

Hanna Stevens, MD, PhD
University of Iowa Carver College of Medicine
Iowa City, IA

Donna Sudak, MD
Friends Hospital
Philadelphia, PA

Sourav Sengupta
University at Buffalo School of Medicine
Buffalo, NY

Michael Travis, MD
Western Psychiatric Institute and
Clinic at the University of Pittsburgh
Pittsburgh, PA

Ashley Walker, MD
University of Oklahoma School of Community Medicine
Tulsa, OK

Randon Welton, MD
Wright State University
Dayton, OH

Sidney Zisook, MD
University of California, San Diego
San Diego, CA

New Training Director Symposium
Thursday, March 9, 2017

Presenters:
Dorothy Stubbe, MD
Sallie DeGolia, MD, MPH
Sandra DeJong, MD
Adam Brenner, MD
Deborah Cowley, MD-TBA
Kim Kirchner, Program Administrator

Educational Objectives:
1) To provide new Program Directors with basic information and important tools to succeed in the administration and coordination of their programs;
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);
3) To provide a forum for interactive discussion in small groups led by senior Program Directors to discuss common problems new directors face.

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.

The workshop has three parts:
1) **Moments in Mentoring:** Seasoned program directors and AADPRT members will be stationed at several tables set up based on key training director topics to enable more intimate discussions among new TDs.
2**) 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 brings together master clinician-teachers to orient the new training director to the organization and initiatives of AADPRT (Sandra DeJong, MD, AADPRT President; Adam Brenner, MD, Program Chair); to review the “nuts and bolts” all new training directors should know (TBA) and to acquaint new PDs with the importance of the Program Administrators (Kim Kirchner). In addition, leadership of the Program Coordinators’ group will provide practical tips for working effectively with your Coordinator;
3) **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.

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. They quickly need to learn the numerous administrative requirements and expectations set by regulatory agencies. 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.

New Training Director Program

Thursday March 9, 2017
Continental 4

9:00-9:15	Welcome by Membership Co-Chairs	Sallie DeGolia & Dorothy Stubbe
	Welcome by AADPRT President	Art Walaszek
	Welcome by AADPRT Program Chair	Adam Brenner
	Welcome by AADPRT Administrative Director	Sara Stramel-Brewer
9:15-10:15	*Nuts & Bolts of Being a Training Director*	Sallie DeGolia
10:15-10:25	BREAK	
10:25-10:45	*A Day in the Life of a Program Director*	Dorothy Stubbe
10:45-11:00	*Working with your Program Coordinator*	Kim Kirchner, Caucus Chair Carol Regan, Past-Caucus Chair Laura Covert, Program Administrator
11:00-11:15	Question & Answer	All
11:15-11:30	BREAK for Lunch – pick up lunches on way out of Continental 4	

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11:30-12:45 New Training Directors Breakout & Lunch

NEW TRAINING DIRECTORS LUNCH AND BREAKOUT GROUPS	Region	ROOMS:
Joan Anzia, MD - Training Director	4	Union Square 1
Shashank Joshi, MD - Child Training Director	6	Union Square 2
Eugene Beresin, MD, MA - Child Training Director	1	Union Square 3
Kim-Lin Czelusta, MD - ATD	5	Union Square 4
Arden Dingle, MD - Child Training Director	5	Union Square 5
Marshall Forstein, MD - Training Director	1	Union Square 6
Erick Hung, MD - Training Director	6	Union Square 8
Michael Jibson, MD, PhD - Training Director	4	Union Square 9
Anita Kablinger, MD - Training Director	5	Union Square 10
David Roane, MD, Fellowship Director	2	Union Square 11
Ann Schwartz, MD - Training Director	5	Union Square 12
Erica Shoemaker, MD, MPH - Child Training Director	6	Union Square 13
Asher Simon, MD - Associate Training Director	2	Union Square 14
Tim Wolff, MD - Associate Training Director	5	Union Square 15
Kristen Dunaway, MD - Associate Training Director	7	Union Square 16

Early Career Workshop
Thursday, March 9, 2017
10:00 am – 11:15 am

Conflict, Cooperation, and Change: Herding Cats 101

Presenters:
Asher B. Simon, MD (Mount Sinai)
Lisa Catapano, MD, PhD (George Washington University)
Erick Hung, MD (UCSF)

Educational Objectives:

By the end of this workshop participants will be able to

1. Identify key qualities important in leading effectively and influencing fiercely independent & overworked faculty
2. Identify how to best prepare themselves for creating high-stakes curricular changes
3. Describe some of the essential dynamics of a successful negotiation
4. Demonstrate the ability to negotiate both 'up' and 'down' the hierarchy of power

Practice Gap:

Early career faculty who are passionate about teaching and mentoring residents are drawn to positions as Training Directors and Associate Training Directors. Once in these roles, they discover that much of the success of their educational mission, as well as their own personal satisfaction, depends on the effectiveness of their negotiation and leadership skills, especially when it comes to effecting one's vision and creating change. Unfortunately, most academic physicians have had little to no formal instruction in negotiation or leadership, and accordingly find these tasks to be particularly stressful aspects of their professional duties. Last year, we focused on using techniques of resilience and positive psychology to maintain one's stride in implementing a vision for one's program. As a follow-up, our workshop this year will focus on helping PDs and APDs learn to exert effective and powerful influence as they work to create curricular changes and bring their programmatic aspirations to life.

1. Palm K, Ullström S, Sandahl C, Bergman D. Employee perceptions of managers' leadership over time. Leadersh Health Serv (Bradf Engl). 2015;28(4):266-80.
2. Kirch DG. "From Moses to Multipliers: The New Leaders for Academic Medicine." Presidential Speech at the AAMC 123rd Annual Meeting. San Francisco, CA. Nov 4, 2012.
3. Kotter JP. Accelerate! Harvard Business Review. Nov2012, Vol. 90 Issue 11, p44-58.
4. Birken SA, Lee SY, Weiner BJ, Chin MH, Chiu M, Schaefer CT. From strategy to action: how top managers' support increases middle managers' commitment to innovation implementation in health care organizations. Health Care Manage Rev. 2015 Apr-Jun;40(2):159-68.
5. Gabel S. Physician Leaders and Their Bases of Power: Common and Disparate Elements. Acad Med. 2012;87:221–225

AADPRT 2017
Mid-Career Workshop: Adding to the Toolbox for the Program Director

A workshop for mid-career program directors with 5-10 years experience in the role

Facilitators:
Mary Ahn, MD
Joan Anzia, MD
Peter Daniolos, MD

Educational Objectives:
At the conclusion of this workshop, participants will:

1) Understand the current challenges facing academic institutions and the healthcare industry
2) Describe models for improving faculty well-being and preventing burnout
3) Identify personal and career values
4) Begin to establish a "Leadership Identity"

Practice Gap:
There is very little published information on the career satisfaction of mid-career psychiatry program directors, and there is sparse evidence on effective means of promoting engagement and dedication in the program director role at this career phase.

Abstract:
There is limited data on the career experience of psychiatry program directors, including changes in their job satisfaction and role engagement. One study of assistant program directors found decreased job satisfaction in the four-five year group compared with the one-three year and > six year assistant program director groups[1], suggesting that there may be important changes and pressures at that juncture. The ACGME highlights the importance of longevity in the program director role for continuity and stability in training programs, and strongly favors minimum terms of 5 years or longer for program directors. This workshop will focus not only on identifying sources of tension and burnout in the mid-career program director, but on highlighting resources for enriching, stimulating and enlarging our experience as we move beyond the first five to ten years.

[1] Arbuckle MR, DeGolia SG, Esposito K, Weinberg M, Brenner A. Job Satisfaction Among Associate Training Directors in Psychiatry: A Bimodal Distribution. Academic Psychiatry, 37:2, March-April 2013

Lifer Workshop 2017: Maintaining Wellness and Resiliency During the Aging Process: Insights, Strategies and Practices

Facilitators: Gene Beresin, MD, MGH/Harvard Medical School and Tony Rostain, MD, MA, Perelman School of Medicine, University of Pennsylvania

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

1. discuss important challenges that the aging process presents to career educators ("Lifers")
2. define strategies for maintaining physical, psychological and spiritual wellbeing as an aging physician
3. discuss insights, strategies and practices that physicians promote wellbeing and resilience in their senior years

Practice Gap:
The practice of medicine is a high risk profession, with considerable dangers of burnout, mental and physical health problems, and dysfunction in balancing personal and professional life. Until recently the importance of incorporating practices that promote wellbeing have been largely neglected in undergraduate, graduate and postgraduate education, and far too few efforts have been instituted among practicing physicians. This workshop will help illuminate efforts we can incorporate in our personal and professional lives as senior academic psychiatrists to foster wellbeing and resilience.

Abstract:
"These are the duties of a physician: First.... to heal his mind and to give help to himself before giving it to anyone else." From the epitaph of an Athenian doctor, 2 AD (1)
This experiential workshop will focus on the impact of aging on our professional, personal, and spiritual lives. It is intended to provide a forum for participants to reflect on significant events and experiences that are shaping us and the ways we are facing the aging process. In particular, we will focus on the many forces that work against personal and professional wellbeing, and consider insights, strategies and practices that we as senior academic psychiatrists may avail ourselves of to promote health and resilience.

It is well established that medicine is a high risk profession. Risks include burnout that fosters problems in self and patient care, medical error and diminished medical health (2). Physicians have significantly higher mental health problems and suicide compared with the general population (3). Additional problems facing doctors include conflicts in balancing personal and professional life including high divorce rates, demoralization, cynicism and decreased empathy (2). Such problems have been shown to begin in medical school, and continue through graduate medical education and into practice (4,5).
In light of the risks to physicians, there is a growing recognition that we as medical educators have failed to provide adequate education, training and strategies for promotion of physician wellbeing (6). However, in recent years and across many disciplines, training programs are

introducing new curricula to assist medical students, residents and fellows face the challenges of stress and burnout and learn skills that promote wellbeing and resilience (7,8).

Resilience is the ability of an individual to maintain personal and social stability in the face of adversity (9). Resilience is, in many ways, a double edged sword – on the one hand it is protective and preventative, fending off hardships; and on the other it is corrective, allowing for effective coping strategies in times of stress and trauma. Engagement, attachment and personal awareness and reflection all combine to promote resilience.

The key focus for our workshop this year is to share our experiences in education, training, and our personal and professional lives that enhance wellness and resilience. We invite participants to prepare for this workshop by considering the following questions and reading the attached references so as to be able to share concrete strategies and practices with other participants:

1. What experiences in medical training and practice tend to diminish wellbeing and resilience and how are these addressed in your program?
2. What have you found in your personal and professional life that helps you improve your own wellbeing and resilience?
3. Consider the following practices or considerations that have been (or could be) effective in promoting wellbeing. How have you engaged in any of these in your own life? How might we build them into medical student education and residency training; in junior faculty development; and in changing the culture of medical practice?
    a. Small group, process oriented reflective groups
    b. Curricula that enhance wellbeing and resilience for medical students and residents
    c. What are the means of enhancing engagement, attachment and reflection in our profession?
    d. The role of nutrition, exercise, meditation, yoga or other means of enhancing personal and professional life
    e. The value of the arts and humanities in medicine as a means of fostering wellbeing
    f. Increasing personal awareness of burnout and mental health problems
    g. Working to combat the stigma associated with having mental health problems in medicine. How may we change our culture and hidden curriculum?
    h. How can we influence institutions to promote wellbeing and resilience? Consider increased professional responsibilities, decreased reimbursements, and other institutional forces that promote burnout. Is there a way to offset these harsh realities of current medical practice?
    i. What is our role as Lifer's in serving as advocates to prevent potential harm in our students, residents and junior faculty?

References:

1. Maas PL, Oliver JH: An ancient poem on the duties of a physician. Bull Hist Med. 1939; 7:315-23.

2. Krasner MS, Epstein RM, Beckman H et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. JAMA. 2009;302:1284-93.
3. Zwak J, Schweitzer J: If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. Acad Med. 2013;88:382-9.
4. Goebert D, Thompson D, Takeshita J et al. Depressive symptoms in medical students and residents: a multischool study. Acad Med. 2009;84:236-41.
5. Sen S, Kranzler HR, Krystal JH et al. A prospective cohort study investigating factors associated with depression during medical internship. Arch Gen Psychiatry. 2010;67:557-65.
6. Beresin EV, Milligan TA, Balon R, Coverdale JH, Louie AK, Roberts LW: Physician wellbeing: a critical deficiency in resilience education and training. Acad Psychiatry. 2016;40:9-12.
7. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet Sept, 2016. http://dx.doi.org/10.1016/ S0140-6736(16)31279-X.
8. Epstein RM, Privitera MR. Doing something about physician burnout. Lancet Sept, 2016. http://dx.doi.org/10.1016/ S0140-6736(16)31332-0
9. Luthar SS, Cicchetti D, Becker B: The construct of resilience: a critical evaluation and guidelines for future work. Child Dev. 2000;71:543-62.

Input Session

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.

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.
- Describe national trends in psychiatric education.
- List new developments in the field of psychiatry, as well as mental health care policy and funding.

Overview of the ABPN's Credentialing and Certification Processes

Presenter: Larry Faulkner, M.D., President and CEO, ABPN

Education Objectives:
By the end of this plenary, attendees will be able to describe:

1. The application process for certification in psychiatry and the subspecialties
2. The requirements for certification in psychiatry and the subspecialties, including clinical skills evaluations
3. The role of training directors in ensuring that their residents meet these requirements and in documenting the training of individual residents in the on-line data base system (preCERT)
4. Changes in the Psychiatry Certification Examination, including content outline revisions and transition to DSM-5
5. Special education and research programs offered by the ABPN

Practice Gap:
What is/are the professional practice gap(s), the difference between current practice and optimal practice that are being addressed by this program?
Current practice: Based on the experience of ABPN credentialing staff, not all training directors understand their role in ensuring that their residents meet the requirements for certification, including appropriate documentation of training, nor do they have up-to-date information on the ABPN's certification, education, and research processes.
Ideal practice: All training directors would appropriately document training for their residents and provide up-to-date information to their residents on the ABPN's certification, education and, research processes.

Description: This session will begin with a 20 minute presentation from Dr. Faulkner with 10 minutes allotted for questions from the participants. Other ABPN staff will be present to provide information and answer questions.

The Accreditation Process for Psychiatry Residency Programs – THE RRC ESSENTIALS

Presenters:
George Keepers, MD, Chair, Review Committee, Psychiatry, ACGME
Tiffany Hewitt, BFA, Accreditation Administrator, Review Committee, Psychiatry, ACGME

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.

Educational Objectives: This session will:

1. Provide information regarding the accreditation requirements for residency programs in Psychiatry and psychiatric subspecialties.
2. Describe in detail recent modifications in these requirements.
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 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.

Shein Lecture: My Journey Through Madness with the Help of Psychiatry

Presenter:
Elyn Saks, MD

Education Objectives:
By the end of the plenary, attendees will be able to:

1. Understand one person's experience of psychosis from the inside
2. Understand factors that can help the patient deal with her psychosis
3. Learn the sorts of things psychiatrist can do that can help and hurt the patient

Description:
Everyone becomes psychotic in his or her own way. Still, a person's rich description of what this feels like could increase understanding of the patient experience. In the same way, hearing about the factors that have led to recovery could help others. Finally, suggestions are made as to ways psychiatrists can best help their patients—what is the optimal way for them to approach patients who may be terrified by their psychosis.

Define Psychiatrist: TED Talks and Discussion

Presenters: Adam Brenner MD (moderator), John Burruss MD, Deborah Cabannis MD, Michael Travis MD PhD

Educational Objectives:

At the end of this session, participants will:

1) Have a deepened appreciation of the roles of neuroscience, psychotherapy, and evolving healthcare systems in shaping the identity and role of the psychiatrist.
2) Have grappled with the challenge of integrating these diverse influences into their own definition of 'psychiatrist'

Practice Gap:

Psychiatry training directors are tasked with fulfilling many specific regulatory requirements as part of their administration of their programs. In the midst of these many 'trees' it is important that the director maintain sight of the 'forest', their vision for what a psychiatrist should be. This requires opportunities to periodically rethink and redefine – both individually and as a community of training directors - what it means to be a psychiatrist.

Abstract:

Three speakers will present TED style talks on the theme 'Define Psychiatrist'. These talks will describe visions of the psychiatrist of the future from the perspectives of the place of psychotherapy in the work of the general psychiatrist, the place of neuroscience in the identity of the general psychiatrist, and the impact of changing health care systems on the role of the general psychiatrist. Following the talks, the speakers will have the opportunity to respond and engage each other in dialogue and the audience will be called on to join in the same.

AADPRT Forum on Supporting IMGs in Residency Training

Presenters:

Shalini Bhutani, PhD
Eleanor Fitzpatrick, MA
Tristan Gorrindo, MD
Jed Magen, DO, MS

Educational Objectives:

After this session, participants will be able to:
1) Share with AADPRT members current understanding of regulatory effects on IMGs
2) Share with PD how best to support IMG residents and faculty
3) Learn advocacy strategies available thru organized psychiatry

Practice Gap:

Residency training directors are uncertain as to how best to address the concerns of their residents and faculty who are international medical graduates and who may be impacted by proposed changes to immigration law and procedures.

Description:

The AADPRT Forum on Supporting International Medical Graduates will convene a panel of experts to discuss proposed changes to immigration law and procedures, how these might impact residents and faculty who are IMGs, and what residency training directors can do to best support them. The format will be a panel discussion of thought leaders and experts in these areas, with a goal of providing residency training directors guidance and support. We will collect questions from our members prior to the meeting in order to help focus the discussion.

President's Symposium on Resident Wellness

Presenters: Art Walaszek MD (moderator), Heather Vestal MD, Eugene Beresin MD, Joan Anzia MD, Mark Servis MD

Educational Objectives:
At the end of this session, participants will:

1) Identify several methods of assessment and intervention for individual program directors in the service of their residents wellness
2) Understand the responsibility and potential roles of health care institutions and professional organizations in supporting resident wellness.

Practice Gap:
Physician wellness is increasingly appreciated as a pressing challenge for our field. Deficits of wellness lead to burnout, put physicians at risk for depression, and impinge on the physician's capacity to care for patients. Wellness can be a particularly difficult issue for residents because of the stresses of clinical training, time constraint, and relocation/disruption of social supports. Program directors are in need of guidance regarding how to best assess their residents' wellbeing and how to intervene – at different organizational levels – to foster wellness.

Abstract:
A moderated panel of four speakers will individually address the following questions:

1. How can the program director measure and assess resident wellness?
2. How can the program director enhance and support resident wellness?
3. What should our sponsoring institutions (hospitals and medical schools) do for resident wellness?
4. What should AADPRT and other professional organizations be doing in the service of resident wellness?

Time will be reserved for discussion and Q/A with the audience. An emphasis will be placed on providing attendees with concrete 'best practices' to take back to their home institutions.

Educational Workshops

Session 1 – Friday, March 10, 8– 9:30 a.m.

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

Presenters
Ashley Walker, MD
Bryan Touchet, MD
John Laurent, MD

Educational Objectives
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 applicants 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 residency 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.
1. Best Practices for Conducting Residency Program Interviews. Association of American Medical Colleges. Washington, D.C. 12 September 2016.

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 which 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
Introductions and defining the practice gap (Walker, Touchet, Laurent, 5 minutes)
Define CBBI and its evidence-base (Walker, 10 minutes)
Introduction to identifying competencies (Laurent, 5 minutes)
Practice identifying relevant competencies using 3-3-3 method (Touchet, 10 minutes)
Development of questions and rating scales (Walker, 10 minutes)
How to train interviewers (Touchet, 5 minutes)
Practice the CBBI interview (small groups) (Walker, Touchet, Laurent, 15 minutes)
Practice using rating scales (Walker, 10 minutes)
Sharing what we've learned and how to tailor the process (Walker, Touchet, Laurent, 10 minutes)
Questions and discussion (Walker, Touchet, Laurent, 10 minutes)

Developing or Enhancing a Mentorship Program at Home

Presenters
Sallie DeGolia, MPH, MD
Deborah Cowley, MD
Jesse Markman, MBA, MD

Educational Objective
1. Appreciate the importance of mentorship for faculty
2. Identify the components of setting up a mentorship program
3. Develop first steps to developing a program at home
4. Anticipate possible pitfalls of developing such a program and how to strategize to prevent them.

Practice Gap
As program directors, we are often charged with helping trainees and our clinician educators find mentorship in order to navigate a meaningful career path. However, with increasing clinical and administrative demands, finding adequate time for mentorship is often difficult. Not only does the prevalence of mentoring in academic medicine vary

widely (1) but mentorship efforts have often focused on research faculty, leaving others to rely of their own intuition to learn about career options (2).

The benefits of strong mentorship are well documented within the medical community (3-6). Though the literature suggests that "organically derived" mentorship relationships may be more satisfying or productive, assigned mentorship is better than none (7). Given the importance of mentoring in professional development, formal mentorship programs may provide the needed structure to ensure the provision of mentorship among faculty – particularly among clinician educators (3). However, such a program should be carefully designed to include key components for success (1,8,9).

1. Kashiwagi et al. Academic Medicine, Vol. 88, No. 7 / July 2013)
2. Feldman et al Medical Education Online. 2010; 15:10.3401/meo.v15i0.5063
3. Sambunjak et al. J Gen Intern Med. 2010;25:72–8.
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5. DeAngelis CD. JAMA. 2004;292:1060–1.
6. Reynolds HY. Lung. 2008;186:1–6.
7. Chao et al. Personnel Psychology. 1992; 45; 619-636
8. Allen et al. J of Appl Psychology 2006. 91(3):567-578.
9. Lewellen-Williams et al. Acad Med. 2006 Mar;81(3):275-9.

Abstract
This workshop focuses on how to develop an effective mentorship program within your home institution or program. We will review seven key components outlined in the literature and present a few program examples. By the end of this interactive workshop, participants will be able to identify important components of a formal mentoring program, consider strategies for how to design such a program and ways to avoid pitfalls that may lead to ineffective mentorship.

Agenda
a. Overview & benefits - 5 min
b. Mechanics of effective mentorship programs with two Mentorship Programs examples - 20 min
c. Breakout Session - 25 min
d. Barriers to developing a mentorship program - 10 min
e. Breakout Session - 20 min
f. Discussion - 10min

Enhancing Your Substance Use Disorder Training Through the Development of Personalized Action Plans

Presenters
John Renner, MD
Andrew Saxson, MD
Hector Colon-River, MD
Tristan Gorrindo, MD

Educational Objectives
At the end of this workshop, attendees will be able to:
1. List areas of strength and deficit with regards to substance use training within their residency programs, specifically as related to opioids, alcohol, tobacco, and medication-assisted treatment.
2. Describe resources which can be used to strengthen substance use disorder training within their program.
3. Describe a personal action plan for improving substance use disorder training within their program.

Practice Gap
In 2010, of people aged 12 and older, an estimated 9% or approximately 22.6 million used illicit drugs, 7% or 17.9 million could be classified as having alcohol use disorder, and 27% or 69.6 million people used tobacco (SAMHSA 2011). Substance abuse treatment modalities have been shown to be effective in treating these populations. One study showed that medications used to treat persons with SUDs can be as effective in terms of relapse rates and adherence as medications used to treat chronic medical illnesses such as diabetes mellitus, asthma, and hypertension (McLellan 2000). However, despite the efficacy of available treatments, approximately 90% of Americans with treatable SUDS are not in active treatment (SAMSHA 2011). Despite the fact that many persons with SUDs are already in psychiatric care settings, they are not being screened, diagnosed, and treated (Ewing 1999, Fleming 1991). One survey found that psychiatrists reported alcohol and drug abuse patients to constitute only 10% of their caseloads. (Dorwart 1992) Many general psychiatrists report they do not feel they have the adequate core competency skills to treat SUDs (Ewan 1982). This may explain why the treatment gap for alcohol abuse is estimated at 78% as compared to other mental disorders like schizophrenia that has an estimated treatment gap of 32% (Kohn 2004).

Trainees and general psychiatrists who are competent in substance abuse diagnosis, prevention, and treatment would be able to increase the proportion of persons with an SUD receiving treatment and improve the morbidity and mortality while reducing the dangerousness of their comorbid patients. Proper training in the treatment of SUDs can also reduce recidivism, emergency room visits, inpatient days, and psychiatric and substance use relapses, while improving medication adherence and treatment retention. To meet this end, more attention must be paid to training the psychiatry resident in outpatient treatment of patients with SUDs.

A 2008 survey showed that the total number of curricular hours over the 4 years of training has increased since the 1990s. However, more than 80% of resident encounters with patients with SUDs occur in the psychiatric emergency room, consultation liaison service, and inpatient units. More exposure to and supervision in the treatment of outpatients with SUDs would improve general psychiatrist competence in treating these disorders (Fleming 1994, Shorter 2008).

Abstract
The highly interactive workshop will focus on identifying strengths and deficits within general residency training programs as related to substance use disorders (SUD). Utilizing a resource document developed by the American Psychiatric Association's (APA) Council on Addiction Psychiatry, participants will complete an inventory as to how their programs are addressing the recommended competencies within the resource document. Such competencies include:

a. Screening, brief intervention, and referral to treatment (SBIRT);
b. Management of alcohol, opioid, sedative-hypnotic withdrawal
c. Management of psychoactive substance intoxication;
d. Medication-assisted treatment for Opioid Use Disorders;
e. Medication-assisted treatment for Alcohol Use Disorder;
f. Medication-assisted treatment for Tobacco Use Disorder;
g. Evidence-based psychosocial interventions for substance use disorders; and
h. Management of co-occurring substance use disorders and severe mental illness

Agenda
The workshop will be broken into four discrete parts:

Part 1: Foundations for the workshop (15 minutes). Faculty will present a high-level overview of the SUD epidemic and describe the American Psychiatric Association's (APA) Council on Addiction Psychiatry's Training Resource Document.

Part 2: Inventory of current SUD training (20 minutes). Participants will complete a check list of competencies detailing specific SUD prevention and treatment skills for psychiatrists and the setting/rotation currently teaching the skills in their program using APA's Resource Document. A completed checklist will help each attendee identify strengths and deficits related to SUD training within his/her program.

Part 3: Facilitated small group discussion (35 minutes). Working in pairs, attendees will compare checklists and discuss training gaps. Examples of cost-effective adaptations to existing training programs as well as elements of other effective strategies will be highlighted. Each group will collaborate to develop and describe an ideal training program in which the skills could be taught or reinforced. Groups will summarize their discussion and recommendations for other participants.

Part 4: Creating a Personal Action Plan (30 minutes). Attendees will be introduced to the APA/NIDA SUD Curriculum Review Project which includes a categorized and peer-reviewed inventory of over 120 online and open-source SUD training resources in the public domain. Participants can select resources from the inventory to fill training gaps identified in their own programs or which might be needed in developing a training program which more closely aligns with their ideal program. Participants will then create a personal action plan for how they will improve their own programs.

Entrustable Professional Activities (EPAs) in Action: Wrestling with Implementation

Presenters
John Q Young, MPH, PhD, MD
Erick Hung, MD
Caitlin Hasser, BA
Colin Stewart, MD
Jeff Kohlwes, MPH, MD

Educational Objectives
1. Appreciate how the framework of Entrustable Professional Activities (EPAs) can complement and enhance a Milestones-based assessment program.
2. Assess the usefulness and applicability of Psychiatry EPAs developed by AADPRT's EPA Sub-Committee.
3. Compare and contrast implementation of EPAs across institutions.

Practice Gap
A number of RRCs, the AAMC, and specialty societies in other countries have endorsed EPAs as a framework for milestone-based assessment. To date, EPAs have not been systematically developed for psychiatry in the US, though they have been developed for several other US specialties. This workshop will address this gap and review the implementation process in Psychiatry and Internal Medicine.

Abstract
With the emergence of the competency-based framework and the consequent development of the milestone-based evaluation system in 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. AADPRT has charged an EPA task force to develop EPAs for psychiatry training programs. This workshop will briefly orient participants to the EPA framework and present the task force's proposed EPAs for the field of psychiatry. The main focus of this workshop will be implementation of EPAs in psychiatry residency programs. We will share experiences from multiple institutions as well as the perspectives of both Psychiatry and Internal Medicine to identify the factors that lead to successful implementation. Areas of implementation will include: (1) selection of EPAs for specific contexts (i.e. inpatient psychiatry, ambulatory psychiatry, C/L psychiatry, and emergency psychiatry), choice of assessment tools for entrustment decisions, entrustment decision-making, practical use of EPAs in Clinical Competency Committees, and faculty development.

Agenda
Introduction (LG group discussion, 5 min)
Brief orientation to EPAs (instructional, 3 min)
Proposed EPAs for Psychiatry (instructional, 2 min)
Selecting EPAs for Rotations – Context Matters (SG discussion, 10 min)
Selecting assessment tools/choosing evidence that will be used to assess resident performance on the EPA (10 min)
Entrustment Decisions – Ad Hoc Decisions vs. Clinical Competency Committees (SG discussion, 15 min)
Faculty Development (LG discussion, 15 min)
Wrap Up (10 min)

Graduate Medical Education Funding Make Less Complex

Presenters
Jed Magen, DO
Alyse Ley, DO
Katherine Krive, DO

Educational Objective
Training Directors will understand:
1. Basics of current Graduate Medical Education Funding mechanisms
2. How hospitals and programs may respond to regulatory changes as a result of the ACA and other health care reforms
3. Overview of GME reform possibilities

Practice Gap
Training directors do not receive any formalized training in how their programs are financed. There are few articles in the literature describing mechanisms of GME financing in an understandable way. The workshop in past years has had attendance of 20+ individuals making it a popular program.

Abstract
Graduate Medical Education programs rely heavily on Medicare funding mechanisms. Direct and indirect medical education funding continues to decrease based on sequester legislation and programs are potentially faced with continuing small cuts. Caps on hospital residency numbers decrease flexibility to change numbers and other regulations increasingly constrain programs. The Affordable Care Act resulted in some changes in GME regulations. The influential Institute of Medicine (IOM) report in 2014 will likely be given strong consideration by policy makers in the next administration. This seminar will help training directors understand current basic mechanisms of program funding, review recent GME regulatory changes and IOM recommendations.

Agenda
The following topics will be discussed:
1. The basics of Graduate Medical Education Funding
    a. direct GME costs/reimbursement
    b. indirect GME costs/reimbursement
    c. disproportionate share funding and it's relevance to GME funding
    d. caps on housestaff numbers and years of training
    e. workforce issues
    f. changes in Medicare payment for services and where does all the money go?
2. Possible Responses
    a. resident generated revenues
    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. Possibilities for GME reform based on the Affordable Care Act, the Institute of Medicine Report on GME financing and other trends in health care organization and funding
4. Discussion/questions

Helping Our Residents Heal after Patient Suicide: Using the "Collateral Damage" DVD in Residency Education.

Presenters
Joan Anzia, MD
James Lomax, MD
Priti Ojha, MD
Deepak Prabhakar, MPH, MD
Sidney Zisook, MD

Educational Objectives
1) To inform program directors about the range of effects of a patient suicide on psychiatry residents
2) To describe a full range of tools to both a) educate residents about the emotional, cognitive and behavioral impact of losing a patient to suicide, and b) policies and processes that enable programs and departments support residents and faculty in the aftermath of a patient suicide.
3) To acquaint program directors with the DVD 'Collateral Damage" and how to integrate this in a curriculum for residents.

Practice Gap
Until 2007 there was very little research and only a few publications about the impact of patient suicide on psychiatrists and psychiatry trainees. Although there have been several publications and the creation of a number of online curricula and meeting workshops since then, and the creation of an educational video ("Collateral Damage") in 2009, newer program directors seem to be unaware of these curricular resources to help their trainees.

Abstract
This year, stakeholders in American medical education and practice are expressing a growing concern about rates of burnout, depression and suicide in our profession. This focus is partly stimulated by greater awareness of newer research about wellbeing of physicians and medical trainees. Although there are many variables implicated in burnout and depression in physicians, oftentimes the "last straw" in the stress load is an adverse medical event. For psychiatrist, the worst adverse event is a patient suicide, which triggers a unique cascade of emotions, thoughts and behaviors. In 2009, the workshop presenters created a DVD comprised of an introduction describing the impact of patient suicide on psychiatrists and five, 10 minute video vignettes in which two well-known senior psychiatrists and three trainees describe their personal experiences with a patient suicide. This DVD was distributed to program directors around the U.S. and studied in a fourteen-program pilot curriculum. It has been several years since the DVD has been shown at AADPRT, and in light of our current concern about resident wellbeing, a "revisit" to this topic may be in order.

Agenda
1) 15 minutes: Description of impact of patient suicide on psychiatrists and psychiatry residents
2) 15 minutes: DVD intro and first video vignette.
3) 10 minutes: Participant discussion of vignette
4) 10 minutes: Second video vignette

5) 10 minutes: Participant discussion of vignette
6) 20 minutes: Small group discussion of varieties of curricular formats in which DVD and other available educational tools could be utilized in residency
7) 10 minutes: Final group discussion and wrap-up.

How to Rescue a Drowning Hip(p)o (or How to Coach the Underperforming High Potential Resident and Faculty)

Presenters
Josepha Cheong, MD
Mark D. Cannon, PhD

Educational Objective
1. Identify the key issues for underperformance by a trainee and/or faculty member
2. Identify the barriers to effective feedback and address these barriers
3. Apply the principles of executive coaching to facilitate effective feedback in a difficult
4. Apply the principles of executive coaching to facilitate personal and professional development in an underperforming trainee or faculty member

Practice Gap
Identification and remediation of the impaired or disruptive physician/trainee/faculty has become more standardized over the past 20 years of academic medicine. Despite this, arguably - the more difficult issue to address is the underperforming or "difficult" individual that does not have a clear cognitive or behavioral issue. Barriers such as defensiveness to feedback, limited time, and lack of relative urgency (compared to management of an impaired physician) enable these underperformers to continue - ultimately at the cost of the team or department performance. This workshop strives to brings expertise from the world of organizational performance and executive business coaching to apply these principles to academic medicine to facilitate professional development of trainees and faculty.

Abstract
Academic medical centers are an example of a continuous learning organization. As defined by Peter Senge, a learning organization is an organization that facilitates the learning and development of its individual members to continuously transform itself in the service of creating excellence towards a common goal. Learning – on a personal as well as organizational team level – is key to the success in achieving the common goal. This workshop strives to reframe the issue of the problematic trainee or staff member not as a disciplinary issue but one of learning and professional development.

One of the more common and frustrating situations that confront program directors and senior faculty is the underperforming or “difficult” trainee or faculty member. GME trainees and faculty can be defined as high potential (HiPo) or high performance (HiPe) staff. For a multitude of reasons, talented and capable individuals underperform or present with issues such as interpersonal difficulty with colleagues, lack of professionalism, or persistent marginal performance. Unlike individuals who cannot perform appropriately due to clear and identified cognitive or behavioral impairment, and/or substance use issues, underperformers are more difficult to address given marginal (but not failing) performance. Barriers to effective management are varied and

appropriate feedback and constructive management requires a conscientious and thoughtful approach. This workshop will examine the various barriers to effective management of underperforming hi-performers. Following identification of the barriers, a discussion of the techniques of executive coaching will be presented. The application of the principles of executive coaching in resident and staff supervision will be explored. Participants are encouraged to come prepared to discuss “real-world cases” throughout this workshop. Outside expertise for this presentation is drawn from the field of business management and organizational performance. Learner engagement will be stimulated by the deployment of several interactive exercises including role play.

Agenda
5-10 min - Intro and Disclosures, Survey of Learners
15 min - Presentation of a case and Learner engagement exercise
15 min - Overview of Concepts
20 min - Principles of Performance Coaching
20 min - Interactive Discussion and Role Play
10 min - Debrief and Q + A

Improving psychotherapy supervision using the A-MAP – An opportunity for faculty development

Presenters
Randy Welton, MD
Amber Frank, MD
Erin Crocker, MD

Educational Objectives
By the end of this workshop participants will be able to:

- List the common elements of psychotherapy which are found in the psychiatry milestones
- Describe how to use the A-MAP (AADPRT-Milestone Assessment for Psychotherapy)
- Identify the benefits of standardizing the expectations and conduct of psychotherapy supervision
- Explain how regular use of the A-MAP can improve the quality of psychotherapy supervision

Practice Gap
Psychiatry residencies need to evaluate residents' competence in psychotherapy using the anchor points of the psychiatry milestones. There are few validated tools that can be used to measure the common elements of psychotherapy. The A-MAP provides residency programs with a tool they can use to assess resident competence and to provide specific formative feedback to their residents.

Programs struggle to ensure the quality and consistency of psychotherapy supervision provided to their residents. Faculty members may have widely varying degrees of experience and training in psychotherapy and psychotherapy supervision. The A-MAP provides a foundation upon which to build uniform expectations for psychotherapy supervision.

Abstract
In developing the psychiatry milestones, the ACGME forced residency programs to develop new methods for assessing resident performance in clinical settings. The Patient Care - 4 milestone, Psychotherapy, assesses four threads: empathy, boundaries, therapeutic alliance, and the use of supervision. The AADPRT Psychotherapy Committee created a standardized tool, the A-MAP, which can be used to measure the first three threads, the common elements of psychotherapy. The tool has been utilized in a number of programs across the country. As experience with the A-MAP has been growing, an additional benefit has been noted; the A-MAP provides programs with an opportunity to improve the consistency and quality of psychotherapy supervision. The A-MAP ensures that supervisors assess empathy, therapeutic alliance, and boundaries in a deliberate and standardized fashion. Supervisors and programs who use the A-MAP as a regular part of supervision are discussing these common elements with their supervisees more frequently. The A-MAP helps provide structure to supervision and create objective goals based on resident's strengths and weaknesses. This seminar will discuss the use of the A-MAP as a means of assessing resident competence in psychotherapy and the potential to use the A-MAP as a means of improving the quality of supervision provided by our faculty members.

Agenda
5 minutes - Welcome and introductions (didactic)
5 minutes - History of the development of the A-MAP and piloting it in the committee members' programs (didactic)
40 minutes – Demonstrate A-MAP by having attendees rate a video of psychotherapy and supervision (active learning)
10 minutes – Have attendees discuss differences in A-MAP ratings (active learning)
15 minutes - Conceptualizing the A-MAP as a means of Faculty Development (didactic)
15 minutes – Brainstorming with attendees about how to best use the A-MAP to improve the quality of psychotherapy supervision (active learning)

Remediating Professionalism Lapses: One Size Does Not Fit All

Presenters
Susan Stagno, MD
Kathleen Crapanzano, MD
Anne Schwartz, MD
Jacob Sperber, MD
Lee Tynes, PhD, MD

Educational Objective
After attending this workshop the participant will be able to:
1) Describe the "levels" of professionalism concerns and appropriate interventions commensurate with the seriousness of the concern.
2) Identify concrete methods of developing remediation strategies for professionalism concerns.
3) Recognize developmental issues as a potential aspect of professionalism lapses and address this in remediation.
4) Understand the concept of professionalism "coaching" in working with residents.

Practice Gap
Residency training directors often do not feel well-equipped to help their residents to remediate professionalism issues that arise during residency training and tend to rely on disciplinary actions to address these situations. However, residents are still in training and cannot be expected to have fully mastered the competency of professionalism, therefore requiring both educational and remediation strategies in residency.

Abstract
Identifying professionalism concerns among residents is relatively easy for most training directors, but having effective strategies to deal with professionalism lapses is more challenging. Commonly, training directors rely on the disciplinary processes in place in graduate medical education rather than viewing the lapse as "developmental" and needing remediation.

Because residents are still evolving to become mature clinicians, they should not be expected to be functioning at a "proficient" or "expert" level (Level 4 and 5 of the Milestones) particularly early in their training. It is therefore important for residency programs to be able to assess the seriousness of the professionalism lapse and to develop remediation strategies that take into account the development of the resident and ways in which the resident can use the lapse as an opportunity to learn and develop insight about how these behaviors can impact their future patients and themselves.

This workshop is designed to familiarize participants with remediation strategies that can address professionalism lapses and help to develop insight, skills and behaviors that will allow residents to progress along the trajectory of development in professionalism. These strategies will include reflective writing, coaching and review of medical literature on issues regarding professionalism.

Agenda
Welcome - presenters and participants introduce themselves; participants indicate what they hope to gain from attending the workshop - 15 minutes
Brief overview of professionalism lapses and approaches to remediating them- 15 minutes
Small Group discussion re: vignettes that present a professionalism lapse and the group will be asked to propose remediation strategies to address the lapse - 30 minutes
Large group reconvenes to share insights from the small group discussion - 20 minutes
Wrap up – 10 min

Strategies for Success for Early-Career Academic Physicians: Writing for Publication

Presenter
Laura Roberts, MA, MD

Educational Objectives
To improve participants' understanding of peer-reviewed journal publication processes
To identify participants' personal strengths as writers
To provide information about the roles of editors, authors, and reviewers in publication

Practice Gap
Academic Psychiatry editors often receive queries from prospective authors about how to get started in educational research, such as how to choose a specific topic, what would be of interest to readers, and what scientific design to use. The journal aims to promote original research and to support new researchers among the members of its sponsoring organizations, including AADPRT.

Abstract
This workshop is a down-to-earth, hands-on introduction to the essential skills of writing manuscripts for publication in peer-reviewed academic medical journals. In helping participants to build their writing skills, the workshop will include valuable and detailed information on the framework of empirical and conceptual manuscripts and of specialized-format papers, such as annotated bibliographies, review papers, and brief reports. Participants will be introduced to the process of getting a paper published, including manuscript preparation, submission, editorial review, peer-review, revision and resubmission, editorial decision-making, and publication production. This process will be discussed in a step-by-step fashion, giving insights from the perspective of writers, reviewers, and editors. Specific strategies for assessing one's strengths and motivations as a writer and collaborator, for choosing the "right" target journal for a paper, for selecting the "right" presentation of the content, for responding to reviewers' concerns, and for working with editors will be addressed. The workshop will also cover important, but seldom discussed, considerations related to collaboration with co-authors, authorship "ethics," and scientific integrity issues. This workshop will involve interactive learning and Q&A formats, and it will have a tone of warmth and collegiality. It is aimed at enhancing the skills of early- and middle-career academic physicians but will be valuable for more senior faculty who serve as mentors, senior authors, and guest editors. Up-to-date resource materials will be provided to all participants.

Agenda
10 minutes – overview of workshop and coming up with an idea
15 minutes – small group discussion about manuscript ideas
10 minutes – overview of kinds of papers and anatomy and logic of papers
15 minutes – small group discussion about writing challenges
10 minutes – overview of peer-reviewed journal publication processes
20 minutes - breakout groups divided by specific needs of participants / level of experience / status of writing projects
10 minutes - summarize findings from breakout groups and strategies for success

Sub-specialty psychiatry recruitment barriers and opportunities: finding the missing link

Presenters
Anna Kerlek, MD
Fauzia Mahr, MD
Sejal Shah, MD
Rebecca Lewis, MD
Jessica Kovach, MD

Educational Objective
At the end of this workshop, the participants will be able to:
1. Identify recent trends in various sub-specialty psychiatry fellowship recruitment;
2. Verbalize barriers to effective recruitment in psychiatric sub-specialties;
3. Share and discuss strategies and practices across the nation to overcome barriers and improve sub-specialty recruitment.

Target Audience: Fellowship directors, Training administrators

Practice Gap
The AADPRT Recruitment Committee aims to develop and implement strategies leading to improved recruitment in Psychiatry residency and fellowship programs. It has the ultimate goal of increasing the Psychiatry work force to meet the nation's growing demand for Psychiatrists. Federal authorities have designated 4,000 shortage areas for mental health professionals. Under-served areas report as little as 1 psychiatrist for every 30,000 people. The shortage of Child and Adolescent Psychiatrists across the nation is critical. The US population under age 20 is projected to grow by 33% over the next 40 years and to increase from 84 million to 114 million by 2050. There are fewer than 8,500 Child and Adolescent Psychiatrists across the continent and the average wait time for an intake appointment is 7.5 weeks.

This overall shortage has affected all Psychiatric sub-specialties. Many sub-specialty fellowships go unfilled, and fellowship directors reported to the Recruitment Committee during the 2016 open meeting and ongoing conference calls that they have great difficulty recruiting qualified applicants. During the 2016 AADPRT Recruitment Committee workshop, sub-specialty program directors voiced that the barriers and challenges for fellowship directors are different from those faced by general adult training directors.

Sub-specialty-specific barriers include financial burden, career opportunities, public image of a sub-specialty, and visa related issues. According to the AACAP work force crisis documents, increased debt, longer training period, and reimbursement problems discourage residents from pursuing sub-specialty interests. Additionally, trainees may not receive a higher salary with additional training and may not wish to move again for a 1-2 year training program. Programs that do not participate in the NRMP match, such as Forensics, Addiction, and Geriatric Psychiatry, face pressures to offer positions early in the interview season in order to guarantee a filled fellowship.

This workshop will address challenges and barriers unique to psychiatry sub-specialty recruitment.

Abstract
In this workshop, we will highlight the latest NRMP, Bureau of Health professions and ERAS data regarding recruitment and workforce trends. We will review barriers to effective recruitment in various Psychiatric sub-specialties including Child and Adolescent, Forensic, Addiction, Psychosomatic and Geriatric Psychiatry. Additionally, we will facilitate small group discussion regarding barriers and best practices to overcome these barriers. Best practices will later be shared with the entire group and posted on the AADPRT recruitment committee website. The main goal of this workshop will be to identify barriers and review opportunities to effectively improve recruitment into Psychiatry sub-specialties.

Agenda
Introduction (30 min) Overview of recruitment data for sub-specialties in psychiatry, overall challenges and opportunities in each area
Break out group #1 (20 min) Break out by type of fellowship, discuss recruitment strategies specific to your sub-specialty, report back
Presentation #2 (10 min) How to convince people they need fellowship training even though they could potentially practice without fellowship training
Break out group #2 (10 min) Break out by type of fellowship, discuss how to address the need for specialty training specifically for that sub-specialty, report back
Presentation #3 (5 min) Recruitment day strategies
Conclusion (15 min) Compile best practices

Teaching with Technology

Presenters
John Luo, MD
Robert Boland, MD
Patrick Ying, MD
Carlyle Chan, MD

Educational Objective
At the end of this workshop, participants will be able to: 1) create interactive learning lessons using file, slides, websites, etc. using Nearpod 2) utilize higher level design and automated methods to deliver online surveys 3) use an interactive fiction platform to teach how to manage clinical decision making 4) download and embed videos from YouTube and other sources to be incorporated into PowerPoint

Practice Gap
In the midst of what at times seems like a flood of new technologies, training directors must be aware of those with potential application to education in order to select technologies that increase innovation and efficiency without distracting from the core mission, that of educating the next generation of psychiatrists. It is difficult for an individual to stay up to date with the new educational technologies that emerge each year. The TWT workshop therefore "crowd sources" ideas for using technology in education. This year's workshop features inexpensive technologies that facilitate routine tasks commonly performed by program directors. Drawing from the previous year's online feedback, suggestions made by attendees during previous workshops, and ideas solicited via the listserv, the TWT workshop explains how to use the technologies requested by AADPRT members, and maintains an online repository of "how-to" handouts for member use.

Abstract
New technology will never replace good teaching but it can make good teachers into more effective ones by affording them a host of easy-to-use tools. This workshop will focus on electronic resources for residency training submitted or requested by AADPRT members in response to a call for suggestions. In response to comments in previous years, this year's workshop will feature a smaller number of more in-depth "how-to"

sessions as well as shorter demonstrations of recent software and hardware useful for program directors. Participants in this year's TWT workshop will learn how to:

- use Nearpod, an interactive lesson app to create content with slides, web content, and movies, which can incorporate polls, open-ended questions, and quizez
- use Google Forms, a free online platform, to facilitate quick and easy feedback.
- use KeepVid.com and other software to download videos from YouTube, then embed them into PowerPoint
- use a variety of apps, hardware and online resources for teaching—the specific demonstrations will be based on newly released software and hardware solutions at the time of the meeting

Emphasis will be placed on consideration of the risks and benefits of each technology in education, and on specifics of how to use each technology demonstrated. "How-to" handouts from previous TWT workshops can by found in the Virtual Training Office on the AADPRT website. Participants having laptops or tablets with cellular internet access may wish to bring them to the session.

Agenda
Introduction & needs assessment 5 minutes (Luo)
Using NearPod (Ying 20 min including Q&A)
Using Inform to create text based clinical cases (Luo 15 min including Q&A)
Online Feedback Quick and Easy (Boland 20 min including Q&A)
TapForms (Chan 20 min including Q&A)
Open Q&A, Feedback, brainstorming, ideas for the future 10 minutes (Benjamin, Boland, Chan, Luo)

"That Resident is Terrific, Give Her a 3!" and Other Forms of Bias in Clinical Competency Committee Meetings

Presenters
Chandlee Dickey, MD
Barbara Cannon, MD
David Topor, BA
Christopher Thomas, MD

Educational Objective
The educational objective of this workshop is to increase awareness of the potential for cognitive bias to cloud judgment during deliberations of residents' milestone sub-competency levels. In addition, training directors will learn how to label bias and integrate discussion of bias into their clinical competency committee (CCC) discussions. Training directors will leave with exercises to use with their own CCC during a faculty development session.

Practice Gap
Programs hold CCC meetings to determine resident-specific milestone sub-competency levels. Normal, unconscious cognitive biases may distort judgment in CCC meetings. The goal of this workshop is to enhance awareness of unconscious bias, learn how to integrate discussions of bias in CCC meetings, and to give training directors exercises to use with their own CCCs to diminish the effects of cognitive bias.

Abstract
After breakfast, judges give more lenient sentences. When asked, judges deny the tendency. As judges see more cases, and make more negative rulings, the more likely they are to make another unfavorable ruling. Unfavorable court rulings are emotionally draining, but also take less time to deliver and write than favorable ones. These judges, while striving to be impartial, are demonstrating unconscious biases due to high work demands.

In CCC meetings, faculty may also be subject to unconscious cognitive bias. Committee members know the residents, have worked with them, and may have even socialized with them. In short, committee members have pre-formed opinions about the residents. Committee members are unaware of these biases -- biases are unconscious. In addition, within the meeting, group dynamics come into play, with some members having more influence and others less. The dynamic is accepted, thus, not examined. Pre-formed opinions and group dynamics can make CCC meeting deliberations rife with bias. These biases can affect resident milestone level determinations.

Participants of this workshop will learn more about unconscious cognitive biases; learn how to label bias as it arises in CCC meetings and how to discuss them; and have exercises to use with their own CCCs. Participants will role-play CCC deliberations as a way of learning about bias. While cognitive biases cannot be eliminated, being more mindful of them can help CCCs examine resident evaluations more deliberately.

Participants from last year may wish to attend this year, as the role-play of bias in CCC deliberations will be extended to include how to talk about bias in a CCC.

Agenda
The experiential session will begin with a brief exercise to elicit unconscious biases that we all have. The purpose of this exercise is to open participants' minds toward the possibility of bias occurring within their CCC meetings. Volunteers will role-play a CCC discussion regarding a resident. One person will act the role of the CCC chair, and someone else will role-play a member exhibiting the bias. Observers will reflect on what they saw unfold. As these biases are generally unconscious, it can be challenging to discuss them as a group. Participants will learn how to identify and label the bias and also how to discuss the bias in the course of CCC discussion. In all, four vignettes will be enacted. Participants will share with the whole workshop things they noticed and learned from the exercise. The session will close with participants sharing their thoughts on how this workshop could be improved. Participants will leave with a model of how to raise awareness of cognitive bias and how to address it in a CCC meeting. This final step is what is different in this workshop compared with last year—this year, participants will learn to identify types of bias and how to discuss them in a CCC meeting.

The Forgotten Stage: Developing Model Curricula in General Psychiatry and CAP Training Programs to Improve the Mental Health of Transitional Age Youth (TAY)

Presenters
Zhanna Elberg, MD
Daniel Kirsch, MD
Shreya Nagula, MD
Michael Scharf, MD
Timothy VanDeusen, MD

Educational Objective
After attending this workshop participants will be able to
1. Identify curricular gaps at their own institutions related to TAY
2. Recognize the importance of curricular guidelines geared towards TAY
3. Utilize material presented at the workshop to develop TAY specific competencies and learning objectives
4. Describe a model curriculum in TAY that can be implemented at their own institutions

Practice Gap
The Institute of Medicine and the National Research Council published a report in 2014 entitled "Investing in the Health and Well-Being of Young Adults". This report identified Transitional Age Youth as a discreet population with specific developmental needs that are not being adequately met within the existing systems of care. Very few programs exist focusing specifically on TAY. Some of this group's mental health needs are being met on college campuses with many deficits in the delivery of care. The October 2015 edition of Academic Psychiatry focused on the College Student Mental Health (CSMH) system and the challenges in treating this population. Derenne and Martel proposed a "Model CSMH Curriculum for Child and Adolescent Psychiatry Training Programs" in the special edition. In a survey of adult residency programs published in 2013, DeMaria, et al found only 35/182 (19%) psychiatry programs to have rotations in college or university counseling centers. There is virtually no data on specific TAY training experiences outside of the college counseling centers. Our group presented a workshop at the 2015 and 2016 AADPRT meeting focusing on TAY and CSMH in General Psychiatry and CAP training as a way to highlight the importance of training residents in caring for this unique population.

Abstract
Transitional Age Youth (TAY) refers to youth between mid-late adolescence (16-17 years) and young adulthood (25-26 years). This is a tumultuous period as TAY take on adult roles and negotiate critical developmental tasks. Incomplete brain development, particularly in the prefrontal cortex, contributes to struggles with impulse control, decision-making and emotion regulation. 75% of mental illness becomes manifest before 24 years. Mental health and substance use disorders cause the greatest portion of disability among all medical conditions in 15-24 year olds in the U.S. Long delays in seeking help are the rule, underscoring the extreme vulnerability of this population and stressing their urgent need for mental health services. While the developmental arc of TAY covers about a decade, the division between "pediatric" and "adult" services is often presented as a sharp divide, yet the age at which this divide occurs is different for different medical specialties, health care systems, education, the legal system, and

community agencies. Mental Health Services typically place this divide at age 18, and training programs in child and adolescent and general psychiatry generally reflect this.

TAY straddle both the child/adolescent and adult systems of care, but their needs are primarily met by general psychiatrists. General psychiatry residents, primarily trained to evaluate and treat psychopathology in adults, are less well trained to manage emerging mental illness in the context of the developmental issues in TAY. Fellows in CAP, while trained to formulate psychopathology within a developmental framework, are taught that adolescence as currently understood persists into the mid-twenties, yet generally do not see youth above the age of 18 years in their fellowship rotations. The specific mental health needs of TAY, coupled with the current system of inadequate treatment resources, provide an excellent rationale for including TAY/CSMH training experiences in both general and child psychiatry training programs.

This workshop is aimed to provide participants with the necessary tools and resources to develop TAY focused model curricula in their home institutions. Through the use of didactic, audience participation, and group discussion, participants will learn about existing training experiences and model curricula with TAY/CSMH within general and child psychiatry, and will have an opportunity to develop TAY specific competencies and begin to design their own model of a feasible and sustainable TAY curriculum at their home institutions. This workshop is intended to address Development Through the Life Cycle (MK1), and Treatment Planning and Management (PC3) Milestones.

Agenda
Intended audience: Training directors, associate training directors, chairmen, and residents.
Introductions: All presenters - 5 min
Background: -5 min
Current TAY Curricula: implementation/outcomes, presenters will describe and reflect on curricular models (handouts with overviews will be provided) - 20 min
Ideas, barriers, individual participants' action plan development: All presenters facilitating small groups - 40 min
Discussion and questions: All presenters- small group leaders report what each group identified, followed by discussion -20 min

“This is the Coolest Thing Ever!” – What You, and Your Learners, Will Say After Taking Your Didactic Curriculum Online

Presenters
Ross Yaple, MD
Ravinderpal Singh, MD
Kenneth Warren, EdD

Educational Objective
At the end of this presentation, the participants will be able to:
1. Identify internet-based platforms that can be used to create an online didactic program.
2. Describe how a variety of adult-learning/teaching methods can be facilitated by an online curriculum.

3. Understand issues including security measures, use of public vs. proprietary content, and the importance of a good relationship with your educational IT department.

Practice Gap

Adult-learning principles in medical education can present a variety of challenges to program directors and faculty involved with teaching younger and younger generations of medical students, residents and fellows. Shifting from traditional didactic models and PowerPoints to flipped classrooms and active learning paradigms requires a fair amount of preparation, curriculum design, and an ability to communicate expectations and objectives easily with the learners, all seemingly daunting tasks. Though rarely used in residency programs, the use of internet-based platforms as a centralized tool for curriculum management can help to solve these issues in an efficient manner, and opens the door for faculty, as well as learners, to contribute to significant innovations in learning and teaching.

Abstract

We have all had the experience of attempts to give that "really great" didactic on a particular topic, based on our wealth of knowledge (as well as previously prepared PowerPoint slides), only to find that we are undermined by factors including the trainees' busy clinical day, post-prandial blood flow to the gut and general lack of having read the pre-assigned article. Having experienced this several times at VCU, we set out to alter our didactic approach using a combination of active learning principles, flipped classroom, and problem-based learning strategies. As a fundamental part of these changes, we also decided to centralize our curriculum and create a website with the help of our medical school's educational information technology department.

This workshop is intended to demonstrate to program directors and faculty just how fun, interesting and efficient an online curriculum can be. Our experience of the benefits of this curriculum has been through a well-planned website, the trainees have permanent access to posted resources as well as goals, objectives and active learning assignments for each learning encounter. Use of the website allows for the freedom to utilize a variety of teaching approaches, from traditional didactic sessions to Just in Time Teaching (JiTT), Problem-Based Learning (PBL) cases, Process Oriented Guided Inquiry Learning (POGIL), Team-Based Learning (TBL), among others. Additionally, the platform allows for the generation of quizzes for PRITE Review sessions complete with anonymized data analysis, as well as for trainee contributions, including posting articles and procedures for Journal Clubs, reference resources from active learning portions of PBL, blogs, as well as comments and reviews of learning sessions. Finally, the platform can include embedded curriculum calendars as well as faculty development resources through which to enhance faculty teaching skills and to organize the curriculum, all centralized to one place.

This workshop will also address common concerns related to access management and security for the curriculum website, as well as potential pitfalls to avoid in terms of the use of specific content, especially proprietary content found online (videos, etc.). The presenters, while demonstrating existing products in use at VCU, will strive to discuss alternate products/platforms as well to promote a fair and unbiased representation of what is readily useful and available on the internet.

Agenda
The intended audience for this workshop includes any participants interested in use of technology in the didactic education of trainees and the use of adult-learning principles and teaching strategies. Participants DO NOT need to understand any form of computer coding to benefit from these strategies.
5 minutes – Introduction, Disclosures, Objectives and Overview
25 minutes – Presentation of Core Concepts, PowerPoint Slide Presentation
50 minutes – Interactive, Live Demonstration of Use of an Online Platform Including Content Generation
10 minutes – Consolidation, Discussion and Questions

When 5 is more than 3+2: Creating an effective Child Track for Psychiatry Residencies

Presenters
Edwin Williamson, MD
Dorothy Stubbe, MD
Sourav Sengupta, MPH, MD

Educational Objective
Participants will learn of different components of participating programs (SUNY Buffalo, University of Pittsburgh, Vanderbilt, and Yale) at each post-graduate level.
Participants will learn of the current climate of training, including the number and characteristics of current programs.
Participants will learn reasons for integrated training programs from three perspectives: workforce, training program and trainee.
Participants will learn the process of creating an integrated training track and recruiting for an integrated training track.
Participants will learn of challenges and obstacles to creating and maintaining an integrated training track.
Participants will participate in formulation of outcome measurements to track success of child psychiatry integrated training programs.

Practice Gap
1. There is a growing interest in cultivating "direct from medical school" training tracks for Child and Adolescent Psychiatry.
2. Despite this interest, there has been no research, collaboration between programs, outcome measurements or formulation of "best practices" for this training track.

Abstract
Objective:
To inform participants of the characteristics of an integrated training program that combines the components of General Psychiatry and Child and Adolescent Psychiatry, starting after medical school, often in some abbreviated time period. Participants will learn about the creation, management, recruitment and challenges of hosting an integrated training track within a Psychiatry residency program.
Background:
Over the last two decades, several psychiatry residencies have created integrated child and adolescent psychiatry training programs lasting between five and six years. Our

group, representing, Vanderbilt, SUNY Buffalo, Pittsburgh and Yale, have taken different approaches to an integrated training program. Until now there has been no formal meeting of the directors of these programs, no shared research and no "best practice" initiatives have been designed.
Methods:

- Representatives from the above integrated training programs will present on the following aspects of training:
  Different components of the programs at each PGY level
- The current climate of training, including number of programs and length of training
- Advantages to integrated training:
- Challenges and obstacles to integrated training programs

We will also have an opportunity for a Discussion/Question and Answer period to promote interaction between other programs that are considering integrated child tracks or who have already developed integrated child tracks. We will present some ideas and opportunities to join together in educational research projects, workforce recruitment efforts, and advocacy efforts.

Results:
This presentation does not include research findings. We expect participants to better understand components of an integrated child and adolescent psychiatry track. We expect interested training directors and CAP trainees to come away with a better understanding of how and why they might create their own integrated track at their respective training institutions. And for those participants already involved in integrated tracks, we expect that they will benefit from an exchange of ideas with other educators and the opportunity to collaborate on future projects that advance child and adolescent psychiatry training.

Conclusion:
Through this presentation we will bring together training program directors who host integrated programs, interested program directors, trainees and medical students. Through the Special Interest Study Group we hope to create a colloquium of integrated programs to share development strategies, “best practices,” potential research data and collaborations, as well as clinical and education programs.

Agenda
1. Intended Audience: Program Directors, Trainees, and students
2. Introductions (5-10 minutes) After introductions, we will break into 4 groups and rotate through the four stations.
3. Station 1: Logistics: Setting up a child fast track; The relationship between Child Program Director and General Psychiatry Program Director; State of the Field: Number of programs, characteristics; Outcome discussion: what outcomes would measure success in the establishment and management of an integrated training program? Discussion prompts: How do you work with coordinators? Do you establish a separate NRMP code? Who administers the program in areas like semi-annual reviews, CCC meetings and milestones? How do you get buy-in from a chair?; “What if.s”: Someone wants to leave the track? Someone wants to enter the track?
4. PGY1-2: Partnerships with Pediatrics; Integrating Supervision; Specialized rotations; Specialized academic projects and an integrated research track; Outcome measurement discussion: what outcomes would measure success in the first two years

of an integrated training program? Discussion prompts: What flexibility do you have in your programs? What child experiences do your residents typically engage in?
5. PGY3-5: Outpatient and Transition: Customizing outpatient clinics - Longitudinal CAP clinic example; Elective opportunities; Outcome measurement discussion: what outcomes would measure success in the transition years of an integrated training program?; Discussion prompts: What current outpatient experiences do your residents have? What could a resident who stays at your program continue?
6. Perspectives: Pros and Cons: Residency's perspective – Recruitment, Stability/forecasting PGY4 numbers; Fellowship's perspective – Recruitment, Building community and scholarly activity; Trainee's perspective – Predictability, Cost/effort, Career planning; Outcome measurement discussion: what outcomes would measure success from each perspective?
7. Recap/discussion 20 mins; Survey completion

Session 2 – Friday, March 10, 1:15-2:45 p.m.

3-Step Supportive Psychotherapy: A Brief Supervisory Manual for Busy Services

Presenter
Deborah Cabannis, MD

Educational Objective
After attending this workshop, participants will:
1. Be familiar with the 3 Step Supportive Psychotherapy Manual
2. Be able to use the 3 Step Supportive Psychotherapy Manual with a supervisee (resident)
3. Be able to teach the 3 Step Supportive Psychotherapy Manual to other supervisors (faculty)

Practice Gap
Supportive psychotherapy is widely used in the treatment of psychiatric patients. The ACGME recognizes supportive psychotherapy as a core psychotherapeutic modality to be taught in residency. Despite this, variability exists in supervision of residents on supportive psychotherapy techniques. Factors that may contribute to this are the lack of clear consensus on the knowledge and skills supervisors hope to impart on trainees and variability among supervisors. A survey of Psychiatry Residency Training directors showed that while supportive psychotherapy is the most widely practiced psychotherapy among residents, it receives less didactic and supervision time than other ACGME-designated core psychotherapeutic modalities (1). A recent survey of Columbia Psychiatry residents showed that residents received the least amount of supportive psychotherapy supervision on inpatient, ER, and CL settings, and a survey of US Psychiatry Residency training directors showed there is interest in teaching supportive psychotherapy in these settings, but that time and service requirements are major barriers (2,3)
1. Sudak, D.M. & Goldberg, D.A., Trends in Psychotherapy Training: A National Survey of Psychiatry Residency Training, Acad Psychiatry (2012) 36: 369.
2. Havel, LK (personal communication)

3. Blumenshine P, Lenet A, Koehler L, Arbuckle MA, Cabaniss DL. Thinking Outside of Outpatient Underutilized Settings for Psychotherapy Education. Academic Psychiatry. Acad Psychiatry (2016) [online publication before print].

Abstract
In response to the finding that time and service requirements are a barrier to having psychotherapy objectives for busy rotations such as inpatient, CL, and ER, we created the 3 Step Supportive Psychotherapy Manual for Busy Rotations. This 4 page manual is designed to be used by a supervisor/supervisee dyad in order to facilitate supportive psychotherapy supervision on busy services. The three steps are: 1) evaluating the patient's function; 2) setting realistic goals for the supportive psychotherapy, and 3) setting the frame for the treatment. The manual also suggests techniques that residents can use in order to achieve the goals they set. The manual should take no more than 15 minutes to go through, and thus is a very efficient tool for incorporating psychotherapy supervision on busy services. In this workshop, participants will observe a training video, and then work in groups to role play psychotherapy supervision using the 3 Step manual in response to vignettes.

Agenda
1. Introduction to the 3 Step Supportive Psychotherapy Manual, with information about the practice gap (5 minutes)
2. Training video (15 minutes)
3. Group work - role play using the 3 Step Supportive Psychotherapy Manual in response to vignettes (20 minutes)
4. Sharing group work (20 minutes)
5. Discussion and trouble-shooting (20 minutes)
6. Next steps (10 minutes)

Back to the Basics of Faculty Development- Encouraging Faculty to Teach on the Fly and Love It!

Presenters
Cosima Swintak, MD
Joan Anzia, MD

Educational Objective
At the completion of this workshop, program directors will be able to:
1. Teach their faculty to perform a brief but thorough learner assessment
2. Acquaint their faculty with a range of interactive learning formats - team based learning, problem based learning and flipped classrooms
3. Help their faculty to apply the “One Minute Preceptor” approach to multiple learning situations

Practice Gap
Ever increasing financial pressures in academic departments, exponential advances in technology and the electronic medical record, as well as a new generation of millennial learners all mean that training residents “the way we’ve always done it” is often no longer possible or even desirable. Many program directors find themselves in the

position of needing to motivate their faculty to make changes and think of "teaching moments" in a new light. Helping faculty to develop skills necessary to teach in multiple different formats and venues can go a long way in helping maximize learning opportunities for residents. It can also increase faculty comfort and satisfaction.

Abstract

The "One-minute Preceptor", a five-step "micro skills" model of clinical teaching was first introduced in the family medicine literature in 1992. It provides a framework around which a learner/teacher conversation can be built. Key features of brevity, easy to grasp concepts and a focus on key teaching behaviors make it applicable in multiple learning environments and settings.

In this workshop, we will review the five micro skills of the "one minute preceptor" model: 1) Get a commitment, 2) Probe for supporting evidence, 3) Teach general rules, 4) Reinforce what was done correctly and 5) Correct mistakes. We will then collaboratively perform a learner assessment, modeling how simple it can be to both do and demonstrate. We will then review a variety of interactive learning formats and why they are particularly applicable to today's millennial learners in small and large group conversation. Finally we will talk about the role of modeling good clinical instruction in psychiatric practice, how we are currently preparing our trainees to assume that role, and what we as psychiatric educators believe would be the ideal approach- - again using both large and small group formats.

By the end of the workshop, attendees will be ready to think about next steps in implementation of a faculty development curriculum which will maximize faculty efficiency and satisfaction and optimize learner opportunities.

Agenda

5 minutes: Welcome and orientation
5 minutes: Overview of the 5 micro skills of the "one minute preceptor" approach
15 minutes: Large group discussion and demonstration of performing a learner assessment
15 minutes: Large group discussion on a variety of interactive learner formats
10 minutes: Small group discussion of millennial learner needs
5 minutes: Large group review of smaller group discussion
5 minutes: Large group demonstration of applying the "one minute preceptor" in a variety of situations
10 minutes: Small group discussion or partner pairing to practice micro skills
20 minutes: Large group discussion of feedback and next steps.

Da Vinci code, Take 2: Understanding, interpreting and decoding the PRITE examination and reports

Presenters

Vishal Madaan, MD
Arden Dingle, MD
Robert Boland, MD
Marcy Verduin, MD
Lauren Osborne, MD

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

1) Understand the relevant uses of the PRITE examination for program and resident assessment and improvement
2) Appreciate the benefits, limitations and uses of PRITE exam reports;
3) Understand the importance and meaning of the scores in the PRITE reports;
4) Review the applicability of PRITE reports to support the educational needs of psychiatry trainees and programs.

Practice Gap
The PRITE exam has been utilized not only as an educational tool to assess program dissemination of knowledge, but also as means of evaluating the acquisition of medical knowledge in psychiatric trainees. Recent changes in PRITE reporting, especially replacing the percentile scores with standard scores have resulted in a plethora of questions from program directors, ranging from how best to interpret these data, to how to apply these to residents' career development.

Abstract
Over the years, the PRITE exam has evolved from primarily an educational activity to an increasingly formal high-stakes examination for residents and program directors alike, with its use related to milestones and program evaluation. In fact, programs have developed accountability programs as well as remediation measures based on their residents' PRITE performance. Since the PRITE was developed as an educational tool, residents receive a copy of the exam and the answers every year; as a result, most of the questions each year are necessarily new. That fact, combined with the small pool of test takers, means that the PRITE, unlike other national standardized exams (e.g. USMLE), is not normed. As a result, reported percentile ranks varied widely in response to very minor differences in the number of questions answered correctly. Percentiles therefore did not provide truly meaningful information when comparing an individual's performance to local and national peers. To improve the accuracy and reliability of the PRITE reports, percentile ranks are no longer going to be reported and programs are going to be encouraged to use standard scores. Standard scores offer a better frame of reference to interpret the examination results since they are transformed from raw scores generated by the number of correctly answered questions.

In this interactive workshop, the PRITE and Child PRITE editors will discuss the new outline for each exam, review the process of exam development, provide information on standard scores, explain how to use these scores to interpret resident and program performance, and elaborate the content of the different types of reports sent to program directors. Finally, we will talk about using the PRITE as a mechanism to evaluate ACGME milestones. Participants will be provided ample opportunity to seek clarifications and provide feedback on the PRITE exam in both lecture and small group formats.

Agenda
10 mins - Introduction and overview
30 mins - Interactive lecture to review and actively engage the audience while presenting specific PRITE reports, reviewing the meaning of the reported information, and recommending approaches for interpretation of the exam reports
30 mins - Break into small groups and review examples of PRITE reports and their

inclusion in resident (including milestones) and program evaluations
20 mins - Questions, summarize and wrap up

From Babies to Boards: Navigating Parental Leaves During Psychiatry Training

Presenters
Sandra DeJong, MSc, MD
Sol Adelsky, MD
Tamar Katz, MPH, MD
Felicia Smith, MD

Educational Objectives
By the end of this session, participants will be able to:
- Describe 5 top concerns of residents considering parental leave during training
- Describe 5 top concerns of training directors in working with residents requesting a parental leave during training and how to address these in program policies
- Identify frequent challenges in applying parental leave principles and policies to real-life scenarios and suggest ways to resolve them.

Practice Gap
As more women engage in medical training (up to 70% in CAP fellowships, for example), as the overall culture of medicine has changed, and as millennial learners offer different expectations of balancing personal and professional life during training, psychiatry training directors are increasingly faced with managing male and female residents' parental leaves. Some authors have estimated that up to 44% of women residents will have their first baby during training (1). ACGME and other training-focused organizations provide few guidelines in how parental leaves should be handled, during either residency or fellowship. While some institutions and Graduate Medical Education offices develop parental leave policies for trainees, many programs are left on their own to do so. This workshop will explore the primary concerns of both trainees and training directors in successfully managing parental leaves by focusing on a series of clinical vignettes. It will then critically assess strengths and vulnerabilities of existing parental leave policies, and consider what core issues need to be addressed in a policy that adequately protects the needs of residents and training directors while satisfying compliance requirements. Finally, it will examine potential challenges in applying policies to practice.

Abstract
This workshop aims to clarify for training directors the critical concerns of both trainees and programs in considering a resident's parental leave, and to help programs develop an appropriate parental leave policy. It will begin with two trainees, one a general psychiatry resident and the other a CAP fellow, describing their experience with parental leaves during training and their primary concerns during the process. Next, two training directors, one from a general psychiatry residency and the other from a CAP fellowship, will share their experience and primary concerns. The group will then divide into small groups and each will discuss a different vignette. The vignettes aim to describe a range of specific situations and concerns. The large group will then reconvene to share thoughts on the vignettes. A brief discussion of parental leave policies will follow,

including compliance with ACGME, HR and house officer unions. The small groups will then critically assess sample policies with the goal of culling core principles and best practices to present to the large group. Discussion will include how to best apply policy to practice. Participants are invited to bring copies of parental leave policies from their home institutions, which may be explored during small group discussion.
(1) Sayres M, Wyshak G, Denterlein G, Apfel R, Shore E, Federman D. Pregnancy during residency. N Engl J Med. 1986;314:418-423.

Agenda
1) "Top 5 Trainee Concerns In Navigating Parental Leave," Adelsky, Katz (10 mins)
2) "Top 5 Program Director Considerations Around Trainee Parental Leave," Smith, DeJong (10 mins)
3) Small group discussions of vignettes (10 mins)
4) Large group discussion of small group proceedings (15 mins)
5) Introduction to parental leave policies, DeJong, Smith (5 min)
6) Small group discussions of key policy elements, review of policies provided by participants (15 mins)
7) Large group discussion and crowd-sourcing of best practices (15 mins)
8) Open discussion, Q&A (10 mins)

Lessons Learned from the IMG Training Experience: What Lies Ahead?

Presenters
Nyapati Rao, MS, MD
Jacob Sperber, MD
Richard Balon, MD

Educational Objective
Upon completion of the workshop, participants will be able to:
1. Trace the place of IMG physicians in the US medical workforce, including the essential roles they have played which USMGs are less likely to fill.
2. Define 3 specific educational interventions which orient IMG trainees to the expectations of US psychiatric residencies
3. List 3 ways IMG residency applicants can increase their chances of being selected for residency
4. Explain two current changes in US medical practice which affect the opportunities for immigrant physicians

Practice Gap
1. Training Directors can be more aware of cultural differences which affect the way international medical graduates understand US patients
2. IMG trainees can have deeper understanding of the goals of the competencies and milestones
3. Clinicians can have deeper grasp of the ways immigration trauma affects IMG physicians

Abstract
Psychiatry Residency Training in the US has undergone radical revision in the past

decade, with increased focus on Competencies, Milestones and the NAS, and CSVs. Throughout the decade, 25% of US psychiatry residents have been international medical graduates (IMGs). Under the editorial leadership of two experienced psychiatry education experts, with contributions by many leaders in the field, a summary of the wisdom learned from training IMG residents, particularly in psychiatry, has been published as International Medical Graduate Physicians - A Guide to Training, Editors: Rao, Nyapati R., Roberts, Laura Weiss © 2016. The timing of this volume's appearance could not be more synchronous with America's cultural crisis related to immigration. The recent presidential campaign exposed Americans to campaign rhetoric which openly attacked ethnic and immigrant groups in a way which has not been seen for a long time.

Discrimination and prejudice have been a part of the obstacles immigrant physicians face when seeking to enter the US medical profession, in addition to the complex educational, bureaucratic and cultural trajectory they must traverse. This workshop will focus on multiple pearls of wisdom culled from the chapters of this new training guide, consisting of lessons IMG doctors must learn and lessons we as teachers must learn from them. The list of authors includes a rich array of experienced trainers of IMGs who will offer a balanced view of the complexity of training IMGs to become outstanding psychiatrists. The workshop will review evidence about the strengths that more experienced IMGs bring to their professional roles, as well as their specific educational needs.

Despite an acutely-felt US shortage of psychiatrists, especially child psychiatrists, there has been a lack of political will to expand the number of residency training slots. In addition, the number of American US and Caribbean and US osteopathic medical graduates has increased to the degree that non-US IMGs will no longer be needed to fill US residency slots. What factors should influence how we weigh the applications of international graduates against US graduates? And what have we learned from the training of IMGs that will change our understanding of the practice of psychiatry in the current cultural crisis affecting us all. Participants in the workshop will receive copies of the Guide.

Agenda
1. Introduction: Dr. Rao, Lessons Learned from the IMG narrative (10 minutes)
2. Participant discussion (10 minutes)
3. Lessons learned for helping IMGs: Dr. Balon (15 minutes)
4. Participant discussion (10 minutes)
5. Cross cultural issues re professionalism and ethics: Dr. Sperber (10 minutes)
6. 3 IMG Trainee Case studies for participant discussion (30 minutes)
7. Summary: Dr. Rao (5 minutes)

Not All Evidence is an RCT: An EBM Refresher to Invigorate Your Teaching

Presenter
Jane Gagliardi, MSc, MD

Educational Objective
By the end of this workshop (or after reading the poster and discussing with the presenter), participants will:
1. Be able to describe the "hierarchy of evidence" and rationale
2. Be able to describe major study designs utilized in creating the evidence base for psychiatry
3. Gain experience using a case-based approach to learn the "evidence cycle"
4. Use accepted validity criteria to go through the methods involved in an article dealing with therapy
5. Take away ideas for implementing interactive and case-based teaching in evidence-based medicine

Practice Gap
Evidence-based medicine (EBM) is described as the "conscientious, explicit and judicious use of the current best evidence in making decisions about the care of individual patients." A functioning knowledge and use of EBM is embedded in core competencies of systems-based practice and practice-based learning and improvement, and implementing the best evidence on a systems-wide level is a central feature of quality improvement activities. Though EBM is best conceived as a clinical tool, it is not possible for the training director to ascertain that all faculty members are skilled in its implementation or instruction. Some training directors may lack confidence in their own knowledge and skills to instruct their faculty and trainees in the use of EBM.

Abstract
Evidence-based medicine (EBM) was introduced in the mid-1990s and, at the time, was considered somewhat controversial. Initially limited to cardiology and medicine subspecialty practice and education, the use of EBM has expanded to other disciplines, including psychiatry, and is inherent in the ABPN-ACGME Milestones, particularly in systems-based practice and practice-based learning and improvement competencies. In reality, the conscientious, explicit and judicious use of the current best evidence in the care of individual patients is best practiced in the clinical arena, using EBM as a clinical tool. This workshop is designed as a refresher / booster to help training directors and faculty members re-energize regarding their use of and teaching regarding EBM.

Agenda
The intended audience is training directors, associate program directors, core faculty, vice chairs, and residents interested in facilitating interactive sessions about topics in EBM.

The 90-minute workshop will be conducted as follows:
30 minutes - Introductions, Background and Rationale – participant introductions, discussion of EBM and how it is taught, explanation of curriculum development, Introduction to EBM and Hierarchy of Evidence
10 minutes - Interactive game: Name That Study Design
40 minutes - Introduction of a case to use in teaching EBM with Interactive session centering on an issue of therapy
10 minutes - Take-Home / Intentions for Home Programs – participants brainstorm cases and set intentions for teaching EBM in their own programs

Preparing Psychiatrists for Value-Based Care: Applying Principles of Collaborative Care in your training program

Presenters
Anna Raztliff, PhD, MD
Hsiang Huang, MPH, MD
Tristan Gorrindo, MD

Educational Objectives
1) Describe how the core principles of Collaborative Care deliver value-based mental health care;
2) Utilize the APA-SAN training to develop faculty expertise in Collaborative Care and develop a plan for enhancing integrated care training for residents at their own institution
3) Describe a national practice transformation initiative that will provide opportunities for graduating residents.

Practice Gap
Interdisciplinary teamwork for integrated care is a key psychiatric competency, including the new milestone SBP4, which focuses on developing skills to provide psychiatric consultation to non-psychiatric medical providers and non-medical systems (e.g., military, schools, businesses, forensic). However, teaching psychiatric trainees to work as part of an integrated care team is often challenging because of lack of faculty development opportunities and other institutional barriers. This workshop will provide practical solutions to address this gap.

Abstract
Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving healthcare reform landscape using Collaborative Care. This emerging practice opportunity allows a psychiatrist to leverage their expertise through a team-based approach to care for a population of patients in primary care. There are challenges, however, to providing collaborative care training opportunities in resident training programs including lack of funding for programs and lack of faculty development opportunities. The APA has received a grant to support the development of a workforce of psychiatrists trained in Collaborative Care principles which may help address this need. This workshop will describe the principles of Collaborative Care: patient-centered team care, population-based care, measurement-based treatment to target, use of evidence-based strategies and accountable care. Participants will complete several exercises from the APA's training toolkit, reflect on how collaborative care principles can be utilized in the practice settings available at academic institutions and will work together in small groups to design training plans for including Collaborative Care in their training programs. Lastly, in an effort to connect trainees with primary care practices looking for psychiatrists trained in collaborative care, participants will be oriented to the CMS Transforming Clinical Practice Initiative (TCPI), APA's Support and Alignment Network (SAN), and the national network of Practice Transformation Networks (PTNs) which are seeking to achieve large-scale health care transformation through innovative care strategies.

Agenda
Teaching methodologies and the time allotment for each:
20min Collaborative Care principles as part of value-based care Anna Ratzliff, Hsiang

Huang: Didactic
20min Which principles do you use currently? Anna Ratzliff, Hsiang Huang: Reflection and discussion
15min Overview of APA-SAN education approach Tristan Gorrindo: Didactic
25min Plan for Integrated care curriculum development All: Small Group Activity
10min Closing Discussion All: Group Discussion

In the first 20min, we will use a didactic approach to describe Collaborative Care principles as part of value-based care which will be the foundation of the workshop. The next 20min will be used for a reflection exercise and discussion to identify how these principles apply to the participant's practice and educational settings. The next 15min will provide a didactic overview of APA-Support and Alignment Network education approach and a description of the national Transforming Clinical Practices Initiative. We will then use 25min for a small group activity for participants to plan how to utilize these resources at their own institution. The last 10 min will be used for a closing discussion and reflection on plans developed during the small group activity.

Problem Residents and Resident Problems: Across the Generational Divide

Presenters
Kim Lan Czelusta, MD
Carol Bernstein, MD
James Lomax, MD

Educational Objectives
1) Review guidelines in the assessment and management of resident problems,
2) Systematically develop an intervention plan, in collaboration with GME office, legal counsel, and/or human resources, to achieve specific, desired outcomes,
3) Consider generational characteristics and how to address conflicting perspectives.

Practice Gap
Training directors spend significant time assessing residents with a variety of difficulties that interfere with residents' training. As documentation requirements for residency training continue to increase and licensing agencies continue to request more details about graduates, residency directors must carefully balance supporting residents while helping them appreciate professional concerns that could eventually result in official negative action. A better understanding about the millennial generation can be helpful to guide effective tools for addressing concerns.

Abstract
This workshop is a reconfiguration of prior workshops on strategies and ethical obligations of the training director with problem residents and resident problems. Challenges and opportunities of working with millennials will be reviewed, with a specific focus on "softer" issues such as professionalism, attendance, social media, work/life balance, etc. General guidelines about working with residents with difficulties will be discussed by three current or former Residency Directors. During the latter half of the workshop, participants will be divided into small groups. In each group, participants will

have the opportunity to share their own experiences and challenges, and the workshop presenters will lead the small group consultation.

Agenda
Overview of guidelines in assessment and management of problems (20 min)
Sample cases involving attendance, work/life balance, social media and professionalism will be presented (20 min)
Breakout group round#1: audience will be split into three smaller groups, with one presenter leading each small group consultation (20 minutes)
Breakout group round #2; presenters will rotated to a different small group to continue consultation with perspective of different presenter (20 minutes)
Wrap up as larger group about recurring themes and experiences among different programs (10 minutes)

Recruitment Tips, Tricks and Turbulence: From Application Avalanche to A+ Intern Class

Presenters
Jessica Kovach, MD
Anna Kerlek, MD
Mark Servis, MD
John Spollen, MD
Glenda Wrenn, MD

Educational Objective
At the end of this workshop, participants will be able to: 1) discuss factors which contribute to medical student recruitment into psychiatry 2) be aware of the most recent data regarding applications from LCME, Osteopathic, and FMG schools 3) Discuss common barriers to effective recruitment and "best practices" to address these barriers 4) Discuss ways to continually adapt to changing recruitment pressures.

Practice Gap
The purpose of the Recruitment Committee is to solicit and address member concerns related to recruitment. The recruitment committee conducted a survey of AADPRT members in September and October 2016 in order to ascertain current member needs. Recent dramatic increases in the number of applicants can be managed in different ways, but the extent of this challenge has fueled concern among PDs that they are not recruiting the best applicants for their program as effectively as in the past. Other barriers to effective recruitment include competing demands for PDs and faculty during recruitment season, geographic location, and ability to accurately discern applicant interest in the program. Across the continent, program directors are struggling to find solutions to these and other common problems, with few opportunities to engage in shared problem-solving with other psychiatry program directors.

Abstract
The purpose of the Recruitment Committee is to solicit and address member concerns related to recruitment. The recruitment committee conducted a survey of AADPRT members in September and October 2016 to elicit member needs in response to recruitment-related concerns endorsed by several members anecdotally and on the

listserv. The most commonly endorsed barriers to effective recruitment include lack of PD and faculty time, geographic location, and ability to accurately discern applicant interest in the program. Eighty-four percent of respondents saw an increase in the number of applicants from 2014 to 2015, 42% offered more interviews, and 39% ranked more applicants than the previous year. Approximately half of respondents think that psychiatry is increasingly being used as a "back up" specialty, and 79% think that highly qualified applicants are using interview slots for back up reasons. Across the continent, program directors are struggling to find solutions to common problems. While respondents shared many recruitment "best practices" with the committee through the survey, they also responded that they were much more likely to communicate with psychiatry clerkship directors, non-psychiatry program directors, and fellowship directors within their own institution than to do so with other psychiatry program directors.
In this workshop, we will review the most recent NRMP and ERAS data regarding applications as well as recently-published data about factors affecting medical student choice of psychiatry as a career. An overview of program director response to nationwide trends in recruitment elicited by the 2016 AADPRT Recruitment Committee survey will be summarized. We will then facilitate small group discussion of barriers to effective recruitment and strategies to address these barriers. The focus of discussion will be on sharing practical tips and identifying specific strategies that program directors can bring to their home institution.

Agenda

Introduction: (10 min)
Introduce workshop members, have participants share their name, position, and what they are hoping to gain from the workshop. Introduce the purpose and structure of the recruitment committee, review website recruitment resources (demo on-screen).

Presentation #1 (10 minutes)
Presentation of data on medical student career goals & psychiatry. Who is going into psychiatry, and what are the school/programmatic factors that we know affect recruitment into psychiatry?

Presentation #2 (10 minutes)
What are the current recruitment numbers? Key findings from NRMP post-match survey.

Presentation #3 (10 minutes)
How are program directors responding to increased volume of applications and other challenges?
Presentation of key findings from 2016 Recruitment Committee survey including qualitative summary of solutions shared by members.

Interactive Small Groups (35 minutes)
In groups of 3-5, participants will be guided through two rounds of facilitated discussions exploring: 1) Increasing number of applications and other common barriers to effective recruitment facing programs and 2) Specific strategies and practices that have been helpful to address challenges. Small groups will include several members of the recruitment committee who will also exchange ideas.

Teaching Cultural Awareness: An Experiential Method

Presenters
Zsuzsa Meszaros, MD
Nanette Dowling, DO
Ayame Takahashi, MD
Mario Fahed, MD
Mirabelle Mattar, MD

Educational Objective
1. To provide an overview of existing methods to teach cultural awareness and sensitivity in medical settings.
2. To introduce existing standardized interviews (APA's Cultural Formulation Interview, Brief Cultural Interview 2009) and assessment tools (Cultural Sensitivity and Awareness Checklist) for cultural formulation.
3. To share examples of culturally challenging interviews.
4. To explore the usefulness of experiential learning techniques in teaching cultural awareness.

Practice Gap
Our nation is rich in cultural and racial diversity. The ACGME has recommended that psychiatry residency programs "should provide residents with instruction on 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." Attending physicians and residents are reluctant to address culturally sensitive topics during routine clinical interactions. Standardized interviews are too time consuming to administer in clinical settings. In the safety of a peer support group, experiential learning techniques may promote cultural awareness and sensitivity.

Abstract
"Culture is an organized group of learned responses, a system of ready-made solutions to the problems people face that is learned through interactions with others in society [1], [2]."It includes beliefs, customs, arts of a particular society, group, place or time. Residency training programs struggle to find curricula to foster cultural sensitivity and awareness.

Multiple approaches have been attempted in the past. These include culture-sensitivity groups, didactic courses, field experiences, study groups, grand rounds, journal club, clinical experiences, practicum experiences [3]. Standardized cultural formulation interviews and assessment tools are available, but rarely utilized. There is no consensus on a stepwise curriculum to sensitize residents to culture-bound biases throughout the course of residency training.

At Southern Illinois University (SIU) residents attend a sociocultural psychiatry class. Cultural barriers to learning psychotherapy are explored. Residents are required to write a short ethnographic paper, and at the end of the class everyone brings a food dish that is representative of their culture.

At the SUNY Upstate Department of Psychiatry, we shaped our curriculum with the awareness that an education in culturally bound nuances is not enough to make one more culturally competent. Person to person variations are paramount. To that end, we turned to an experiential-based approach. It allows residents to learn to inquire about cultural variations with their own peers in a safe environment. This skill set takes several years to acquire. It begins in the very first month of training, during our month-long "Cornerstone" block, with the "Family of Origin" seminar. Residents are encouraged to introduce their family and explain how they came to be who they are. We focus on the role of culture, ethnicity, religion and institutions in shaping personality. In the third year of training, residents attend a "Self, Society and Culture" seminar. This 6-month long, 90 min weekly seminar offers each resident an opportunity to develop skills pertaining to awareness of his or her personality and cultural heritage in the context of clinical practice.

This workshop provides an opportunity to learn about our own unconscious biases observing a videotaped interview and completing a Cultural Sensitivity and Awareness Checklist. We will introduce residents and fellows, who attended our "Family of Origin" and "Self, Society and Culture" seminars, to role-play a presentation and to share their insights. Finally, we will demonstrate a Cultural Formulation Interview.

[1] P. Seibert, P. Stridh-Igo, and C. Zimmerman, "A checklist to facilitate cultural awareness and sensitivity," J Med Ethics, vol. 28, no. 3, pp. 143–146, 2002.
[2] M. Amodeo and K. L. Jones, "Viewing alcohol and other drug use cross culturally: A cultural framework for clinical practice," Families in Society: The Journal of Contemporary Social Services, vol. 78, no. 3, pp. 240–254, 1997.
[3] LoboPrabhu, "A Cultural Sensitivity Training Workshop for Psychiatry Residents," Acad Psychiatr, vol. 24, no. 2, pp. 77–84, 2000.

Agenda
1. Introduction/Icebreaker - 5 min
2. Overview of existing methods to teach cultural awareness and sensitivity (Power Point Presentation) - 10 min
3. The SIU method for teaching cultural awareness: sociocultural psychiatry class (Power Point Presentation) - 10 min
4. Video vignette #1, Cultural Sensitivity and Awareness Checklist - 15 min
5. Role-playing our experiential method - 15 min
6. Discussion / Questions - 10 min
7. Video vignette #2, Cultural Formulation Interview - 15 min
8. Wrap-Up - 10 min

The Family CSE. Demonstrating competency in family interview and assessment as a requirement for graduation in Child and Adolescent Psychiatry Training (and an option for General Psychiatry, too!)

Presenters
Kathleen Baynes, MD
Alma Guerra, MD
John Sargent, MD

Michael Scharf, MD

Educational Objectives
After attending this workshop, participants will be able to:
1. Define the unique importance of family assessment in Child and Adolescent Psychiatry training

2. Discuss the role of family assessment in General Psychiatry training
3. Identify challenges, barriers, and opportunities to creating didactic and clinical experiences that target family assessment
4. Advocate for inclusion of a family based assessment CSE as part of process for Board Certification in Child and Adolescent Psychiatry

Practice Gap
AACAP practice parameters highlight the profound role of the family assessment in the psychiatric care of children and adolescents. ACGME and ABPN further support the critical role of family assessment in fellowship training by elaborating a sophistication of skill in family engagement as targeted and evolving milestones in eleven of twenty-one competencies in the Milestone Project. Child and adolescent fellows see strong family work as critical to patient care and an important required competency, yet their perception is that skills and training in family assessment is relatively weak. This discrepancy between valuation of the skill and perceived competency in the skill is further compounded by an absence of an instrument to assess educational outcomes. As long-term hospital and institutional settings are increasingly limited, the educational value of a strong assessment of the family becomes increasingly important in treating the precipitating and perpetuating factors of psychiatric illness in children. These same training issues are relevant for the child and adolescent training within general psychiatry residency and also have implications for working with families and families of patients across the lifespan.

Rait DS. Family therapy training in child and adolescent psychiatry fellowship programs. Acad. Psychiatry. 2002 Nov 1; 36(6): 448-51.

Abstract
Family assessment is a critical component of the psychiatric assessment of the child, and may be useful in working with patients across the lifespan. This includes an appreciation of the precipitating, maintaining and potentially perpetuating factors in the family that contribute to illness in the child/identified patient. Family members offer information about strengths, challenges, and resources, as well as history and narrative. Family interventions have positive outcomes in mood, psychotic, impulse and behavioral disorders. This workshop will highlight the critical importance of training in high quality family assessment in an age when healthcare resources are directed away from institutional care and towards family and community based resources. The workshop will present complimentary didactic and clinical training experiences in family assessment and therapy in general psychiatry and child and adolescent psychiatry programs. The workshop will present a rationale for including a family based clinical skills evaluation as a requirement for graduation and a component of ABPN board certification in Child and Adolescent Psychiatry. A model instrument to facilitate and document this evaluation will be presented and discussed. Presenters will facilitate discussion of enhanced family assessment training in participants' home institutions.

Milestones Addressed: PC1 2.2, 2.7, 3.1, 3.5, 4.5; PC2 1.1, 2.1, 4.2, PC3 1.1, 3.2; PC4 2.3, 2.4, 3.4, 4.2, 4.5, 5.1; PC5 1.2, 3.3; MK1 2.5, 3.4; MK4; MK6 3.2; SBP1 3.1; SBP3 2.2; PROF1 1.2, 4.4

Agenda
Intended audience: Training directors, associate training directors, chairmen, and residents.
1. Outline practice gap regarding family based assessment and family therapy training in both psychiatry residency and child and adolescent psychiatry fellowship (5 min)
2. Outline critical need to strengthen family assessment in training (10 mins)
3. Highlight a diverse range of didactic and clinical teaching; mirror based co-taught family therapy, supervised family assessment and psycho-education across inpatient settings, supervised outpatient family therapy, core didactic curriculum (25min)
4. Ideas, barriers, individual participant action plan development: All presenters facilitating small groups (30min)
5. Small group feedback, closing discussion, and summary (20min)

The Zero Suicide Model: Bringing evidence-based suicide prevention practices to psychiatry clinical training

Presenters
Beth Brodsky, PhD
Sidney Zisook, MD
Joel Bernanke, MD
Yael Holoshitz, MD

Educational Objectives
1. Participants will learn about the National Zero Suicide Initiative and how it informs filling the gap of best practice suicide prevention training in residency
2. Participants will learn about evidence based suicide risk assessment and safety planning training for residents
3. Participants will engage in an interactive discussion regarding overcoming obstacles to incorporating suicide prevention best practice training into residency training programs.
4. Participants will leave this workshop with a model they can use to incorporate best practice suicide prevention training that addresses the current gap in residency education

Practice Gap
The Zero Suicide model is a strategic framework put forth by the National Strategy for Suicide Prevention and created by the National Action Alliance for Suicide Prevention, for creating a systematic approach to suicide prevention in the health care system. It promotes the development and dissemination of evidence-based and best practice interventions for suicide prevention. Psychiatrists, as inpatient and Emergency Department Attendings, and as outpatient clinicians with hospital admitting privileges, are often on the front lines in treating individuals at risk for suicidal behavior and making decisions about hospitalization. Yet, standard psychiatric clinical training generally does not include direct instruction or training in the best practices put forth and recommended

by the Zero Suicide model. A national survey of chief psychiatry residents (Melton and Coverdale, 2009) suggests that, while a majority of residency programs routinely provide basic instruction in the recognition of risk factors and warning signs for suicide, learning how to manage these risk factors and warning signs warrants further attention. Thus, current standard levels of instruction may leave graduating residents feeling under-equipped in the clinical management of suicidal behaviors, which may detract from willingness to and confidence in doing so. Training residents in conducting the most up to date, evidence -based interventions can enhance a sense of competence and responsibility as future psychiatrists to feel able and willing to treat patients at risk for suicide, as well as to more effectively manage the associated anxieties and pressures. Given the alarming increase in the suicide rate in this country over the past decade, and the lack of suicide prevention-specific training, residency training programs are a crucial point of intervention that needs to be examined and targeted for improved delivery of evidence based and best practices. To address this training gap, the Zero Suicide model provides a framework for explicit repackaging of current suicide prevention training as well as the incorporation of evidence based and best practices for suicide risk assessment and suicide-specific clinical interventions into psychiatry training curricula.

Abstract

Over the past ten years, deaths by suicide have dramatically increased across the US. In 2014, there were 42,773 suicide deaths, an increase of 4% from the previous year and a 32% increase over the past decade (CDC WISQARS, 2014). The Zero Suicide model is a strategic framework put forth by the National Strategy for Suicide Prevention and created by the National Action Alliance for Suicide Prevention for creating a systematic approach to suicide prevention in the health care system, and it promotes the development and dissemination of evidence-based and best practice interventions for suicide prevention. Yet, standard psychiatric clinical training generally does not include instruction in these best practices, or in any suicide-specific clinical intervention other than basic risk assessment (asking about current suicidal ideation, planning and intent), contracting for safety, and decision making regarding hospitalization. To address this gap, this workshop will familiarize participants with best practice suicide prevention interventions, and learning materials that have been developed and incorporated into the Columbia psychiatry residency training program, as models for dissemination for training and clinical practice. Beth Brodsky, Ph.D., a suicide prevention researcher and educator, will present an overview of the Zero Suicide initiative, including a review of Zero Suicide recommendations for clinical management of suicidal behavior, based on evidence-based and best practices for suicide risk assessment, brief intervention, and guidelines for enhanced monitoring within ongoing treatment as well as during the high suicide risk periods of care transition. She will present how the Zero Suicide framework can inform the “repackaging” of existing suicide prevention training that may already be taking place, as well as identify and address the gaps in evidence based training. Sidney Zisook MD, Distinguished Professor and Psychiatry Residency Training Director at the University California San Diego, will present the opportunities and obstacles for incorporating suicide prevention best practices into residency training programs, and how this type of training might best be mapped onto existing clinical rotations. Joel Bernanke MD, a PGY-IV Columbia psychiatry resident, will present Silverman’s “Suicide Risk Assessment and Suicide Risk Formulation” model and the Columbia Suicide Severity Rating Scale (C-SSRS) to teach risk assessment and therapeutic risk management in residency training. Yael Holoshitz MD, a public psychiatry research and clinical psychiatrist, will present an overview of the Safety Planning Intervention, a best practice alternative to “contracting for safety”, and efforts to incorporate safety planning

training into the Columbia University psychiatry residency program in different clinical settings. The workshop will culminate in a discussion led by Drs. Zisook and Brodsky with participants regarding overcoming obstacles to the introduction of these learning materials into residency training programs as well as into ongoing practice of clinical psychiatry.

Agenda
I. Introduction - The gap, and Zero Suicide as a framework for best practice suicide prevention training - Beth Brodsky, Ph.D. – 15 minutes
II. Opportunities and obstacles: How to incorporating ZS model into residency training: Sid Zisook – 20 minutes
III. Assessment: Suicide risk management training at Columbia – Joel Bernanke – 15 minutes
IV. Intervention: Safety Planning Intervention training at Columbia–Yael Holoshitz, 30 minutes
V. Concluding discussion – moderated by Dr. Zisook and Brodsky – 10 minutes

Unconscious Bias and Stereotype Threat in the Clinical Setting – Causes, Effects, and Remedies Through Teaching

Presenters
Erick Hung, MD
Demian Rose, MD, PhD
Laura Kaplan, MD
Andrea Rosati, PhD, MD
Amanda Wallace, MD

Educational Objective
1. Appreciate and describe how individual biases may impact the clinical teaching environment.
2. Define the concept of stereotype threat and appreciate its impact on the educational environment.
3. Discuss and apply teaching strategies (e.g. structured feedback) to mitigate the impacts of stereotype threat on one's own learners.

Practice Gap
Promoting workplace diversity and addressing inequities is an essential value in graduate medical education. As described by the AAMC and the ACMGE through CLER, workplace diversity is a topic that has received national attention in its importance to medical education. Addressing disparities in the workplace is critical in order to optimize the learning environment. There is currently a gap in policies and curricular interventions to address unconscious biases in the workplace.

Abstract
Unconscious biases and stereotypes (with respect to gender, race, ethnicity, sexual orientation, and disabilities) exist in the workplace and can negatively impact the environment amongst faculty, staff, and learners and the patients to which these groups serve. Specifically, stereotype threat, the situational predicament in which people are or feel themselves to be at risk of confirming a negative stereotype about their social group,

can negatively the performance of patients, our students, our staff, and our faculty. Acknowledging the stereotype threats that exist in medical education and developing strategies to mitigate their effect on learners are critical to address disparities in workplace performance. This workshop will provide an overview of unconscious bias in the workplace and explore stereotype threat in medical education. Participants will appreciate and describe their own biases by completing the Individual Association Test (IAT) developed by Harvard University. Participants will describe the role of stereotype threat in graduate medical education and its effect on learners in the workplace. We will review policy and curricular strategies to mitigate the effects of stereotype threat in the learning environment. Through case vignettes and role play, participants will apply a specific teaching strategy (i.e. a specific model of giving feedback to learners) that can mitigate the impacts of stereotype threat on learners. At the completion of this workshop, participants will be able to appreciate, better assess, and begin to mitigate the effects of stereotype threat at their local institutions.

Agenda
Participant introductions with trigger question on why one is attending this workshop on unconscious bias in the clinical teaching setting (group-share) (0:00 – 0:10)
Definition of stereotype threat, the context for its impact with our students, and interventions to mitigate the influence of stereotype threat in the environment (instructional) (0:10 - 0:30)
Review implicit association test findings and reaction to those findings as it could related to teaching in the clinical setting (pair-share) (0:30 – 0:45)
Discuss case vignette #1 on stereotype threat in medical education (group discussion) (0:45 – 1:00)
Exercise on how a specific feedback approach can mitigate the influence of stereotype threat on our learners (instructional, role play with case vignette #2, and pair-share) (1:00 – 1:20)
Wrap Up (group discussion) (1:20 – 1:30)

Using Clinical Vignettes to Teach Residents about Autism Spectrum Disorder and Intellectual Disability

Presenters
Kathleen Koth, DO
Roma Vasa, MD

Educational Objectives
1. To present a clinical vignette based approach to strengthening training in the assessment and treatment of co-occurring mental health conditions in individuals with autism spectrum disorder (ASD) and intellectual disability (ID) that training directors can implement at their respective institutions
2. To engage training directors in a discussion about the strengths and weaknesses of the proposed ASD/ID vignette based curriculum as well as potential strategies to improve its relevance to programs with different levels of resources.

Practice Gap
Individuals with ASD and ID suffer high rates of psychopathology, yet there are very few psychiatrists with adequate training to treat these populations. This problem was first

documented in 1991 when data collected by the American Psychiatric Association Task Force reported that 96% of state institutions for individuals with ID had difficulty hiring a psychiatrist (Szymanski et al., 1991). Insufficient training in ASD/ID was cited as the main obstacle to hiring, with 8% of child and adolescent training programs reporting optional or no training in this area.

Almost 25 years later, findings from a survey conducted by the American Academy of Child and Adolescent Psychiatry (AACAP) Autism and Intellectual Disability Committee indicated that this problem still persists. Survey data showed that child psychiatry training programs currently offer an average of 7 hours of lectures on ASD/ID, an exposure to 1-5 outpatients, and up to 10 inpatient ASD/ID cases per year (Marrus et al., 2014). Major obstacles to training in ASD/ID included a shortage of specialists, specialized developmental disabilities services, and funding within institutions. A more recent follow up study of general and child psychiatry programs in New York state (response rate over 60%) yielded similar findings indicating a shortage of resources to enhance training in ASD and ID (Vo et al., presentation at AACAP 2016). Adequate training is just as important in general psychiatry training programs. Two studies of general psychiatry residents, who received specialized training in ID, found their training experiences to be quite valuable even though many chose not to work with this population post-residency (Reinblatt et al, 2004; Ruedrich et al., 2007).
Collectively, these findings highlight the importance of improving training in neurodevelopmental disorders in both child and general psychiatry residencies and emphasize the critical need to disseminate training resources to program directors to facilitate this goal.

References:
1. Marrus N, Veenstra-VanderWeele J, Hellings JA, et al. (2014) Training of child and adolescent psychiatry fellows in autism and intellectual disability. Autism 18(4):471-5
2. Reinblatt SP, Rifkin A, Castellanos FX, et al. (2004) General psychiatry residents' perceptions of specialized training in the field of mental retardation. Psychiatric Services 55: 312–314.
3. Ruedrich S, Dunn J, Schwartz S, et al. (2007) Psychiatric resident education in intellectual disabilities: one program's ten years of experience. Academic Psychiatry 31: 430–434.
4. Szymanski L, Madow L, Mallory G, et al. (1991) Report of the Task Force on Psychiatric Services to Adult Mentally Retarded and Developmentally Disabled Persons. Washington, DC: American Psychiatric Association.
5.Vo et al. Preference for Training Resources in Autism Spectrum Disorders and Developmental Disabilities. AACAP Systems of Care Fellowship Project presented at The American Academy of Child and Adolescent Psychiatry's 63rd Annual Meeting, New York, 2016.

Abstract
A subgroup of members of the AACAP Autism and Intellectual Disability Committee were charged with drafting a curriculum for training in ASD/ID for psychiatry trainees. The overarching goal of this curriculum is to provide training directors with realistic training goals, learning resources, and guidance to improve training in ASD/ID at their respective programs. A key feature of this curriculum is its adaptability because training directors will be able to organize training experiences based on the availability of resources within their particular program. A preliminary version of this curriculum was presented at the 2016 AADPRT meeting. This curriculum was compromised of five

modules which included lectures, clinical precepting materials, clinical vignettes, career planning, and recommendations. Feedback from attendees about the overall curriculum was overwhelmingly positive. During the past year, the AACAP training workgroup has continued to develop different modules of this curriculum. The current submission builds on last year's work and presents one aspect of this curriculum, the use of clinical-based vignettes, in more detail. The vignette-based teaching module provides training directors with additional teaching materials to discuss and emphasize key teaching points. The vignettes are clinically diverse and each includes key teaching points for the program director. The workshop will be interactive. Participants will divide up into small groups to discuss these vignettes, and develop a structured approach to utilizing them as a teaching tool. Based on that experience, the participants will provide feedback to the presenters about how the vignette portion of the curriculum could be improved.

Agenda
1. Describe the history and evolution of the ASD/ID curriculum (10 min)
2. Present the vignette portion of the curriculum design and purpose (10 min)
3. Split into small groups and put the vignettes to use having attendee play roles as both teacher and trainee. (45 min)
4. Group discussion and feedback about the model of vignettes including educational structure, feasibility of use, and implementation (25 min)

Using How We Learn to Learn How We Learn

Presenters
Kari Wolf, MD
Jane Ripperger-Suhler, MA, MD
Santosh Shrestha, MD

Educational Objective
- List 7 key brain learning principles that can be used to enhance learning and apply at least 3 in a teaching minisession.
- Evaluate one's own and other's teaching for use of key brain learning principles.
- Incorporate key brain learning principles into one's realtime teaching on a regular basis.

Practice Gap
Neurobiology can inform teaching and improve student learning but application of what is known about the neurobiology of learning to teaching requires a change in practice. Teachers often think about teaching in the way they were taught which usually involves conveying information via lecture and powerpoint. Ideally, teachers would be thinking about neurobiology and how it affects learning of their topics at all times and apply at every opportunity. A change in practice first requires translation of new information to practice and then, practice, practice, practice.

Abstract
Few psychiatrists are trained to be educators; yet as practicing psychiatrists, we are all called upon to educate patients, policy-makers, trainees, colleagues, etc. In this fun, interactive workshop participants will learn about the neurobiology of learning by applying the neurobiology of learning. Through this practice, participants will understand

how to be more effective educators.

In this workshop, a flipped classroom technique will be used to provide information ahead of time in the form of a paper from Academic Medicine (Friedlander M, et al: What can medical education learn from the neurobiology of learning? Acad Med: 86(4): 415420, April 2011.) On the workshop day, presenters will lead a simulation activity that translates the learned information into practice and provides one round of practice. Participants are divided into small groups and assigned specific key aspects mentioned in the paper. Groups then plan a teaching minisession of their assigned key aspects using these same key aspects in their teaching. Groups then present their teaching minisession to the whole group and participate in evaluation of their successes. As an extension activity, participants will brainstorm together ways to use key aspects in teaching their own home assigned topics and groups.

Agenda
10 minutes - powerpoint review of paper (Acad Med: 86(4): 415420, April 2011)
5 minutes - instructions for activity
25 minutes - small group activity to plan teaching activity
25 minutes - for presentation of teaching activity in larger group
10 minutes - for 124All selfevaluation of work
15 minutes - for 124All generation of ideas for self application at home institution

“We have to talk”: How to have difficult conversations with residents about adversity in the workplace.

Presenters
Lisette A. Rodriguez-Cabezas, MD
Roberto E. Montenegro, PhD, MD
Auralyd Padilla, MD
Andres Jovel, MD
Kristen Wilkins, MD

Educational Objectives
At the conclusion of this workshop, participants will be able to:
1. Identify different sources of adversity faced by residents in the workplace.
2. Apply at least two modified DBT techniques when supporting trainees who are experiencing interpersonal adversity in the workforce.
3. Apply at least two modified DBT techniques in their own professional interactions should they experience adversity as well.

Practice Gap
Not much emphasis is placed on how to help trainees through mistreatment or interpersonal conflict in the workforce setting. Psychiatrists are not immune to verbal insults, microaggressions or overt racism, sexism and other social slights. Despite our clinical expertise in identifying, treating and dealing with intense high affect situations, it can often be challenging for trainees and attendings alike, to talk about these situations. Especially when these insults or mistreatment are from supervisors or colleagues themselves. Given the imbalance of power inherent amongst trainees as well as with more senior faculty, it can be challenging for trainees to try to address mistreatment. The

onus of responsibility to address workforce mistreatment should not be placed on the trainee. Rather, academic institutions should be training both supervisors and trainees with the appropriate skills needed to navigate these interpersonally challenging work-related interactions. Underrepresented trainees are especially at risk for ostracism, insults, and slights and often find themselves experiencing invalidating interactions or blatant mistreatment. Teaching supervisors and trainees how to use DBT-oriented skills to have these difficult and sensitive conversations can empower individuals to become strong advocates and prevent further worsening the working and learning environment for many trainees.

Abstract
Medical trainees are often mistreated within the confines of our own academic settings. This mistreatment can come directly from attendings, fellows, residents, medical students, other staff members and patients alike. They can range from less overt forms of adversarial comments like microaggressions, to more overt forms of mistreatment such as racist or sexist comments, sexual harassment, derogatory comments regarding sexual orientation, refusal to see trainees of a particular ethnic or religious group, and others. There is an abundance of literature describing the impact of this mistreatment on the trainee's learning environment as well as their personal and professional wellbeing. Faculty response to such mistreatment is variable and complicated by the limited training in having these difficult discussions where emotions can run high and individuals can become defensive. How can educators in psychiatry help their trainees have difficult conversations that can help them address, process and confront situations of mistreatment? How can educators cultivate a positive learning environment in the face of mistreatment?

As different forces continue to shape the role and image of Psychiatry, this workshop intends to reemphasize the need to master interpersonal skills and conflict resolution as core characteristics required to be a competent psychiatrist. Therapeutic communications skills stemming from Dialectal Behavior Therapy (DBT) will be used to facilitate difficult discussions such as those revolving around mistreatment. DBT is an evidence based skill focused approach that has been shown to be effective in challenging clinical situations focusing on interpersonal skills. Faculty and trainee presenters will begin with an introductory lecture on different forms of mistreatment of trainees, including real-life examples. Next, DBT theory and DBT skills will be reviewed and applied to real-life case examples. Participants will then engage in interactive small group discussion and role-playing exercises. Finally, the presenters will summarize main themes of discussion and suggest next steps.

Agenda
The intended audience for this workshop includes academic clinicians, educators, mentors, program directors, and trainees at all levels. This workshop will start with:
1. Introductory brief PowerPoint presentation defining the workshop objectives, pertinent data and important concepts, including different forms of mistreatment (5 minutes).
2. Demonstration of real-life examples of situations in which residents have experienced work-related mistreatment with audience participation. (15 minutes).
3. Presentation of skills needed to handle these situations and will detail DBT theory and modified DBT techniques. (10 minutes).
4. Roleplay of 2 scripted scenarios in which DBT skills are used to address mistreatment by a co-resident and a faculty member. (20 minutes)
5. Audience members will then be paired up and given scenarios to use DBT based

communication skills during difficult interactions. (20 minutes each)
6. Lastly, a collective role-play exercise of a program director-trainee interaction will be used to summarize and synthesize the main theory and skills discussed in the presentation. (20 minutes)

Session 3 – Friday, March 10, 3:45-5:15 p.m.

A Scholarly Activity Initiative: Breaking Barriers and Getting Published!

Presenters
Rashi Aggarwal, MD
Nicole Guanci, MD
Jessica Kovach, MD
Tanya Keeble, MBBS
Justin Faden, DO

Educational Objective
1. To help participants identify barriers to productivity in the scholarly activity process during residency training.
2. To discuss the institution of a scholarly activity initiative at Rutgers NJMS.
3. To discuss barriers and strategies used by Temple University and Spokane Psychiatry Residency Program.
4. To provide concrete steps towards instituting a mentorship program to boost scholarly activity similar to the scholarly activity initiative at one residency training program.
5. To provide roleplay and interactive group experiences to overcome barriers and practice development of a similar process at individual institutions.

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 one program, which was very successful over the course of the previous six years. We also intend to discuss the generalizability of barriers and insights from two 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 mentors, 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 would 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. 1) However, the ACGME does not delineate specific requirements regarding what type of scholarly work should be accomplished by residents. Studies show that fewer than 10% of psychiatry residents will choose research as a career, but publications such as abstracts are important for any

psychiatrist interested in an academic career or in compiling a more competitive curriculum vitae. 2) However, many residents lack the necessary skills for choosing a topic and presenting an abstract for poster presentation, especially if this process entails preparing for publication. According to a study, only 30% of residents had national presentations with 54% having no publications. 3) Further, many psychiatric training programs lack faculty members who are able to mentor residents in these activities. 4) To combat this gap, our program developed a scholarly activity initiative in 2010. The scholarly activity initiative's goal was to boost scholarly activity interest by facilitating the process for residents and faculty. In order to begin this process, we analyzed the barriers at our own program, by meeting with faculty and residents. We then identified one core faculty who was responsible for guiding and encouraging residents through the process of finding a topic and a mentor. 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. After becoming proficient in this process, approximated by completion of a poster presentation or journal submission, senior residents were linked to junior residents in order to develop schools in mentoring scholarly activity. Since instituted, this initiative produced significant scholarly activity output, which is evidenced by production of 3 posters and 2 publications from 2008-2010, to 105 posters, 42 publications, and 8 workshops between 2011-2016.

The goal of this workshop is to assist participants with instituting similar scholarly activity initiatives in their programs. This will be aimed at helping program directors train faculty mentors and guide residents. In this workshop, we aim to facilitate adoption of this scholarly activity process by identifying barriers to lack of productivity and delineating specific techniques for tackling these barriers. Ultimately, we will focus on scholarly activities most attainable for busy residents and departments without significant grant support, including poster presentations and publications such as letters and case reports.
During this workshop, we will delineate a step by step process for instituting a scholarly activity initiative on the residency training program level. We will explain its implementation at one institution, and will also provide insights, suggestions, and barriers from 2 other programs. We will provide interactive sessions using small group discussion and role plays. The goal is to identify barriers in individual programs and discuss ways to address these, with the hope of increasing scholarly productivity for all programs.

Agenda
Introduction and Outline (5 min)
Discussion of Barriers to Scholarly Activity (5 min)
Breakout Groups to Discuss Barriers Faced at Individual Programs (15 min)
Outline of Scholarly Activity Initiative at Rutgers NJMS (10 min)
Overview of Identifying Interesting Topics, Conducting a Literature Review, and Starting the Writing Process to Guide Mentors (10 min)
Discussion of Techniques Used at Two Other Programs (15 min)
Breakout Groups to Roleplay and Design Initiative Frameworks for Participants' Programs (30 min)

Are you as good of a supervisor as you think you are? Self-assessment for supervisors

Presenters
Susan Stagno, MD
David Topor, BA
Eva Mathews, MPH, MD
Andrew Hunt, MPH, MD

Educational Objective
After attending this workshop the participant will be able to:
1) Identify skills and characteristics of excellent supervisors
2) Assess one's own skills through use of a self-assessment instrument and employ a parallel instrument to get a learner's assessment
3) Consider supervisory experiences in different settings (such as psychotherapy supervision, inpatient and community psychiatry) and address expectations that may arise in supervising in these venues

Practice Gap
Both residency programs and individual faculty who supervise residents strive to provide a quality educational experience. However, little attention is paid to identifying the skills and characteristics needed to be an excellent supervisor, and faculty development programs addressing this issue are not well developed or infrequent. The ABPN requires self-assessment for maintaining certification in psychiatry, but no current modules exist on self-assessment as a teacher or supervisor.

This workshop is designed to allow faculty to assess themselves as supervisors, and develop new skills and techniques in supervision using vignettes employing three different venues (psychotherapy supervision, inpatient supervision and supervision in a community setting) addressing various concerns that can arise and which supervisors should be attuned to address.

Abstract
Residency programs and individual faculty who supervise residents strive to provide a quality educational experience. However, little attention is paid to identifying the skills and characteristics needed to be an excellent supervisor or to ways in which faculty can assess themselves or be assessed by others.

This workshop introduces a new self-assessment instrument for supervisors, and provides a parallel instrument for learners to assess and give feedback to faculty supervisors. The workshop will also provide opportunities for participants to engage in discussion around three vignettes that include supervision in different settings (psychotherapy supervision, inpatient supervision and supervision in a community setting) each raising issues that supervisors should be equipped to address. After participating in three small group discussions about each vignette, all 3 groups will come together to share their ideas and insights about the problems raised in the vignettes.

Participants will be invited to develop a "commitment to improvement" plan at the close of the session, identifying gaps in their own skills or knowledge regarding supervision and how they plan to address this going forward.

Agenda
Welcome - presenters and participants introduce themselves; participants indicate what they hope to gain from attending the workshop - 10 minutes
Brief overview of "What makes a good supervisor" - 10 minutes
Self-assessment - introduction of a self-assessment instrument and opportunity for participants to complete - 10 minutes
Small Group discussion re: vignettes (3) - 30 minutes
Large group reconvenes to share insights from the small group discussion - 20 minutes
Commitment to improvement - participants identify 2 or 3 things they wish to change/improve - 10 minutes

Assessment in the age of milestones: Improving and refining your resident assessment program

Presenters
Kathleen Crapanzano, MD
J. Luke Engeriser, MA, MD
Sandra Batsel-Thomas, MD

Educational Objective
At the end of this workshop, participants will be able to
1. Identify and reflect on the weaknesses in their resident assessment system.
2. Use tools provided to implement three different resident assessment approaches
3. Use data collection systems such as New Innovations or MedHub to translate the assessment data into Milestones.

Practice Gap
In this age of Competency-Based Medical Education, accurate resident assessment is more important than ever. Attempting to complete milestone evaluations on residents twice a year has highlighted areas of weakness with learner assessment. For the Milestones to reach their intended purpose which is “first and foremost … to help all residencies and fellowships produce highly competent physicians to meet the health and health care needs of the public ”, programs must continue to revisit, refine and improve their own assessment systems to improve the integrity of the data that is submitted. Equally important, however, is accurate assessment of residents so that appropriate summative and formative feedback can be given within a training program.

Abstract
Resident assessment is important for several reasons—it allows a program to accurately determine a resident’s developmental progress on the Milestones, it allows a program to submit accurate data to the ACGME, and it allows for individualized formative and summative feedback of residents. The challenge is how to accurately perform those assessments in numerous areas on multiple residents. The ACGME has begun sponsoring regional trainings on resident assessment in an attempt to help programs improve their approach to assessment and their own assessment systems. At the ACGME-VUMC Developing Faculty Competencies in Assessment conference this fall, the attendees were encouraged to disseminate the information that was shared in the hopes of helping other programs begin to improve upon their methods of resident assessment. In particular, the rigorous review of three different assessment strategies

and how they can be built into a program assessment system is pertinent for any program struggling with their approach to evaluating residents on the Milestones. While these assessment strategies are not new or unique, the material provided will allow programs to use them in a more meaningful and significant way by creating a comprehensive and integrated assessment system. In this workshop, the facilitators will share the information that was presented so that other psychiatry educators can use it in evaluating and improving their own assessment systems.

Agenda
00:00- 05:00 Introductions and setting the stage
05:00- 10:00 Competency based medical education and assessment of residents (brief didactic presentation)
10:00- 35:00 Evaluating Professionalism and Interpersonal communication skills with Multisource evaluations (Demonstrations and sample evaluation forms)
35:00- 60:00 Global assessments and Entrustable Professional activities: 8 question evaluations that can provide info on all milestones! (Participants will walk through the process of developing their own EPA's as way to organize resident rotation evaluations)
60:00- 85:00 Learning plans and self assessment: In vivo Practice based learning (Sample forms and activities to demonstrate the power of this assessment approach)
85:00- 90:00 Wrap up and evaluation

Avoiding Death by PowerPoint: Strategies to improve your presentation skills

Presenters
Carlyle Chan, MD
Monique Yohana, MD

Educational Objective
Participants will:
1. Recognize optimal slide composition that doesn't detract from their message
2. Learn how to download and imbed videos
3. Understand and utilize creative commons copyright

Practice Gap
Reviews of teaching sessions often contain comments on the quality of accompanying slides.

Abstract
Googling "Death by PowerPoint" results in over 1.8 million hits. The phrase "death by PowerPoint" comes from audiences becoming bored to death by slide presentations that contain too much or distracting materials. All too often, speakers will try to include too much information into their presentations. This workshop will present strategies that will enhance and not detract from your message. We will discuss not only the optimal number of words and lines on a slide but also review font size, color, transitions, imbedding photographs and videos, signal to noise ratio and more. We will examine pre-production concepts, review how to reconstruct wordy slides applying the 1-7-7 rule as well as other approaches, utilize free online sources of photographs while respecting copyright, demonstrate useful animation techniques and analyze the use of color.

Agenda
The workshop will begin with a brief presentation followed by an interactive discussion. Each participant is asked to bring a flash drive containing 2-3 slides from talks they have already made or will make. We will ensure a friendly and collaborative atmosphere to discuss methods of improvement based on the preceding techniques.

Efficient and Effective EMR use - A Model Curriculum

Presenters
John Luo, MD
John Torous, MD
Steven Chan, MBA, MD

Educational Objective
At the end of this workshop, participants will be able to: 1) recognize how using an EMR impacts non-verbal communication and eye gaze during the patient encounter 2) recognize how physical layout of the computer in the office space impacts engagement 3) utilize joint viewing and screen sharing to improve patient engagement 4) make efficient use of templates and text expanding shortcuts to minimize typing 5) use the POISE mnemonic to remember good computer habits while in a patient-doctor encounter (prepare, orient, information gathering, share, educate)

Practice Gap
Of all the new technologies, training directors must be aware how using the EMR impacts the patient encounter. While most hospitals and ambulatory settings provide mandatory classes on how to order medications, laboratory testing, etc. as well as how to find and create documentation, few health systems if any provide education on how to optimally use the computer during the patient encounter such that the computer does not detract from the patient-doctor relationship. This workshop reviews studies in the informatics literature regarding the impact of EMR use on productivity, patient satisfaction, and provider satisfaction, and provides training directors the training on how to use POISE, a set of good computer habits that optimize the patient-doctor encounter when incorporating the computer and EMR in the room.

Abstract
Use of electronic medical records during residency is almost impossible to avoid. Whether working at large academic medical centers, Veteran's Administration hospital and community based outpatient clinics, hospital-based and university practice plan outpatient clinics, county mental health, or even private practice, trainees will be required to learn how to efficiently and effectively use an EMR while also learning how to optimize and manage the patient-physician encounter. Few graduate medical education institutions have a local 'computer expert' or Clinical Informatics board certified faculty member to provide the training on how to manage the patient encounter with EMR as well as optimize the EMR for workflow and quality improvement.

Given the wide array of vendors that have created EMR systems, it is impossible to create curriculum that covers the features of each EMR system. This workshop will focus on education regarding how the EMR impacts the patient-provider encounter in

multiple arenas, and to teach best practices on how to optimize the tools available on the computer and in the system to efficiently and effectively document the encounter.

This workshop is a springboard for a future model curriculum in development that can be shared amongst training directors as part of the virtual training office. Borrowing elements from the National Neuroscience Curriculum Initiative, the future National Informatics Curriculum Initiative seeks to develop a toolkit to enable educators of any level of technological expertise to teach informatics.

Agenda
Introduction & needs assessment 5 minutes (Luo)
Review of Research Regarding EMR Impact on Patient encounter (Chan 25 min including Q&A)
General Optimization Tools on the Computer and EMR (Torous 25 min including Q&A)
Implementation of the good computer habits - POISE (Luo 25 min including Q&A)
Open Q&A, Feedback, brainstorming, ideas for the future 10 minutes (Benjamin, Boland, Chan, Luo)

Enhancing Resident and Faculty Development through a Reverse Clinical Competency Committee

Presenters
Kim Kelsay, MD
Austin Butterfield, MD
Sean LeNoue, MD
Sumru Bilge-Johnson, MD
Liberty Fritzler, MSBA, MD

Educational Objectives
Training directors and residents will
1) Explore the benefits of a reverse clinical competency committee, including resident and faculty development, and the culture of transparency within a training program.
2) Demonstrate underlying tenets that impact this process.
3) Practice tenets and skills in a mock Reverse Clinical Competency Committee (RCCC) for either a small or larger training program
4) Identify next steps to implementation of an RCCC within the learners' respective programs.

Practice Gap
1) Psychiatry residents often have useful observations regarding the teaching and other competencies of their attending faculty, yet they are rarely given the opportunity to organize these observations into descriptive, formative feedback, to practice giving this feedback or to deliver the feedback to faculty.
2) Faculty are often required to give feedback to residents but are frequently not trained in best practices. They rarely have the opportunity to receive feedback from residents or to participate in a parallel process to improve their teaching skills and skills in delivering feedback.
3) Training directors may not have the tools to integrate specific observations from

trainees into descriptive and formative feedback for faculty to improve overall quality of teaching and or other competencies.

Abstract
Psychiatry residents often receive instruction about giving feedback to more junior residents and medical students with whom they are working or supervising, yet are not given instruction about how to gather and deliver feedback to more senior residents or faculty. While some of the basic principles apply, there are critical differences. For example, educational systems and clinical cultures are often created without expectations that senior team members receive or are open to hearing feedback from more junior team members. Faculty are instructed regarding giving feedback and often participate in clinical competency committee. However, they may forget or not have participated in the experience of receiving feedback following a clinical competency meeting. In order to address these gaps and to increase transparency regarding the clinical competency committee, we designed and implemented a reverse clinical competency committee (RCCC) process facilitated by the chief residents. During the RCCC meeting, the chief residents help gather feedback from residents regarding faculty competencies (modified from the 6 core GME competencies for trainees), utilize the group to carefully formulate the feedback to be delivered, and practice delivering the feedback. The faculty then meet with the chief residents, who deliver the feedback. We examined 4 years of experience with this method within a larger program, as well as the initial experience within a smaller program for lessons learned including modifications, to inform this workshop. We included a smaller program based on feedback from last year's presentation to AADPRT. Faculty report they find this experience mildly stressful, valuable, and report that it has impacted their teaching and communication. Residents have noticed changes in faculty teaching and attitudes towards education, in response to feedback. Chief residents report the experience is mildly stressful and helpful in their professional development. Both training directors note this process has helped with the culture of transparency and has improved the specificity of feedback obtained from the residents. Residents in the smaller program feel safer than before implementation regarding sharing feedback. The larger program has modified the structure of the meeting, timing of feedback delivery and information shared between incoming and outgoing chief residents on the basis of 4 years experience and feedback from chief residents, residents and faculty. The smaller program has 1 year of experience and is gathering information in November regarding indicated changes.

Agenda
1) 5 minutes - Introduction of leaders and attendees.
2) 10 minutes - Explanation of the process of the RCCC and set up for the mock RCCC.
3) 30 minutes - Attendees will divide into groups interested in implementing this procedure within a small program or larger program. Each attendee will be assigned a mock role within the group, and each group will be supplied with mock observations regarding 1-2 faculty, and given the task of running a mock reverse clinical competency committee.
4) 10 minutes - Each group's assigned chief resident will deliver feedback to an assigned faculty member (workshop leaders) in front of the larger group,
5) 10 minutes - Each group will reflect and report on their experience.
6) 15 minutes - Attendees will examine tenets of adult learning, lifelong learning, systems based practice, practice based learning and parallel process as they might apply to a reverse clinical competency committee, and their experience as discussed by our chief residents.

7) 10 minutes - Workshop leaders (chief residents and training director) will share some lessons learned and invite each attendee to anticipate implementation of a similar process within their institution including barriers and promoters of this change.

Exploring the 4th Dimension: Developing a Biopsychosociospiritual Model in Psychiatric Residency

Presenter
Timothy Lee, MD

Educational Objective
- Discuss faculty and resident attitudes toward awareness of and incorporation of patients' spiritual beliefs into psychiatric treatment
- Discuss current practices in residencies in regards to teaching and modeling of spiritual assessment and care in psychiatric practice
- Discuss ways in which spiritual beliefs both negatively and positively impact psychopathology and psychiatric treatment

Practice Gap
Transitioning from an acknowledgement of the impact of spiritual beliefs on the psychological well-being of patients to increasing our residents' comfort level with assessing such factors and engaging with patients in conversations about their spiritual beliefs.

Abstract
What is a psychiatrist? Among many things, a psychiatrist is someone who examines all factors contributing to or detracting from his/her patients' psychological well-being. One often-overlooked, or even ignored, aspect of this is a patient's spiritual or religious beliefs. Since 2001, JCAHO has required the administration of a spiritual assessment as a standard component of patient assessment. While this could be left to other members of the healthcare team, studies suggest that patients want their physicians to be aware of their spiritual beliefs and needs. Spiritual or religious beliefs invariably impact a person's psychological well-being in positive and/or negative ways. Is it ethical to ignore this aspect of a patient's internal world? How are we to foster our residents' skill and comfort level in understanding this aspect of their patients' lives?

Agenda
5-10 minute anonymous poll (using Poll Everywhere online tool) of audience members' attitudes toward the incorporation of spiritual assessment in psychiatric practice
15-20 minute small group sharing about incorporation of spiritual assessment into residency curriculum and clinical training, and barriers to this endeavor
15 minute large group discussion
30 minute presentation
15 minute large group discussion of common treatment dilemmas or psychological conflicts at the intersection of spirituality and mental health

Flipped Classroom Pedagogy: Experiential Learning of Liberating Structures

Presenters
Kari Wolf, MD
Jane Ripperger-Suhler, MA, MD
Santosh Shrestha, MD

Educational Objective
By the end of this session, participants will be able to:
• Define Liberating Structures
• Use three different Liberating Structures to learn about Liberating Structures
• Brainstorm areas within Residency/Fellowship Curricula where Liberating Structures would enhance learning
• Design a Liberating Structure exercise than can be applied at one's home institution

Practice Gap
As Jennifer Clark writes in Powerpoint and Pedagogy (1), "Lectures…can be notoriously boring." A 2014 study found that undergraduate students with a lecture-based curriculum were 1.5 time more likely to fail than students in classes that utilize active learning techniques. (2)

As educators we strive to learn new methodologies for conveying important information. Yet we often lack the skills or exposure to different ways to teach. And most institutions do not have the resources to produce glitzy, interactive vehicles for delivering content in an entertaining manner that trainees do not find boring.

A new style of engaging groups in brainstorming or learning has emerged called Liberating Structures. This method provides the framework for structured discussions, brainstorming, conducting meetings, etc. This workshop will introduce participants to several Liberating Structures and provide information on where to learn more about this free resource on-line.

(1) Jennifer Clark (2008) Powerpoint and Pedagogy: Maintaining Student Interest in University Lectures, College Teaching, 56:1, 39-44, DOI: 10.3200/CTCH.56.1.39-46
(2) Freeman S et. al. (2014) Active learning increases student performance in science, engineering, and mathematics. PNAS 111(23): 8410-8415.

Abstract
Resident evaluations of didactics consistently complain about sessions delivered in a traditional lecture-based format. Numerous faculty development initiatives have done little to change the curriculum from a largely lecture-driven format. While faculty understand that active learning is a more effective way to educate learners, many faculty feel ill-equipped to teach using other methodologies.

This workshop will introduce participants to a pedagogy called Liberating Structures. Using several different liberating structures to teach the workshop, participants will both learn about this teaching style while simultaneously practice using this skill.

According to the Liberating Structures website, "Liberating Structures are easy-to-learn

microstructures that enhance relational coordination and trust. They quickly foster lively participation in groups of any size, making it possible to truly include and unleash everyone. Liberating Structures are a disruptive innovation that can replace more controlling or constraining approaches." They afford a specific structure that can be applied to a variety of topics in both large and small settings.

The presenters have participated in Liberating Structures with an audience of 8 as well as an audience of several hundred. After participating in a Liberating Structure exercise only once, the presenters were able to use Liberating Structures to present at other national meetings and within their home department.

This skill-building workshop will equip participants to immediately return home to apply this new pedagogy in their home institutions.

Agenda
I. Liberating Structure: Pecha Kucha Presentation to provide background on Liberating Structures – 10 minutes
II. Liberating Structure: TRIZ Exercise "How can you make didactics as boring as possible for learners?" – 40 minutes
III. Liberating Structures: 1, 2, 4, All (two rounds, 25 minutes total)
IV. Debrief and how to learn about more Liberating Structures—15 minutes

Residents as Teachers: Implementing a Curriculum to Facilitate Clinical Teaching

Presenters
Jane Gagliardi, MSc, MD
Shelley Holmer, MD

Educational Objective
After participating in this workshop, participants will:
1) Be familiar with an eight-session curriculum for trainees in a Psychiatry residency training program
2) Demonstrate the ability to create a Concept Map as a tool for understanding the mind of the learner
3) Begin to create a toolkit and strategies for implementing a RAT Program or elements of a RAT Program for trainees in their home Psychiatry residency training program

Practice Gap
Much of the formal and informal teaching of medical students in psychiatry is done by residents, many of whom are early in their training and often have little experience teaching. They are increasingly busy with their own clinical responsibilities and building competence in psychiatric principles themselves, many times rendering them "too busy" or poorly prepared to teach competently.
Residents on acute care services (where students in our institution rotate) have multiple obligations to meet. They must provide direct patient care, learn how to participate in and eventually lead a multidisciplinary treatment team, and document the care they have provided, all while remaining within ACGME-mandated duty hours.

The incentives for teaching medical students are simultaneously diminishing. In the past, students could meaningfully contribute to the workload for the patient care team. These days, students' role on the healthcare team is increasingly marginalized through regulations (providers may not bill based on medical student work, for instance) and institutional policies (in our institution, medical students may not complete medication reconciliation or modify the electronic medical record in any way other than in a "medical student note tab" that exists outside what is considered "official").

Meanwhile, faculty members are under increasing pressure to decrease patient lengths of stay, improve patient care quality, and help residents adhere to duty hours regulations. In some clinical settings teaching has started to shift towards simulated experiences and non-clinician teachers. An unanticipated (and perhaps unintended) consequence is that residents are not learning how to teach, a skill which is necessary not only for budding academics but for anyone who educates patients and their families and which is reflected in the ABPN/ACGME milestones for Psychiatry trainees.

Abstract

We have developed a Residents as Teachers (RAT) Program with a core goal of bringing teaching back to the clinical setting. In its first year (2013-2014) the RAT Program was a grassroots effort by a PGY3 trainee and the Director of Undergraduate Medical Education; they held noontime conferences with the promise of lunch to entice residents in the PGY1-2 years to pilot their curriculum. The RAT Program was so highly regarded and promising that we incorporated it into the formal didactics conducted during the protected academic half-day (AHD), and it is now in its third year of "official" placement in the AHD curriculum for PGY1 and PGY2 trainees.
Important in medical education is the ability to set expectations and provide formative and summative feedback. The RAT Program teaches trainees methods to more effectively provide feedback and also provides real-time opportunities for trainees to set expectations, give and receive feedback. Another area of emphasis in teaching residents to teach has been "how to give a chalk talk." Published studies evaluate the effectiveness of providing pre-prepared talks to trainees to encourage their engagement with students. Though the approach may be helpful in lowering some trainees' threshold to engage in teaching, it does not provide any direct education to trainees on how to organize and deliver an educational session. An innovative feature of the Duke RAT Program is the introduction of Theory of Mind and Concept Maps to help trainees gauge the preparedness of their learners and tailor their teaching efforts accordingly.

Since implementation of the RAT Program, we have measured resident attitudes toward teaching (pre- and post- participation in the RAT Program) and also have tracked medical student outcomes (performance on the NBME Shelf Examination in Psychiatry; satisfaction with / ratings of the Psychiatry clerkship; and number of students seeking residency training in Psychiatry). Though causality is not possible to determine, the introduction of the RAT Program has coincided with better student scores on the Shelf Examination, higher ratings of the Psychiatry clerkship as compared to other clerkships in our institution, and higher numbers of students selecting Psychiatry as a career.

Agenda

The 90-minute workshop will be conducted as follows:
15 minutes - Introductions, interactive session to learn about participants and their strategies for teaching residents to teach.

15 minutes - Review Duke Psychiatry's eight-session RAT Program for PGY1 and PGY2 residents. Provide an overview of the overall curriculum and goals. Provide data supporting its beneficial effects on trainees and medical students.
15 minutes - Give sample lecture outlining importance of setting goals and providing feedback. Participants will practice giving feedback.
30 minutes - Give sample lecture outlining concept mapping. Participants will break into small groups and work on developing concept maps for sample student topics.
15 - Reconvene in large group, obtain feedback about concept mapping, challenges and benefits to the curriculum and approaches used in the RAT Program.

So You Developed a Great Course, Now What? How (and why) to Create a Model Curriculum

Presenters
John Luo, MD
John Torous, MD
Steven Chan, MBA, MD

Educational Objective
Upon completion of this workshop, participants will be able to:
1) describe the purpose and benefits of developing a model curriculum
2) identify critical components included within a model curriculum
3) transform their courses into resources meeting model curriculum standards
4) navigate the new AADPRT online submission system.

Practice Gap
Psychiatry residency and fellowship programs are required by ACGME to provide comprehensive training to ensure that all graduates demonstrate requisite professional attitudes, behaviors, knowledge, and skills. With an ever expanding list of training requirements and recent implementation of the new milestones, many programs lack the knowledge, skills, and resources necessary to teach all required subjects. In efforts to address these challenges, AADPRT developed the Curriculum Committee to solicit, review and share high quality teaching resources among its members. However, translating courses into a model curriculum that can be implemented and adapted by other programs is not as simple as passing along a PowerPoint slide set. Most psychiatrists have not had formal training in developing educational materials that could be implemented by other programs and would benefit from guidance in how to transform their work into a comprehensive model curriculum. AADPRT members also require an orientation to the new online submission system.

Abstract
Now that you have developed a great course or innovative teaching approach, it's time to further capitalize on your work by adapting the course content into a usable curriculum for other institutions. There are several advantages to disseminating your course. A well-designed, peer-reviewed curriculum is a scholarly product that will directly assist faculty with academic promotion at most institutions and a national reputation. The AADPRT Curriculum Committee encourages AADPRT members to submit high quality, curricula for peer review. Many members may already have excellent course content that has worked well for their individual programs that they would be willing to share so that

others may benefit. However, these curricula may need some revision and shaping in terms of the following criteria to meet the standard of a model curriculum: 1) organization/coherence, 2) comprehensiveness, 3) quality of educational materials, 4) innovation, 5) inclusion of a curriculum guide, 6) evaluation tools, 7) bibliography, and 8) adaptability/portability. The MCC seeks to encourage submissions of model curricula for review and ultimate addition to the AADPRT Model Curricula catalogue. In this workshop, participants will receive an overview of the steps for developing a model curriculum along with hands-on assistance in transforming their own teaching materials into a formal model curriculum submission. Participants will also receive a demonstration of the new online submission system through the AADPRT website.

Agenda
This workshop will begin with a brief didactic presentation regarding the definition, rationale, components, and process for developing and submitting a model curriculum. This will be followed by interactive individual and small-group consultation with experienced Curriculum Committee reviewers. Participants are strongly encouraged to bring their own curricula to this workshop (and will be contacted in advance to do so). Participants will leave with a digital resource portfolio including a high quality example, step-by-step instructions, and a copy of the reviewer rating system.

Teaching Research Literacy through Debates In Psychiatry (DIP into the literature!)

Presenters
Michelle Pato, MD
Erika Nurmi, PhD, MD

Educational Objectives
1. Learn an engaging model for teaching research literacy during training.
2. Learn how DIPs can also be used to keep current and stay competent after residency training.
3. Understand the issues in recommending or not recommending a particular treatment (any biopsychosocial information/treatment) for your psychiatric patients.
4. Understand how the federal government's and/or FDA's stance toward research affect diagnostic methods and treatments coming to market.

Practice Gap
Research literacy, critically evaluating emerging research and integrating it into clinical practice, is an ACGME core competency and part of Maintenance of Certification (MOC) and Life Long Learning (LLL). Yet too often we find our residents complaining that they don't have time to read the literature or "I'm not a researcher anyway, I just want to provide clinical care." After training, most psychiatrists find the current literature too complex to easily translate to practice and rely on review articles, conferences and practice guidelines to inform their practice. Yet developing methods for an effective, engaging, and easily disseminated review of new literature will be the keystone to providing quality training during residency and maintaining life-long competency as a psychiatrist.

Abstract
We have developed a new teaching tool, called “teaching with DIPs,” that makes it interesting and fun to discuss recent research findings and stay current and competent. Debates In Psychiatry (DIPs) combines a brief didactic lecture (30 minutes = 30 slides) with 2 recently published articles to provide background on the topic. The class is then divided into two teams that are guided in a lively debate of the relevant issues. During the debate, course leaders model the types of critical questions that must be asked of presented literature and highlight barriers complicating translation to practice. The two presenters will discuss their experience using DIP with both categorical and research track psychiatric residents and with two interactive DIPs conducted at the 2016 American Psychiatric Association (APA) annual meeting entitled “Should I Recommend Ketamine and Marijuana for My Patients?” Data collected during the APA debate suggest that current residency training in Research Literacy is inadequate, with 55% of respondents (n=111) rating their residency education in research literacy poor or non-existent and only 17% solid or excellent, rendering the majority of psychiatrists unable to critically evaluate emerging literature. Only 25% of respondents reported the ability to identify the limitations of most research reports and evaluate whether findings are clinically actionable, while 66% admitted relying solely on review articles, conferences and practice guidelines to keep their practice up to date (n=141). Importantly, over 80% of participants agreed that they would welcome and utilize DIP as a tool for initial education and subsequent maintenance of competency in research literacy (n=84). In the second part of this workshop, we will show you how to use the DIP method at your institution. We will discuss specific examples of topics to consider that have already been developed and are available online. And finally, we will have the audience participate in a live DIP.

Agenda
To implement any new teaching tool like DIPs into the curriculum, we believe that as a teacher, it is most effective to experience the DIP format yourself. Therefore, the agenda for the workshop is:
15 minutes- to present the concept behind the DIP model, discuss prior experience and provide a list of topics already developed
50 minutes of DIP simulation including:

- 20 minutes of didactic presentation
- 30 minutes dividing the workshop into two debate teams, given each team one article to review and 10 minutes to plan as a debate team and then 20 minutes to debate

25 minutes of Q+A to discuss how it felt and give pointers on how to do it at your institution including how to engage other faculty to be DIP teachers.

Teaching Therapy: A Co-Therapy Model

Presenters
Anita Kishore, MD
Shani Isaac, MD
Dorothy Stubbe, MD
Nina Vasan, MD
Isheetz Zalpuri, MD

Educational Objective

1. Participants will learn the principles of a co-therapy model of psychotherapy education, including adult learning theory.
2. Participants will discuss advantages and potential resistances towards a co-therapy model from the perspective of the supervisor, resident, and patient;
3. Participants will understand the resources and advocacy required to implement a co-therapy model into residency training, including how to address resource issues.
5. Participants will learn how to manage logistical and emotional challenges that may arise in implementing a co-therapy model of education.

Practice Gap

Leaders in psychiatry have long identified the practice of psychotherapy as a core skill of psychiatrists. Despite that, there continues to be concern that psychotherapy practice is declining and that training programs struggle to provide high quality training (Drell 2007). Traditional psychotherapy education for trainees is centered around didactic instruction and supervision via recounting or observation of video recordings, leaving the supervisor one step removed from the patient-doctor interaction. The co-therapy model of education - the epitome of collaboration - is an underutilized approach that offers unique advantages to teaching and learning psychotherapy as well as to patient care.

Abstract

Objective: This teaching workshop provides a primer in principles of adult learning theory that is directly applicable to faculty's teaching and residents' learning experiences during training. The advantages of a co-therapy method of teaching psychotherapy for faculty and residents, as well as frequently improved satisfaction on the part of the patients receiving this model of therapy, are reviewed. The practical aspects of implementation, including resources required and methods of “selling” this approach within the institution, are addressed.

Background: Traditional psychotherapy education for residents is centered around didactic instruction and supervision via recounting or observation of video recordings, leaving the supervisor one step removed from the patient-doctor interaction. The co-therapy model of education - the epitome of collaboration - is an underutilized approach that offers unique advantages to teaching and learning psychotherapy as well as to patient care.

Methods: Participants will discuss and actively practice specific teaching techniques that apply to a co-therapy method of providing patient care. These include facilitating a safe and collaborative learning environment; skills in supervisor-supervisee modeling of effective communication and problem-solving for the patient; and providing bi-directional specific, timely and effective feedback about the therapeutic encounter. Program co-leaders represent a faculty-resident pairing that has completed a co-therapy model of education for child and adolescent psychiatry and will describe their own unique experiences as faculty supervisor and resident respectively. Co-presenters will scaffold the discussion with a background of the topic, adult learning theory, and practical aspects of resource allocation required to implement this model. Additionally, residents in psychiatry programs who have engaged in co-therapy will serve as co-presenters and facilitators during the interactive sessions.

Conclusion: Feedback from this workshop will be used in planning future programs and towards implementation of a multi-institution pilot research collaboration on the

effectiveness of implementing a co-therapy model of training, furthering AADPRT's mission to support the development of teaching excellence.

References:
Drell, M. (2007). Policy Statement: Psychotherapy as a Core Competence of Child and Adolescent Psychiatrists. American Academy of Child and Adolescent Psychiatry. http://www.aacap.org.
Esposito, J. F., & Getz, H. G. (2005). In-the-room supervision: Reactions of supervisors, supervisees, and clients. Professional Issues in Counseling.
Gabarro JJ, Kotter JP. (1993). Managing your boss. Harvard Business Review, May-June, 150-157.
Hendrix, C. C., Fournier, D. G., & Briggs, K. (2001). Impact of co-therapy teams on client outcomes and therapist training in marriage and family therapy. Contemporary Family Therapy, 23(1), 63-82.
Tanner, M. A., Gray, J. J., & Haaga, D. A. (2012). Association of cotherapy supervision with client outcomes, attrition, and trainee effectiveness in a psychotherapy training clinic. Journal of Clinical Psychology, 68(12), 1241-1252.

Agenda
Introduction (Nina Vasan and Anita Kishore)
Meet the presenters and understand individual experiences with co-therapy. 5 minutes.
Overview of Co-Therapy
Understand Adult Learning Theory. Review the literature on co-therapy. 10 minutes. (Dorothy Stubbe)

BREAKOUT SESSIONS
(3 sessions x 20 minutes each = 60 minutes. Each Subgroup will have a Role Play/Vignette and/or Video
1. How to Set the Stage for Co-Therapy (Shani Isaac)
   What key things do you need to consider when starting co-therapy? How do you engage with each other, the patient, and family to create a successful therapeutic experience?
2. How to Make the Institutional Case for Co-Therapy (Dorothy Stubbe)
   While beneficial to education and patient care, co-therapy requires resources. How do you talk to your department chair and justify and faculty time and financial cost?
3. How to Trouble Shoot in Co-Therapy (Isheeta Zalpuri)
   What common problems arise during co-therapy and what specific strategies can you use to address them?

--
Pearls (All)
Q&A and Wrap Up (Anita Kishore and Nina Vasan)—15 minutes

The Disciplinary Process: Navigating Passions, Pressures, and Values

Presenters
Ann Schwartz, MD
Sallie DeGolia, MPH, MD
Adrienne Bentman, MD

Deborah Spitz, 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 program directors, new and old, 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, may misrepresent the issues, or may 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!

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) (DeGolia and provide handouts)

10 min - Remediation plan and the contents of a disciplinary letter (Spitz)
15 min - Challenges and missteps in the Disciplinary Process (DeGolia and Schwartz)
25 min - Pitfalls and Collateral Damage (Spitz and Bentman)
30 min - Discussion, QA and wrap-up

To Dodge or Disclose: Minority Trainees' Perspectives on their own Cultural Identities in Clinical and Supervision Settings

Presenters
Ekta Taneja, MD
Priya Sehgal, MA, MD
Alecia Greenlee, MPH, MD
Amber Frank, MD

Educational Objectives
1. Participants will be able to identify ways in which the current socio-political climate of the United States may impact the interactions between trainees and patients, particularly for trainees from minority backgrounds.
2. Participants will be able to identify opportunities and challenges associated with discussing a trainee's cultural identity in interactions with patients and in supervision.
3. Participants will reflect on the impact of current events and trainees' own cultural identities within their own training programs.

Practice Gap
The ACGME and Institute of Medicine have recognized the importance of providing culturally-informed care, including thoughtful consideration of a patient's cultural background and identity in formulation and treatment planning. In addition to recognition of the importance of the patient's cultural background, the ACGME Psychiatry Milestones also comment on the importance of trainees' development of an ability to reflect on their own cultural backgrounds, including how their own backgrounds may affect patient interactions and care. Despite this, there is limited literature on integrating discussion of trainees' cultural backgrounds into didactic curricula and supervision. This workshop will offer participants the opportunity to explore the intersection between trainees' cultural identities and clinical care in the modern practice environment, as well as how these topics can be safely and productively reviewed in supervision.

Abstract
As the United States' demographics become increasingly racially and ethnically diverse, there is a continuing need to address the impact of cultural factors on clinical care and medical training. This is especially critical in light of recent racially, socially, and politically charged events across the country. While a body of literature exists regarding the importance of cultural formulation and sensitivity for patients' cultural backgrounds, very little has been written regarding the recognition, understanding, and integration of trainees' own cultural identities into their work with patients, supervisors, and their own professional development. This workshop will offer the opportunity for participants to explore some of the ways in which trainees' own cultural backgrounds may impact interactions with patients, colleagues, and supervisors, particularly for trainees from minority backgrounds. The workshop was collaboratively developed by trainees and faculty and will be active in nature, incorporating content based on the actual

experiences of trainees at a racially and ethnically diverse training program. In addition to working through sample scenarios, time will be offered for reflection on participants' individual programs. Topics will include navigation of expressions of bias or personal questions from patients related to a trainee's perceived race, ethnicity, or religion, as well as discussion of how faculty can facilitate sensitive and nuanced conversations about cultural identity with their trainees.

Agenda
Audience: Training Directors, Faculty, and Trainees
Agenda: 1) Welcome/Overview (10 min). Workshop leaders will provide an introduction to the workshop, including discussion of the perspectives of minority trainees from a diverse training program. 2) Scenarios and discussion (60 min). Participants will receive scenarios to illustrate current challenges faced by minority trainees in patient care and supervision. Using the scenarios, workshop leaders will guide participants in an interactive discussion of key themes and potential solutions. 3) Reflection and wrap-up (20 min). Participants will brainstorm ways to advance discussion of trainees' own cultural identities within their own training programs.

Training 21st Century Psychiatrists in Reproductive Psychiatry: Implementing the National Curriculum Project

Presenters
Sarah Nagle-Yang, MD
Caitlin Hasser, BA
Lauren Osborne, MD
Neha Hudepohl, MD

Educational Objectives
By the end of the workshop, participants will be able to:
1. Identify core content areas of reproductive psychiatry that should be included in every psychiatry residency program.
2. Describe 1 educational activity that may increase a resident's comfort and competence in treating women with mental health complaints related to menses, pregnancy, postpartum or menopause.
3. Develop an action plan to increase the Reproductive Psychiatry training opportunities for residents in their own institutions
4. Provide feedback to the Task Force on various methods of implementation that might increase the accessibility of Reproductive Psychiatry training on a national level.

Practice Gap
Over the past three decades, there have been substantial advances in our understanding of the mental health of women during times of reproductive transition. National policies favoring inclusion of women into clinical research have resulted in dramatically expanded knowledge about Reproductive Psychiatry, a specialized field of medicine that seeks to understand and treat mental health disorders related to female reproductive stages. This is evidenced by the growth of international professional societies (such as the Marce International Society for Perinatal Mental Health), has influenced public policy initiatives, and is increasingly disseminated into clinical practice. Specialized clinical programs span the treatment continuum from outpatient to partial

hospital to inpatient settings. Such programs have been created by specialists out of necessity because many general psychiatrists have not sufficiently mastered this new body of knowledge and do not feel competent to treat pregnant and postpartum patients. While there is no doubt that such programs provide outstanding care, they cannot begin to keep up with the clinical demand.

Unfortunately, the education of psychiatrists about reproductive mental health has lagged behind advances in research, public policy initiatives, and innovative models of clinical care. We recently surveyed residency training directors and found that training opportunities in this field vary widely between residency programs. Only 59% of included programs reported any required didactic teaching in reproductive psychiatry, and when didactic time was required, most programs allotted 5 or fewer hours for the field as a whole. Clinical exposure to the field was often dependent on whether or not female patients on non-specialist services happened to be pregnant or perimenopausal. Respondents to our survey indicated that the primary barriers to including or increasing reproductive psychiatry exposure within their programs were lack of time and lack of qualified faculty content experts.

This dearth of reproductive mental health education has had problematic consequences for women patients. There is clear need to ensure all psychiatrists acquire basic knowledge and skills in reproductive psychiatry to ensure competent care of this vulnerable group of patients.

Abstract
The National Task Force on Women's Reproductive Mental Health was founded in 2013 to address gaps in Reproductive Psychiatry education. Since that time we have worked to gather consensus from reproductive psychiatrists at large, have generated two national surveys designed to characterize the current state of education in this field, and have created a working group to develop a proposed standardized residency training curriculum.

This workshop will review current efforts toward developing a standardized national curriculum for reproductive psychiatry in residency training. We will engage with workshop participants in small groups for experiential learning about a sample content area. We will discuss potential delivery mechanisms for implementing a curriculum in programs without established experts through educational strategies such as flipped classroom methods, online courses, or skills based vignettes with a facilitators guide.

Agenda
0-10 min Introduction of presenters and Audience Poll
10-25min Overview of Curriculum Project
25-45min Small group activity on reproductive psychiatry patient care skills using vignettes
45-65 min Small group discussion of implementation strategies for programs without content experts
65-75 min Small groups discuss barriers to implementation and develop an action plan for next steps at individual institutions
75-90 min Wrap-Up, small groups report to large group.

Why in the world would someone become a chair?

Presenter
Laura Roberts, MA, MD

Educational Objectives
Upon completion of this session, participants will be able to:
1) describe the nature of the job
2) express their skills and "fit" with the role
3) understand the process of seeking and getting the job
4) understand and sustain themselves as leaders

Practice Gap
Understanding, nurturing, and supporting genuine leadership is an important commitment in our profession. A new generation of effective, forward-looking, virtuous, and positive leaders will help build a future in which people living with mental illness will be better cared for, stigma will be diminished, and the public health burden of neuropsychiatric disease will be lessened.

Abstract
Different roles have different responsibilities, and some roles have greater significance and influence than others. Department chairs use their expertise to benefit others in many ways, such as in providing direct clinical care, applying expertise (e.g., development of clinical programs, consultation), advancing knowledge across multiple arenas, educating members of the profession, and ensuring that professional standards are upheld. In this interactive workshop, the presenter will describe attributes important for success as a chairman, including a visionary attitude, perseverance, resilience, ability to withstand failure, intrinsic motivation and passion for mental health, cross-cultural communication skills, and wisdom. Faculty who may wish to become chair and faculty who want to figure out what their chairs do all day are welcome and will find the workshop to be useful. This dialogue-based workshop will involve interactive learning and Q&A formats, and it will have a tone of warmth and collegiality.

Agenda
15 min – describing the nature of the job
15 min – breakout partner discussions of motivations for career development
15 min – delineating individual skills and "fit" with the role
15 min – collaborative breakout conversations about preparedness
15 min – describing the process of seeking and getting the job
15 min – describing interviewing and negotiating for a new position

Posters

“Career Roadmap”: A Pilot Curriculum to Support Professional Identity Formation and Wellness for Psychiatry Residents

Presenters
Roxanne Bartel, MD, University of Utah School of Medicine (Leader)
Benjamin Lewis, MD, University of Utah School of Medicine (Co-Leader)
Paul Carlson, MD, University of Utah School of Medicine (Co-Leader)

Educational Objectives
We developed a pilot professionalism curriculum for PGY1 residents to be given during their intern orientation. This curriculum targeted professional identity formation with principles suggested by Cruess et al (2014). Five sessions were developed around themes of physician values, socialization, and wellness. We hypothesize that professional identity formation and resident wellness are linked and that a successful curriculum in this area may improve both professionalism and resident wellness.

Practice Gap
The concept of professional identity formation has been seen as increasingly important in medical education. In the 2010 Carnegie Foundation Report (Irby et al, 2010), it was proposed that professional identity formation should be a major focus in teaching medical students and residents. There have been efforts to link the development of professional identity to the stages of personal identity as delineated by Kegan (Cruess et al, 2015). Despite recent interest in facilitating professional identity formation through GME, there has been a lack of identified measures of professional identity development, and few resources demonstrating curricular interventions (Creuss et al, 2014).

Medical trainee wellness has similarly been a major focus of medical education in recent years. Up to 60% of practicing physicians report symptoms of burnout, which often peak during residency. In a recent GME survey of residents at the University of Utah (U of U GME office, 2016), 46% of residents reported significant symptoms of burnout, with 35 % of residents in the department of psychiatry reporting burnout. In a recent JAMA systematic review (2015), the summary estimate of the prevalence of depression or depressive symptoms among resident physicians was 28.8%, ranging from 20.9% to 43.2%. In the Utah GME survey, depression rate was 16% in all residents, and 10% in the department of psychiatry program.

The relationship between stages of professional development and resident wellness is not clear at this time. Stages of professional development involve role transitions- both in terms of clinical responsibilities as well as individual self-concept. We hypothesize a relationship between points of friction in these role transitions and resident wellness. Identity formation has been closely tied to progressive autonomy in clinical care- a process that has been prolonged and, in many ways, limited by the trend in national GME to curtail resident autonomy and work hours. We hypothesize that mismatches between estimated appropriate stage of professional development and clinical autonomy and responsibility may contribute to decreased resident wellness. As a result of these national changes in graduate medical education, stages of professional identity formation that have been historically more implicit may require more explicit attention.

Abstract
We hypothesize that a professionalism curriculum for residents targeting professional identity development will also impact resident wellness measures. Our pilot curriculum was organized using the principles outlined in the article, "Reframing Medical Education to Support Professional Identify Formation". The authors suggest that an educational intervention in this area should focus on values and socialization (Creuss et al, 2014). Integration of core values that are accepted by the profession is foundational to becoming a mature physician. "Socialization" in this article refers to learning to "play the role of physician" and understanding how "they are impacted by both negative and positive experiences" in the workplace (Creuss et al, 2014).

We developed a curriculum consisting of five sessions, each lasting one to one and half hours. They were conducted during intern orientation in the last week of June of 2016, and given to our eight incoming PGY 1 residents. Five sessions covered topics pertaining to the themes of values, socialization, and wellness. Session 1: Values and meaning (topics included- core values, what residents want to achieve in training, how will they achieve those goals, what is their strategy to ensure their values are developed, how can the program support process of developing values). Session 2: Training Trajectory (expectations for each year of training, what will happen if expectations not met, what are strengths and vulnerabilities in each year, thoughts on service and education). Session 3: Feedback (How does receiving feedback feel in different scenarios, exploring idea that feedback may be given in different ways). Session 4: Boundaries (patients, peers/colleagues, supervisors, different work settings); Session 5: Wellness (how is work life balance conceived, discussion of wellness activities)

Educational strategies in these sessions included writing assignments, worksheets, role -play, case studies, and open discussion. Pre-intervention worksheets assessed resident's prioritization of core values in their profession.

We will conduct post-intervention assessments to include completing the values worksheet again at six months. (mid-point of internship). We also plan to utilize the Oldenburg Burnout Inventory to track resident wellness across years of training. Finally, we will survey the interns as to their perceptions of the usefulness of our pilot curriculum.

Future goals include expansion of this curriculum over all PG years as developmentally appropriate, and obtaining IRB approval for more careful study of its effectiveness.

References:

Creuss RL, Creuss SR, Boudreau D, Snell L, Steinert Y. Reframing Medical Education to Professional Identity Formation. Acad Med. 2014; 89(11): 1446-1451.

Creuss RL, Creuss SR, Boudreau D, Snell L, Steinert Y. A Schematic Representation of the Professional Identity Formation and Socialization of Medical Students and Residents: A Guide for Medical Educators. Acad Med. 2015; 90(6): 718-725.

Irby DM, Cooke M, O'Brien BC. Calls for Reform of Medical Education by the Carnegie Foundation for the Advancement of Teaching. Acad Med 2010; 85:220-227.

Sanfey H et al. Service of Education: In the Eye of the Beholder. Arch Surg. 2011; 146(12): 1389-1395.

A Module-Based Curriculum to Enhance Resident Teaching Skills

Presenters
Laura Pientka, DO, University of Minnesota (Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)

Educational Objectives
1) To recognize importance of resident teaching on medical student learning during the psychiatric clerkship
2) To improve instruction skills, attitudes, materials, and resources available for residents to teach medical students
3) Enhance resident confidence in teaching abilities of medical students and demonstrate competence in the ACGME Teaching Milestone (PBLI3)

Practice Gap
It has been estimated that resident physicians provide from 20% to 70% of the clinical teaching to medical students. In addition, medical students who were taught by a highly-rated instructor (including both faculty and residents) during a rotation were more likely to choose that specialty. Psychiatry continues to face a shortage of providers and high-quality resident teaching may attract more medical student interest in this specialty. In addition, as established by the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology, residents must demonstrate competency in teaching as a part of the Practice-Based Learning and Improvement Teaching Milestone.

Teaching by residents is significant to medical student education and is essential for residents to demonstrate competency within the teaching milestone. The issue is not whether residents should teach, but how to help residents be more effective teachers. In addition, residents report little instruction on how to teach or report a lack of material and resources to teach students.

Abstract
Background: Residents often report a lack of easily accessible materials and resources to teach medical students during their psychiatric clerkship. Residents also report a lack of formal instruction on how to teach medical students. In addition, medical students also requested that residents develop a “Lesson of the Day” to enhance their clerkship experience. A curriculum was developed to address these concerns through the use of resident-led teaching modules.
Methods: Ten powerpoint modules were developed based on high-yield topics for medical students. The modules were designed to be 5-10 minute presentations in length and to be given by PGY-1 and PGY-2 residents on the University of Minnesota’s inpatient psychiatric services. Instructions on how to utilize the modules would be given during the PGY-1 and PGY-2 protected didactic time. Anonymous surveys will be sent to residents and medical students rotating on each service after each rotation period to evaluate the 1) perceived utility of the modules by residents and medical students as

teaching tools, 2) assess the resident reported confidence in resident teaching abilities. In addition, resident teaching scores from the medical student evaluation system will also be analyzed to identify any changes in resident teaching scores based on utilization of the teaching modules.
Results: Results of the surveys, which will be available by the time of the poster presentation.
Conclusion: This ongoing quality improvement project will assess whether residents feel that the module-based curriculum and instruction is helpful in improving their teaching skills. Limitations and future directions will be discussed.

Assessment of Communication in a Minority, Inner-city, Teaching Child & Adolescent Psychiatry Outpatient Clinic

Presenters
Marian Moca, MD, Brookdale Univ Hospital Medical Center (Leader)
Deborah Dwoskin, MBA, Brookdale Univ Hospital Medical Center (Co-Leader)
Mastan Lokireddy, MBBS, Brookdale Univ Hospital Medical Center (Leader)
Lizzet Garcia, MD, Brookdale Univ Hospital Medical Center (Co-Leader)

Educational Objectives
Participants will be able to:
1) Recognize the role of communication and interpersonal skills in training and daily practice.
2) Describe the relationship between communication and cultural competence in the racially and economically disadvantaged populations.
3) Appraise the discrepancy in the perception of communication in patients versus physicians in teaching facilities.
4) Integrate ongoing education on communication and cultural competence during residency and after.

Practice Gap
We live in an era where everything revolves around 'customer satisfaction'. The medical field is no exception to this rule. Major nation-wide accreditation bodies expect healthcare organizations to measure patient satisfaction. A national survey of physicians indicates majority believe disparities in treatment “rarely” or “never” happen, based on income, language, education, race or ethnicity. Racially, economically disadvantaged patients are more likely to have lower levels of trust and satisfaction with their physicians resulting in less diagnostic and treatment information, patient control over communication and involvement in treatment decision. Good interpersonal and communication skills are key elements to providing the best 'service' to our patients, and, hence, one of the ACGME core competencies . This comprises in the knowledge of context, cultural and social factors, skills such as listening, eliciting and providing information, educating patients and families, self-observation, and working in a team. Physicians in training come from diverse cultural backgrounds. While this is enriching,to the overall environment, it can also be a barrier to effective communication across cultures. ACGME as well as certifying boards now require training in communication and cultural competency. However, the literature shows that training does not always prepare residents and practicing physicians to meet the needs of patient populations.

Given this practice gap, our goal was to identify if such a problem exists in our community-based teaching child and adolescent psychiatry outpatient clinic. Preliminary results suggested that communication is not optimal. Next steps will be studies to further determine barriers to communication and design training strategies to address them.

References:
1. Castillo, DJ, Listening and Communicating = Patient Satisfaction and Better Care, Leadership Blog, The Joint Commission, September, 2013

Abstract

This is the work of two child & adolescent psychiatry fellows at Brookdale University Hospital and Medical Center, M. Lokireddy, PGY 5 (CAP 2) and L. Garcia, recent graduate, with M. Moca, Fellowship Director, as mentor. D. Dwoskin, Fellowship Administrator was part of the team and co-author.

Interpersonal and communication skills, one of the 6 ACGME core competencies, should lead to an effective exchange of information and a sense of teaming with colleagues as well as patients and families. Racially, economically disadvantaged patients are more likely to have lower levels of trust and satisfaction with their physicians resulting in less diagnostic and treatment information, patient control over communication and involvement in treatment decision. National survey of physicians indicates majority of physicians believe disparities in treatment “rarely” or “never” happen, based on income, English fluency, education, race or ethnicity. The goal of our project was to examine communication between patients and physicians in our teaching outpatient child & adolescent psychiatry clinic, located in a community that struggles with multiple socio-economic and health care disparities.

Methods:
A three-month pilot study was conducted to better understand strengths and weakness in our patient care system. A total of 600, 10 question, patient satisfaction surveys consistent with NY Office of Mental Health (OMH) Standard of Care (SOC) practice guidelines were distributed to primarily black and/or Hispanic, economically distressed patients. A racially diverse, focus group (faculty and trainees) was convened to explore physician’s perception of communication in the clinical setting.

Results:
Qualitative data was analyzed from 200 completed patient surveys and opportunities for improvement were identified in the domain of communication and information sharing with a low average relative score of patient satisfaction (41%). The focus group reported relative good communication (75%) with patients and colleagues. The focus group further identified barriers and opportunities regarding information sharing and integration.

Discussion:
Results are based on qualitative analysis and may be reflective of perceptions of communication of patients versus providers. They are influenced by factors related to the patients (only 30% of the survey responders) as well as factors related to the physicians (bias). Studies link cultural competence and communication skills training with better patient outcomes such as greater patient satisfaction.

Conclusions:
Our findings suggest a discrepancy between patient and physician reports of communication. More training on communication and cultural awareness is needed in the residency curricula and CME. Future steps will further explore options and design strategies to fulfill these desired outcomes.

References:
1. Kaiser Family Foundation, National Survey of Physicians - Doctors on Disparities in Medical Care, Menlo Park, March, 2002
2. Alegria M. et al, Racial and Ethnic Disparities in Pediatric Mental Health, Cultural Issues in Pediatric Mental Health, Child & Adolescent Psychiatric Clinics of North America, Oct, 2010
3. Thomas C. et al, Child and Adolescent Psychiatry Milestones Project, A Joint Initiative of ACGME and ABPN, July 2015
4. Cegala DJ, Lenzmeier Broz S., Physician Communication Skills Training: A Review of Theoretical Backgrounds, Objectives and Skills, Med Educ, Nov, 2002

Child and Adolescent Psychiatry Milestones: A Nationwide Survey of Fellow and Faculty Experiences

Presenters
Shannon Simmons, MD,MPH, University of Washington Program (Leader)
Christopher Varley, MD, University of Washington Program (Co-Leader)

Educational Objectives
After viewing this poster, participants will be able to:
1. Summarize faculty and fellow respondents' subjective experience with the milestones
2. Discuss future directions to improve the perceived value of the milestones.

Practice Gap
There are very little data on psychiatry faculty and fellows' subjective experiences with the milestones format of evaluation. A survey of internal medicine residents in 2015 yielded generally positive perceptions, [1] but no systematic review of child psychiatry faculty or fellows can be found in the literature. Anecdotal reports suggest that faculty have questions about the value of implementing this new process, and that fellows are not well informed about the intended benefits.

There is a strong need to understand how trainees and faculty experience the milestones, as this will impact their perceived value as targets for progression through training. Modifications and refinements may be needed over time in order for the milestones to be "meaningful, measurable, and manageable" as the Milestones Working Group intended. [2] Given the magnitude of this change for training programs, sharing and pooling of experiences, pitfalls, and successes will add to the efficiency and efficacy of this shift.

[1] Angus, S. et al. (2015). Internal Medicine Residents' Perspectives on Receiving Feedback in Milestone Format. Journal of Graduate Medical Education, June 2015, 220–224.

[2] Bernstein, EV, Balon, R, Coverdale, J. (2014). The Psychiatry Milestones: New Developments and Challenges. Academic Psychiatry, 38:249-252.

Abstract
Background:
The ACGME introduced milestones as a "framework for the assessment of the development of the resident physician in key dimensions."[3] They are intended to be used in semi-annual reviews and to report on the six ACGME core competencies. Child and Adolescent Psychiatry began using the milestones in July 2015.

Methods:
A brief survey was designed, with slight wording variations generating one version for fellows and one for faculty. There were five opinion questions about the milestones in a five-point Likert scale, four demographic questions, and an optional comments section. A link to this survey was emailed to every CAP program director in the USA and Puerto Rico with a request to send it to their fellows and core teaching faculty. The list of program directors was generated from the ACGME Accreditation Data System website. Survey responses were analyzed, and comments were categorized as negative, positive, mixed, or neutral.

Results:
Seventy-eight fellows and 101 faculty members from programs across the country, with a range of experience levels, participated. No significant differences were seen when comparing responses by program size, geographic region, or years of experience.

Averaged over the five survey items, 52.7% of faculty and 49% of fellows gave positive responses (agree or strongly agree). Neutral responses were given by 29.2% of faculty and 32.7% of fellows, and negative responses by 18.1% of faculty and 23.4% of fellows. The item with the highest proportion of positive responses by both faculty (67.3%) and fellows (56.4%) was, "The milestones effectively identify areas in which the fellows are in need of growth or improvement." The question with the highest proportion of negative responses for faculty was "The milestones effectively communicate rotation goals and objectives;" for fellows, "Compared to the previous evaluation format, the milestones are more helpful overall."

Fifty-four percent of faculty and 28% of fellows commented. Of faculty comments, 59% were assessed as negative, 17% positive, 19% mixed, and 6% neutral. Of fellow comments, 59% were negative, 14% positive, 18% mixed, and 9% neutral. A common negative theme was the perception that the process was burdensome. A common positive theme was the ability to differentiate levels of skill over time.

Conclusions:
Approximately half of faculty and fellows responded positively to survey questions about the milestones, with neutral responses given by approximately one third of each group. However, most comments were negative. Reasons for this discrepancy are unclear, though many comments were about topics not covered in the survey questions.

These findings contribute to our understanding of faculty and fellows' early experiences with the milestones. Future directions include working to understand how to best orient

faculty and trainees to the process, and how to implement the milestones efficiently and in a way that is truly valuable.

[3] The Child and Adolescent Psychiatry Milestone Project: A Joint Initiative of the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology. October 2014.

Combined Training in Internal Medicine and Psychiatry at Duke University

Presenters
Jane Gagliardi, MD,MSc, Duke University Medical Center (Leader)

Educational Objectives
After reading this poster, participants will
1. Be familiar with combined training in internal medicine and psychiatry in general
2. Be able to state proposed benefits of combined training
3. Understand the curriculum provided in the Duke combined residency in medicine and psychiatry

Practice Gap
With ongoing changes in the method of healthcare delivery, the provision of behavioral healthcare in patient-centered medical homes is anticipated to play a large role in institutions' ability to provide high-quality care at lower costs. Over many decades data have convincingly demonstrated the important role of behavioral health care provision in lowering morbidity and expenses (including hospital and ED visits as well as quality of life metrics) from medical problems. In 2015 the ABPN lifted the moratorium on new combined residency training programs. Training directors in institutions without combined residency training programs may not be aware of the fact that the moratorium has been lifted or of the possible benefits for both combined trainees and trainees in individual departments of having a combined training program.

Abstract
The Duke University Hospital Combined Residency in Internal Medicine-Psychiatry was started by training directors in the Categorical Medicine and Categorical Psychiatry programs in the mid 1995s when the healthcare landscape seemed to indicate a coming prominence of healthcare management organizations (HMOs). At the time, primary care and outpatient work were envisioned as the main niches for combined physicians to practice. Over the years, the combined training program has remained strong and enjoys support and positive regard from chairs in both departments. In 2001 a combined medicine-psychiatry service was opened; this has remained one of the core Medicine rotations for Categorical Psychiatry interns as well as a requirement for combined trainees in the intern year and beyond. The presence of the combined program has facilitated the introduction of evidence-based medicine into the Categorical Psychiatry residency program and has catalyzed the development of a hospital-based model for psychiatry acute care service delivery in the institution. Innovations including a stepped-care case-management model of integrated collaborative care, psycho-oncology, transplant psychiatry and other consultative and embedded models have been

undertaken by trainees and graduates of the program. The poster highlights the philosophy, goals, curriculum, activities and educational outcomes for the Duke combined residency in Internal Medicine and Psychiatry.

Cultivating Trainee Skills and Interests in Advocacy through Participation in an Asylum Clinic

Presenters
Nina Sreshta, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Nikhil "Sunny" Patel, MD,MPH,MS, No Institution (Co-Leader)
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
J.Wesley Boyd, PhD,MD, No Institution (Co-Leader)

Educational Objectives
1) Describe an elective experience in performing refugee asylum evaluations for adult psychiatry residents
2) Identify the benefits of this experience for trainees and patients
3) Outline basic steps that training programs can take to implement similar electives at their home institutions

Practice Gap
The importance of cultivating both cultural competence and ethical practice for trainees in psychiatry has been widely recognized in the undergraduate and graduate medical education communities. The ACGME Milestones in psychiatry also describe skills and activities in advocacy as higher-level goals for resident learners. Despite general agreement on the importance of these educational objectives, clinical learning opportunities in which residents have the opportunity to integrate all of these skills and attitudes can be limited. This presentation describes the implementation of elective work in a Refugee Asylum Clinic as a way of meeting both a critical patient need and these educational needs for residents. Benefits to learners and patients will be described, and challenges to implementation will also be discussed. Critical considerations for implementation of similar programs at other institutions will also be reviewed.

Abstract
At present, one out of every 122 persons worldwide is a refugee, internally displaced person, or an asylum seeker. Refugees and asylum seekers almost always have significant trauma exposure and thus are at high risk for post-traumatic stress disorder; several studies have estimated rates of PTSD among the refugee population to be between 27-60%. [1] Symptoms of PTSD, such as disordered memory, numbness, and reduced responsiveness to the outside world, can make it difficult for asylum seekers to be granted asylum. Psychiatrists, as expert witnesses, can provide context and corroboration for an asylum seeker’s trauma and thus reinforce the credibility of the asylum seeker, as well as explain how mental illness affects behaviors, ability to talk about the trauma one might have suffered, and overall demeanor.

Over the last eight years, psychiatry residents at the Cambridge Health Alliance (CHA) have participated in conducting approximately 70 pro-bono psychological assessments for people seeking asylum through the staff psychiatrist-supervised CHA Asylum Clinic.

Psychiatry trainees participating in the clinic are able to perform a variety of services, including meeting and discussing the asylum-seeker's case with the immigration lawyer, reviewing pertinent records, performing a diagnostic psychiatric evaluation, and preparing a psychological assessment affidavit, all under the supervision of a staff psychiatrist. The resident also has the opportunity to witness staff psychiatrists testify before an immigration judge. In addition to providing essential psychiatric services to a vulnerable population, this work has been an invaluable part of psychiatric training for resident physicians. This poster will describe some of the benefits of participation in this program for resident-trainees, including the opportunity to come face to face with significant trauma, shape a code of ethics, and effect change in the lives of those they meet. Considerations for other institutions interested in implementing similar programs will also be described.

1. Robjant, K., Hassan, R. and Katona, C., 2009. Mental health implications of detaining asylum seekers: systematic review. The British Journal of Psychiatry, 194(4), pp.306-312.

Do Characteristics of Resident Applicants Predict Future Board Certification in Psychiatry?

Presenters
Matthew Macaluso, DO, University of Kansas School of Medicine, Wichita (Leader)
Tara Richardson, MD, University of Kansas School of Medicine, Wichita (Co-Leader)
Rosey Zackula, MA, University of Kansas School of Medicine, Wichita (Co-Leader)

Educational Objective
1. Evaluate if residency recruitment can be studied in a way that informs candidate selection.
2. Understand if characteristics of the residency applicant predict future board certification in psychiatry.

Practice Gap
Recruiting applicants who complete graduate medical education and become board certified is a goal of all residency programs. Outside of psychiatry, other disciplines have rigorously studied the characteristics of applicants that predict future specialty board certification. Other medical specialties have focused on United States Medical Licensing Exam (USMLE) scores, prior research experience, honors in medical school, class rank, and dean's letter as factors predictive of future board certification. Despite this focus, such studies do not point toward definitive characteristics of residency applicants as predictive of future board certification, nor do they involve psychiatry residency programs.

Our general psychiatry residency program, which has a total complement of 20 residents annually, typically interviews sixty to eighty applicants for five PGY-1 positions. Applicants are chosen based on objective measures including medical school grades, USMLE/COMLEX Step I and II scores, class rank, and medical school honors. There are intangible factors that are difficult to measure, such as the quality of a candidate's personal statement and letters of recommendation. Despite these well-established

practices at our institution, a review of the literature yielded scant evidence to support any measure as predictive of achieving board certification in psychiatry. Therefore, we investigated the extent to which attributes of past incoming residents were predictive of achieving board certification in psychiatry.

Abstract

OBJECTIVE: The overall goal of this study was to understand if residency applicants in psychiatry could be studied in a systematic way that informs resident selection. In order to do so, we completed a pilot study using a retrospective, cross-sectional design to identify characteristics of residency applicants that predicted certification by the American Board of Psychiatry and Neurology (ABPN).

METHODS: We extracted data from personnel files and application materials of 106 residents who entered the psychiatry program at the University of Kansas School of Medicine-Wichita between 1972 and 2010. A dichotomous outcome (certified or not certified) was utilized to evaluate associations between applicant characteristics and future ABPN certification. However, data were sparse and an analysis of the missing data revealed random occurrence of missing values (MAR). To estimate the missing data and correct for the possibility of a biased sample resulting from listwise deletion during the model building process, we conducted five runs of multiple imputations. All available information was incorporated into the runs, including personal characteristics, medical school performance, and residency performance. Measures with over 50% missing values were not imputed, nor were they considered when constructing a predictive model for outcomes (board certification). Descriptive statistics, Chi-square tests, and binary regression with a complementary log-log link were conducted in IBM SPSS Statistics version 23.

RESULTS: Pooled model results showed that applicants with prior experience in volunteer work (RRadj ranging from 1.3 to 3.5) or research (RRadj ranging from 2.9 to 7.9) were significantly more likely to become board certified when compared with those with no such experience. Graduating from a medical school located in the U.S. versus outside the U.S., number of work experiences, age at graduation, delay from medical school graduation to start of residency, and USMLE Step 1 scores were not significantly associated with board certification.

DISCUSSION/CONCLUSION: Our data show that medical students who are involved with volunteer work or research are significantly more likely to achieve ABPN certification. Residents with 1 or 2 research experiences while in medical school were about three times as likely to achieve board certification compared with those having no research experience, which means these individuals successfully completed the program, met the board's criteria, and passed the board's examinations. Similarly, those with 3 to 4 volunteer experiences were more than twice as likely to achieve board certification. An interesting finding from our sample was the lack of association between performance on USMLE/COMLEX step examinations and future board certification, which contradicts literature from other specialties. These results demonstrate that systemic evaluation of residency applicants may inform candidate selection. The study results are limited by small sample size, sparse data, and a focus on only one training program. Further study on a larger scale is needed to validate and replicate these findings.

How Does Viewing Webcam Footage in Case Conference Affect Diagnostic Consensus?

Presenters
Shayne Tomisato, MD, Maricopa Integrated Health System (Leader)
Jennifer Weller, PhD, Maricopa Integrated Health System (Co-Leader)
David Drachman, PhD, Maricopa Integrated Health System (Co-Leader)

Educational Objectives
1. Learn how viewing webcam footage during case conferences and presentations affects or does not affect diagnostic consensus among types of raters in child/adolescent psychiatry fellowship training programs.
2. Learn how diagnostic consensus in the context of child psychiatry case conferences does or does not differ among mental health professionals, trainees, and medical students.

Practice Gap
In psychiatry, clinicians often encounter diversity of opinion among peers with respect to conceptualization and selection of patient diagnoses. Case conferences are one mechanism by which mental health professionals in training programs not only explore diagnostic possibilities but also attempt to build consensus about what actual psychiatric diagnoses are represented by specific symptom presentations. This study aims to address the practice gap that exists in understanding how use of video technology, which provides audio and visual observation of patients, does or does not affect diagnostic consensus compared to presentations that utilize only verbal and written material about patients. Using a unique format, this study identified differences in diagnostic consensus among raters at case conferences, and discussed potential reasons why clinicians may interpret symptoms and apply them to DSM diagnostic criteria in different ways.

Abstract
In traditional case conferences, faculty or trainees present information about patients using a verbal format. With video recording equipment, training programs can utilize audio and visual data to augment case discussions. In a 2016 AADPRT poster presentation, the authors examined ways in which observing webcam footage might improve diagnostic conceptualization of patients. The current presentation explores how viewing webcam footage affects diagnostic consensus among raters. Participants in child and adolescent psychiatry (CAP) diagnostic case conferences listened to an oral presentation and viewed written patient and family histories of a child case. Next, participants rendered their top three diagnostic impressions of the child in order of perceived importance and their degree of confidence in these impressions. Raters then observed webcam footage, and recorded their post-view top three diagnostic impressions and confidence rating in those diagnoses. Highlights from the March 2016 poster were that diagnoses did not change significantly within broad diagnostic categories after viewing webcam footage; however, some raters reordered them to reflect a different primary diagnosis. Raters expressed greater confidence in their diagnoses after video presentations. In the current poster, the

issue of diagnostic consensus among raters is explored. Study raters included attending child psychiatrists, attending psychologists, first- and second-year CAP fellows, a master's level social worker, and rotating medical students. Overall consensus between and among raters did not change to a statistically significant degree from pre- to post-viewing, but trends were noted. Different rater groups had different levels of consensus in diagnostic impressions. Medical students showed the lowest level of consensus among themselves and when compared to other rater groups. This finding makes sense in light of their limited exposure to the mental health field. Second-year CAP fellows showed the highest degree of consensus among themselves, and first-year CAP fellows showed the second highest degree of consensus among themselves. There was a moderate level of consensus among attendings, which was still lower than level of consensus among CAP fellow rater groups. The higher level of consensus among CAP fellows is of interest because it may contradict the notion that attendings (with the greatest level of clinical experience) should have the highest degree of diagnostic consensus. This finding would imply that shared training experiences are more influential when formulating diagnostic impressions than number of years in practice. Attendings at case conferences were trained at a variety of fellowship programs and may conceptualize cases somewhat differently. Although clinicians like to think that we assess psychiatric symptoms and disorders accurately and in ways that are consistent with peers, trends in this study suggest otherwise. Diagnostic formulation can be influenced by training program experiences, length of training, interaction with professional colleagues, and subjective interpretation of DSM criteria, among other factors. In this study, reviewing auditory and visual information through webcam footage during case conference did not have a significant impact on rater consensus of diagnosis, beyond the level of consensus established after presentation of written and verbal case information.

Institutional Variables Association with Student Recruitment Rate into Psychiatry

Presenters
John Spollen, MD, University of Arkansas for Medical Sciences (Leader)
Matthew Goldenberg, MSc,MD, Yale University School of Medicine (Co-Leader)
D. Keith Willaims, PhD, University of Arkansas for Medical Sciences (Co-Leader)
Tristan Gorrindo, MD,PhD, American Psychiatric Association (Co-Leader)

Educational Objectives
Participants will be able to:
1. Describe the effects of school location, student debt, class size and clerkship length have on recruitment rates and postulate possible mechanisms through which these factors may exert their influence.
2. Predict the effects of increasing class size, growing student debt and shrinking clerkships may have on psychiatry recruitment rates and describe interventions that may mitigate these effects.

Practice Gap

There is a shortage of mental health specialists, including psychiatrists, in the US health system. Recruitment of medical students into psychiatry has long been important to psychiatric educators and has increasingly become a priority of health policy makers as well. While the percentage of U.S. seniors choosing psychiatry has increased slightly over the last several years to 5% in 2016, only 50-62% of psychiatry residency positions have been filled with graduates of allopathic US medical schools since 2011. Over the last decade the mean recruitment rate from individual allopathic medical schools in the United States varied from less than 2% more than 8% which is consistent with the theory that there are institutional effects on recruitment rate. There has been little recent literature on medical school factors-related to recruitment rates and understanding these factors could assist with development of interventions to increase psychiatry specialty choice.

Abstract

Background: Medical student recruitment into psychiatry is frequently reported as a concern worldwide. In the United States, while the average recruitment rate by medical school is around 4%, the mean recruitment rate for individual schools over the last decade varied from less than 2% more than 8% which is consistent with the theory that there are institutional effects on recruitment rate. Previous research identified several institutional factors associated with US psychiatry recruitment rates including public versus private schools, the section of the country the school was in, and length of the clerkship.

Purpose: To understand which factors are associated with recruitment rates so effective interventions can be developed to increase psychiatry recruitment rates.
Methods: Institution level data from 130 allopathic medical schools in the United States including tuition and fees, graduating student debt, and clerkship duration from 2003-2015 were obtained from the Association of American Medical Colleges. A generalized linear model was used to evaluate their association with the school's annual recruitment rate into psychiatry. Recursive partitioning was used to identify subgroups with significantly different recruitment rates.

Results: Using logistic regression, significant associations with recruitment rate were found for region of the country, student debt, class size and clerkship length: Western, Northeastern and Southern schools had higher recruitment rates than Central schools; for every 10% increase in percentage of graduates with >200K in debt, the odds of choosing psychiatry decrease by 4%; for every increase in class size by 30, the odds of choosing psychiatry decrease by 4%; and for every additional week of a clerkship, the odds of choosing psychiatry increase by 9%. Using recursive partitioning, class size of 154, Central vs. all other regions, % of graduates with >200K in debt of either 17% or 61%, and clerkship length of either 4 or 6 weeks were all factors that could identify subgroups of schools with significantly different recruitment rates.

Discussion: The growth of medical student class size and national trends of increasing costs of medical school and graduate indebtedness may be a drag on future psychiatry recruitment rates. Clerkship length appears to have a measurable effect on recruitment rate, although the mechanism of that effect is unknown. Further analysis will include student evaluations of the psychiatry clerkship and preclinical courses obtained from the AAMC Graduation Questionnaire.

Integrated care: should it count as community psychiatry training for psychiatry residents?

Presenters
Kevin Buhr, PhD, No Institution (Co-Leader)
Robert Factor, PhD,MD, No Institution (Co-Leader)
Art Walaszek, MD, University of Wisconsin Hospital & Clinics (Leader)
Elizabeth Zeidler, PhD, No Institution (Co-Leader)

Educational Objectives
1) List attitudinal aims of community psychiatry rotations.
2) Compare integrated care rotations with "traditional" community psychiatry rotations with regards to outcomes in attitudinal aims.
3) Compare integrated care rotations with "traditional" community psychiatry rotations with regards to satisfaction with teamwork and approach to patient care.

Practice Gap
There have been recent reports in the literature of curricula to train psychiatry residents in the integrated care model. However, there have been no such reports comparing “traditional” community psychiatry rotations with integrated care rotations. Anecdotally, several psychiatry residency programs are 'counting' integrated care rotations as community psychiatry experiences. Even if integrated care rotations meet many Accreditation Council for Graduate Medical Education (ACGME) requirements for community psychiatry experiences, it is important to establish that they also meet many of the aims of traditional community psychiatry experiences, if they are to be considered as replacements for more traditional rotations. Attitudinal aims of community psychiatry rotations may be more important than knowledge- and skill-based ones. These attitudinal aims include: increasing comfort with management of severely psychiatrically ill patients in the community as opposed to in long-term institutions; satisfaction with opportunities for work in interdisciplinary teams; maintenance of hope for severely ill psychiatric patients; and satisfaction with the level of care that can be provided in community settings. Outcomes related to these aims of integrated care versus traditional community psychiatry rotations have not been reported in the literature to date.

Abstract
Psychiatry residents are required by the Accreditation Council for Graduate Medical Education (ACGME) to be exposed to community psychiatry. Historically, this occurred in public hospitals or Assertive Community Treatment (ACT) teams. A newer model of psychiatric care delivery, integrated care, has become prevalent. It is unclear if integrated care rotations can accomplish the aims of traditional community psychiatry rotations. This pilot study compares an integrated care rotation with a traditional community psychiatry rotation. Pre- and post-rotation surveys were disseminated to post-graduate year (PGY)-3 residents (N=8) randomly assigned in a 1:1 ratio to complete a three-month long community psychiatry rotation at one of two sites: a “traditional” community psychiatry site, i.e., an ACT team at the Veterans Affairs Hospital, or an urban federally qualified health center (FQHC) as part of an integrated care team. Survey instructions included a fictional case of a patient with severe and persistent mental illness, with six related questions asking the resident to estimate level

of safety risk, functional status, intensity of long-term psychiatric care needed, and treatment recommendations given certain levels of psychiatric decompensation. There were not any single correct answers to the questions, but they allowed general attitudinal tendencies to be assessed. Total pre- and post-rotation conservativeness-of-care scores were then calculated for each resident. Survey instruments also asked questions to assess the residents' pre-rotation anticipated satisfaction with teamwork and with the approach to patient care at the assigned setting, and post-rotation actual satisfaction with teamwork and the approach to patient care at that setting. Survey data were analyzed using R version 3.2.3. Descriptive statistics for total conservativeness-of-care and satisfaction scores and individual questions were calculated at both time points and for pre-post differences. Pre-post change in the full n=8 cohort was assessed with paired t-tests; differences in scores and/or pre-post changes between rotations were assessed with two-sample t-tests. By rotation end, many individuals in both settings changed how 'conservative' they were in treatment philosophies. However, there was no consistent shift towards more or less conservativeness of care in the residents as a whole (n=8, p=0.96) and no evidence of a difference by rotation type (p=0.39). Residents in both settings ended up significantly more satisfied with teamwork and with the approach to patient care at their assigned settings than they anticipated they would be prior to the rotation (p=0.04). There was no evidence of a difference in change in satisfaction by rotation type (p=0.41). Residents in both groups expressed overall satisfaction with their rotations. In conclusion, training in integrated care may be a reasonable alternative to traditional community psychiatry rotations for providing required community psychiatry exposure for psychiatry residents. This study may serve as a pilot proposal on which future, larger studies can build.

Knowing Our Roles and Reaching Our Goals—Defining Modern Psychiatry As It Is, and Ought To Be

Presenters
Benjamen Gangewere, DO, Allegheny General Hospital Program (Leader)
Krithika Krishnarao, DO, Allegheny General Hospital Program (Co-Leader)
Steve Wolfe, DO, Allegheny General Hospital Program (Co-Leader)
Gary Swanson, MD, Allegheny General Hospital Program (Leader)

Educational Objectives
Learners will identify and compare the essential roles of a psychiatrist as seen from the perspectives of family practitioners and internists, both those in training and in practice. Learners will describe the current perception of what psychiatrists do well from the perspective of family practitioners and internists, as well as what psychiatrists currently do not do well.

Practice Gap
The role of a psychiatrist has been constantly changing over the decades. Communication between psychiatrists and other medical specialties has been an ongoing source of concern, particularly in the outpatient and primary care settings. Psychiatrists entering the workforce, as well as starting in training, are being asked to provide consultation and psychiatric care while integrated in primary care settings with internists and family practitioners. Physicians from varying specialties likely have very different perceptions of who psychiatrists are and what they will do. These perceptions

may lead to a variety of expectations, that are important to understand if communication is to be improved and integration is to be successful for all involved. These perceptions and expectations need to be formally assessed.

Abstract
1. The profession of psychiatry has undeniably changed over the last several decades due to many factors including: progress in neurobiology, the deinstitutionalization of many patients, the shortage of psychiatric services, the availability of more pharmacologic and non-pharmacologic interventions, and the dawn of newer fellowships and subspecialties within the psychiatric field. In accordance, the role of a psychiatrist as perceived by other medical specialties has also been progressively changing. It is important for psychiatrists, as a profession, to define who we are and what we do. That definition determines our purpose, how we achieve that purpose, and how we educate the next generation of psychiatrists. Perhaps equally important is to understand how our physician colleagues in the other specialties view our roles, our responsibilities, and our duties as psychiatrists.

2. Our hospital system is in the process of initiating integration of psychiatrists and other clinicians into primary care settings. We surveyed all of the internal medicine residents, internal medicine attendings, family medicine residents, and family medicine attendings in our system to understand how they perceive our current psychiatric role and what they expect it to be. The survey included perceptions and expectations of the roles of psychiatric care providers in patient management for a number of psychiatric problems, as well as chronic medical conditions, end of life care and substance abuse. We also assessed their perceptions and expectations in regard to medication initiation, maintenance and adherence; the importance of outpatient follow up; psychotherapy vs pharmacology; communication strategies; and overall integration into the primary care setting.

3. We expect to use this information to guide our psychiatric care providers as they start to work in an integrated setting, and to continue to assess effectiveness of our care and satisfaction with our services.

Physician self-care: A resident initiated and run wellness group

Presenters
Michelle Weckmann, MD,MS, University of Iowa Hospitals & Clinics (Leader)
Alison Lynch, MD,MS, University of Iowa Hospitals & Clinics (Co-Leader)
Holly Thro, MD, University of Iowa Hospitals & Clinics (Co-Leader)

Educational Objectives
After viewing this poster, participants will:
1) be familiar with the incidence and impact of burnout among physicians, specifically residents;
2) be able to describe a resident run model for a wellness group;
3) be aware of the potential impact on residents when incorporating a resident run wellness group during training.

Practice Gap
Recent studies have highlighted significant levels of physician burnout in trainees as well as seasoned physicians (medical students 44-50%; residents 60-76%, practicing physicians 54-60%). Burnout is associated with a host of negative physician outcomes including increased rates of depression and substance abuse and decreased professionalism. Various strategies have been proposed to decrease burnout including: mindfulness training; increasing feelings of belonging and connectedness; improving work-life balance/satisfaction; facilitated discussion groups; and employing self-care techniques. The ACGME milestones mandate that we track a resident's progress with regards to physician impairment and maintenance of personal well-being. Therefore, the identification of factors related to burnout and the promotion of strategies to increase wellness and resiliency have the potential to enhance milestone activities while providing residents with the skills needed to thrive in their careers.

1. Holmes et al. Taking Care of Our Own: A Multispecialty Study of Resident and Program Director Perspectives on Contributors to Burnout and Potential Interventions. Acad Psychiatry. 2016 Jul 19. PMID: 27436125

2. Dyrbye et al. A narrative review on burnout experienced by medical students and residents. Med Educ. 2016 Jan;50(1):132-49. PMID: 26695473

3. McKenna et al. The Missing Link: Connection Is the Key to Resilience in Medical Education. Acad Med. 2016 Sep;91(9):1197-9. PMID: 27438155

Abstract
OBJECTIVES: The goal of this poster is to describe a resident initiated wellness activity. Senior combined family medicine-psychiatry residents, recognizing the importance of self-care, brought up the idea of a regular time to promote wellness. After brainstorming, they proposed the development of a scheduled resident run "wellness time."

METHODS:
1. With the overarching goal to not increase stress or workload, the residents all decided to combine wellness time with the previously established monthly journal club time. Their proposal was to alternate each month between wellness and journal club.
2. The residents agreed to read and discuss the book Stop Physician Burnout by Dike Drummond, MD and to utilize and discuss the app Burnout Proof.
3. Interested residents meet bi-monthly for 60-90 minutes to discuss the book, app and other resident-raised topics.
4. The residents will be surveyed prior to the AADPRT meeting as to the usefulness of the wellness group.

RESULTS: Results of the survey, which will be available at the time of the poster presentation, will reflect the residents' attitudes about the utility of a resident run wellness group for promoting physician self-care activities.

DISCUSSION/CONCLUSION: Physician wellness and self-care is an important skill for residents to learn. It is hoped that a resident wellness group that was suggested, organized, and run by residents will be perceived as useful and beneficial to their well-being and will increase resilience.

Presence with Residents: The role of a brief experiential mindfulness curriculum in promoting resident wellness.

Presenters
Alexandra Hedberg, MD, McGaw Medical Center, Northwestern University (Leader)
Mason Hedberg, MD, University of Chicago (Co-Leader)
Elaine Cheung, MD,PhD, McGaw Medical Center, Northwestern University (Co-Leader)
Joan Anzia, MD, McGaw Medical Center, Northwestern University (Leader)

Educational Objectives
1) To describe the benefits of mindfulness training and practice for physician trainees
2) To describe the implementation of a brief curriculum on mindfulness training in a residency program, and the resulting benefits as reported by PGY2-PGY4 residents.
3) To explore a variety of ways in which training in mindful meditation could be implemented in residency training programs.

Practice Gap
There is abundant evidence of the benefits of mindfulness practice in improving quality of healthcare delivery and mitigation of physician burnout , but few studies of the feasibility of implanting mindfulness training and practice into psychiatry residency programs, and the benefits from such programs.
There needs to be more research on feasible, effective means to implement mindfulness training and practice in residency.

Abstract
A growing body of medical literature on mindfulness practice promises utility for both patients and practitioners. Research on the benefits of mindfulness practice for physicians is extensive - mindfulness training not only improves quality of healthcare delivery but also mitigates physician burnout. There is little data on the efficacy and feasibility of incorporating mindfulness curriculum into residency training. In this poster, we discuss a pilot program at the Department of Psychiatry and Behavioral Sciences at Northwestern Feinberg School of Medicine. 18 psychiatry residents ranging from PGY2-PGY4 were participants in a half-day on-site meditation retreat as part of their regularly scheduled didactic curriculum. This mini-retreat was followed by weekly elective 30-minute refresher sessions for one month. Self-report surveys evaluating perceived stress, self-compassion, burnout, mindfulness and barriers to practice were filled out prior to the retreat and at one-month follow up. At the one-month follow-up, residents reported increased mindfulness ($t(13) = -2.44$, $p = .029$) and greater meditation frequency ($t(13) = -3.22$, $p = .007$) relative to baseline. There were no observed changes in perceived stress, self-compassion or burnout as reported in larger, more robust studies of physician meditators. Our data is limited by the design of this small pilot study, but our findings suggest that psychiatry trainees can and do utilize mindfulness skills. Further scholarly attention is necessary to determine what constitutes an optimal exposure to mindfulness in psychiatry residency training so as to make a meaningful impact on resident wellness.

Professional Identity Formation in the Community of Psychiatric Practice

Presenters
Sandra Rackley, MD, Mayo School of Graduate Medical Education (Leader)

Educational Objectives
1) Define professional identity formation
2) Describe how psychiatry residents experience their professional identity formation during residency
3) Describe Lave and Wegner's concept of Legitimate Peripheral Participation in Communities of Practice

Practice Gap
To be worthy of the public's trust, good physicians need to not only possess requisite knowledge and technical skill, but also to "think, act, and feel like a physician." What we desire as an outcome of medical training is not just a person who can behave like a doctor, but someone who IS a doctor. A good physician builds "doctor" into their sense of themselves, making it part of their identity, and is then consistently recognized as a "doctor" by those around them.

Professional identity may be particularly relevant to the practice of psychiatry, given its emphasis on the use of the physician's self and the doctor-patient relationship as a core diagnostic and therapeutic tool. Psychiatric diagnosis and treatment decisions are often highly complex and ambiguous, relying as they do on the physician's interpretation of subjective data provided (or withheld) by the patient and other observers. These decisions become even more complex when made in the setting of illnesses that impair patient autonomy and self-determination, or when involuntary treatment intensifies the power imbalances in the doctor-patient relationship. A competent psychiatrist's decisions about what to do in ambiguous situations arise out of their identity as a psychiatrist – the values, attitudes, and beliefs that have become part of who they are. Professional identity formation is an essential aspect of becoming a psychiatrist.

However, in the context of advances in behavioral neuroscience and financial pressures shaping the way many psychiatrists practice, a consistent definition of what it means to be a psychiatrist is elusive and evolving. Thus, psychiatry residents are forming their professional identity even as the definition of that identity is changing. A better understanding of how professional identity formation occurs in psychiatrists is needed if training programs are to support and encourage that development in the midst of complexity.

Abstract
Introduction: There have been increasing calls to attend to physician professional identity formation in medical education, but scant empiric evidence exists that describes how this occurs, particularly beyond the undergraduate medical school years. Psychiatric training, with its particular focus on use of the self of the physician in diagnosis and treatment, provides a rich setting in which to examine phenomena of professional identity formation.

Methods: The central research question was "how do psychiatry residents experience

their professional identity formation?" Because the central research question is focused on understanding and making meaning of an experience, these questions are best examined with qualitative methodology. In particular, to describe the essence of a shared experience, phenomenological methods were used in this study.

We focused on psychiatry residents in a single residency program, given the theoretical suggestion of the close tie between identity formation and social context. All residents in their final six months of general Psychiatry training (n=6) were invited and agreed to participate. In order to maximize variation, invitations to participate were also extended to current psychiatric subspecialty fellows who had completed their residency at the same institution. Out of 12 potential participants, 11 agreed to participate in the study. Each resident participated in a semi-structured interview lasting 60-90 minutes. Questions focused on the evolution of the residents' sense of themselves as psychiatrists and salient aspects of their experience. Subjects were asked to participate in a second interview of 30-60 minutes to clarify themes from the first interview and to share any further reflections that had emerged. Interviews were audio recorded and transcribed by a professional transcriptionist.

Consistent with phenomenological methods, data analysis occurred simultaneously with data collection. Following the procedures outlined by Moustakas, data were analyzed through a process of "horizonalization." Transcripts were coded, and as themes emerged from the data that reflected various horizons of the experience of professional identity formation, these were clustered through the process of phenomenological reduction to capture the essence of the shared experience of professional identity formation. No predetermined codes or themes were used, and imaginative variation was employed to develop a cluster of themes that best represented the data.

Results: Themes of participant responses highlighted two core dimensions of the experience of professional identity formation during psychiatric residency: 1) psychiatric residents form their professional identity through increasing identification with the community of psychiatric practice and confirm this through their increasing authority to define the practice, and 2) professional identity in psychiatric residents grows from resolution of a "nexus of multimembership," with trainees engaging in active and reflective processes to integrate disparate aspects of identity into their professional identities.

Conclusion: This study provides empiric validation of Lave and Wegner's concept of professional identity formation via legitimate peripheral participation in a community of practice. This understanding may help program directors incorporate a more explicit focus on professional identity formation during residency training.

Psychiatry Resident Inter-professional Simulation Lab: A Pilot Project

Presenters
Laura Montgomery-Barefield, MD, University of Alabama at Birmingham (Leader)
Blessing Falola, MD, University of Alabama at Birmingham (Co-Leader)

Educational Objectives

1) To increase confidence of incoming psychiatry interns in handling challenging clinical encounters with the use of simulation in integrating didactic knowledge into critical skills in a controlled environment.
2) The use of simulation to reduce the steep learning curve interns often experience during transition from medical school to psychiatry residency.
3) Reinforcement of the concept of teamwork with interdisciplinary professionals early in training.

Practice Gap

There is a dearth of simulation use in psychiatry residency training comparable to other medical specialties; scarcity might be related to the challenge of integrating the intricate psychological characteristics encountered in psychiatric care (1). The clinical care of patients with psychiatric illness however, can present a diagnostic challenge for the novice intern given the variability in exposure to psychiatric patients during medical school training (5). The use of simulation serves as a training tool to eliminate this vulnerability of psychiatric interns in dealing with complex symptoms in the context of psychiatric illness.

Abstract

The clinical care of patients with psychiatric illness can present a diagnostic challenge for the novice intern given the variability in exposure to psychiatric patients during undergraduate medical training (5). Simulation fosters ability to integrate didactic knowledge into critical skills in a controlled environment. A previous project on Standardization of the Psychiatric Resident Training Call program in which we developed a standardized curriculum for incoming interns (2). Extension of the project via a simulation approach stems from feedback received from the pilot intern group requesting practical demonstration of skills not easily mastered theoretically. This project investigated if a Simulation Lab would reduce steep learning curve and improve confidence among interns in handling variable psychiatric patient scenarios to further improve resident training and excellence in clinical care.

The Pilot Test was demonstrated during 2016 Intern Orientation Training, involving the interns as the pilot trainee group while the PGY 2-4's served as patient simulators and educator observers for debriefing (3).

A pre-intervention confidence survey was administered based on 6 clinical scenarios including suicide/homicide risk assessment, handling of critical cross-covers, AMA discharge, agitated patient, challenging team communication, and competence in interdisciplinary team interaction (4). A 14-item multiple choice questions were completed by trainees, followed by a brief presentation on cases after which trainees were still uncertain about competence on handling cases with no significant change from rating on pre-confidence survey. Participants proceeded through the simulated cases that were cloned as closely as possible to represent the ideal psychiatric patient interaction with standardized responses from simulators for equity in experience and data outcome. There were sub-stations following each of the 6 stations for answering questions from immediate clinical encounters. A post-intervention confidence survey was administered and data analyzed comparing the pre- and post-surveys using paired t-test.

6 out of 8 (75%) incoming interns participated. As expected the pre-test confidence levels were generally low (<2.0 points out of 5). The simulation intervention yielded

statistically significant 1.5 point increment in the handling of an AMA discharge (p=0.002), cross-covers (p=0.03) and an agitated patient (p=0.04) and 0.5 to 1.0 increment in other three areas with borderline significance. The average confidence level in handling an agitated patient was higher than those of the other clinical cases.

Practical simulation of patient scenarios as part of orientation demonstrates significant increase in the confidence of interns in translating acquired skills to real world patient care interaction.

The unexpected higher baseline confidence level in the handling of agitated patient suggests that the incoming interns might be feeling overconfident in this area given that the confidence level is lower in risk assessment. This may highlight the vulnerability of an overly confident attitude in novice clinicians in dealing with agitation in the context of psychiatric illness. The result should be interpreted with caution given limitation of small data.

We are currently piloting integrated simulation with emergency medicine interns and newly employed hospital nurses using professional standardized patients in a simulation lab controlled environment in collaboration with our simulation center.

Psychiatry Residents in Social Media (PRISM)

Presenters
Anne Leonpacher, MD, Johns Hopkins Medical Institutions (Co-Leader)
Matthew Peters, MD, Johns Hopkins Medical Institutions (Co-Leader)
Margaret Chisolm, MD, Johns Hopkins Medical Institutions (Co-Leader)

Educational Objectives

1) To examine resident attitudes and practices towards the use of social media in medical education
2) To explore feasibility of alternative methods of disseminating educational material in residency training

Practice Gap

Residents' schedules are rigorous and variable, and distributing resources for medical education to all residents within a program in a way that is accessible and engaging can be a challenge. One solution to this problem is the use of social media, an approach that allows residents to access information on their own time using a platform with which they often have some familiarity. However, despite social media use being ubiquitous in our culture - including among medical trainees - studies that examine the use of social media in graduate medical education (GME) are lacking, particularly in the field of psychiatry. Many medical specialties are now beginning to incorporate social media tools into GME and to investigate their impact on learners. For example, innovators in the field of Emergency Medicine (EM) have launched the Academic Life in Emergency Medicine website, which provides educational materials to EM trainees (and practitioners) around the world through multiple online platforms (e.g., blogs, podcasts, videos, and book/journal clubs), about which the site's creators have published. Similarly, educators in the Johns Hopkins Bayview internal medicine residency program created the Social Media and Resident Teaching for Medical Education initiative and launched a Twitter

page, posting messages, photos, videos, and links to educational content for their residents. By contrast, psychiatry has no comparable online project and little has been published in general on the use of social media in psychiatry GME, compared to other fields.

In an attempt to bridge this gap, the Psychiatry Residents Integrating Social Media (PRISM) research project was launched at Johns Hopkins University. PRISM is designed to: (1) examine Johns Hopkins psychiatry resident attitudes and practices towards the use of social media in medical education and (2) explore feasibility of alternative methods of disseminating educational material in psychiatry GME.

Abstract

Background: Residents' schedules are rigorous and variable, and distributing resources for medical education to all residents within a program in a way that is accessible and engaging can be a challenge. One solution to this problem is the use of social media, an approach that allows residents to access information on their own time using a platform with which they often have some familiarity. However, despite social media use being ubiquitous in our culture - including among medical trainees - studies that examine the use of social media in graduate medical education (GME) are lacking, particularly in the field of psychiatry. Many medical specialties are now beginning to incorporate social media tools into GME and to investigate their impact on learners. For example, innovators in the field of Emergency Medicine (EM) have launched the Academic Life in Emergency Medicine website, which provides educational materials to EM trainees (and practitioners) around the world through multiple online platforms (e.g., blogs, podcasts, videos, and book/journal clubs), about which the site's creators have published. Similarly, educators in the Johns Hopkins Bayview internal medicine residency program created the Social Media and Resident Teaching for Medical Education initiative, surveying residents before and after the launch of their Twitter page on attitudes and practices towards social media. By contrast, psychiatry has no comparable online project and little has been published in general on the use of social media in psychiatry GME, compared to other fields.

Purpose: The Psychiatry Residents in Social Media (PRISM) research project was created to: (1) examine resident attitudes and practices towards the use of social media in medical education and (2) explore feasibility of alternative methods of disseminating educational material in psychiatry GME.

Methods: The study was approved by the Johns Hopkins School of Medicine Institutional Review Board. Prior to and 6 months after the launch of the PRISM research project, psychiatry residents completed pre- and post-intervention surveys about their use of Twitter and other social media in medical education, including attitudes towards social media use and type and frequency of use.

Results: Response rate was 100% (n=49). Report of at least twice-weekly use of any social media for medical education purposes significantly increased post-intervention, from 4 (8.2%) to 9 (18.3%) ($p<0.005$). The use of Twitter for medical education and having an individual Twitter account also increased, from 4 (8.2%) to 14 (28.6%) ($p<0.01$) and 19 (38.8%) to 29 (59.2%) ($p<0.01$), respectively.

Discussion: Following the launch of PRISM, use of any social media for medical education, use of Twitter for medical education, and having an individual Twitter account all significantly increased, consistent with findings in other medical specialties.

Conclusions: Although this study suggests that social media use in psychiatry training is acceptable and feasible on a short-term basis, further research is necessary to assess whether use of Twitter and other social media platforms can be sustained over time, as well as the impact of such use on clinical knowledge/practice and patient outcomes.

Put Burnout in Jeopardy

Presenters
Wei Du, MD, Drexel University College of Medicine (Co-Leader)
Mark Messih, MSc,MD, Drexel University College of Medicine (Leader)

Educational Objectives
1) Discuss resident wellness and burnout
2) Promote discussion of institution level strategies for preventing burnout
3) Develop novel ways of engaging residents about wellness

Practice Gap
The aim of this paper is to address a gap of in program activities to educate about resident burnout. Existing literature has identified the necessity of dealing with burnout at the individual level and institutional level in residency programs. Also, research has show the impacts of not dealing with burnout on resident wellness. According to the APA, institutions must be engaged in the promotion of resident wellness, and an increasing number of programs are working to that end. This represents the first use of a jeopardy style group activity to promote wellness.

Abstract
Burnout amongst physicians in training has received increasing attention by residency programs. Incidents of medical student and resident depression and suicide have fueled the development of residency wellness programs and resources for practicing clinicians as well. Burnout can been defined as a multidimensional concept with components of exhaustion, depersonalization and a low sense of personal accomplishment. Burnout has been linked with lowered job satisfaction and productivity; increased levels of depression, suicidality and even cardiovascular disease and inflammatory markers. At the institution level, programs are devising novel ways of promoting wellness. In one study, 70% of psychiatry residents reported experiencing burnout and 14% reportedly felt depressed. Surveyed program directors identified lack of time for self-care, conflicting responsibilities at home and work and lack of mentoring or guidance as contributing factors. Accordingly, there has been more focus on this area at the training level and at a larger professional level as well. In this paper, we put forward a novel group based intervention to engage residents across all years of the Drexel University General Adult Psychiatry Residency Training Program about wellness and burnout. In this approach, the program developed a Jeopardy style group exercise with categories related to burnout and wellness. After, a group survey was administered to all residents who participated to assess the efficacy of this exercise and hear any recommendations on how to build on this project. developed a Jeopardy style trivia game which had 5 categories divided into 10,20,30,40 and 50 point questions. These categories were; Burnout, Wellness, Relaxation, Personality Burnout and “Double Jeopardy”. Residents across four years of the training program were present for weekly didactics and played the game. This exercise presents a novel method of educating residents about wellness

and burnout through group gameplay and discussion. Based on resident feedback, the Jeopardy format was effective about relaying information about what burnout is and how to identify in one's self and peers. The Double Jeopardy questions, which received the highest score, were also the most vigorously debated and discussed questions, suggesting that the more interactive the experience, the more enjoyable and memorable the questions were to participants. Moving forward, residents wanted more information on ways of dealing with stressors and discussion of systemic issues such as duty hours that can contribute to stress. We believe that this exercise can be easily improved based on resident feedback and incorporated into a broader wellness curriculum

Research Watch: Development and Impact of a Resident-led Research Newsletter

Presenters
Awais Aftab, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Leader)
Cathleen Cerny, FAPA,MD, Case Western Reserve University/University Hospitals of Cleveland Program (Leader)

Educational Objectives
1) understand the development and structure of a resident-led research newsletter
2) appreciate the educational impact of a resident-led research newsletter
3) recognize that resident-led research newsletters could be another potential tool for educators in residency training

Practice Gap
The idea of a research digest is not new. A number of journals, newsletters, and professional services are devoted to this task – and many provide their products for a fee. The format and scope of these digests vary considerably. Here, we describe an initiative entitled Research Watch which differs from established publications because it is led by residents and is directed primarily at an audience of residents. Such resident-led research digests in psychiatry residency programs are uncommon, and to the best of our knowledge, the educational impact of such an initiative on resident learning has not been reported before.

Abstract
Introduction and Development: Research Watch is a monthly newsletter created and managed by psychiatry residents at University Hospitals Cleveland Medical Center/Case Western Reserve University. It aims to inform residents & faculty of notable articles published in prominent psychiatry journals. Such resident-led research digests in residency programs are uncommon, and to the best of our knowledge, the educational impact of such an initiative on resident learning has not been reported before. A dedicated team of curators, headed by a chief curator, reviews psychiatry research journals, and provide concise summaries of the results and findings. This project was launched in August 2016. The curator team under the guidance of chief curator selects key psychiatric journals and divides them amongst curators for review. A regular feature titled "Highlights" further synthesizes the key points of each reviewed article, creating a high-yield section that is quick to read. Once assembled, the newsletter is circulated via

email to the residents and faculty. Of note, this research digest has been lauded as valuable by Ohio Psychiatric Physicians Association, and all issues of the e-publication are available for viewing on their website. We wondered if this project has had an impact on the scholarly interests and productivity of our trainees. By means of a self-report resident survey, we set out to investigate this question. We hypothesized that the newsletter exerts educational impact with a dose-response relationship.

Methods: An anonymous, voluntary paper questionnaire was distributed to all psychiatry residents at the program. The survey inquired about the degree of exposure (quantified as ‘exposure index’) and contribution to the newsletter. A set of questions asked residents to estimate how much of the improvement they attributed to the influence of the newsletter, rating the attribution between 0% and 100%, in the areas of interest in scholarly activities/research, knowledge of current psychiatric research, participation in scholarly activities/research. The survey also inquired if the newsletter had any impact on their clinical practice.

Results: Of 29 residents in the program who received the survey, 27 (93%) responded. The percentage of residents reporting perceived non-zero impact of the newsletter on specific areas of improvement was as follows: interest in scholarly activities/research (44%), knowledge of current psychiatric research (48%), participation in scholarly activities/research (40%), and clinical practice (40%). Exposure index significantly and positively correlated with self-reported percentage attribution for knowledge (correlation coefficient 0.422, p value 0.028) and self-reported impact on clinical practice (correlation coefficient 0.660, p value 0.000), and degree of contribution significantly and positively correlated with self-reported percentage attribution for knowledge (correlation coefficient 0.488, p value 0.010).

Conclusions: Resident-led research newsletters can have a positive perceived impact on the residents' interest, knowledge and participation in research, as well as a positive perceived impact on clinical practice.

Resident Attitudes Concerning Physician Mental Health

Presenters

David Roane, MD, Mount Sinai Beth Israel (Co-Leader)
Marla Shu, MD, Mount Sinai Beth Israel (Co-Leader)
Lisa Botticelli, MA, No Institution (Co-Leader)
Aryandokht Fotros, MD, University of California, San Diego (Co-Leader)
David D'Souza, MD, Mount Sinai Beth Israel (Co-Leader)

Educational Objectives

1.To understand the major obstacles that prevent resident physicians from accepting mental health treatment
2. To have increased awareness of factors that can promote resident acceptance of mental health treatment
3. To learn to be more effective advocates of resident mental health treatment at teaching institutions

Practice Gap

Resident physicians have high rates of depression and the transition to residency is marked by an increased frequency of depressive symptoms. Previous research has demonstrated that 'lack of time', 'stigma', and other factors account for the low rate of mental health treatment in residents. However, these studies are generally limited to single institutions or have relatively low response rates among surveyed residents. Further, most studies focus on barriers to treatment and do not emphasize potential ways to promote treatment acceptance. This poster will present survey results that will help psychiatrist educators to better understand why residents avoid treatment and how these educators can best promote treatment at their institutions. This will enable psychiatrist educators to be more successful advocates for the mental health of physicians at the beginning of their careers.

Abstract

Background: Recent studies show that physicians have elevated rates of suicide as compared to the general population. Furthermore, physicians and medical students have low rates of help-seeking for mental illness. Preliminary studies show most common reasons for not seeking help for depression include: lack of time, lack of confidentiality, stigma, cost, and fear of documentation on academic record. In this cross-sectional study, we attempt to further characterize medical residents' attitudes about mental health issues facing physicians.

Methods: Medical trainees (PGY1-5) at Mount Sinai Beth Israel, Mount Sinai St. Luke's and West, and University of California San Diego were recruited for voluntary participation during grand rounds and required didactic lectures. Residents completed a 22-item questionnaire administered anonymously on personal electronic devices that included questions to ascertain their attitudes about help-seeking behaviors and coping strategies. Basic demographic information was also obtained.

Results: 316 residents from multiple specialties responded to the questionnaire. Of 18 presentations that included only residents, 236 out of 269 completed the survey yielding a response rate of 87.8%. Within the additional 6 presentations that included medical students, fellows, and faculty members, overall response rates ranged from 76.9-100%. A majority of 69% of residents surveyed responded, that if faced with depressive symptoms, house staff would most likely "cope with it alone". When asked about barriers to seeking treatment, the highest rated responses for the most significant hindrance were lack of time (42%) and stigma (36%). Residents indicated that their own most effective strategy for coping with stress involved connecting with friends and family (51%). Based on rank ordered responses to the attitude questions, ANOVA analysis showed that female residents were significantly more likely than male residents to indicate that easy access to mental healthcare would encourage them to seek help for depression ($p<0.01$). Conversely, males were significantly more likely than females to say that the urgings of their supervisors would encourage them to seek treatment ($p<0.01$). Furthermore, residents aged over 30 were significantly more likely than those 30 and under to indicate that acceptance of treatment in the workplace would encourage them to seek help for depression ($p<0.02$). Preliminary analysis found no association between PGY level of training or specialty and attitude question responses.

Discussion: To our knowledge, this is the first multi-site survey of residents' attitudes about mental health with a high response rate. Our findings suggest that most residents cope with depression all by themselves and that stigma continues to play a significant factor in decision making about treatment seeking for depression. Improving access to mental health services might encourage more residents (especially females) to seek treatment.

Residents Across Specialties Have Limited Education Regarding Family Planning and Contraceptive Use in Patients with Severe and Persistent Mental Illness

Presenters
Matthew Macaluso, DO, University of Kansas School of Medicine, Wichita (Leader)
Christina Bowman, MD, University of Kansas School of Medicine, Wichita (Leader)
Donna Sweet, MD, University of Kansas School of Medicine, Wichita (Leader)
Rosey Zackula, MA, University of Kansas School of Medicine, Wichita (Leader)
Christina Bourne, MD, University of California, Davis (Co-Leader)

Educational Objectives
1. Assess the adequacy of training across multiple specialties regarding family planning and contraceptive use for patients with Severe and Persistent Mental Illness (SPMI).
2. Evaluate resident knowledge, attitudes, and comfort level regarding family planning and contraceptive use in SPMI populations.
3. Identify barriers that limit residents from providing effective counseling on family planning and prescription of contraceptives for patients with SPMI.

Practice Gap
One of the Healthy People 2020 goals is to improve pregnancy planning and spacing, and prevent unintended pregnancy. This mandate includes vulnerable patient populations with special healthcare needs, such as those with Severe and Persistent Mental Illness (SPMI), who represent about 4.9% of the adult population in the United States (9.8 million adults). (Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Individuals with severe and persistent mental illness (SPMI) have complex symptoms and require ongoing treatment, typically with varying types and dosages of medication. Prescribing contraceptive medication to patients with SPMI requires knowledge and understanding of drug-drug interactions, drug-disease interactions, cost considerations, and issues with adherence. Lack of knowledge and training in these areas may lead to patient harm or unsafe prescribing practices. Residency curriculums across specialties should include training and education on these topics.

The primary goal of this study is to assess adequacy of training in the areas of contraceptive prescribing and family planning for patients with SPMI. This includes resident comfort level with prescribing contraceptives to patients with SPMI. The secondary goal is to explore resident knowledge, attitudes, and behaviors towards patients with SPMI and to identify barriers to providing effective counseling on family planning and prescription of contraceptives.

Abstract
OBJECTIVE: We surveyed residents from multiple specialties across the United States to assess their perceived adequacy of training regarding the reproductive health needs of patients with SPMI.

METHODS: We emailed survey invitations to a convenience sample of residency programs in internal medicine, family medicine, obstetrics/gynecology, and psychiatry within the United States. Program coordinators with access to email listings forwarded a survey link to their current residents. 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 contraceptive use in patients with SPMI. Residents did not have to answer all questions to participate. The University of Kansas Human Subjects Committee approved the study.

RESULTS: Responses were collected over a two-month period in 2016; 791 residents consented to participate. All submitted surveys were included in the analysis. The majority of responses came from Family Medicine (44.1%), followed by Obstetrics and Gynecology (25.7%), Internal Medicine (15.7%), and Psychiatry (14.5%). Responses by residency year included 27.3% from first year residents, 30.9% from second year residents, 30.4% from third year residents, and 11.4% from fourth year residents. Over 60% of all respondents “disagree” or “strongly disagree” that they received adequate training on the prescribing of contraceptives for patients with SPMI. More than 88% “agree” there should be “coordinated care between primary care providers and mental health providers regarding contraceptive use in SPMI patients”; about 72% believed family medicine should be the primary specialty. Over 51% of participants stated they would be “willing to prescribe contraception to SPMI patients if they had adequate training during residency.” Residents appear to have varying attitudes towards contraception: 50% of residents “strongly agree” that “SPMI patients are sexually active,” and over 43% “agree” the “rates of unintended pregnancies are prevalent in the SPMI population.” Over 64% of residents were “neutral” or “disagree” when asked if “hormonal contraception was contraindicated in patients taking antipsychotic medication.” Regarding training barriers almost 40% of residents reported “limited training regarding types of contraception that are appropriate for SPMI patients.” Over 38% reported they were “unsure of drug interactions” and 38% reported “limited training about the reproductive health needs of SPMI patients.”

DISCUSSION/CONCLUSION: Residents across specialties agreed education and training on contraception in the SPMI patient population was lacking. The willingness of most residents to prescribe contraception is encouraging; however, they reported a need for more education and training.
One limitation of our study was the inability to calculate a response rate; program coordinators with access to email listings sent the survey link to an unknown number of residents, which could have biased the sample. Regardless, results indicate the need for additional education and training regarding contraceptive use in the SPMI population. We hope that by identifying this gap in knowledge, education and training, that residency programs will modify their curricula to allow for additional training regarding the health care needs of the SPMI population.

Sketches & Squiggles: Comics in Child & Adolescent Psychiatry Pedagogy

Presenters
Craigan Usher, MD, Oregon Health Sciences University (Leader)
Anandam Hilde, MD, MPH, Oregon Health Sciences University (Co-Leader)
Timmi Claveria, MD, Oregon Health Sciences University (Co-Leader)
Jennifer Chaffin, MD, Oregon Health Sciences University (Co-Leader)
Paria Zarrinnegar, MD, Oregon Health Sciences University (Co-Leader)

Educational Objectives
Viewers of this poster will be able to:
1. Define the term graphic medicine.
2. Understand how comics distill the complexity of these registers of human experience through it's own artistic language: thought bubbles, an array of symbols that convey feelings—such as beads of sweat emanating from one's temples to convey nervousness, and behavior—including speech bubbles or actions—often shown through motion lines.
3. Describe the uses and limitations of using children's drawings as an assessment of cognitive skills and as psychological projectives.
4. List three ways in which comics can be useful in medical and psychiatric pedagogy.

Practice Gap
For many years, comics have been used by medical educators to help medical students and residents to reflect upon their experience, promoting a sense of professional identity and empathy--for patients and for one another. We used comics in this way and advance the notion that understanding the "language of comics" is a way of "drawing" children, teens and families into the therapeutic work. To our awareness, this is the first time a poster on the use of comics in child and adolescent psychiatric pedagogy has been presented at AADPRT.

Abstract
Graphic medicine is a relatively new term which describes a wide range of practices in the medical humanities and medical education—chiefly using graphic novels which vividly capture patients' and family members' experiences to promote empathy and asking learners to draw their own cartoons and comics, promoting self-reflection (1-4). In this poster presentation we reflect on the power of drawings and sequential art in child and adolescent psychiatry. We note that comics are a powerful psychoeducation tool and should, as Art Spiegelman (author of Maus) notes, really be called "co-mix" as they are a blend of words and images that paradoxically separate and integrate thoughts, emotions, somatic feelings, speech, actions and relationships and have the potential to vividly represent the biopsychosocial roots of mental illness and treatment in a manner that text alone cannot (5,6).

In this poster we will:
--explore some static and dynamic uses of drawings in the assessment of children
--offer ways in which comics may be used in child and adolescent psychotherapy
--discuss learning activities where drawing and comics proved useful in our child and adolescent psychiatry fellowship
--highlight texts that explore the subjective experience of trauma, loss, living as a gender

non-conforming individual, or of managing various medical and psychiatric illnesses, promoting a developmental understanding and helping students/residents/fellows enjoy an empathic view (7,8).

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Stability of and Pre- and Intra-Medical School Factors Influencing Psychiatry Specialty Choice: Analysis of AAMC Survey Data

Presenters

Matthew Goldenberg, MSc,MD, Yale University School of Medicine (Leader)
D. Keith Williams, PhD, University of Arkansas for Medical Sciences (Co-Leader)
John Spollen, MD, University of Arkansas for Medical Sciences (Co-Leader)

Educational Objectives

Participants will be able to:
1. Describe the stability rate of psychiatry specialty choice from matriculation to graduation and how that compares to other specialties.
2. List of factors that are significantly associated with eventual psychiatry specialty choice and how those factors differ between people that either chose psychiatry or another specialty at matriculation.

Practice Gap

There is a shortage of mental health specialists, including psychiatrists, in the US health system. Recruitment of medical students into psychiatry has long been important to psychiatric educators and has increasingly become a priority of health policy makers as well. The percentage of U.S. seniors choosing psychiatry has recently been between 4 and 5% and only 50-62% of residency positions have been filled with graduates of allopathic US medical schools since 2011. Understanding the timing and stability of and factors related to student career choice could aid in the development of recruitment and mentoring strategies to increase the number of students choosing psychiatry. One potential strategy could be to attract to medical school those students who are more likely to choose psychiatry. An alternative approach could be to target recruiting efforts at those already matriculated medical students, particularly those who might be most amenable to changing to psychiatry.

Previous studies of specialty choice timing and stability have yielded varied results. A survey of students at 15 US medical schools found that for most specialties, including psychiatry, only a quarter to a third of students maintained their initial specialty interest through graduation. A more recently published study of Canadian medical students suggested that about half of students in all disciplines were consistent in their specialty preference, with the highest stability found in family medicine. Another study found that 45 percent of students correctly predicted their ultimate specialty choice at matriculation and nearly 70 percent did so prior to beginning their clinical clerkships. None of these studies were sufficiently powered to determine whether students choosing psychiatry differed from other students in the timing or stability of their choice.

A student's choice of medical specialty is often multidetermined—a combination of student characteristics, values and needs, medical school experience/curricula and perceptions of specialties. Several small studies have examined factors related to a choice of psychiatry including student level factors (e.g. demographic, educational background and experience) and school-level factors. A number of small studies have identified several potentially significant factors but all of these studies had either a limited scope or low number of participants.

In order to generate a sufficiently large and representative sample of students choosing psychiatry, a national dataset is required. The Association of American Medical Colleges (AAMC) conducts annual surveys of medical students at all allopathic medical schools at the beginning of medical school with the Matriculating Student Questionnaire (MSQ) and then at the end of medical school with the Graduation Questionnaire (GQ). Both surveys include an item on preferred specialty in addition to a variety of items related to pre- and intra-medical school experiences. We sought to utilize this large dataset to evaluate psychiatry specialty choice stability, what types of specialties students who eventually switched to psychiatry initially preferred, and what of a long list of potentially relevant factors included in AAMC surveys were associated with eventual psychiatry specialty choice to better inform recruitment efforts.

Abstract

Background: Psychiatry is a shortage specialty internationally. In the US, on average only about 4 percent of medical school graduates enter psychiatry residencies. Understanding factors associated with choosing psychiatry may inform recruitment strategies. We sought to examine the timing and stability of student career choice of psychiatry compared to other medical specialties and determine what pre-medical

school and medical school factors, obtained from annual surveys by the Association of American Medical Colleges (AAMC), were associated with eventual career choice of psychiatry.

Methods: We used linked demographic information, matriculation student questionnaire (MSQ) and graduation questionnaire (GQ) survey data from 29,714 students who graduated medical school in 2013 and 2014 and completed at least one of the surveys. We determined the rates of psychiatry specialty choice at both beginning and end of medical school and the stability of a specialty choice of psychiatry. A logistic model was employed to estimate the multivariate adjusted level of association of 29 factors with a student's choice of psychiatry versus all other fields. Recursive partitioning analysis was used to find combinations of variables that predicted psychiatry specialty choice.

Results: The percentage of students who indicate specialty choice of psychiatry increases considerably (from 1.6% to 4.1%) over the course of medical school. Just over half (50.2%) of those indicating a preference for psychiatry at matriculation ultimately chose the specialty, a rate of stability higher than any other specialty. Only 20.6 % of future psychiatrists indicated a choice of psychiatry at the beginning of medical school. Students who switched their preference to psychiatry initially preferred internal medicine (18.1%), pediatrics (14.8%), family medicine (9.3%) and neurology (8.4%) among other specialties. Among students who preferred psychiatry at matriculation, the only significant factor associated with psychiatry specialty choice at graduation was having significant pre-med exposure to LGB people (OR=1.85). Among students who preferred something other than psychiatry at matriculation, the factors most associated with eventual psychiatry specialty choice included highly valuing work-life balance (OR=2.83), a student's rating of the psychiatry clerkship as excellent (OR=2.63) and having an undergraduate psychology degree (OR=1.89). Recursive partitioning analysis identified clerkship ratings, valuing work-life balance, having a Bachelors of Arts undergraduate degree and being open to different perspectives as factors that could be used to predict statistically higher and lower recruitment rates.

Conclusions: Students who entered medical school with an interest in psychiatry were rare but over half of them chose choose psychiatry at graduation, a stability rate higher than any other specialty, indicating that recruiting more medical students with an initial interest in psychiatry would likely increase recruitment rates. However, most students who became psychiatrists made that decision during medical school. Using our findings, potential strategies to increase recruitment rates would include increasing the number of students with a Bachelor of Arts or psychology degree, providing an excellent psychiatry clerkship experience, and discussing favorable work-life balance issues in psychiatry with uncommitted students.

Supportive Psychotherapy in Child and Adolescent Psychiatry Training: A Needs Assessment

Presenters
Lauren Havel, MD, No Institution (Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives

After viewing this poster, participants will: 1) be familiar with recent research in general residents' and supervisors' perceptions of supportive psychotherapy supervision in acute clinical settings; 2) be able to describe the perceptions of child and adolescent psychiatry fellows regarding supervision on similar services; 3) appreciate the need for further study and implementation of tools to address gaps in training.

Practice Gap

The ACGME and the Psychiatry Residency Review Committee (RRC) recognize the importance of supportive psychotherapy in residency training and note it as a core psychotherapy. Furthermore, its importance in acute settings, those in which psychiatric trainees are often practicing, has long been recognized [1,2]. In training, supportive psychotherapy is the most frequently used by residents, but receives less didactic time and supervision than other core psychotherapies [3]. Recent studies have identified a similar mismatch, particularly in acute psychiatric settings. A local survey of Columbia Psychiatry general residents regarding their overall training in supportive psychotherapy showed that trainees identified the greatest need for more supervision in supportive psychotherapy on the consultation-liaison (CL) and inpatient services [4]. A follow-up needs assessment, including both residents and supervisors, closely mirrored these results [5]. A national survey of US Psychiatry Residency training directors showed there is interest in teaching supportive psychotherapy in inpatient and CL and inpatient settings, but identified major barriers to doing so [6]. Taken together these data suggest that this mismatch between the need for and provision of supportive psychotherapy supervision on acute clinical services may be widespread and amenable to an intervention to improve training.

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Abstract

Background: Our group has been conducting studies of resident training in supportive psychotherapy over the past two years, which identified similar results in both local and national surveys. Given the consistency of the results, we wondered whether a similar training gap existed in other types of training programs. In child and adolescent psychiatry (CAP) training, trainees are expected to provide psychotherapy on several types of acute psychiatric services. We decided to conduct a needs-assessment survey of CAP residents. Our first aim was to characterize supportive psychotherapy training and supervision in the first year, when trainees are working on the types of acute services that have previously been identified as areas in which trainees have wanted

more supervision. Second, we hope to implement an educational intervention to address the perceived gaps in training.

Methods: We designed and distributed an anonymous, online survey to CAP residents. The survey included questions regarding their satisfaction with their supportive psychotherapy training on the three types of services in the first year (CL, inpatient, emergency room), barriers to supportive psychotherapy supervision, and other types of psychotherapy supervision they received in the first year. Residents were only prompted to answer questions on those rotations they had completed. Based on the results of these surveys, an educational intervention will be developed and implemented on selected clinical services. A follow-up survey will be conducted to assess the impact of this intervention.

Results: 78% (21 of 27) of CAP residents surveyed responded to this survey. We defined “insufficient” supportive psychotherapy supervision as either no supervision or supervision that was not characterized as sufficient by the CAP resident. Using those criteria, 54% reported insufficient supportive psychotherapy supervision on their inpatient rotations, 70% on their CL rotations, and 93% on their emergency rotations. Trainees felt that supportive psychotherapy was most relevant on inpatient and CL rotations and wanted to learn more on these services. They identified barriers to learning supportive psychotherapy including lack of emphasis on service and time demands. Trainees did note other types of psychotherapy supervision they received on acute services, most importantly family therapy and CBT. Overall, 90% of second year fellows felt their psychotherapy supervision in the first year was not sufficient. Further data regarding a targeted intervention and its results will be available by the time of poster presentation.

Conclusions: Based on the results of both local and national survey studies, a gap in psychotherapy training in adult and child and adolescent psychiatry programs has emerged. Residents, particularly on inpatient and consultation-liaison services, feel in need of increased supportive psychotherapy supervision. This gap is an opportunity for the implementation of an educational tool that will target the identified barriers.

Teaching medicine in a psychiatry residency: A medical consultation service by psychiatriy residents for psychiatric inpatients

Presenters
Panagiota Korenis, BS,MD, Bronx Lebanon Hospital (Leader)
Jeffrey Levine, MD, Bronx Lebanon Hospital (Co-Leader)

Educational Objectives
To educate residency directors about innovative strategies to teach primary care to psychiatry residents.

Psychiatry residents have found it valuable to learn about managing medical conditions in the psychiatric population. In addition, this has also proven to be an effective way to address the challenge of improving health care for this population who is at risk of receiving suboptimal medical care.

Practice Gap

Psychiatry residents do not develop sufficient competence in managing common medical conditions which have extraordinarily high prevalence among patients with chronic mental illness. Currently, little evidence exists regarding the manner in which psychiatry residents in training are taught primary care. Here we present an innovative teaching model that has shown to help psychiatry residents learn how to manage medical conditions in psychiatric patients.

Abstract

Individuals with chronic mental illness frequently suffer from co-occurring medical illnesses, including hypertension, diabetes, hyperlipidemia, hepatitis, and HIV/AIDS and others. As a result, patients with chronic mental illness die on average fifteen to twenty-five years earlier than persons without mental illness. Disparities in health care for this vulnerable population are well described. Because of these urgent needs, integration of health and mental health care is a recognized national priority. Currently, the Accreditation Council for Graduate Medical Education (ACGME) describes core program requirements for psychiatry residents that include four months of training in a primary care setting to learn about medical conditions and their management. While the ACGME has developed criteria about the duration and type of training, individual institutions determine the manner in which they carry out the rotation within their residencies. In most facilities, psychiatry residents rotate on acute hospital services alongside family medicine or internal medicine residents. Little research exists about the effectiveness of this approach in developing competency or about variations in this clinical rotation. There are concerns that the duration and setting of such training are inappropriate for the modern expectations that practicing psychiatrists will be competent to assume responsibility for managing chronic medical illnesses in mental health setting. In an attempt to address this challenge, we have developed a unique rotation in which psychiatry residents fulfill part of their general medical training under the supervision of generalist physicians while providing medical consultation to psychiatry inpatients in the very setting in which they also are learning psychiatry. We hypothesize that state dependent learning will promote the development of competency and confidence among our residents to assume increased responsibility for the provision of medical care to their chronically mentally – and medically – ill patients.

Methods: Approximately 1080 psychiatric patients were consulted on by the medical consult service from 2015-2017. An anonymous survey of the residents who completed this unique rotation was conducted and compared to an anonymous survey of psychiatry residents who were not exposed to this rotation. In addition, a survey of the Attending Psychiatrist's perspective of care of medical issues on the inpatient psychiatric unit was also conducted to ascertain their satisfaction with the service..
Results: Psychiatry residents who completed this rotation found benefit to treating the medical conditions of patients who have mental illness and better appreciate the challenges that exist when providing medical care to those with mental health issues.

Teaching Practice-Based Learning on Inpatient Psychiatric Services

Presenters
Agnes Kalinowski, PhD,MD, Stanford University School of Medicine (Leader)
Kristin Raj, MD, Stanford University School of Medicine (Co-Leader)
Belinda Bandstra, MA,MD, Stanford University School of Medicine (Co-Leader)

Educational Objectives
After this poster session, the participant will:
1) Gain familiarity with Active Learning Principles.
2) Describe a successful format for teaching practice-based learning, alongside medical knowledge, in a group setting on the inpatient units.
3) Recognize opportunities for incorporating these strategies in a variety of patient-care centered settings to rapidly educate in new topics in psychiatry.

Practice Gap
Given that the information base of psychiatry is rapidly evolving and growing, there is a need for psychiatrists to be able to adeptly identify knowledge gaps and incorporate new information into their clinical practice. Indeed, the ACGME mandate to teach Practice-Based Learning, and in particular the “development and execution of lifelong learning through constant self-evaluation, including critical evaluation of research and clinical evidence” (Psychiatry Milestones PBLI1), is reflective of the importance of this skill. We provide inpatient psychiatry trainees a novel team-based opportunity to practice patient-centered, self-directed learning. Since this learning experience occurs on a busy inpatient unit, residents get practice rapidly researching a topic in the medical and scientific literature immediately applicable to the care of an inpatient.
This opportunity has also provided a venue for the incorporation of new topics into the educational experience quickly, as compared to formal long-range didactics. This also allows for rapid incorporation of pieces of learning modules, such as from the National Neuroscience Curriculum Initiative.

Abstract
Background:
Active learning techniques for education have been extensively validated in undergraduate education in STEM, and increasingly in medical education. Problem- and team-based learning strategies are more effective than traditional approaches and cultivate a culture of lifelong practice-based learning, essential for medical professionals. Here, we present a method of incorporating active learning principles such as brainstorming learning objectives, case-based problem solving, and peer instruction in the setting of an academic inpatient psychiatry unit.

Method:
The learning experience occurs over a 2-consecutive-day period, with a 1-hour session each day. An assigned resident introduces a patient case currently on the unit. The patient is interviewed either by another resident or an attending. Then, the case is discussed and residents brainstorm learning objectives. The session leader consolidates the learning objectives and assigns a narrow topic for each of 3 inpatient teams, consisting of 2 residents and 1-3 medical students, to research. The following session,

each team presents their findings, with discussion encouraged and mediated by the session leader.
After the experience, each resident and medical student is provided an anonymous survey to complete. The survey assesses perceptions regarding how engaged they were in the learning experience and how effective they found the experience. They are also asked to note which ACGME Core Competency Areas were addressed in the session.

Results:
We will present a list of topics generated in these sessions over the course of a year, to demonstrate the breadth of inpatient topics addressed by this educational series. Thus far, these have included: Perimenopause and Menopause and its Relationship to Psychiatric Symptoms; Capacity and Competency; Suicide Risk Factors; the Role of Epigenetics in Psychiatric Presentations; Treatment of OCD; and Depression Treatments that Target the Neural Circuit. The session leader has integrated brief learning modules from the National Neuroscience Curriculum Initiative when applicable. We will also present results of the survey. In preliminary findings (11 total residents surveyed thus far), residents rate the learning as experience as engaging, 4.45/5 +/- 0.52, a score of 1 as “Strongly Disagree” and a score of 5 as “Strongly Agree;” and effective, 4.0/5 +/- 1.1 on the same scale. Similarly, medical students rate the learning as experience as engaging, 4.4/5 +/- 0.7, and effective, 4.0/5 +/- 0.7. 100% of residents and medical students stated that the session addressed the “Medical Knowledge” ACGME Core Competency and 73% of residents and 60% of students stated that the session addressed “Practice-Based Learning and Improvement.” 36% of residents and 50% of medical students stated that the learning experience addressed “Patient Care.”

Conclusion
Overall, both medical students and residents find the learning experience to be engaging and effective. The major Core Competencies that are addressed are Medical Knowledge and Practice-Based Learning and Improvement. This novel approach, based on evidence-based active learning principles, is feasible to implement on a busy inpatient unit, provides residents an opportunity to build their practice-based learning skills and allows residents to learn new topics, such as clinically-oriented neuroscience, readily.

The Dr. June Jackson Christmas Medical Student Summer Fellowship: Guiding the Flow of the Pipeline Towards Psychiatry

Presenters
Patrice Malone, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Stephanie LeMelle, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Jean-Marie Alves-Bradford, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Catherine Lowenthal, BS, Columbia University/New York State Psychiatric Institute (Co-Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Leader)

Educational Objectives

After viewing this poster, attendees will: 1) Have an increased awareness of the dearth of ethnic and racial diversity in the profession of psychiatry and 2) Appreciate the feasibility of developing a program of their own to recruit, encourage, and support minority medical students interested in psychiatry.

Practice Gap

In 1991, the AAMC launched a national campaign to increase enrollment of underrepresented minority (URM) medical students matriculating in medical school from 1,485 to 3,000 by year 2000 call Project 3000 by 2000. Unfortunately, instead of an increase in URM enrollment there was a dramatic decline as a result of bans on affirmative action in many states. For instance, in California, Florida, Texas and Washington there was a 27.5% and 30% drop in Latino and African-American enrollment in medical schools. In 2012, 16% of the US population was Latino and 14% African-American, but constituted 9% and 7%, of medical students.

Medical schools have been actively trying to increase the diversity of their students through a number of initiatives. Of course, there is a trickle-down effect that extends to residency programs, making some medically specialties disproportionately underrepresented in terms of minorities (1). In psychiatry residency programs, for instance, African-Americans and Latinos consist of 8.4% and 7.4% of the residents (2). It is imperative to increase the diversity of mental health providers, because we know this is key in reducing mental health care disparities. This is due in part to the idea that minority providers treat a higher proportion of minority patients (3-4). Moreover, the ethnic match between providers and clients encourages patients to stay in treatment.

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Abstract

Background: As an outreach effort to provide minority students with additional exposure to psychiatry, we created a five-week summer program for medical students from underrepresented racial and ethnic groups. Students rotated on five different clinical sites: mobile crisis, outpatient, inpatient, the comprehensive psychiatric emergency program, and the consult liaison psychiatric service. In addition, they were paired with a resident or fellow mentor, participated in didactics, and went on weekly site visits to other treatment settings in the community such as a shelter housing individuals with dual diagnoses and a forensic facility, all in an effort to reinforce and broaden their interest in psychiatry.

Methods: A website was designed describing the five-week summer experience for students between their first and second years of medical school. Information about the program was sent through various list serves, as well as directly to Offices of Diversity of

medical schools all around the country. Twenty-five applications were received. An application review committee was assembled that ranked the top ten applicants who were subsequently interviewed via video conferencing. Five applicants were invited to participate in the program of which all five accepted. At the start and end of the five-week program the applicants were polled on their attitudes, knowledge, and expectations regarding a career in psychiatry and the program experience. Survey questions were rated on a five-point Likert scale with 5 representing strongly agree and 1 strongly disagree.

Results: During the initial survey, all of the medical students indicated that they had a desire to learn more about psychiatry. Every participant ranked the clinical rotation as the most useful component of the summer program. Out of the five medical students, two ranked the didactics and two ranked the site visits in the community as the second most influential part of their summer experience. By the end of the program the average answer for "I am confident that I am going to pursue psychiatry as a career" moved from 4 to 4.6.

Conclusions: The five-week summer program that we designed, created an opportunity for medical students from historically underrepresented racial/ethnic groups to experience the breadth of psychiatry from mobile crisis teams in the community to state forensic units. This more comprehensive clinical experience than what they would normally receive during their psychiatry clinical clerkship appears to have influenced their thoughts of choosing psychiatry as a profession. However, follow-up in six months, a year, and then after residency match will ultimately determine the influence this program may have had on their choice of medical specialty.

The Good, the Bad, and the Worthy: A Pilot e-Professionalism Curriculum for General Psychiatry Residents

Presenters
Marika Wrzosek, MD, Medical College of Wisconsin (Leader)

Educational Objectives
After viewing this poster, participants will be able to:
1. Understand the components of one program's curriculum to teach e-professionalism
2. Utilize aspects of this curriculum at their home institution
3. Apply feedback from this curriculum to improve didactic programs at home institutions

Practice Gap
87% of physicians use social networking sites for personal purposes, and 67% use them for professional reasons. The ACGME now identifies Milestones related to online professionalism in the professionalism and interpersonal communication skills subcompetencies. Despite the surge in social media use among physicians, unpublished data that has been presented at several annual meetings of professional organizations demonstrate that only 8 adult psychiatry residency training programs have a dedicated (formal) curriculum on the topic. Those programs that do have a formal curriculum utilize the published AADPRT guidelines, while others depend on guidelines from the American Psychiatric Association. Many other residents are teaching e-professionalism in smaller, less formal fora. Given the need to teach this critical topic in a formal setting, the author

presents a pilot e-professionalism curriculum implemented over the 2015-2016 academic year at a small residency program.

Abstract
It is crucial for psychiatry residency educators to ensure psychiatry trainees, many of whom are digital natives, can navigate an ever-present online influence while upholding the ethics of a field where privacy is paramount. Given that all programs are required by the ACGME to ensure residents are skilled in navigating online professionalism, and that only a small minority of programs in the United States actually have a dedicated, formal curriculum to the topic, the author now presents a pilot curriculum to teach e-professionalism.

In the 2015-2016 academic year, all 16 general psychiatry residents were required to attend a newly implemented e-professionalism course, held over 10 sessions spaced our over the academic year. The course objectives focused on appreciating and understanding the theoretical and practical aspects of professionalism and online professionalism, then applying those principles to participants' own behavior, especially as they related to practice in an increasingly digital world. Each segment had session objectives that supported the course objectives, and the format was one of small group discussion, large group discussion, with brief didactics and pre-readings.

Pre/post feedback was solicited for each session, and an overall evaluation was obtained near the conclusion of the course. The course had the highest attendance of all didactics offered, despite initial resistance. All respondents (n=14) reported that the course met its stated objectives. Feedback also showed that changing the timing and frequency of sessions would help, but that the 90-minute segments allowed sufficient time for discussion. The majority of respondents felt the highly interactive, discussion based format was effective, and that the course should be continued, though with certain logistics adjusted to better fit the schedule. The author encourages other programs to use the curriculum components and further refine this pilot curriculum.

The Role of the Vice Chair for Education in Departments of Psychiatry

Presenters
Deborah Cowley, MD, University of Washington Program (Leader)
Gregory Dalack, MD, University of Michigan (Co-Leader)
Jon Lehrmann, MD, Medical College of Wisconsin (Co-Leader)

Educational Objectives
1. Based on surveys of Chairs and Program Directors, identify how commonly Departments of Psychiatry have a Vice Chair for Education.
2. Describe the role and responsibilities of the Vice Chair for Education, according to Chairs and Program Directors.
3. Discuss themes regarding the advantages and disadvantages of having a Vice Chair for Education, as perceived by Chairs and Program Directors.

Practice Gap

Increasingly, Departments of Psychiatry are appointing Vice or Associate Chairs for Education. Although there is some literature discussing the role and responsibilities of the Vice Chair for Education in Departments of Medicine and Surgery, there is none that we know of regarding this role in Departments of Psychiatry. This poster will present results of national surveys of Chairs (AACDP members) and Program Directors (AADPRT members) regarding whether their departments have a Vice Chair for Education, the role and responsibilities of this person, and advantages and disadvantages of having an individual in this position.

Abstract

Increasingly, Departments of Psychiatry are appointing Vice or Associate Chairs for Education. However, little is known about how commonly Departments of Psychiatry have a Vice Chair for Education, the defined roles and responsibilities associated with this position, the FTE allocated, or the advantages and disadvantages to Chairs and Program Directors of having an individual in this position. Here, we present results of identical surveys regarding the role of the Vice Chair for Education administered to Chairs of Departments of Psychiatry and Psychiatry Residency Directors in April-May 2016. Respondents were 62/111 Chairs or Interim Chairs who were members of the American Association of Chairs of Departments of Psychiatry (AACDP; 55.8% response rate) and 97/220 general psychiatry residency directors who were members of AADPRT (44.1%). 56.7% of Chairs and 66.1% of residency directors stated that their department had a Vice Chair for Education and in 47% of cases this was also the general psychiatry residency director. There was a written job description for the Vice Chair for Education in less than 20% of cases. The FTE allocated for the position ranged from 0.10-0.75 FTE. Roles and responsibilities included oversight and development of educational programs, faculty development and mentorship, promotion of educational scholarship, and responsibility for the department's education budget. Chairs and residency directors provided narrative responses regarding advantages and disadvantages of having a Vice Chair for Education. Major themes common to and differing between these two groups will be presented.

The Yale Clinical and Academic Skills Enhancement (CASE) selective: Engaging in scholarship

Presenters

Dolores Vojvoda, MD, Yale University School of Medicine (Leader)
Gerrit Van Schalkwyk, MBBS, Yale University School of Medicine (Co-Leader)
Theddeus Iheanacho, MBBS,MD, Yale University School of Medicine (Co-Leader)
Robert Rohrbaugh, MD, Yale University School of Medicine (Co-Leader)
Vinod Srihari, MD, Yale University School of Medicine (Co-Leader)

Educational Objectives

After viewing this poster, attendees will be:
1. Understand the importance of scholarship within the core competencies of a graduating resident psychiatrist
2. Understand an exemplar approach to embedding meaningful experiences in scholarship within a General Adult Residency training program.

Practice Gap

Core requirements articulated by the ACGME for all physician trainees include specific language on the need for training in or exposure to research or scholarship:

Medical Knowledge
IV.A.5.b).(3).(i).(iii) The program must provide residents with research opportunities and the opportunity for development of research skills for residents interested in conducting research in psychiatry or related fields. The program must provide interested residents access to and the opportunity to participate actively in ongoing research under a mentor. If unavailable in the local program, efforts to establish such mentoring programs are encouraged.

IV.B. Residents' Scholarly Activities
IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
IV.B.2. Residents should participate in scholarly activity.
IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities."1

While there is broad agreement on the importance of research to the scientific basis of psychiatric practice, there is no consensus on the extent to which residents in general adult psychiatry programs (or indeed in any other medical specialty) should actively participate in scholarly activities and how best to plan curricula around this objective. With the rapid growth of research activity in neurobiology, including domains such as genetics and neuroimaging and other relevant domains of scholarship in anthropology, sociology, philosophy and cognitive science, there is an urgent need to address this gap and thereby better prepare graduates to at least understand, if not participate in, the salient debates that will influence the development of psychiatric practice over their careers.

Abstract

Background: Residency training is a period of intense exposure to a wide variety of clinical settings. Trainees typically learn a little about a lot of topics. In contrast, the capacity to deepen understanding of a more focused area –or to engage in scholarship – is comparatively challenging to implement within crowded clinical training workflows. Furthermore, residents arrive with a wide variety of scholarly interests and abilities. Significant flexibility and tailoring of the curriculum is required to optimize learning.
In 2006, Yale's Department of Psychiatry established the 3-month PGY2 CASE selective with >85% time spent away from usual clinical activities. Elective time in the PGY 3 and 4 years is available to continue projects begun during CASE. This poster will detail the curricular implementation and lessons learned.

Methods: A curriculum is an 'educational theory in action'2. The main elements of the CASE curriculum thus include:
(a) WHAT will be learned: Scholarship in CASE is defined broadly,3 and includes understanding a basic disease process, exploring applied clinical questions, synthesizing a body of work, or developing tools for teaching. Examples of these (in the same order) include: attending and presenting at the 'lab meetings' of a translational research group, developing a protocol for a clinical trial, writing a review to educate colleagues or developing teaching materials for patients.

(b) HOW such learning will occur: Learning is structured around 3 components:
(i) Meetings with the CASE Director to ensure personalized support, and head off barriers ranging from conceptual to logistical (e.g. change in topic or mentor, lack of computer access).
(ii) Faculty mentorship. A key component with trainees expected to spend most (>75%) of their time in activities overseen by the research mentor and his/her laboratory.
(iii) Clinical experience: either in a screening clinic or an equivalent half-day/week experience tailored to the trainee's interests or deficits.
(c) ASSESSMENT of individual learning and EVALUATION of the curriculum is centered on (formative) peer review of a written/spoken product. Such 'products' are presented at the end of CASE and can range from a research protocol, a draft journal article, educational slides or informational materials for patients.

Results: Ten generations of residents have rotated through CASE. A rich variety of traditional scientific papers, review articles, book chapters, narrative pieces and slides for classroom teaching have resulted. Several lessons have been learned. The availability of an appropriate mentor and a focused project were identified as key ingredients for success, but some trainees struggled with one or both. In response to this, in 2015 a new 4-week PGY1 rotation was implemented. Trainees near the end of the PGY-1 year now have dedicated time (>75%) to develop a draft proposal and finalize a mentor for CASE.

Discussion/Conclusions: CASE has enabled meaningful scholarship during residency training. Projects and mentoring relationships begun in CASE often continue beyond residency training. A broad notion of scholarship, protected time and an educational experience that is carefully tailored to individual trainee interest can produce a rich and unexpectedly productive engagement with scholarship for most residents.

Towards the Development of a Gold Standard Method for Evaluating Psychiatry Residents as Teachers

Presenters
David Latov, MD,BA, Columbia University/New York State Psychiatric Institute (Leader)
Mimi Levine, BA,MD, Columbia University/New York State Psychiatric Institute (Leader)
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives
To develop a consensus agreement on assessable teaching skills relevant to psychiatry residents for the purpose of developing an observed structured teaching examination for psychiatry

Practice Gap
ACGME has identified teaching as an important resident skill (1). The Psychiatry Milestone project specifically included "development as a teacher" and "observable teaching skills" as milestone domains (2). While evidence suggests that the majority of psychiatry training programs provide formal teaching for residents about how to teach,

these methods are heterogeneous, as is the evaluation of residents' teaching skills (3). Regarding the latter, it was found that few programs utilize observed structured teaching examinations or video and audiotape observations, which are considered some of the most highly valid and reliable tools for resident skill assessment (3,4). One of these tools, the Objective Structured Teaching Examination (OSTE), has been used in internal medicine, pediatrics, and obstetrics and gynecology residencies to help residents learn how to teach effectively and improve their skills in this area (5,6). Given the low use of structured teaching assessments in psychiatry residency programs, the OSTE could be an effective intervention to address this need.

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Abstract

Residents serve a crucial role in the education of medical students. While there are numerous tools available for evaluating residents' teaching abilities, the objective structured teaching examination (OSTE) is considered to be the gold standard, as it allows for direct observation and objective evaluation of several elements of teaching. The OSTE has been adapted for use in internal medicine, family medicine, pediatrics, and obstetrics and gynecology residencies to evaluate and improve trainee teaching skills, and to study the effectiveness of residents-as-teachers interventions in multiple randomized controlled trials (RTCs) in those fields. To our knowledge, the OSTE has never been adapted for psychiatry, and is not transferrable in its current form. A psychiatric OSTE would allow for a standardized method of assessing residents' abilities to teach, and could be used both to provide feedback for improvement and to assess the effectiveness of psychiatry residents-as-teachers interventions in RCTs. Barriers to the development of this OSTE include lack of consensus agreement on skills to be tested, as well as implementation costs and resources. The aim of the present study is to develop OSTE stations, which will reflect teaching skills relevant for psychiatry residents. In line with literature from other specialties, we will conduct a focus group study of medical students, residents, and attendings to arrive at consensus recommendations. These recommendations will be used in future implementation studies, with the goal of developing a cost-effective, reproducible, standardized assessment that can be used to evaluate both residents and teaching interventions in psychiatry.

Using the Program Evaluation Committee to Meet Maintenance of Certification Part IV Requirements for Faculty

Presenters
Matthew Macaluso, DO, University of Kansas School of Medicine, Wichita (Leader)
Gretchen Dickson, MD, University of Kansas School of Medicine, Wichita (Co-Leader)
Nancy Davis, PhD, University of Kansas School of Medicine, Wichita (Co-Leader)

Educational Objectives
1. Describe the American Board of Psychiatry and Neurology (ABPN) and American Board of Family Medicine (ABFM) requirements for Maintenance of Certification (MOC) Part IV, performance in medical practice (PIP).

2. Review the Accreditation Council for Graduate Medical Education (ACGME) requirements for the Program Evaluation Committee (PEC).

3. Illustrate how the Program Evaluation Committee (PEC) can be used to meet Maintenance of Certification (MOC) Part IV (performance in medical practice) requirements for faculty in psychiatry and family medicine.

4. Use the PEC to evaluate clinical based performance, implement an improvement plan, and re-evaluate results at regular increments.

Practice Gap
Residency program faculty have busy schedules including clinical practice, resident supervision and teaching, research and scholarly activity. Each of these domains has specific regulatory requirements including those set out by the ACGME, the Center for Medicare and Medicaid Services (CSM), and the Office for Human Research Protections, to name a few. Maintenance of certification (MOC) is a recently released requirement of physicians certified by the member boards of the American Board of Medical Specialties (ABMS), which includes the ABPN and ABFM. Physicians must meet maintenance of certification requirements including continuing medical education (CME) requirements, self-assessment, and performance in medical practice in order to remain certified by their specialty board. MOC Part IV, performance in medical practice, targets performance improvement and involves examining practice habits, developing an improvement plan, and re-evaluating specific metrics at a pre-determined time in the future. The process has been questioned both in terms of validity and the time commitment required. The goal of this program is to create efficiencies by using existing processes aimed at quality improvement to help physicians meet performance in medical practice requirements for MOC Part IV. The program evaluation committee (PEC) is an ACGME requirement in all programs and involves evaluating clinically based performance parameters, developing an improvement plan, and re-assessing those parameters on a regular basis. At our institution, we have developed a process for board-certified physician faculty who participate in the PEC to document their work to meet MOC Part IV requirements.

Abstract
OBJECTIVE: To create efficiencies, we used the program evaluation committee (PEC) to help physician faculty meet Maintenance of Certification (MOC) Part IV requirements for performance in medical practice (PIP). The PEC is a committee that oversees quality

improvement of clinically based training, which has significant overlap with the requirements for MOC Part IV. This ensures the continued competency of residents, safety of patients, and quality of care provided.

METHODS: The PEC is an ACGME required committee tasked with systematically evaluating the clinical curriculum at least annually, with the goal of continued program improvement. The PEC evaluation includes the following items, which can be used by physician faculty to meet MOC Part IV requirements as approved by our University, which is an approved sponsor of the ABMS Multispeciality MOC Portfolio Program to provide MOC credit for PIP.
1. Resident evaluation of faculty including faculty knowledge, teaching ability and professionalism.

2. Resident evaluation of the program including resources and patient safety.

3. Evaluation of program processes directly related to patient safety including patient handoff, resident and faculty burnout, and documentation.

4. Evaluation of clinical experiences, service lines, and clinical practice as they pertain to the residency program.

5. Evaluation of ITE scores

This is not an exhaustive list of the PEC's task, but are the items we focused on relative to MOC Part IV requirements. For each area, we developed performance measures, benchmarks and targets for improvement. Different tasks of the PEC could be used to meet MOC requirements.

DISCUSSION/CONCLUSION: Our institution approved the PEC process as meeting the MOC Part IV requirements for performance in medical practice, which creates efficiencies for faculty while maintaining an environment for continued review of practice and quality improvement.

Virtual Coffee: A Program Administrator Professional Development Webinar Series

Presenters
Aparna Sharma, MD
Michelle Armstrong, MD
Tara Lauriat, MD

Educational Objectives
1. Identify a new opportunity for professional development throughout the year. 2. Describe ways that program administrators can contribute to the field beyond their role at their institutions. 3. Identify technological resources that can be used to host professional development webinars.

Practice Gap
There is a significant lack of professional development opportunities and resources available to help the program administrators to advance their careers. Continuing education is required for ongoing certification by Training Administrators of Graduate Medical Education (TAGME). Some administrators are unable to attend the annual meeting and others have few opportunities throughout the remainder of the year. Moreover, much of the training that is offered by stakeholder organizations is focused on keeping administrators up to date with new accreditation requirements and policies. Faculty members and residents have opportunities to attend leadership development programs; program administrators need similar opportunities. Without programs of this nature, many program administrators will find it difficult to advance in their careers.

Abstract
Introduction: Program Directors and Program Administrators are the key to the success of a residency or fellowship program. Program Administrators play a key role in managing residency training programs as they provide the administrative support and along with the program directors ensure implementation of ACGME milestone project. From focus groups at the ACGME workshop: Building Effective Programs Together, Program Directors would like to see the administrators building a united public front, serve as the accreditation guru, be involved in strategic planning and overall curricular goals of the program and contribute towards the shared vision of program goals.

Methods: The Program Administrator Professional Development Committee has established a new webinar series called “Virtual Coffee”. The series provides ongoing education throughout the year organized entirely by program administrators. With the official recognition of coordinators as administrators by AADPRT, the first session included a guest speaker with extensive experience in coordinator professional development who provided suggestions on getting institutions to recognize the administrator language and role. The second session focused on writing and publishing in Graduate Medical Education and featured a retired coordinator who wrote a handbook for coordinators and the editor of her books. The committee utilized a variety of technologies to host the webinars, offer online registration, and disseminate surveys to collect participant feedback.

Conclusion: Overall feedback has been positive and program administrators are eager to have additional sessions. Costs are minimal and thus the sessions can be offered free of charge and with no external funding. Notably, the committee received no support from faculty members or technology experts. Once fully established, the program may serve as a model for coordinator associations in other specialties. References: O'Sullivan, Patricia S., et al. "Educational development program for residency program directors and coordinators." Teaching and learning in medicine 18.2 (2006): 142-149. Bland, Carole. "Effective approaches to faculty development." Models that Work (1998): 14.

Skills Fair for Training Directors

Presenters: Consuelo Cagande MD, Donna Sudak MD, Suzanne Murray MD, Melissa Arbuckle MD PhD, Julie Penzner MD, Marcia Verduin MD, Chandlee Dickey MD PhD, Sandra DeJong MD, Erica Shoemaker MD, Michael Jibson MD, PhD

Educational Objectives:
At the end of this session, participants will:

1) Have new or improved proficiency in 3 core skills essential to efficient and effective functioning as a training director
2) Be able to identify at least two ways in which they could use these improved/acquired skills to improve their functioning as a training director

Practice Gap:
Psychiatry training directors are trained in psychiatry and, to some extent, graduate medical education. Few are trained in the sorts of logistical skills needed in order to function successfully and efficiently as a training director. The kinds of skills needed have changed significantly over time, particularly given the advent of technology and the changing landscape of healthcare and graduate medical education. Training directors need quick, efficient updates in the following key skills: management of the application process, maintaining their wellness, and promoting scholarship among residents.

Abstract:
Workshops will be offered in areas of management of the application process, maintaining their wellness, and promoting scholarship among residents. There will be three rooms, each focused on one of these areas:

1. Drownproofing for the Application Flood: These presentations will cover how to use ERAS to screen hundreds of applications, how to assess international graduate applicants, and how to remain compliant with the NRMP.
2. Program Alchemy: Turing Residents into Scholars: These presentations will cover how to nominate residents for awards, how to teach residents to do a literature search, and how to teach residents to publish case report.
3. Put Your Oxygen Mask on First: Wellness for the Program Director: These presentations will cover use of yoga and mindfulness to sustain wellness, effective time management, and use of peer mentoring for mutual care.

2017 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	Grant/Research	Consultant	Major Stockholder	Other financial or material support
Steven Chan, MD	UC Davis, American Psychiatric Association/SAMHSA			Employed by University of California, and see patients as a contracted physician of HealthLinkNow. I write for and edit posts on The Doctor Weighs In, and they allow me to cover conferences with free admission, but they do not provide financial reimbursement.
Josepha Cheong, MD				Employed by: Nashville VA Medical Center and University of Florida Psychiatry
Hector Colon-Rivera, MD			GE	
Hsiang Huang, MPH, MD		TCPI APA from CMS		
Michael Jibson, PhD, MD				Royalties from Up-to-Date chapters on antipsychotics
David Kaye, MD	Pfizer, NYS Office of Mental Health	HealthNow		
Matthew Macaluso, DO	Alkermes, Allergan, AssureRx, Eisai, Forum, Lundbeck, Janssen, Naurex/Aptinyx			
Vishal Madaan, MD	Purdue, Sunovion, Pfizer, Allergan, Medgenics, CureMark			Royalty: Taylor & Francis (Routledge)
Anna Ratzliff, PhD, MD	APA-SAN from CMS	Community Health Plan of Washington		Spouse employed by Allergan
Michael Travis, MD	NIMH R25 MH101076 02S1, and R25 MH086466 07S1			

GEORGE GINSBERG, MD
FELLOWSHIP AWARDEES

Award Winner/Program	*Region/Training Director*
Rustin Carter, MD **PGY 3** University of Texas Health Sciences Center Houston, TX	**Region V: Southeast** Iram Kazimi, MD
Abhisek "Chandan" Khandai, MD PGY 3 Northwestern University Chicago, IL	**Region IV: Midwest** Joan Anzia, MD
William Bradley Pitts, MD PGY 4 Tripler Army Medical Center Tripler, HI	**Region VII: Far West** Judy Kovell, MD
Misty Richards, MD, MS PGY 5/Fellow UCLA Semel Institute Los Angeles, CA	**Region VI: California** Sheryl Kataoka, MD
Desiree Shapiro, MD (2016 winner) PGY 5/Fellow Rady Children's Hospital San Diego, CA	**Region VI: California** Jay Giedd, MD
Bryce Wininger, MD PGY 4 Georgetown University Medical Center Washington, DC	**Region III: Mid Atlantic** Mayada Akil, MD

George Ginsberg, MD Fellowship Committee Chair: Timothy Sullivan, 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.

NYAPATI RAO AND FRANCIS LU INTERNATIONAL MEDICAL GRADUATE (IMG) IN PYSCHIATRY FELLOWSHIP AWARDEES

Award Winner/Program	*Training Director/Region*
Toral Desai, MD PGY 5/Fellow University of Virginia Health System Charlottesville, VA	**Region V: Southeast** Roger C. Burket, MD
Srinath Gopinath, MBBS PGY 5/Fellow SUNY Downstate Medical Center Brooklyn, NY	**Region II: New York** Romain Branch, MD
Fabiano Nery, MD, PhD PGY 5/Fellow University of Cincinnati Medical Center Cincinnati, OH	**Region IV: Midwest** Brian Evans, DO
Maria "Loly" Rubio, MD, PhD PGY 4 Massachusetts General Hospital/McLean Adult Psychiatry Boston, MA	**Region I: New England** Felicia Smith, MD
Geetanjali Sahu, MBBS PGY 4 Maimonides Medical Center Brooklyn, NY	**Region II: New York** Joseph Carmody, MD

Nyapati Rao and Francis Lu IMG Fellowship Committee Chair: Vishal Madaan, 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.

PETER HENDERSON, MD
MEMORIAL PAPER AWARDEE

Kristen Eckstrand, MD
PGY 2
Western Psychiatric Institute and Clinic
Pittsburgh, PA
Training Director: Mike Travis, MD
Region III: Mid Atlantic

Paper Title: "Social Reward and Adolescent Sexual Behavior"

Abstract
Limited neurodevelopment research exists on adolescent risky sexual behavior, yet such behavior can lead to significant physical and mental health consequences. Developing neurocircuitry underlying sexual risk behaviors suggests that increased reward responsiveness – particularly to peer social reward – contributes to risky sexual behavior. Typically developing adolescents (*N*=47; 18M, 29F; 16.3±1.4 years) completed a social reward fMRI task and the Youth Risk Behavior Survey (YRBS). Activation and functional connectivity analyses compared response to social reward between adolescents with higher- and lower-risk sexual behavior. Adolescents with higher-risk sexual behaviors demonstrated increased activation in the right precuneus and the right temporoparietal junction during receipt of social reward compared with adolescents with lower-risk sexual behaviors. Greater functional connectivity was observed between the precuneus and the temporoparietal junction bilaterally, dorsal medial prefrontal cortex, and left anterior insula/ventrolateral prefrontal cortex. Greater activation and functional connectivity in self-referential, social reward, and affective processing regions in response to social reward among adolescents engaging in higher-risk sexual behaviors underscore the importance of social influence underlying sexual risk behaviors. Further, these results suggest an orientation towards and sensitivity to social rewards among youth engaging in higher-risk sexual behavior, perhaps as a consequence of or vulnerability to such behavior. Mental health professionals, including psychiatrists, should receive training in how to evaluate the perception, impact, and consequences of peer influence among children and adolescents to develop effective interventions targeting risky sexual behavior and promote health sexual development in youth.

Peter Henderson, MD Memorial Paper Committee Chair: Arden Dingle, MD

The Henderson Award was established by AADPRT to honor the memory of Peter B. Henderson, MD, Director of Residency Training in General and Child Psychiatry at the University of Pittsburgh, and Past President of AADPRT. Peter devoted his career and energy to psychiatric education and guided and mentored countless residents and junior faculty members. He pioneered an integrated residency curriculum that blended the best of adult, child, and adolescent psychiatric education. His vision, persistence, and charm were the major forces leading to child psychiatry training directors becoming full partners in AADPRT. Dr. Henderson died in 1986 at the age of 47. This award recognizes the best-unpublished paper on a child or adolescent psychiatry topic submitted by a resident in psychiatry, child and adolescent psychiatry, or psychiatric subspecialty.

ANNE ALONSO, PhD
MEMORIAL AWARDEE

Michael Laney, MD
PGY 4
University of Texas Southwestern Medical School
Dallas, TX
Training Director: Adam Brenner, MD
Region V: Southeast

Paper Title: "Jorge Luis Borges and the Psychoanalytic Encounter"

Introduction

Almost from the beginning, literature and literary thinking have served as justifications and catalysts for psychoanalytic thought. The theories and practices born from Sigmund Freud's self-analysis found validation in the canonical works of the western tradition, which could even be seen as providing frameworks for his understanding (Sprengnether, 2012). Thomas Ogden, a psychoanalyst writing more than a century later (2001, pp. 13-14), describes poetry and fiction "not only as sources of pleasure, but also as sources of disturbance." In the spirit of catalyst and disturbance, this paper will interpret the literary works of Jorge Luis Borges, particularly his ideas about the nature of memory, identity, reality, and fantasy, in the context of the psychoanalytic encounter. In doing so, I hope to show how his literary imagination can both enrich and challenge the way we think about the kind of work we do.

Jorge Luis Borges, born in 1899, was one of the great writers of the twentieth century and is best known for his short prose texts that use absurd situations to investigate the experience we have of ourselves and the world (Williamson, 2013). Among his contributions to literature was to illustrate how a text is radically altered by the context in which it is read, and in effect to make the reader "critically aware of his or her own process of reading" (Nicol, 2009, p. 61). In this way, Borges dealt some of the most artistic blows to positivism, a mindset in Freud's world that assumed the independence of the text from the reader, the researched from the researcher. In many ways, this contribution of Borges will be the unifying, interpretive stance from which we will view the frequent juxtaposition of his work and ours.

Borges was skeptical of psychoanalysis and particularly of its founder, whom he considered a madman. In his kindest appraisal, he called psychoanalysis nothing more than "a kind of mythology, or a kind of museum or encyclopedia of curious lores" (Burgin, 1969, p. 109). Borges' antagonism to psychoanalysis had much to do with his suspicions about the integrity of the self and the role that memory played in its constitution. In "The Nothingness of Personality" (1922/1999, p. 3), he condemned personality as a "mirage maintained by conceit and custom" and rejected memory as the basis for personality. He wondered what was to be made of those "elapsed instants that, because they were quotidian or stale, did not stamp us with a lasting mark" (p. 4).

It is precisely these piled-up instants and their memory conscious or otherwise that are examined in two of his greatest works, "Pierre Menard, Author of the *Quixote*" (1941/1998) and "Funes, His Memory" (1944/1998). Taken together, they will be used to enrich a way of thinking about how these piled-up instants, buried in the unconscious, can be shared in that space between patient and analyst.

Borges' artistic elaborations will continue to intersect the psychoanalytic encounter as he writes about the influence that seemingly autochthonous fantasy worlds, cryptic and labyrinthine, can have on our reality, an influence often recognized too late. This theme will

be addressed more fully in our investigations of “Tlön, Uqbar, Orbis Tertius” (1941/1998) and “The Garden of Forking Paths” (1941/1998), two fictions that detail the haunting incursions of these fantasy worlds into the real and provide a dramatic stage for our epistemological doubts even as they point toward how that space between patient and analyst stimulates change.

Along the way, we will have brief, but relevant, interludes of certain psychoanalytic and philosophical writers whose works have some bearing on the issues being explored. These writers will be speaking from different eras and orientations, but all have something to say about the problems that confront both Borges and us.

Anne Alonso, PhD Memorial Award Committee Chair: Robert Waldinger, MD, MBA

This award is given for the best unpublished paper on psychotherapy written by a resident, was originally named in honor of Frieda Fromm-Reichmann, MD. The award now recognizes Dr. Anne Alonso, a gifted psychotherapist, teacher, supervisor, and Clinical Professor of Psychology in Psychiatry at the Harvard Medical School. When Dr. Alonso died in 2007 The Endowment for the Advancement of Psychotherapy (EFAP) and AADPRT thought it most fitting to rename the award in her honor.

VICTOR J. TEICHNER
AWARDEE

Caroline Fisher, MD, PhD
Psychiatry Residency Training Director
Samaritan Health Services Psychiatry Residency Program
Corvallis, OR

Victor J. Teichner Award Committee Co-Chairs: Sherry Katz-Bearnot, MD; Gene Beresin, MD

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.

THE LUCILLE FUSARO MEINSLER PSYCHIATRIC RESIDENCY PROGRAM ADMINISTRATOR AWARDEE

Juliet Arthur, BS, MHA
Senior Staff Assistant/Residency Program Coordinator
SUNY Health Science Center at Brooklyn
Brooklyn, NY
Training Director: Romain Branch, MD
Region II: New York

The Lucille Fusaro Meinsler Psychiatric Residency Program Administrator Recognition Award Committee Chair: Nancy Lenz, BBA, C-TAGME

The Lucille Fusaro Meinsler Psychiatric Residency Program Administrator Recognition Award recognizes a psychiatry residency program administrator'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 program administrator meetings.